1980

Attitudes of Psychologists, Mental Health Clients and State's Attorneys in Illinois Towards Confidentiality and Third Party Disclosure

Helen Pugacz Appleton  
Loyola University Chicago

Recommended Citation
https://ecommons.luc.edu/luc_diss/2010

This Dissertation is brought to you for free and open access by the Theses and Dissertations at Loyola eCommons. It has been accepted for inclusion in Dissertations by an authorized administrator of Loyola eCommons. For more information, please contact ecommons@luc.edu.  
Creative Commons License  
This work is licensed under a Creative Commons Attribution-Noncommercial-No Derivative Works 3.0 License.  
Copyright © 1980 Helen Pugacz Appleton
ATTITUDES OF PSYCHOLOGISTS, MENTAL HEALTH CLIENTS AND
STATE'S ATTORNEYS IN ILLINOIS TOWARDS
CONFIDENTIALITY AND THIRD PARTY DISCLOSURE

by

Helen Pugacz Appleton

A Dissertation Submitted to the Faculty of the Graduate School
of Loyola University of Chicago in Partial Fulfillment
of the Requirements for the Degree of
Doctor of Philosophy

December
1980
ACKNOWLEDGMENTS

I am grateful to Dr. James Johnson for his advice and encouragement during the preparation of this dissertation and throughout my graduate student career. I thank Dr. Eugene Kennedy, from whom I learned the essence of psychotherapy, and Dr. LeRoy Wauck for their recommendations, pertinent ideas and helpful comments. Dr. Gerard Egan deserves thanks for his suggestions on the committed secret as does Dr. Frank Slaymaker for his advice on experimental design. Appreciation is extended to Ms. Carol Hurt for her help with the data analysis and to Ms. Gale Draper for typing this manuscript.

Finally, I thank the Mental Health Centers of Central Illinois for sponsoring this research project and the psychologists, State's Attorneys and mental health clients who participated in this study.
DEDICATION

This dissertation is dedicated to my parents, Myron and Alice Pugacz, whose love, guidance and encouragement gave me the necessary tools to pursue this task, and to my husband, Tom, whose love, understanding and support provided the atmosphere for attaining this goal.
VITA

The author, Helen Pugacz Appleton, was born on December 20, 1949, in Alexandria, Virginia.

She attended grade and high schools in Hamilton, Ohio, and Downers Grove, Illinois, and graduated from high school in Naperville, Illinois in 1968.

In May, 1972, she received a Bachelor of Arts degree in Psychology from Augustana College, Rock Island, Illinois.

In September, 1972, she began graduate studies in clinical psychology at Loyola University of Chicago. In February, 1977, she was awarded the Master of Arts degree in Psychology.

From June, 1973, to September, 1973, she served a psychology clerkship at West Side Veteran's Administration Hospital in Chicago. She also served a second year clerkship in 1974 and a psychology internship from October, 1974 to August, 1975 at West Side Veteran's Administration Hospital. An internship in child psychology was served at Loyola Child Guidance Center and Day School from September, 1975 to May, 1976.
Since August, 1976, Ms. Appleton has been employed as a therapist at Mental Health Centers of Central Illinois, Springfield. She was a part-time instructor in the Psychology Department of Sangamon State University, Springfield, from January, 1980, to May, 1980. She has been a part-time consultant on the children's unit at Andrew McFarland Mental Health Center, Springfield, since February, 1980.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACKNOWLEDGMENTS</td>
<td>ii</td>
</tr>
<tr>
<td>DEDICATION</td>
<td>iii</td>
</tr>
<tr>
<td>VITA</td>
<td>iv</td>
</tr>
<tr>
<td>LIST OF TABLES</td>
<td>ix</td>
</tr>
<tr>
<td>LIST OF FIGURES</td>
<td>x</td>
</tr>
<tr>
<td>CONTENTS OF APPENDICES</td>
<td>xi</td>
</tr>
</tbody>
</table>

Chapter

I. INTRODUCTION ........................................ 1

II. REVIEW OF RELATED LITERATURE ..................... 7

Confidentiality - A Recent Issue ........................ 7
  Growth of Mental Health Care .......................... 7
  Increased Interest in Privacy ........................ 18
  Increased Requests for Information .................... 22
Confidentiality - A Moral and Historical Perspective ........................................ 26
  A Brief History of the Seal of Confession ............ 28
  Similarities in the Discussions on Confidentiality and the Seal of Confession ............. 33
Confidentiality - A Psychotherapeutic Perspective ........................................ 50
  Major Theorists-Practitioners ........................ 50
  Basic Texts and Manuals ................................ 59
  Research Pertinent to Confidentiality ................ 62
  Codes of Ethics ...................................... 64
Confidentiality - A Legal Perspective: Privacy ........................................ 67
  Tort Law ............................................ 68
  Constitutional Law ..................................... 71
  Illinois Law ......................................... 76
Tarasoff v. Regents of the University of California ........................................ 82
Confidentiality - Legal Cases ........................................ 85

vi
TABLE OF CONTENTS (continued)

Summary ........................................ 90
Confidentiality - A Legal Perspective: Privileged Communication ............... 90
  History of Privileged Communication ........................................... 91
  Lifschutz ........................................... 96
  Illinois Law ......................................... 101
  Summary ........................................... 107

III. INTEGRATION AND HYPOTHESES ............................................. 109
  Psychotherapist Reaction ....................................................... 110
    Overall Effect of Laws ....................................................... 110
    Effects of Specific Laws .................................................... 115
    Effects of Disclosing Information .......................................... 127
  Client Reaction ...................................................... 128
    Overall Effect of Laws ....................................................... 128
    Effects of Specific Laws .................................................... 134
    Effect of Having Information Disclosed .................................... 137
    Hypotheses ...................................................... 138

IV. METHOD .................................................. 143
  Subjects .................................................. 143
  Design Overview ..................................................... 145
  Materials ..................................................... 145
  Procedures ..................................................... 149

V. RESULTS .................................................. 151
  Manipulation Check ..................................................... 151
  Evaluation of Hypotheses .................................................... 151
  Other Findings of Interest .................................................. 164

VI. DISCUSSION ............................................... 174
  Psychologists ........................................... 174
  Type of Information ..................................................... 178
  Recipient of Information ................................................... 180
  Subjects ..................................................... 184
  Conclusions and Recommendations ............................................ 189

SUMMARY .................................................. 194
REFERENCES .............................................. 196
<table>
<thead>
<tr>
<th>TABLE OF CONTENTS (continued)</th>
</tr>
</thead>
<tbody>
<tr>
<td>REFERENCE NOTES</td>
</tr>
<tr>
<td>APPENDIX A</td>
</tr>
<tr>
<td>APPENDIX B</td>
</tr>
</tbody>
</table>
LIST OF TABLES

<table>
<thead>
<tr>
<th>Table</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Analysis of variance summary table for type of information and recipient of information for psychologists, clients and State's Attorneys</td>
<td>154</td>
</tr>
</tbody>
</table>
# LIST OF FIGURES

<table>
<thead>
<tr>
<th>Figure</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Mean Information Opinion Indices for each type of information for each subject group and all subjects combined</td>
<td>156</td>
</tr>
<tr>
<td>2.</td>
<td>Mean Recipient Opinion Indices for each recipient of information for each subject group and all subjects combined</td>
<td>159</td>
</tr>
<tr>
<td>3.</td>
<td>Mean Recipient Opinion Indices for each recipient of information for each type of information</td>
<td>172</td>
</tr>
</tbody>
</table>
## CONTENTS OF APPENDICES

<table>
<thead>
<tr>
<th>Appendix A</th>
<th>Illinois Law on Confidentiality</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>I.</td>
<td>Physician-Patient Relationship</td>
<td>208</td>
</tr>
<tr>
<td>II.</td>
<td>Psychiatrist-Patient Relationship</td>
<td>209</td>
</tr>
<tr>
<td>III.</td>
<td>Disclosure of Information by Psychologist</td>
<td>210</td>
</tr>
<tr>
<td>IV.</td>
<td>Social Workers - Disclosure</td>
<td>211</td>
</tr>
<tr>
<td>V.</td>
<td>Confidentiality Act</td>
<td>212</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Appendix B</th>
<th>Survey Materials</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>I.</td>
<td>Cover Letter I</td>
<td>222</td>
</tr>
<tr>
<td>II.</td>
<td>Survey of Opinion - Form A</td>
<td>223</td>
</tr>
<tr>
<td>III.</td>
<td>Survey of Opinion - Form B</td>
<td>225</td>
</tr>
<tr>
<td>IV.</td>
<td>Demographic and Additional Information Form</td>
<td>227</td>
</tr>
<tr>
<td>V.</td>
<td>Cover Letter II</td>
<td>228</td>
</tr>
</tbody>
</table>
CHAPTER I

INTRODUCTION

The purpose of this dissertation is to examine the issues of confidentiality and privileged communication in psychotherapy. The term "confidential communication" is generally used to describe those statements that are told with the belief and trust that the other person will keep them private. In psychotherapy, there is an implicit understanding that the therapist will maintain the privacy of all statements the client makes. The term "privileged communication" is more specific in its use in that it refers only to communications that are protected from use as evidence in a legal proceeding. Depending upon the specific situation and the law of each state, statements a patient makes in psychotherapy may or may not be privileged communication or legally respected as private.

The term "psychotherapy" is derived from the Greek words "psyche" and "therapeia", meaning "spirit, soul" and "to nurse, cure", respectively, or "cure of the spirit". Webster (1970) defines "psychotherapy" as treatment of mental disorder by any of various means involving communication between a trained person and the patient..." (p. 1148). This communication, the manner in which it is treated and the ways it may or may not be used has increas-
ingly become an issue for psychotherapists, psychotherapy patients and lawmakers.

Psychotherapists have generally regarded such communications as private and confidential and professions involved in the work of psychotherapy have incorporated privacy into their various ethical codes. However, the codes are often unclear in their statements and definitions. For example, the phrase "clear and imminent danger" is used to describe a situation under which information may be disclosed in the Ethical Standards for Psychologists (1979). Would or would not this phrase include such acts as robbery, adultery or driving while intoxicated?

The legal system has not been any clearer. English common law, upon which our laws are based, does not allow a psychotherapist to refuse to give testimony in court about communications with a client and laws of privileged communication vary from state to state. While some states have statutes to protect confidentiality in psychotherapy, in many states courts have the right to require testimony as they deem necessary, regardless of ethical considerations. Needless to say, conflicts and issues have arisen, both within those professions involved in providing psychotherapy and in their interactions with the legal system.

In a well-intentioned rush to resolve these conflicts and issues regarding confidentiality in psychotherapy and to demonstrate the high ethical standards of their
professions, psychotherapists have been pushing and convincing lawmakers to pass legislation explicitly stating how communications between a psychotherapist and client may or may not be disclosed; however, this seems to be taking place without a complete examination of the subtle effects that such laws could have on the practice of psychotherapy. In addition, courts of law are assuming the responsibility of deciding what legal duties are involved in being a psychotherapist (e.g., Tarasoff v. Regents of the University of California, 1976).

The resulting confusion is sharply evident in the professional literature of psychotherapists as well as in legal writings on evidentiary issues and on the rights of patients. Slovenko (1974), for example, notes that there are so many exceptions in laws of psychotherapist-patient privilege, that there might as well be no privilege. Reynolds (1976), Sadoff (1974), Siegel (1979), Slawson (1969), Strassburger (1975) and numerous others address concerns raised in response to the laws and court decisions. The title of Bersoff's (1976) article, "Therapists as protectors and policemen: New roles as a result of Tarasoff?" suffices to indicate the identity crises and role conflicts that therapists are facing in trying to reconcile their legal duty, their duty to society, their duty to the practice of psychotherapy and their duty to the individual client.
If one is to understand and evaluate the current issues regarding confidentiality in psychotherapy, it is necessary to have a full understanding of those factors having a significant influence on the development of the present situation. This dissertation is an attempt to thoroughly examine the moral, medical-therapeutic and legal rationales of confidentiality in psychotherapy, to discuss and explore the implications and subtle effects of current legal interventions and to clarify what this means for the individual psychotherapist and for the profession as a whole. Most of the published literature on privacy in psychotherapy centers on the legal philosophy and technicalities of privileged communication. Much less has been written on the client's need and desire for confidentiality in psychotherapy unrelated to testimony in a legal proceeding. This dissertation includes a discussion of privileged communication, but differs from previous writings by giving greater emphasis to the individual's need for privacy by examining the position on confidentiality of major practitioner-theorists in psychotherapeutic techniques, historical and philosophical discussions on secrets, the legal history of privacy, research that either directly or indirectly assesses whether confidentiality or lack of confidentiality has any effects on success in psychotherapy and the impact that legal intervention has on the practice of traditional psychotherapy.
This dissertation can be divided into six major sections. The first four sections make up the literature review and offer a background for understanding issues of confidentiality in psychotherapy. The first part of the literature review deals with trends in medicine, mental health care and society that have led to the current high level of interest in confidentiality. The second part of the literature review offers a historical and moral background to confidentiality by exploring the concept of natural law, the seal of confession and the committed secret as discussed in Roman Catholic writings. Although this part is largely a review of material published elsewhere, the discussion of the parallels between debates regarding the seal of confession and confidentiality in psychotherapy is original. The third part of the literature review discusses the viewpoints of major theorists in psychotherapeutic techniques as they relate to confidentiality and examines the development of codes of ethics for psychotherapists, particularly psychologists.

The fourth part of the literature review focuses on legal intervention in confidentiality in psychotherapy. This part discusses laws and court decisions related to privacy, specifically those regarding confidentiality in psychotherapy and reviews privileged communication as it relates to psychotherapy.

The fifth major section, the "Integration and
Hypotheses", brings together the previous chapters and focuses on the differences in the approaches of natural law, psychotherapists and the legal system to confidentiality and on the specific and subtle implications that current legal intervention in confidentiality has on the practice of psychotherapy. This chapter is viewed as a statement of the problems which confront the professions of psychotherapy as well as the individual therapist. It also reviews research regarding attitudes toward confidentiality and raises hypotheses for evaluation.

The sixth major section is an attempt to grapple with a portion of the problems raised in the integration of the early chapters. Chapters Four and Five offer the methodology and results of a test of the hypotheses in a survey of the reactions of mental health professionals, mental health care recipients and Illinois State's Attorneys to hypothesized situations where a psychotherapist either discloses specific kinds of information to specific persons without the client's clear consent or does not disclose information because he/she does not have the client's clear consent to disclose. Chapter Six discusses these results and offers conclusions for the professions of psychotherapists, particularly psychologists, based upon the survey and literature review.
Confidentiality - A Recent Issue

The issues of confidentiality and privileged communication in psychotherapy are gaining increased interest from lawmakers, psychotherapists and mental health care recipients. As will be seen in the section discussing confidentiality from a historical and moral perspective, interest in privacy is not new in our society, but it is accentuated in recent times. The growth of interest at this time occurs for a wide variety of reasons including the following developments: (1) a growing number of people receiving mental health care, usually in their home community; (2) an increasing interest in privacy by society in general, due at least partially to sophisticated systems of record keeping and fears of their potential abuse; and (3) increasing requests for information or testimony from mental health professionals by third party payers and the courts. This chapter will discuss each of these three developments, how and why they have come to occur and how they contribute to an increased interest in confidentiality in psychotherapy.

Growth of Mental Health Care: In the last 15 years the number of people receiving mental health care has
increased at a rate considerably greater than the rate of population growth. In June of 1963, the inpatient and outpatient census of people receiving mental health care at state hospitals, zone centers and state operated or state aided mental health centers in Illinois was less than 54,000. In June, 1978, the census was nearly 118,000. This latter figure is considered a very low estimate of the people actually receiving mental health care in Illinois during all of 1978 as it represents only the number of active cases, i.e., the number of people receiving mental health care in the month of June, 1978 (Bronk, 1979).

A breakdown of these figures indicates a trend toward seeking outpatient mental health care in one's own community. In 1963, over 34,000 of those persons receiving mental health care in Illinois were inpatients in state hospitals or zone centers, compared to less than 20,000 persons receiving outpatient services. In June, 1978, less than 5,000 of the active cases were residents in state hospitals or zone centers. Over 113,000 active cases were outpatients at state operated or state aided mental health centers (Bronk, 1979).

Advances in the fields of psychiatric medicine, psychotherapy and counseling have probably contributed more than any one other factor to more people seeking mental health care and to the trend toward outpatient treatment in one's own community. Discoveries in psychopharmacology and
new psychotherapeutic techniques have led to vast changes in the entire mental health care delivery system. With the use of psychiatric medications, starting in the 1950's, the need for long term confinement in asylums or mental institutions has been greatly reduced. In the United States, the number of patients in state and county mental institutions dropped from about 560,000 in 1955 to 350,000 in 1970 despite the fact that the population as a whole increased about 40%, from 166 million to 205 million (United States Public Health Service, 1970).

Reports by the American Medical Association (1973) state that psychiatric admissions to hospitals rose from 362,000 in 1960 to 602,000 in 1971, but the average daily census of psychiatric patients dropped from 672,000 to 339,000, indicating a considerably shorter average length of hospital stay. More people are receiving psychiatric treatment in hospitals, but they are recovering more quickly and being released and treated on an outpatient basis. In addition, many patients can now entirely avoid psychiatric hospitalization, remaining at home and functioning in a number or all of their usual daily activities while undergoing treatment.

People with less serious emotional problems, who would not have sought psychiatric help in the past, are also seeking mental health care in their home communities due to increased knowledge and awareness of the public that
something can be done to alleviate stress, depression and other difficulties. Problems that might have previously been handled in the home or family doctor's office are increasingly being referred to the mental health professional. People are learning that the mental health professional can often be an important resource.

More people are also receiving mental health care in their home communities because of the increased availability of such services to persons of all income levels. The public was made more aware of mental health problems during World War II when five million men were disqualified from military service by the Selective Service, 40% of these for neuropsychiatric defects. Of those inducted and later discharged for medical reasons, neuropsychiatric disability was the most frequent cause (Beigel & Levenson, 1972). The first National Mental Health Act was passed just after the end of the war in 1946. This awareness of mental health problems and financial support by the government and charitable organizations have made it possible for most anyone who desires mental health care to receive it at costs they can afford. In fact, mental health care has become a significant part of government budgets. In Illinois, the Department of Mental Health and Developmental Disabilities employs more workers than any other state department. Its budget for 1963 was 91.7 million dollars
and by 1978 had grown to over 400 million dollars (Flood, 1979).

Since the Community Mental Health Centers Act was passed by Congress in 1963, the emphasis of government funding has been on community facilities rather than large, custodial-residential institutions. Studies have shown that when mental health care facilities are available within a close distance of where people live, they will make greater use of them (Babigian, 1977). The growth in the number of community mental health centers has made mental health care more accessible.

Health insurance has also served to make mental health care more affordable. Comprehensive insurance programs have increased their coverage of mental illness so that many persons having medical insurance can afford prompt psychiatric care in a hospital or on an outpatient basis.

Increased involvement of professionals other than physicians in the mental health care delivery system has augmented the accessibility of mental health services. In 1970, there were 8.35 mental health care workers and professionals in federally funded mental health centers for every one psychiatrist. In 1975, this number had grown to 15.14 mental health workers and nonphysician professionals for every one psychiatrist (Provisional Data, 1976). Professionals such as psychologists and psychiatric social workers
are trained to handle most mental health problems that do not involve medication. With the limited number of psychiatrists available, increased numbers of other mental health professionals make it much easier to obtain mental health care.

More people with problems are inclined to seek mental health care due to increased enlightenment and decreased stigma regarding mental illness. Mental illness is no longer considered to be associated with demonology or witchcraft as in past centuries and the fears about it have been greatly reduced. Crocetti, Spiro and Siassi (1974), in their extensive literature review and research on attitudes toward mental illness, go so far as to conclude that the mentally ill are being shown "nearly total acceptance in all but the most intimate relationships" (p. 88). As age was negatively correlated with acceptance, they predicted that acceptance of the mentally ill will continue to increase in the future. Reduced stigma and increased knowledge have made seeking mental health care more acceptable and less frightening.

All of the above developments, i.e., scientific advances in medication and therapeutic techniques, public awareness of emotional problems, government funding of mental health care, more outpatient mental health centers, increased numbers of non-physician mental health professionals, payment of mental health care by health insurance
plans and decreased stigma, have contributed to more people receiving mental health care, most in their home communities. These developments reflect broad social changes that have resulted in a democratization of mental health care. These developments have also added to the problems of confidentiality in psychotherapy.

Prior to the last generation, for the majority of people receiving mental health care, absolute confidentiality was not as important as today. In times when mental health treatment took place over extended periods in asylums, it was often common knowledge in a community as to whom had been "sent away" and why. People were labelled because of their past behavior and confinement and were treated accordingly, often very courteously, but as the "odd" person in the community. Few people sought mental health care unless they had problems that were very obvious to others.

Now, because of scientific advances in treatment and changing attitudes, many people seeking mental health care are not seriously emotionally disturbed. And many of those who are presently diagnosed as seriously emotionally disturbed are substantially helped with psychopharmacology. Frequently they are helped to the extent that their neighbors or work colleagues may not be aware of the extent of their mental illness. Most patients receiving outpatient mental health care are able to continue in their jobs and
daily activities. Behaviors resulting from mental illness and emotional problems may or may not interfere signifi­cantly with functioning in these areas.

Despite the evidence that there has been a reduc­tion in stigma towards mental health care, this stigma still does exist to some degree. Regardless of a person's real abilities or level of functioning, there are discrimi­nating acts frequently practiced toward those who have sought mental health care. Applications for employment frequently ask whether a person has a history of psychi­atric care. Life insurance companies frequently demand case histories before considering a mental health care recipient's application and the fact that a person has received mental health care may influence the decision of whether or not they are issued a policy and at what rate, whether or not there is any indication that the individual would have a shorter life expectancy than most people. People who have been hospitalized for psychiatric reasons are forbidden to have a gun permit in Illinois, whether or not they have ever evidenced any behavior that would sug­gest they might be dangerous to themselves or others. Public reaction to the news that Senator Thomas Eagleton had received electric convulsive therapy forced him to withdraw himself as a candidate for Vice-President of the United States. A negative stereotype of the mental health patient not only still exists, but more importantly,
enroaches on the right and privacy of former patients.

In times when many mental health care recipients are not diagnosed as seriously emotionally disturbed and are attempting to continue their usual daily activities, the person who is labelled and discriminated against because he is receiving mental health care and not because of inappropriate behaviors resulting from psychopathology, has much to lose in terms of finances, social relationships and self-esteem. The individual patient now has more reason to desire confidentiality, but the growth of the mental health care delivery system has made confidentiality more difficult.

Increased availability of mental health services and financial support by the government raise concerns regarding confidentiality since more mental health care and funding have meant a greater need for records and accountability. Accountability for receipt of funds and for licensing has meant not only that a minimum amount of specific information must be in patient records, but that outside evaluators must be permitted to review at least some of the records to make sure that certain regulations, intended to upgrade and maintain a good quality of patient care, are being followed. In Illinois, it is a requirement that mental health centers receiving state funds submit specific information to the Department of Mental Health and Developmental Disabilities (DMHDD) on each mental health
care recipient. Outpatient facilities are not required to submit names or other identifying information, but DMHDD does keep a record of the name, diagnosis and other information of all persons who have been patients in state hospitals or zone centers. A policy on the length of time this information is saved has not been clearly stated.

In a study by Noll and Hanlon (1976) 51% of mental health programs responding to a questionnaire indicated that they reported at least one piece of identifying information, i.e., name, address or social security number, to their state department of mental health or its equivalent. Of those state mental health program directors responding to the questionnaire (with an 87% return rate for the 50 states and four territories), 66% reported that they received at least one kind of the above types of identifying information from mental health centers. In addition 36% of mental health centers who submit identifying information to their state departments reported that they "did not inform their patients that they did so" (p. 1287). Needless to say, the more widely that such information is disclosed, the less private and confidential it is.

Some minimal records are necessary for continuity of care, both over a long period of time with one therapist and if it is necessary to transfer to another therapist. Records are especially necessary in documenting the progress and the effects of types of intervention, including
medication. As the number of patients and records increase, there are more medical librarians, typists, file clerks, i.e., more people outside of the therapist having contact with and access to confidential information. With more people having access to such information, there is a greater possibility of a breach of confidentiality.

Third-party payers add another source of difficulty in confidentiality in psychotherapy. Before health insurance companies and other health care programs (e.g., Public Aid) will reimburse for services, they require the diagnosis, type of treatment and dates of treatment for each individual client. This information is frequently given without the client's knowledge and/or formal consent.

Professionals other than psychiatrists becoming involved as therapists in the delivery of mental health care have also added to concerns of confidentiality. The added concern was initially due to the fact that most state laws in effect that protected the confidentiality of psychotherapy specifically stated that the therapist was a physician. Fortunately, psychologists and social workers have worked to develop stringent ethical standards regarding confidentiality and have sought to have these standards put into law. For example, in Illinois, a psychologist can disclose information only under very specific conditions. However, there are many people who do not meet the licensing standards of the above professions who are directly
involved as therapists in the delivery of mental health care, but who are not covered by laws protecting confidentiality. Illinois' new Confidentiality Act has possibly resolved this problem by including in the definition of "therapist", "any other person not prohibited by law from providing such services or from holding himself out as a therapist if the recipient reasonably believes that such person is permitted to do so" (Illinois Revised Statutes, 1979, p. 1489). Regardless of the credentials of the therapist, most patients receiving mental health care probably assume that their statements will be kept private. Under current law in most states this is not necessarily possible.

The growth, development and advances of mental health care have made confidentiality more important to the individual patient, as well as more difficult to assure.

**Increased Interest in Privacy:** A second major development contributing to increased concern about confidentiality in psychotherapy is that society has become more interested in the general issue of privacy. This concern for privacy has grown with our advanced technology that allows for swift communication, easy and complete surveillance and efficient record keeping. There is increased public awareness of the extent to which private and government agencies keep records on numerous aspects of our lives from the vital statistics of birth and death to vehicle
violations, medical records and political party affiliation.

In any ordered society there must be some measure of restraint on individuals in order to keep them from infringing on the lives of others. For example, in order to keep people who do not pay their bills from abusing the privilege of credit and loans, it is necessary for persons applying for loans to give information and allow for investigations of their credit histories. The price that all members of society pay is a loss of some degree of privacy. Such invasions of privacy, though not appreciated, are generally viewed as necessary and therefore acceptable.

However, there is a growing concern that information such as that above is being used for purposes other than that for which it was obtained and that much information is being obtained without sufficient purpose or consent. Incidents of record keeping and of observing private citizens for malevolent purposes, not for efficiency or for the protection of society, have come to the public's attention. The wiretapping of Martin Luther King's telephone (New York Times, 1969), the attempt to steal Daniel Ellsberg's psychiatric records, government records of such things as the members of organizations opposed to the Vietnam War and other abuses of privacy by federal and local branches of law enforcement have raised considerable alarm. This alarm has led to state and fed-
eral legislation, including the Public Information Act of 1966 (Public Law 89-554) and the Privacy Act of 1974 (Public Law 93-579).

The Public Information Act of 1966 sets procedures for public access to records kept by the federal government and for declassification of government information previously kept secret. It is an irony typical of our varied and ever stimulating society that at the same time when there is an increase in concern about individual privacy, there is increased public pressure for the right to "know". The Federal Privacy Act follows the Public Information Act and has the purpose of giving individuals greater control over the release of information about themselves by granting the right of individuals to find out what information the government has recorded on them and by limiting disclosure of so-called public information without the consent of the individual. Included in this is the right to inspect, copy, correct and update records and to determine what records pertaining to the individual are collected, maintained, used and disseminated by the government.

Government is not the only offending invader of an individual's privacy. Insurance companies store and routinely share medical information regarding their applicants and clients. Any information attached to a social security number through a computer can follow a person for life without one even being aware of it. Agencies for rating
credit have been known to give out information without due discretion and without always thoroughly checking for accuracy. Once incorrect information is stored in a computer, it is generally a much more laborious task to have it corrected or removed that it was to put it in or than it is to retrieve it for examination. In addition, big business has been known to seek information on individuals whom they view as antagonistic to their practices (Nader v. General Motors, 1969). Increased public awareness of the amounts of information recorded with our computer technology and incidents of misuse of information or undue investigation for information have led to increased demand for the protection of privacy.

This increased demand is visible in the increased attention given to the right of privacy in civil suits and new laws. Several state constitutions have included provisions recognizing a right to privacy and several more states have enacted comprehensive privacy statutes or fair information practices laws.

As one of many areas where greater privacy is being sought, confidentiality in psychotherapy has received its share of attention. Numerous suits and court cases have raised the issue of the right to privacy in psychotherapy. Federal laws, designed to protect the confidentiality of persons in federally funded drug or alcoholism programs, have been enacted. In addition, individual states are
taking steps to insure the protection of confidentiality in psychotherapy. For example, in Illinois, a state which has passed much reform legislation in recognition of patient rights, a comprehensive Confidentiality Act to "protect the confidentiality of records and communications of recipients of mental health or developmental disability services" went into effect in 1979. This act very specifically limits and defines the situations in which communications and records may or may not be disclosed. Whether or not the Confidentiality Act accomplishes its stated purpose will be discussed in later sections.

This federal and state legislation reflects the growing concern with privacy in our society. These laws and court cases that pertain to privacy in psychotherapy will also be discussed in later sections.

**Increased Requests for Information:** A third factor contributing to increased professional and legal concern regarding confidentiality in psychotherapy is that mental health professionals are receiving a greater number of requests for information or testimony about clients from outside sources such as third-party payers, the courts and employers. The trends and advances that have led to greater numbers of people seeking mental health care have also enhanced the prestige of psychiatry and psychology. Mental health professionals are increasingly viewed as experts having special insight, training and ability to understand
and describe an individual's personality and suitability for employment, parole, etc. Mental health professionals are called upon to give opinions on a wide variety of matters including those related to the courts (child custody, juvenile cases, insanity and more), education and industry. In addition, mental health problems have gained increased respectability as an illness and their treatment is covered by an increasing number of health insurance companies.

Third-party payers, including health insurance companies, are one of the biggest requesters of information about mental health clients. Grossman (1971) reports that in a survey of Northern California District Branch psychiatrists, 89% reported that they received requests from health insurance companies for information about clients. As mentioned previously, third-party payers require a minimum disclosure of the psychiatric diagnosis, the dates of therapy sessions and the kind of therapy involved before giving compensation for mental health care. Occasionally, they will request additional information including case histories, medications prescribed and even a review of the patient's entire record which may contain highly personal thoughts and feelings that the patient has expressed to a psychotherapist. This information is similar to that requested by health insurance companies when processing claims for any type of health disorder and does not suggest
an attempt to obtain psychiatric "secrets" about a client. Rather, it is an effort on the part of the insurance company to make sure that reimbursement is paid only for those conditions covered by the policy and that the frequency of treatment is justified by the existing condition. However, as Grossman (1971) points out, such information usually becomes a part of a permanent record, often in a clearing-house where insurance companies exchange information. He cites possible areas of abuse and states, 'There is no predicting the ultimate use and misuse of permanent records of this nature' (p. 65). Third-party payers are an area of concern for the mental health professionals who are interested in the best welfare of their clients, yet need to receive a fair payment from persons who might otherwise not be able to afford their services.

Mental health professionals have established themselves as specialists in the areas of human behavior and mental illness and their expertise is frequently requested for testimony in a court of law. In cases of court requested examinations and evaluations there need be no conflict regarding confidentiality if the person is agreeable to the evaluation and is aware of its purpose at the time of the evaluation. However, many times, a psychotherapist whom a person has been seeing with no intention that the therapist will be called as an expert witness, is requested to provide information such as an opinion of a client's effective-
ness as a parent, suitability for various choices of criminal sentencing (e.g., probation versus incarceration) or stability in general. The legal aspects of these requests will be discussed in greater depth in later sections.

These requests by the courts present a significant threat to confidentiality in psychotherapy and to its value to society as a whole. Obviously, divulging such information as mentioned above will interfere with the progress of the specific client; it could also interfere with the value of psychotherapy as a whole. People in need of treatment because of the stress of such things as marital disharmony or the fact that they engage in anti-social activities may not seek treatment if they have reason to fear that information they discuss with a psychotherapist may later be used against them in a court of law. Needless to say, these are probably some of the very same people for whom society has a strong interest in seeking mental health care.

In addition to requests for information by third-party payers and the courts, mental health professionals are asked to provide expert information, recommendations and opinions to a host of other sources including schools (especially when children are involved in treatment), Social Security offices (for evaluating disability claims), employers (especially as to whether a person is ready to return to work, but sometimes with less honorable ques-
tions) and friends and relatives (some with good intentions and some with not so good intentions). The list of people requesting information and their varied reasons could go on and on.

In summary, the mental health professionals have established themselves as specialists and now others want to make use of their expertise. This position is very flattering and would be quite comfortable were it not for some of the ethical dilemmas that may arise. This dissertation is devoted to further exploring these dilemmas.

Confidentiality - A Moral and Historical Perspective

Confidentiality and privacy in our Western culture have been respected for centuries in certain specified relationships such as husband-wife, client-attorney, patient-physician and penitent-clergyman. Although confidentiality in the patient-physician association, based upon the Hippocratic Oath dating from the fourth century B.C., is the oldest of the nonfamily relationships, historically and philosophically, privacy has been most thoroughly discussed in the writings of the 13th through 17th century Roman Catholic theologians. These theologians debated the circumstances under which the seal of confession, which protects the privacy of confession, should be applied and whether there could or should be any exceptions to the obligation of the seal.

These discussions and the issues they address are
remarkably similar to modern day debates regarding confidentiality in psychotherapy. A review of the philosophical and historical writings related to confidentiality, secrets and privacy is helpful to understand the foundations of the moral right to secrecy and privacy, to explore how others have handled the conflicts and dilemmas inherent in the concept of a private individual in society, to provide a background of ethical decision making and to demonstrate how similar struggles have gone on for hundreds of years despite the fact that privacy is a relatively new legal issue.

The discussions regarding the seal of confession are additionally pertinent as "confession", though often called by other names, is usually considered a significant part of the therapeutic process. Mowrer (1961) compared the psychotherapeutic process with the sacrament of confession and expiation. He noted that psychotherapy allowed for a confession of one's errors, but did not encourage atonement or reparation. Jung (1975) directly compared the role of the priest with that of the psychotherapist and stated, "The first beginnings of all analytic treatment of the soul are to be found in its prototype, the confessional" (p. 55). The Roman Catholic church also recognizes the commonality of these roles. Religious writers refer to confessors as "spiritual physicians" and state that they have a duty to become knowledgeable in mental hygiene and
psychiatry (Halligan, 1967, p. 144).

A Brief History of the Seal of Confession: In modern day practice, the seal of confession is the strictest obligation to maintain absolute secrecy regarding all information learned from a penitent during the sacrament of penance. The Code of Canon Law, the body of laws of the Roman Catholic church, states:

The sacramental seal is inviolable. Consequently, the confessor must exercise all diligent care not to betray the penitent in any degree by word, sign or in any other way or for any cause whatsoever (c. 889; as quoted in McCarthy, 1967, p. 133).

The phrase "any cause whatsoever" emphasizes the absolute nature of the seal, whether there be risk of death, harm to others or treason.

In light of modern day practices, it seems anomalous that some historians report it was the custom among early Christians to have public confession (McCarthy, 1967). This may be true as early Christians lived in very closely knit communities. Their zeal and enthusiasm for following the teachings of Christ and making reparation in many circumstances outweighed their concern with the consequences of public confession and penance. It is also thought that confession by the earliest Christians was practiced only once, when they converted from paganism; therefore, it was not a frequent practice or an integral part of Christian life. Confession did not receive much attention from theologians during the first few centuries,
A.D., and it is difficult to know precisely how the early Christians practiced confession and penance, especially as the word that has frequently been translated to mean "confession" can also refer to the entire rite involved in gaining absolution, not just the specific part of confession (Harrington, 1950).

Church historians to this day disagree on whether public confession was actually practiced or required by the early church and it is believed that the practice of rites varied greatly from place to place (Barton, 1961; Harrington, 1950; Jungmann, 1959). Most of the evidence from early theologians suggests that private confession was available for sins that were committed in secret (Origen, Homily on Psalm 37, ii, St. Cypian, De Lapsis, xxviii, as reviewed and discussed in Harrington, 1950; Epistle of Barnabas, 1st century, Bishop Aphraates of Syria, 4th century, St. Ambrose, 4th century, as reviewed and discussed in Kurtscheid, 1927).

Although strong evidence of public confession in the early church is lacking, public penance seems to have been customary, usually even for sins committed in secret. Often this was exercised only in the gravest of secret sins (murder, apostacy or adultery) and consisted of a form of excommunication (Barton, 1961; Jungman, 1959). However, there developed an awareness of the impact society can have on the individual when a public penance gives clues as to
what sins may have been confessed. For example, the churches of Asia Minor had very specific lengths of time as penance for various sins, thereby making it possible to figure out one's sin from the public penance the person was required to perform (Palmer, 1963). St. Basil (4th century) made a statement against the use of such public penance that might suggest the specific sin, especially in the case of women who confessed to adultery as, if exposed, they would be subject to capital punishment under civil law (Kurtscheid, 1927).

Greater awareness and concern about the effects of public penance on one's reputation, as well as potential punishment under civil law, seems to have arisen around this same time as others were demanding secret confession and penance and silence on the part of the confessor for secret sins so that people were not hated or exposed to contempt (Aphraates, 4th century, St. Ephraem, 4th century, as reviewed and discussed in Kurtscheid, 1927). Pope Leo I, in a protest against the public reading of each penitent's list of sins in the year 459, demanded secret confession and silence on the part of the confessor so that shame and fear of legal prosecution would not deter many from seeking absolution (Leo's Epistle 168, Denz 145, as discussed in Barton, 1961; Kurtscheid, 1927). Modern day psychotherapists also have an interest in seeing that clients are not deterred from seeking psychotherapy because
of the fear of being subject to public humiliation or legal problems.

The above theologians recognized how social pressure and fear of civil law could deter individuals from seeking absolution if confession were not private. Cultural pressures for privacy, from the Celtic branch of the church, also influenced the practice of confession and penance. In the Irish and Anglo-Saxon churches, public penance had never been customary. This is attributed primarily to two reasons. First, due to the nature of national customs and the character of the people, missionaries found it easier to convert the Anglo-Saxons if they did not insist on the humiliation of public penance. Second, the Celtic churches were isolated and did not experience the same influences as the continental church (Barton, 1961). When the Anglo-Saxon branch of the church became stronger and sent its own missionaries back to the continent during the 6th century, they influenced the already growing trend toward a simple, less rigorous and private confession and penance. In addition, the Celtic church brought the practice of repeated confession and penance, possibly resulting from monastic influence, to the continent (Barton, 1961; Palmer, 1963).

This trend toward privacy of confession continued until the Council of Douzy (874) which decreed that:

Penitents, whether clerics or laymen or women, who con-
fess their sins in secret to the priest are in no way to be betrayed. By no indication whatsoever are their sins to be revealed to anyone save God alone (as quoted in McCarthy, 1967, p. 135).

At this period in time the details of the obligation of silence were not yet uniformly regulated and there continued to be discussions and controversies. The seal of confession received considerable attention at synods and numerous theologians addressed the various issues related to it.

It was at the Fourth Lateran Council in 1215 that the obligation of the seal of confession was put into ecclesiastical law. In this ordinance there is "...a strict command to the confessor not to betray the sinner in the least in whatever manner, either by word or sign or in any other way" (Kurtscheid, 1927, p. 116). The purpose of the seal was to safeguard the sacrament of penance and the obligation rested solely on the confessor. The Fourth Lateran Council allowed for a priest to consult with a superior concerning the confession of a penitent if the identity was not disclosed. It also specified that a confessor who broke the obligation of the seal of confession would be "deposed from his priestly office...[and] incarcerated in a monastery to discharge a penance all his life" (Denz 814 as quoted in McCarthy, 1967, p. 135) indicating the gravity of such an offense.

However, questions about the seal of confession continued to be debated. What constituted a sacramental
confession? Were interpreters or persons who overheard a confession also bound by the seal? What if breaking the seal would be beneficial to the penitent? What if breaking the seal would prevent potential harm to the penitent or others? What does one do about information learned during the confession that does not pertain directly to the penitent's sins? Can one use confessional information if the seal is not broken? In what ways?

Similarities in the Discussions on Confidentiality and the Seal of Confession: It is at this point in the historical and theological discussions and writings on the seal of confession that there develops a remarkable similarity to the present day debates on confidentiality in psychotherapy. Presently, psychologists have an ethical code, comparable to ecclesiastical law, that states:

Safeguarding information about an individual that has been obtained by the psychologist in the course of teaching, practice or investigation is a primary obligation of the psychologist. Such information is not communicated to others unless certain important conditions are met (American Psychological Association, 1979, p. 4).

This allows for a breach of confidentiality under some circumstances, but is vague about what these circumstances might be. Many believed that the ordinance of the Fourth Lateran Council was also intended to allow for exceptions, a belief which was not absolutely refuted until the phrase "for any cause whatsoever" was added in 1917 when the obligation of the seal was established in the Code of Canon Law.
Before discussing how the early debates and writings regarding the possible exceptions to the seal compare to those regarding confidentiality in psychotherapy, it is necessary to understand the bases of the seal and the types of secrets defined by moral theologians. There are three levels on which the seal is justified and protected. The highest level of protection for the penitent is that of divine positive law. Divine positive law is based on the authority of God and is viewed as pertaining to the seal by interpreting Christ's statement, "if you forgive the sins of any, they are forgiven; if you retain the sins of any, they are retained" (John 20:23, RSV), as implicitly granting the right to have one's confession heard secretly. Otherwise, the faithful would be deterred from participating in the sacrament of penance and having their sins forgiven, something that the theologians believe that Christ would not have intended. "The obligation of the seal follows from the very nature of the Sacrament of Penance as instituted by Christ" (McCarthy, 1967, p. 134). St. Thomas Aquinas adds that a confessor cannot repeat a penitent's sins as he cannot "know" as a man those things that he has heard as God's minister (McCarthy, 1967). The discussions by the theologians of divine positive law will not be covered in any greater depth here as this level of justification of privacy does not have a parallel in psychotherapy. Most would agree that there is no implied command of
God for believers to seek psychotherapy!

The second level of protection provided to the penitent is that of natural law. Natural law is that which the average man, using observation and reason, would recognize as a principle of God's will (Marshall, 1960). The utilization of natural law involves taking the principles of justice and charity and applying them in the circumstances of daily living. Confession would be governed under natural law as a natural secret. Regan (1941) states:

This type of secret is designated natural because the obligation of secrecy which it imposes arises directly from the natural law; no contract, express or implied, is needed to make it binding (p. 5).

Haring (1966) states that the revelation of a natural secret "by the very nature of the case would here and now violate justice and charity" (p. 568). Duns Scotus (around 1300 A.D.) states that there are three reasons for the natural obligation to keep the seal of confession: (1) it is best for the general welfare not to be deterred from seeking penance, (2) because of the lines in Matthew 7:12 and Luke 6:31 that instruct people to do unto others as they would have done unto themselves, and (3) confession has the characteristics of a secretum commissum, which is covered by natural law (Kurtscheid, 1927).

Secretum commissum, or committed secret (also called "entrusted secret"), is that knowledge "which is obtained under the explicit or implicit condition of se-
crecy" (Haring, 1966, p. 569). Regan (1941) notes that "the distinguishing note of the entrusted secret is that the agreement of maintaining secrecy is made anterior to, and is the sine qua non condition for, the disclosure" (p. 7). This is in contrast to the "promised secret" in which a promise to keep the secret is made after obtaining the secret knowledge. The committed secret therefore carries a heavier burden of obligation and is a greater sin to violate as the secret information may very well not have been revealed were it not for the prior understanding that it would not be disclosed.

The most common example of the committed secret is the professional secret, i.e., information told to a doctor, lawyer or other professional with the understanding that it will be kept confidential. The professional secret may be explicit, as when a promise of secrecy is directly requested and given, or it may be implicit, as when no promise is asked for or received in so many words but the position or function of the person to hear the secret information clearly indicates that the secret will be vigorously protected, an assumption that is frequently made by persons seeking psychotherapy. The discussions of the theologians regarding how natural law, justice and charity, which obligate one to the professional secret, also obligate one to the seal of confession are therefore very pertinent to confidentiality in psychotherapy. For a thor-
ough discussion of the relationship between natural law and confidentiality in psychotherapy, see Alves (1959).

Ecclesiastical or church law is the third level of protection of the privacy of the penitent. The Code of Canon Law includes the obligation of absolute secrecy by a confessor. The law allows no exceptions and there are severe punishments for breaking it. If the seal is broken knowingly, under present day church law the confessor would be excommunicated immediately. If a disclosure is indirect and accidental, the punishments are less severe.

This third level of protection is comparable to both the "laws" of a professional code of ethics and to civil law, although professional codes and civil laws do have exceptions, both specified and implied, in regard to confidentiality in psychotherapy. Also, punishments are not so severe as those specified in Canon Law, yet an intentional and unwarranted disclosure of confidential information by a psychologist can result in the psychologist receiving consequences from professional organizations and under civil law. Indirect and accidental disclosures would probably not result in any punishment unless the psychologist was grossly negligent. The discussions regarding the possible exceptions to ecclesiastical law, prior to 1917 when it was made clear that there were no exceptions, are comparable to present day discussions of possible exceptions to professional codes and/or laws.
regarding confidentiality in psychotherapy.

One of the major sources of conflict that arose regarding the seal of confession, and which has a direct parallel regarding confidentiality in psychotherapy, concerned the issue of preventing the penitent from committing future sins and from harming others. Huguccio, writing shortly before the Fourth Lateran Council (1215), proposed that if a person confessed a sin but refused to do penance or planned to commit another sin, persons who would be helpful in persuading the penitent to refrain from evil without causing harm to him could privately be told about the confession (Kurtscheid, 1927). He made it clear that past sins are covered by the seal of confession. Huguccio based his opinion on the thinking that a priest would essentially be an accomplice in sin if he silently stood by and allowed it to occur. Additionally, he stated that if the authorities are informed, this may cause great injury to the penitent and thereby by a sin against the natural law of charity. The solution is to tell someone in a position to prevent the sin without harming the penitent. This opinion is shared by many theologians in the 13th to 15th centuries, some of whom further suggested that under some circumstances it would also be appropriate to warn a person whom the penitent has threatened to harm (without revealing the penitent's name) and advise this person to make amends with all enemies so that he/she does not get
hurt. William of Rennes (Apparatus, 1241, as reported in Kurtscheid, 1927) states that a priest has a duty to discreetly inform potential victims when it can be done without sin or scandal. Great emphasis is given by all writers to the point that this should be done without injury to the penitent.

This exception to the seal of confession that Huguccio and other canonists suggested is indicative of the human emotion and conflict of the confessor. This same conflict occurs in psychotherapists when clients speak, while in psychotherapy, of harming someone. Psychotherapists may feel irresponsible or like accomplices if they do not make efforts to prevent clients from committing dangerous acts. It may also subject clients to undue harassment and punishment to report them to criminal authorities for acts that they have not actually committed. Psychotherapists, under current Illinois law, are permitted but not required to warn potential victims as was suggested by several theologians of the Middle Ages. They have the additional option of working with other mental health professionals and a noncriminal portion of the legal system to have people committed to psychiatric hospitals to prevent harm to themselves or others. This latter option might be compared with disclosing to a person who can persuade a penitent to stop sinning, the solution suggested by Huguccio which would be in line with natural law. Other
states have not all given the psychotherapist as much discretion as Illinois (Tarasoff v. California Board of Regents).

There is one very definite difference between present day discussions by psychotherapists about preventing clients from injuring themselves and/or others and discussions by theologians of the Middle Ages. This is the definition of what constitutes an act planned with sufficient seriousness to warrant disclosure. Sins, such as not believing in the teaching of the Roman Catholic church (heresy), were considered important enough to be reported to friends or relatives of the penitents who might be able to help them. Beavais in Speculum Historiale (1244, as reported in Kurtscheid, 1927) went as far as to say that the priest should warn others of heresy he has heard in confession so that they may avoid the heretic and not be perverted. The only situations that psychotherapists can report, according to the various ethical codes and to Illinois state statutes, pertain to physical danger to others or to the client and to abuse, physical or emotional, and/or neglect to children.

Another source of conflict discussed by theologians regarding the seal of confession and paralleled today in issues of confidentiality in psychotherapy concerns the attitude of the penitent. Attitude and intent of the penitent is given much attention in the writings of the church
canonists in the sense of asking whether or not a confession is sacramental and subject to the seal if a person does not intend to try to stop sinning. The question arises as to whether or not a confession that is made without remorse, but as a routine because confession is required at least on an annual basis, should be given the same privilege and privacy as a sincere and contrite confession. In the interest of encouraging the faithful to continue to participate in the sacraments, canon law does not allow for the confessor to make the above discrimination in regards to the seal although the priest is allowed to use judgment in so far as whether or not absolution is granted.

This conflict regarding attitude and intent might be compared to that experienced by psychotherapists who have clients who are forced to participate in psychotherapy for any number of reasons (e.g., a condition of probation, in order to keep a job after some unusual behavior or to placate a spouse who is thinking about divorce) but do not make appropriate use of the therapy time because of such matters as missed appointments, arriving consistently late or refusing to talk. This is the kind of behavior that can make psychotherapists feel inadequate, frustrated and angry, feelings that may interfere with a clear perception of what is the most therapeutic and ethical response to the question of whether or not others should be informed
that the client is merely going through the motions of seeking mental health care.

Even without these feelings a psychotherapist may question whether confidentiality in these types of cases is in the best interest of society or even in the best interest of the individual. Obviously, professional codes of ethics and statutes in many states forbid such disclosures and serve to protect psychotherapists from their own feelings and conflicts, just as the Code of Canon Law protects confessors from revealing information they have heard in confession. Just as granting privacy to all confessions, whether sincere or not, serves to encourage people to participate in the sacraments of the church, granting confidentiality to people who may fail to use or misuse psychotherapy, may benefit society and enhance the profession of psychotherapy by offering encouragement and a trusting environment for these same people to make better use of psychotherapy and by demonstrating to others that psychotherapists are serious when they say that psychotherapy is confidential.

Another issue of increasing concern is the client's right to informed consent. In the case of psychotherapy, it has been suggested that informed consent includes being advised of the limits of confidentiality (Siegal, 1979). This means that, if clients do not have this information, they cannot validly consent to be patients in psychothera-
apy. A parallel proposal was made by William of Rennes (Apparatus, 1241, as reported in Kurtscheid, 1927) in a discussion of whether future sins are protected by the seal of confession. He states that when a confessor decides he has a duty to disclose information from confession, he also has a duty to inform the penitent that the confession is not protected by the seal. In the situation discussed by William of Rennes, the informing was done after a confession was found to be unreceivable. Under the present Code of Canon Law this would no longer be an issue as it allows for no exceptions to the seal.

Some psychotherapists are currently proposing that a potential client be explicitly advised of the limits of confidentiality before therapy starts so that the client very clearly understands the relationship. Siegal states: "The initial interview should incorporate a straightforward sharing with a client of whatever limits may exist in the confidentiality of the material presented" (1979, p. 256). This concept of warning the client is gaining popularity. On the one hand it presents the psychotherapist-client relationship in a realistic and honest manner and assures that clients will not disclose information without knowledge of the possible ramifications. The clients will also not feel so deceived if the psychotherapist must later disclose information. On the other hand, this approach may sensitize clients to such an extent that they have greater
difficulty (both conscious and unconscious) exploring and relating their thoughts and feelings.

The question of gaining client consent to disclose information also has parallels in the writings on the seal of confession. In a discussion of whether a confession can be revealed to prevent sins, Henry of Segusia (Summa, 1253, as reported in Kurtscheid, 1927) states that general warnings can be given in order to prevent great crimes, but that the penitent must not be identified, no matter what misfortune may occur, unless the confessor has the permission of the penitent. The major ethical means that psychotherapists have for disclosing information, should it be deemed necessary, is to obtain the permission of the client. This practice has since been changed as regards to confession as it was generally assumed, especially in cases regarding court testimony, that if penitents refused to grant permission to the confessor to disclose information, they were probably guilty or had something to hide. A priest can still disclose information, with consent, when a parishoner talks to him outside the confessional.

It is frequently assumed that, if a client refuses to grant permission to a psychotherapist to disclose information, the client is guilty or has something to hide. This is a major reason why some psychotherapists will not reveal any information, positive or negative, even with the consent of the client. The contention of these psychothera-
ists is that any pertinent information could be obtained from another source where confidentiality was not assumed to be inherent in the relationship. For example, if a decision regarding the stability of a second marriage was needed in a child custody case, neighbors, co-workers, friends and relatives or the use of an expert witness who does an evaluation for the court with the consent and knowledge of those involved, could provide sufficient data upon which to make this decision.

Political pressures also had an effect on the interpretation of the seal of confession. The Gallicans, an order which had declared independence from the authority of Rome were officially recognized as leaders of the French national church from the late Middle Ages to the French Revolution. With no separation of church and state, the Parlement (the highest legal court in the country) at that time reviewed all papal decrees and only accepted them if they were consistent with the teachings of the Gallican Church (Harney, 1941).

In France, civil law required the public denunciation of any individual who expressed murderous intent against the King. This civil law was supported by the Gallicans but opposed by the Jesuits, who, as leaders in moral theology, used the strictest interpretation of the seal of confession. The Gallicans were bitterly opposed to the Jesuit attempts to establish colleges and universities
in France and used all their influence to limit and de­
nounce the Jesuits. They had even been successful in
having the Society banished from France following an attempt
on King Henry IV's life in 1595. The Jesuits were per­
mittted to return to France in 1603 and when they sought
permission to open a college in 1611, the solicitor-general
urged the Parlement to refuse permission on the grounds
that the Jesuits did not follow certain laws and teachings,
among them those concerning the seal of confession. It was
demanded that the Jesuits subscribe to the rule regarding
the safety of the monarchy. Although the Jesuits did not
agree to divulge the name of any penitent, they did agree
to report any murderous intention on the King they heard in
confession, making an accommodation to civil law in order
to receive permission and funding for their colleges in
France (Kurtscheid, 1927).

Political and financial pressures are present in
the practice of psychotherapy as well, especially when a
psychotherapist is working in an agency that receives
public funding. These pressures are probably more acutely
felt by those in the position of making administrative and
policy decisions than by the individual psychotherapist.
For example, although the State of Illinois does not re­
quest the names or identities of clients seeking only
outpatient mental health care, it is required that state
funded community mental health agencies release informa­
tion, including identities and dates of visits, about clients who have received recent inpatient care in a state facility to the Department of Mental Health and Developmental Disabilities (DMHDD). This information is required so that DMHDD can monitor the care that former inpatients receive with the hope that this will prevent their reentry into a state mental hospital. Refusal to comply with such a requirement by the department that recommends how much funding each agency receives could have negative ramifications.

Financial pressures are present for the psychotherapist who receives reimbursements for services from health insurance companies. These companies require specific information, including diagnosis, before they will pay the psychotherapist.

In summary, any time when there is a situation in which a psychotherapist receives funding from someone other than the client for providing services, there is the likelihood of laws and/or accountability interfering with confidentiality.

One interesting aspect of the seal of confession is that all persons hearing the actual confession are bound by the seal just as much as the confessor. This might include anyone from an interpreter to other penitents waiting their turns to see the confessor. In psychotherapay, there are parallels in terms of the clerical help who keep track
of billings and records as well as in a group therapy situation. In the case of clerical help, it has been held in the courts that secretaries are an extension of their professional employers and are bound by the same laws of privilege and privacy as those professionals. The Illinois Confidentiality Act also provides that clerical help are bound to confidentiality by law.

Group therapy has been a source of problems for the mental health professional. Although the psychotherapist-client relationship has held privileged status in some states, group therapy has allowed for loopholes as fellow group members have generally not been considered able to claim the privilege. Illinois law has attempted to remedy this problem by including the phrase "or in the presence of other persons" (Illinois Revised Statutes, 1979, p. 1489) in the definition of a "confidential communication" or "communication" and states that "All records and communications shall be confidential and shall not be disclosed except as provided in this Act" (Illinois Revised Statutes, 1979, p. 1489), allowing clients to have only the same avenues of disclosure of information regarding other clients as do psychotherapists.

In summary, many of the same problems and conflicts discussed by early theologians in regards to possible exceptions to the seal of confession, including the dilemma when a crime could be prevented, when the attitude of the
penitent is insincere, the issue of disclosure with consent, political pressures and occasions when others overhear a confession, have parallels in modern day problems and conflicts in regard to confidentiality in psychotherapy. Psychotherapists also have some of the same motivations in keeping the two acts, confession and psychotherapy, confidential, i.e., the desire to not do anything that would deter people from seeking participation in these acts and a concern for the consequences of these people if information is revealed. The confessor and the psychotherapist are additionally both bound by natural law and ecclesiastical or civil law. The seal of confession has the additional basis of divine law. In the opinion of this author, divine law removes any conflict or question and makes the moral responsibilities of the confessor clearer and easier to handle than those of the psychotherapist.

Even though the psychotherapist may be said, as above, to be bound by natural law, this is not generally in the conscious awareness of psychotherapists who tend to look to their ethical codes and civil law in making decisions regarding confidentiality. The approach to decision making used by moralists and the Roman Catholic church is to take the principles of natural law and apply them to the situation. As will be discussed in following sections, ethical codes and civil law, while having input from natural law, approach decision making in a different manner.
Confidentiality - A Psychotherapeutic Perspective

The purpose of this section is to explore the judgments of several major theorist-practitioners with reference to confidentiality in psychotherapy. It will also discuss the development of professional codes of ethics for psychotherapists, particularly psychologists.

Major Theorists-Practitioners: Openness and trust in the treatment setting have been viewed as a necessity by early and modern theorists-practitioners (e.g., Cautela, 1977; Freud, 1959; Jung, 1961; Maslow; 1954; Rogers, 1961). Many techniques have been developed to help the client be more open and self-disclosing, including Freud's "free association", Jung's "dream recall" and Adler's "earliest memory." It is generally assumed by those who study the major theorists that any information revealed by a patient/client to a therapist will be kept confidential; however, the specific concepts of privacy and confidentiality are seldom mentioned. Privacy seems to have been automatically assumed as present and essential by theorists-practitioners and has rarely been discussed as an issue.

Sigmund Freud (1856-1939), recognized by psychotherapists as developing the first comprehensive theory of personality and technique of psychotherapy, did not give confidentiality very much attention in his writings; however, the small amount of attention he did give is direct and to the point. For example, he stated "...we [the
psychotherapist and the patient] make our pact, complete candor on one side and strict discretion on the other" (Freud, 1949, p. 31). A very brief explanation of a part of his theory will explain why Freud believed that this "candor and discretion" were essential elements for the process of psychotherapy.

A major thesis of Freud's theory of psychopathology is that the ego, in an attempt to deal with the demands of reality, the id and the superego, and to preserve its own organization, will repress a great deal of its memory and experiences into the unconscious. This repression is done with the purpose of protecting the ego and alleviating stress, but it may backfire in that the ego may be altered or disorganized by the intrusion of these same repressed and unconscious elements. The psychoanalyst assists the patient by helping to discover conflicts and interpreting material that is influenced by the unconscious, thereby giving the ego greater awareness of the unconscious elements that may intrude. He provides knowledge to the patient so that his ego may gain control and organization over the parts of the psyche.

Freud (1949) stated that the patient must agree "to put at our disposal all the material which its self-perception yields it" (p. 30) and that "what we want to hear from our patient is not only what he knows and conceals from other people; he is to tell us too what he does
not know" (p. 31).

He is to tell us not only what he can say intentionally and willingly, what will give him relief like a confession, but everything else as well that his self-observation yields him, everything that comes into his head, even if it is disagreeable for him to say it, even if it seems to him unimportant or nonsensical (p. 31, Freud's emphasis).

Because the ego has repressed experiences, thoughts and feelings that may be a source of anxiety, it is resistant to the discovery of this material and the risk of stress it may cause. The ego is reluctant to let this material into the preconscious (available to the conscious) or the conscious awareness of the patient, and even more reluctant to make this material available to the awareness of the psychotherapist. Another source of interference with complete candor in psychotherapy is the fact that the unconscious does not operate by logical rules. Freud refers to the unconscious as the "realm of the illogical." Conflicting urges can independently exist side by side. The workings of the unconscious seem nonsensical at times. This lack of sense may be a source of embarrassment for the client—a deterring force to openness in the therapeutic setting.

Freud repeatedly emphasized that the fundamental rule a patient must follow in psychoanalysis is complete candor. Freud also recognized that the rule is very difficult to follow and emphasized the necessity of strict discretion by the psychotherapist in order to make the
patient's task possible. Despite the fact that Freud's theory was in a continual state of growth and change while he was alive, the assumption of professional discretion is made throughout his writings. It is clear from his writings that the basic concept of confidentiality is essential to the therapeutic process.

Although varying in theory and approach, other major theorist-practitioners have followed Freud's lead in finding an important place for confidentiality in psychotherapy. Alfred Adler (1870-1937), an associate of Freud's who later broke away from him viewed emotional problems in a social context and developed a cognitive and educational approach to psychotherapy. In discussing his approach to psychotherapy, Adler noted that the client must feel trusting enough to divulge private thoughts and implied a need for confidentiality:

All cases of failure which we have seen involve a lack of cooperation. Therefore cooperation between patient and consultant, as the first, serious scientifically conducted attempt to raise social interest, is of paramount importance, and from the start all measures should be taken to promote the cooperation of patients with the consultant. Obviously, this is only possible if the patient feels secure with the physician (Ansbacher & Ansbacher, 1956, p. 341).

Adler also demanded confidentiality directly, stating matter of factly and without further explanation that "... the physician must promise and keep strictest secrecy" (Ansbacher & Ansbacher, 1956, p. 345). His writings indicate an assumption of privacy without any discussion or
question that it will most certainly be present. Like Freud, Adler clearly stated a need for confidentiality for successful psychotherapy, but did not elaborate or discuss possible exceptions to the rule.

Carl Jung (1875-1961), another early associate of Freud's who later came into some conflict with him, does not address confidentiality as directly as Freud or Adler, although his writings leave the clear impression that he assumed confidentiality in psychotherapy to be necessary out of respect for the client and for the process to work.

Jung repeatedly noted the role of the psychotherapist as a person whom the client/patient must trust in order for psychotherapy to work. He stated that the "personal contact is of prime importance, because it is the only safe basis from which to tackle the unconscious" (1970, p. 97). He believed that the recounting of a past traumatic event was helpful at least partially because the client/patient "does not stand alone with these elemental powers, but some one whom he trusts reaches out a hand, lending him moral strength to combat the tyranny of uncontrolled emotion" (1975, p. 132). In another discussion he stated, "The patient...can win his own inner security only from the security of his relationship to the doctor as a human being" (1975, p. 116). All of these statements point to a view of trust and safety being essential in the therapeutic setting and the fact that the psychotherapist must
set such an atmosphere. Despite this, in his discussions of theory and technique, Jung does not directly address the issue of confidentiality.

Abraham Maslow (1908-1970), a theorist, teacher and practitioner, like Jung, did not directly address the issue of confidentiality in his writings on psychotherapy. Maslow is generally viewed as representing humanistic psychology. With a more optimistic attitude than Freud, Maslow viewed the basic inner nature of man as being good, or at worst neutral, rather than bad, and stated that people would profit from bringing this suppressed or repressed material out and nurturing it so that it would add to the happiness of their lives.

Maslow went on to describe psychoanalysis as an "uncovering therapy" and noted that in psychotherapy, the patient will continue to try to avoid becoming conscious of painful truths and will actually "...fight the efforts of the therapist to help us see the truth" (1968, p. 60), the phenomena called resistance. Maslow stated that "All the techniques of the therapist are in one way or another truth revealing, or are ways of strengthening the patient so he can learn the truth" (1968, p. 60) and that "Self-knowledge seems to be the major path of self-improvement, though not the only one" (p. 165).

Maslow recognized that the client needs to be able to speak frankly and openly in psychotherapy and that it is
the task of the therapist to help the client be more open, but he did not directly address confidentiality as a way of providing this help.

Harry Stack Sullivan's (1892-1949) theoretical approach emphasized interpersonal relationships. Sullivan (1970) noted that the psychotherapist has a need for certain kinds of information about the client. He stated that the leaving out of thoughts or ideas by the client "may cause the therapeutic process to miscarry" (1970, p. 84). He added that the client wants to talk frankly, but has deeply ingrained cautions about doing so. He discusses an important aspect of the task of the psychotherapist as being that of understanding the dynamics of the psychotherapist-client relationship and acting in a way that uses this understanding to reduce anxiety (not suppress, repress or totally alleviate as mild to moderate anxiety can be educative) so that the client will be able to speak more candidly.

Although Sullivan does not use Freud's concept of the unconscious in discussing his therapeutic approach, he is still very much aware of the fear, anxiety and shame that people may feel when discussing their behavior, thoughts and experiences and how these feelings may interfere with the process of psychotherapy. With this awareness, he addresses the concept of confidentiality in psychotherapy.

A person who consults anyone with the idea of estab-
lishing a frank relationship with him has already overcome some pretty heavy inhibitions laid down by the culture. If the interviewer then chooses to violate the confidential relation, he must be very skillful in doing it, and quite sure that he has adequate cause for so doing (1970, p. 66).

As stated above, Sullivan believed confidentiality to be necessary for psychotherapy, but he explicitly added that the psychotherapist may come upon occasions when it is in the client's best interest to breach confidentiality.

Carl Rogers (1902-19 ), who originated the non-directive or client-centered approach to psychotherapy, viewed the person-to-person relationship between the therapist and client as the significant element in the psychotherapeutic process. He believed that a major task of the therapist is to set an atmosphere of trust, acceptance and unconditional positive regard. He did not directly address issues of confidentiality in his writings, but his emphasis on the trusting therapeutic environment implied a belief in discretion, except when the therapist has the client's permission to have students observe or to record psychotherapy sessions. Rogers (1951), like Jung (1961), seemed to assume that confidentiality was a part of the therapeutic relationship, but did not address it directly.

The behaviorists have found confidentiality to be an important issue in treating clients as more concern is expressed about the privacy of a behavioral analysis. In describing his methods, Cautela (1977) states:

The client is assured that the information will be
kept completely confidential and that even the secretary does not look at the files... Additionally they are informed that six months following termination case records will be destroyed unless otherwise requested (p. vii).

Cautela goes on to explain that the procedure for destroying records is based upon the assumption that should new symptoms occur or old ones recur after successful therapy, then a new behavioral analysis is needed.

This approach is used to help the client be more frank in disclosing information of which he is conscious, in contrast to the analytic rational of helping to explore unconscious material. Confidentiality is assumed by the behaviorists for practical, common sense reasons.

Ellis (1973), the innovator of rational-emotive therapy, stated that people want to talk about themselves but are afraid to because of what others may think of them. He noted that psychotherapy progresses when a person can reveal "shameful" things to the therapist and believed further progress occurs when the client also self-discloses outside the therapy setting. This opinion regarding the importance of self-disclosure is similar to Jung's statements regarding secrets. Like Jung, Ellis does not directly address confidentiality.

The issue of confidentiality is not addressed as an important component of psychotherapy in the literature on the Gestalt oriented approach, but is viewed as a necessity during the initial stages of psychotherapy as many people
need, or at least want, the assurance of privacy (Polster & Polster, 1973).

All of the major, traditional theorist-practitioners surveyed, with the exception of Maslow who does not even indirectly address the issue, suggest in their writings that confidentiality is necessary for successful psychotherapy in that it sets a trusting environment where the client can allow thoughts, images and feelings to emerge from the unconscious for exploration and understanding and/or where the client can freely explore the interpersonal relationship.

As the behavioral, rational-emotive and Gestalt approaches of therapy all focus on conscious awareness and behavior rather than the unconscious, confidentiality is not viewed as so necessary for therapeutic reasons, but more for practical reasons, i.e., so that clients will seek therapy in the first place and so that they will be more honest in the therapeutic setting.

Basic Texts and Manuals: Psychotherapists, in their training and practice, have traditionally assumed the concept that confidentiality is a necessary component of psychotherapy with little or no further discussion of the topic. This is demonstrated not only in the works of the major theorist-practitioners noted above, but also in basic texts and manuals on how to do psychotherapy. Even though a number of such works have been published since the in-
crease in interest and legal intervention in confidentiality in psychotherapy, very few go beyond a simple statement regarding the importance of confidentiality.

For example, Bruch (1974), in a basic text titled Learning Psychotherapy, stated:

The patient, when agreeing to such a conference, should have the privilege of outlining which problems can be taken up with a relative and of deciding what he considers definite "privileged communications" not to be divulged to others (p. 41).

Bruch did not elaborate on any situations or laws that may lead a psychotherapist to question whether there might be an exception to absolute confidentiality. She emphasized that even the fact that a person is a client should not be divulged.

Wolberg (1977), in his extensive work, The Technique of Psychotherapy, stated:

It is usually advisable to explain to the patient that any information revealed to the therapist is completely confidential and will, under no circumstances, be divulged. This allays the patient's fear that the therapist will discuss him with others. The same reassurance may be given the patient about his case record, and he may be told that it will not be released, even to the patient's personal physician, without his permission (p. 508).

Wolberg did not even refer to possible exceptions or legal conflicts regarding confidentiality in psychotherapy.

Neuhaus and Astwood (1980) in a recent book on the basic techniques and practical issues of psychotherapy also emphasized the importance of confidentiality in the therapeutic relationship. They stated:
Maintaining and respecting confidentiality is nowhere more crucial and mandatory than in a therapeutic relationship. In our age where individual privacy is constantly threatened, invaded, and infringed upon by society's mania for record keeping, psychotherapy stands as one of the few professions that must maintain the individual's confidences. For without trust between the therapist and patient, little will be accomplished. The authors subscribe to the idea that no information, which the patient has provided the therapist, can be divulged to anyone unless the patient gives permission... Therapists must, at all costs, respect a person's confidences. To betray a confidence is a violation of trust. And such violations will only impair the ability of the therapist to help a suffering human being (p. 29).

Once again, no exceptions to absolute confidentiality but patient permission were discussed. Confidentiality was assumed without further elaboration.

While most basic texts and manuals on psychotherapy either do not mention confidentiality at all or make a simple statement that it is necessary, a few texts mention situations under which confidentiality cannot be guaranteed. For example, Reid (1980), in a recent book on intensive psychotherapy, noted that in cases of clear danger to the client or others, it may be necessary to release information to others. He added, "An understanding of the concept of confidentiality and the circumstances under which information will be released should be reached during the first session" (p. 46).

Parry (1975), in a guide to basic psychotherapy, listed several situations in which it may be necessary to disclose information. He stated that, although the therapist should assure the client that information would be
disclosed only under exceptional circumstances, "absolute confidentiality cannot, and should not be guaranteed" (p. 82).

As with the major theorist-practitioners, most basic texts and manuals on psychotherapy simply assume confidentiality to be present and necessary for successful work to be accomplished. Many basic books address the issue directly, but do not discuss confidentiality or possible exceptions in any depth.

Research Pertinent to Confidentiality: Just as the major theorist-practitioners seldom directly stated that privacy was essential in psychotherapy or discussed the concept of confidentiality, there is little or no research that directly assesses the effect of privacy or a lack of privacy on success in psychotherapy. However, just as the theorists implied a need for privacy in their therapeutic rationale and techniques, there is some significant research that suggests that factors requiring an understanding of privacy in psychotherapy are important.

Recently, theorists and researchers have been investigating self-disclosure and some have proposed that self-disclosure is related to good mental health (Gorman, 1973; Hyink, 1975; Jourard, 1959, 1963; Keller, 1976; Mayo, 1968; Taylor, 1965). Other studies have suggested that self-disclosure is positively related to progress in psychotherapy (Braaten, 1958, as reported in Truax, 1961;
Peres, 1947; Steele, 1948, as reported in Truax, 1961; Tomlinson, 1959, as reported in Truax, 1961). Some studies have not found a consistent relationship between self-disclosure and adjustment (Himmelstein & Lubin, 1966; Pedersen & Breglio, 1968; Stanley & Bownes, 1966), but each of these studies used a self-report questionnaire as the measure of self-disclosure. Other studies (Burhenne & Mirels, 1970; Himmelstein & Kimbrough, 1963; Himmelstein & Lubin, 1965; Hurley & Hurley, 1969) have found no significant relationship between self-report questionnaires of self-disclosure and actual self-disclosure in a variety of settings. These latter studies suggest that self-disclosure questionnaires may not correlate with actual self-disclosure in psychotherapy or other situations and may be inadequate for exploring whether good adjustment is related to self-disclosure. The research data on self-disclosure, adjustment and success in psychotherapy suggests that, as postulated by the major theorist-practitioners, self-disclosure is a necessary and beneficial part of the psychotherapeutic process.

In addition, a number of situational factors or conditions, including the characteristics of the person to whom a self-disclosure is made (Himmelstein & Lubin, 1966; Jourard, 1959a; Jourard & Lasakow, 1958), reciprocity of self-disclosure (Chittick & Himmelstein, 1967), perceived liking of and/or similarity to the target person (Cozby,

Although the research on the relationship between privacy, self-disclosure and success in psychotherapy is sparse, it appears that greater self-disclosure takes place under conditions of greater privacy (e.g., Holahan & Slaiken, 1977). Confidentiality is a way of assuring greater privacy in psychotherapy. It logically follows that this should increase self-disclosure and frankness, leading to progress in psychotherapy.

**Codes of Ethics:** In exploring the psychotherapeutic perspective on confidentiality it is important to examine the standards or codes of ethics that psychotherapists have set for themselves. Psychiatrists find the origin of their code of ethics in the Oath of Hippocrates (about 400 B.C.) which stated, among other things:

> Whatsoever things I see or hear concerning the life of men, in my attendance on the sick or even apart therefrom which ought not to be noised abroad, I will keep silence thereon, counting such things to be sacred secrets (as quoted in DeWitt, 1958, p. 23).

Social workers explored the concept of a code of ethics at their national meetings in the 1920's, but the
national association did not finally adopt a code of ethics until 1951. It stated, in part:

The American Association of Social Workers believes that the social worker should:
Respect and safeguard the rights of persons served to privacy in their contacts with the agency, and to confidential and responsible use of the information they give (as quoted in Alves, 1959, p. 113).

Psychologists adopted their first code of ethics, *Ethical Standards of Psychologists*, just one year after social workers, in 1952. The American Psychological Association (APA) had been formally working on the development of a code of ethics since 1957 when the Committee for Ethical Standards for Psychologists was established. This committee elected to formulate a code of ethics based on the conflicts and difficulties that psychologists had actually experienced rather than based simply on what mature professionals believed a code of ethics should say. In accomplishing this task, the committee solicited the 7,500 members of the APA and requested that they submit descriptions of actual ethical problem situations which they had encountered. Principles were drawn up to cover the actual incidents submitted and in 1950, a tentative code was published. After review and revision, the final draft of the code was adopted in 1952. The first code was viewed as too complex and lengthy (171 pages, 106 general principles) and has had two major revisions so that it is presently reduced to nine general principles that are described in an eight page pamphlet.
Principle 5 addresses the issue of confidentiality and states:

Safeguarding information about an individual that has been obtained by the psychologist in the course of his teaching, practice, or investigation is a primary obligation of the psychologist. Such information is not communicated to others unless certain important conditions are not met (American Psychological Association, 1979, p. 2).

This is followed by further explanation which specifies that information is only revealed when there is a "clear and imminent danger to an individual or to society, and then only to appropriate professional workers or public authorities" (p. 2). Under Principle 5, the code also addresses issues of the handling of professional and/or evaluative reports, disguising the identity of clients for the purpose of classroom teaching, the handling of communications from other professionals, the confidentiality of identities of research subjects and provisions for the ultimate disposition of confidential records.

The approach of psychologists used in the development of their code of ethics sharply contrasts with the approach of moral philosophers and theologians. Moralists take the principles of natural law and apply them to situations in coming to a decision as to what is proper or improper. Psychologists approached decision making in an almost opposite manner by using an empirical and inductive approach. Psychologists took actual incidents and situations, and formulated principles that would address these
situations and assist the individual psychologist in making a decision when similar situations were encountered.

The Ethical Standards of Psychologists (1979) differs from recent laws regarding confidentiality as the former was written with the intention of allowing latitude for differing situations and professional judgment. It was intended to be specific enough to provide adequate and meaningful guidelines for psychologists, but general enough to avoid regimentation. Recent laws regarding confidentiality, as well can be seen in the following sections, attempt to address every situation possible and allow little room for professional judgment.

Confidentiality - A Legal Perspective: Privacy

The right to privacy is a relatively recent legal issue in the common law. An article by Warren and Brandeis titled "The Right to Privacy", published in 1890, is the first clear formulation of the subject and is considered a milestone in legal history. Warren and Brandeis stated that political, social and economic changes with the advancement of civilization have led to the recognition of new rights involving man's emotions, sensations and intellect. They describe how the concept of "the right to life", once meaning only the protection of one's body, has grown to mean "the right to enjoy life, --the right to be let alone" (p. 289-90). This chapter reviews the legal highlights of the right to privacy as they relate to con-
fidentiality in psychotherapy.

In the last twenty years, the right to privacy has been a legal issue in a number of different types of cases including the use of contraceptives (Griswold v. Conn., 1965), abortion (People v. Belous, 1969; Babbitz v. McCann, 1970), early Sunday morning investigations of beneficiaries receiving Aid to Dependent Children (Parrish v. Civil Service Commission, 1967), publicity regarding debts (Tollefson v. Price, 1967) and investigations of private citizens by corporations (Nader v. General Motors Corporation, 1969).

The word "private" is derived from the Latin "privatus", meaning "belonging to oneself, not to the state" (Webster, 1970, p. 1131). This definition has generally held so that the "right to privacy", in the legal sense, is frequently used to refer to "a sphere of personal autonomy which is protected from governmental interference" (Morrow, 1976, p. 1). It is also used to refer to aspects of personal autonomy not necessarily related to the state.

Reubhausen and Brim (1965) stated:

The essence of privacy is no more, and certainly no less, than the freedom of the individual to pick and choose for himself the time and circumstances under which, and most importantly, the extent to which, his attitudes, beliefs, behavior and opinions are to be shared with or withheld from others (p. 1189).

This definition is most appropriate when examining the issue of privacy as related to psychotherapy.

Tort Law: Warren and Brandeis took the first step in legal history by proposing privacy as a right under
common law that serves to protect the individual. Prosser (1960), a highly esteemed professor of tort law, went a step further and divided privacy into four distinct and loosely related torts, i.e., he stated that there are four different kinds of wrongful acts involving privacy, which are:

1. Intrusion upon the plaintiff's seclusion or solitude, or into his private affairs.
2. Public disclosure of embarrassing private facts about the plaintiff.
3. Publicity which places the plaintiff in a false light in the public eye.
4. Appropriation, for the defendant's advantage, the plaintiff's name or likeness.

The latter two torts are primarily concerned with issues related to slander, libel, defamation of character and advertising and are not relevant to the present discussion.

Prosser's first privacy tort, hereafter referred to as the privacy-intrusion tort, is generally concerned with being searched and/or observed. The issues involved may range from the use of elaborate electronic surveillance to Peeping Toms and includes such acts as harassing a person who owes you money or simple eavesdropping. The privacy-intrusion tort is pertinent in regards to the providing of mental health care in a number of regards, e.g., a health insurance company's request for more explicit information regarding a patient's treatment and illness, the observation of interviews and/or therapy sessions by students and the sharing of information involved in the team approach
may all be construed as an intrusion on one's privacy.

Prosser's second privacy tort, referred to here as privacy-disclosure, is self explanatory and is probably the most pertinent tort regarding privacy in receiving mental health care. Prosser adds some criteria that must be met for there to be a privacy-disclosure tort, including: (1) the disclosure must be public and not private (therefore telling the details about a client's case at a small cocktail party would not be a tort), (2) the facts related must be private (therefore, the fact that a person has appointments at a mental health center, the dates of the appointments and the number of appointments would not be protected from disclosure as these occurrences would be considered public acts), and (3) the matter made public must be of a nature that would be "offensive and objectionable to a reasonable man" (p. 396). Obviously, these criteria, serving as a guide to issues of privacy, would not offer sufficient common law legal recourse to the patient who feels that confidentiality in the therapy setting has been betrayed.

A secondary weakness involved in the common law tort approach to the right to privacy is that not all states have accepted the right to privacy as common law. At a time when many states had already established the right to privacy by statute, one case, Yoeckel v. Samonig (1956), offers an example of the inconsistency of this
concept from state to state and the ludicrous results that can occur when the court decides to follow the letter of the law. In *Yoeckel v. Samonig*, a woman was photographed while using the ladies' room in a public tavern and the picture was openly shown to other customers. The Supreme Court of Wisconsin dismissed the woman's complaint as an earlier state Supreme Court ruling (*Judewine v. Benzies Montanye Fuel and Warehouse Company*, 1936) stated that there was no common law right to privacy and that it was not the responsibility of the court, but of the legislature in the form of statutes, if it chose, to create a right to privacy. In the twenty years between these two decisions, bills proposing a right to privacy had been defeated in the Wisconsin legislature (Hofstaeder and Horowitz, 1964), giving the courts sufficient reason to uphold the earlier *Judewine* decision.

Regardless of the correctness of the reasoning that the court used to arrive at their decision in *Yoeckel v. Samonig*, the defendant's behavior is clearly a violation of the privacy-intrusion tort and there was adequate basis, using the decisions of courts in other states, for arriving at the opposite conclusion.

Constitutional Law: An alternative to the proposal of a common law basis for the right to privacy is the argument of a constitutional basis to this right. The right to privacy is not explicitly stated in the U.S. Constitution.
However, several amendments imply a right to privacy, and it is frequently claimed as a "constitutional right".

The First Amendment right to free speech and assembly has been interpreted to mean that a person has the right to "association privacy" (Morrow, 1976, p. 2) in that it has been found unconstitutional to require that private associations reveal names of their members (NAACP v. Alabama, 1958). It was thought that such forced revelations would indirectly infringe on free expression, especially when an association is advocating unpopular beliefs and that "privacy in one's associations is indispensable to freedom of association" (Morrow, 1976, p. 2).

The Third Amendment provides a limited protection of the privacy of one's home by forbidding the quartering of soldiers in homes. The Fourth Amendment protects the individual against unreasonable searches and seizures, but allows searches when there is a warrant, probable cause, or in the case of census questionnaires, when there is a reasonable relation to governmental purposes and functions. The Fifth Amendment protects disclosure-privacy in that individuals cannot be required to provide testimony for use in their own criminal prosecution; however, when information is not incriminating, its disclosure is not protected. Written records kept by an individual, whether incriminating or not, are not subject to protection under the Fifth Amendment.
The Fourteenth Amendment is probably the most heavily relied upon in cases concerning the right to privacy. In Roe v. Wade (1973) the Supreme Court found the right to privacy in certain areas to be implicit in the concept of personal liberty as guaranteed in the Fourteenth Amendment. This case involved the desire of a pregnant, single woman to obtain an abortion at a time when Texas state statutes forbade such acts unless the life of the mother was in danger. The concept of personal liberty certainly seems involved in terms of the right to make this choice, but the concept of privacy seems to be thrown in as an attempt by the court to justify what was perhaps an unpopular decision. This impression is supported by the fact that the Supreme Court, in previous cases, had rebuked the too free and liberal use of the concept of personal liberty.

As an additional argument that the right to privacy may be construed to be implied in the constitution, the Ninth Amendment states, "The enumeration in the constitution of certain rights shall not be construed to deny or disparage others retained by the people."

There are numerous cases cited in the legal literature claiming a right to privacy or having been decided on such a constitutional right (several making questionable judicious use of the concept of the right to privacy). This paper will focus on those cases most directly related
to medical and psychiatric care.

One startling, because it occurred so recently, and oft cited case is Griswold v. Connecticut (1965) in which the Acting Director of a Planned Parenthood Center and a physician were found guilty, respectively, of giving advice to married women regarding methods of contraception and prescribing contraceptives. The state laws which the Acting Director and physician were to have broken were passed in 1879 and read as follows:

Any person who uses any drug, medicinal article or instrument for the purpose of preventing conception shall be fined not less than fifty dollars or imprisoned not less than sixty days nor more than one year or be both fined and imprisoned (sec. 53-32).

Any person who assists, abets, counsels, causes, hires or commands another to commit any offense may be prosecuted and punished as if he were the principal offender (sec. 54-196, General Statutes of Conn., as reported in Mayer, 1972, p. 40).

The U.S. Supreme Court reversed the guilty verdict of the Connecticut court in 1965 on the basis that such a law interfered with the privacy and sanctity of the marital relationship, and therefore personal liberty, of the individual citizen. The right to privacy in this case is more obviously abused than in Roe v. Wade, especially when one considers the intrusions of privacy that would be necessary to try to enforce a law against the use of contraceptives.

In cases directly related to privacy of the physician-patient relationship, the courts have included it as one of those areas of privacy implied in and protected by the
constitution, but only insofar as the government does not have sufficient justification to obtain information. In *Doe v. Bolton* (1973), a case challenging the New York Controlled Substances Act which required that the names of patients prescribed certain drugs be given to the State Department of Public Health, it was found that the state did not show just cause for obtaining this information. However, in *Schulman v. New York City Health and Hospitals Corporation* (1975), the New York Court of Appeals ruled that the state had a compelling interest in obtaining the names and addresses of abortion patients so that adequate monitoring of city abortion facilities could be accomplished, presumably through random inquiries of those who had used the services. In both cases, the court's "assumed that disclosure privacy has constitutional protection, but reached different results" (Morrow, 1976, p. 4).

With respect to how these decisions affect confidentiality in psychotherapy, one would assume that it would depend on how adequately the state was able to convince the judiciary as to its compelling interest in obtaining certain information. If the state convinced the judiciary that it had just cause to keep a listing of all persons seeking mental health care, their diagnosis and their personal problems, there would be no constitutional protection of privacy in this matter. It comes down to a definition of "just cause", which depends upon statute,
legal precedent and the individual judge making the decision. Whereas the courts and legislatures may want to avoid too specific of a definition of what is and is not private so that unwise precedent is not set for future, unanticipated situations, the legislature, in the judgment of many, has the responsibility to establish some guidelines so that, as Morrow (1976) states, "decisions need not depend on the predilections of individual judges" (p. 6).

Illinois Law: In the Constitution of the State of Illinois, effective July 1, 1971, the sixth section of the Bill of Rights briefly states the right against "invasions of privacy". The first statute related to the privacy of the psychotherapist-client relationship in Illinois was a general physician-surgeon statute enacted in 1959 which prohibited the disclosure of information learned in a professional capacity except in trials of homicide, malpractice suits, personal injury suits, civil suits involving insurance policies where physical or mental condition was in issue, will contests, trials of abortion, reports of child abuse or when the patient expressly consented to disclosure (Illinois Revised Statutes, 1977, ch. 51, sec. 5.1; see Appendix A for a copy of this law). This law served to protect against a breach of confidentiality only in cases where the psychotherapist was a physician and did not include any consequences of such a breach, such as termination of license or possible criminal prosecution.
Additional legislation providing a psychiatrist-patient privilege, with three exceptions (a fourth exception was added in 1971), was enacted in 1963 (Illinois Revised Statutes, ch. 51, sec. 5.2; see Appendix A for a copy of this law).

The Psychologist Registration Act of 1963 included a provision that psychologists could not disclose information learned in a professional capacity except in trials of homicide where disclosure related directly to the facts or circumstances, in proceedings to determine mental capacity or where a defense of mental incapacity was raised, in malpractice suits against the psychologist, in will contests or when the client had expressly consented to the release of information (Illinois Revised Statutes, 1977, ch. 111, sec. 5306; formerly ch. 91 1/2, sec. 406; see Appendix A for a copy of this law). The Abused and Neglected Child Reporting Act of 1975 provided for an additional exception. The Psychologist Registration Act states that the "violation of any provision of this Act" may be grounds to suspend or revoke any certificate of registration, adding a potential consequence for the breach of confidentiality.

The Social Worker's Registration Act of 1967 provides an even stronger consequence for a breach of confidentiality (Illinois Revised Statutes, 1977, ch. 111, sec. 6324; formerly ch. 23, sec. 5320; see Appendix A for a copy
of this law). This act states that a social worker may not disclose information learned in a professional capacity except to his employer, in a criminal trial where disclosure relates directly to the facts or circumstances of the crime, in malpractice suits or with written consent of the client and adds that the violation of any of the provisions of the Act constitutes a Class B misdemeanor.

All of the above statutes regarding confidentiality with specific professions have been amended by the Illinois Mental Heath and Developmental Disabilities Confidentiality Act which went into effect January 1, 1979 (Illinois Revised Statutes, 1979, ch. 91 1/2, sec. 801). This act is reproduced in its entirety in Appendix A. This act defines "therapist" as:

A psychiatrist, physician, psychologist, social worker, or nurse providing mental health or developmental disabilities services or any other person not prohibited by law from providing such service or from holding himself out as a therapist if the recipient (of services) reasonably believes that such person is permitted to do so (Illinois Revised Statutes, 1979, p. 1489).

Thus, although the individual professions may maintain an additional statement on confidentiality in their respective acts of registration, the Confidentiality Act is the authoritative law for all mental health professionals and, as such, provides guidelines and consequences that are the same for all psychotherapists. This consistency across professions aids in the understanding and implementation of the law.
The Illinois Confidentiality Act delineates numerous exceptions to absolute confidentiality in psychotherapy. The situations in which information may be disclosed according to the Act include:

1. an unlimited disclosure of "any and all confidential communications and records" when there is a general consent for the release of information to insurance companies that are evaluating an application for a policy or a claim on a policy;

2. a limited disclosure to enable a person to apply for and receive benefits;

3. an examination of records, from which personally identifiable data have been removed, for the purposes of funding, accreditation, audit, licensure, statistical compilation, research, evaluation or similar purposes;

4. an investigation by a regional human rights authority of the Guardianship and Mental Health Advocacy Commission;

5. when the purpose of disclosure is for supervision, case consultation, peer review, clerical maintenance of the record, or therapist consultation of an attorney;

6. when the client introduces, in civil or administrative proceeding, his/her mental condition or any aspect of the mental health care services received;

7. certain civil proceedings following a recipient's death;
(8) a malpractice suit;
(9) a court ordered examination or treatment ordered to render a client fit to stand trial;
(10) the determination of competency or need for guardianship;
(11) a civil or administrative proceeding involving the validity of insurance benefits;
(12) when an action is brought to a matter under this Act;
(13) child neglect or abuse;
(14) in order to initiate or continue civil commitment proceedings;
(15) in order to provide emergency medical care to a recipient;
(16) to protect the client or their person against a clear, imminent risk of serious physical or mental injury or disease or death;
(17) limited disclosure when the United States Secret Service requests information about a specific client and it is determined that this information is necessary to protect the life of a person under Secret Service protection;
(18) limited disclosure to the Department of Law Enforcement as to whether applicants for a Firearm Owners Identification Card have had a psychiatric hospitalization in recent years;
(19) when a recipient of mental health care or his/her
guardian gives written consent as specified in the Act.

Throughout each exception of the Confidentiality Act, it is repeatedly emphasized that only that information which is directly relevant to the purpose for which it is disclosed should be released. Several of the disclosures limit the kind of information to be released to the fact that a person received mental health care, the type of treatment and the date of such treatment. In several places, especially when a civil or administrative proceeding is involved, the code suggests how confidential communications may be examined by the court in order to determine what is appropriate and relevant for disclosure.

The Illinois Confidentiality Act states that "any person who knowingly and willfully violates any provision of this Act is guilty of a Class A misdemeanor", therefore adding some strength and motivation for following the law strictly. Under Illinois law, Class A is the most serious misdemeanor and is punishable by a prison sentence of up to one year and/or a fine not to exceed $1,000.

Since the Illinois Confidentiality Act went into effect, there have been numerous attempts to modify and change it. One example of an amendment proposed in 1980 (HB 2960) requires the disclosure of the location of a person receiving mental health care to any peace officer requesting the information if an arrest warrant has been
issued for that person.

Another recently proposed amendment (SB 1453) requires that psychotherapists, who determine that a client is a probable danger to a third party, inform such third party of the danger and be civilly liable for any injuries incurred should they fail to do so. The Confidentiality Act currently allows psychotherapists to use professional judgment in this regard and states:

Records and communications may be disclosed ... when, and to the extent, a therapist, in his sole discretion, determines that such disclosure is necessary to initiate or continue commitment proceedings under the law of this State or to otherwise protect the recipient or other person against a clear, imminent risk of serious physical or mental injury or disease or death (p. 1492).

The proposed amendment would require such disclosure without allowing for professional judgment and because of this rigidity is likely to die in the Senate Rules Committee. Tarasoff v. The Regents of the University of California: The case that set a precedent for the above proposed amendment is that of Tarasoff v. The Regents of the University of California (1976). In this case, a suit was brought against the university regents, psychotherapists and campus police for negligence that resulted in the murder of Tatiana Tarasoff by a psychiatric patient. Reportedly, two months prior to her murder, Prosengit Poddar had seen a psychologist employed by the University and informed him of his intent to kill Ms. Tarasoff when
she returned to the United States from a trip abroad. The psychologist took Poddar seriously enough to contact the campus police in order to initiate the psychiatric commitment of Poddar. The police released Poddar after they concluded that he was adequately rational. The psychologist's supervisor then stepped in and directed that no further action be taken and that records of the action that was taken thus far be destroyed. Neither Ms. Tarasoff nor her family were notified of Poddar's threat.

Ms. Tarasoff's family sued after the murder on the basis that the University, the psychotherapist and the campus police were negligent in their duty to use reasonable care to protect an intended victim against danger. The court found that no cause of action could be taken against the psychotherapist for failure to have Poddar committed as a state statute expressly protects public employees from liability for "any injury resulting from determining in accordance with any applicable enactment ... whether to confine a person for mental illness" (Government Code, sec. 856 as quoted in Tarasoff, 1976, p. 351).

However, the majority opinion of the court was that the Tarasoff family did have a cause of action against the therapist as the therapist had found Poddar to be a danger to Ms. Tarasoff, but had "failed to exercise reasonable care to protect her from danger" (Tarasoff, 1976, p. 353) in that no warning of the potential danger to Ms. Tarasoff
was given to her or her family.

The thinking of the court was based on earlier cases, not involving psychotherapists, that concluded that when a special relationship exists, there is a responsibility to use ordinary care and skill in order to prevent the occurrence of foreseeable harm. These cases include situations in which a cause of action was upheld when parents failed to warn a babysitter of the violent proclivities of their child, when the State failed to warn foster parents of the dangerous tendencies of their ward, and when a doctor, after diagnosing a contagious disease, failed to warn members of the patient's family.

The court concluded:

In our view, however, once a therapist does in fact determine, or under applicable professional standards reasonably should have determined, that a patient poses a serious danger of violence to others, he bears a duty to exercise reasonable care to protect the foreseeable victim of that danger (p. 345).

The defense argued that communications between a potentially violent client and the therapist must be kept confidential if violent-prone persons are not to be deterred from seeking psychotherapy. The defense noted that the legislature had recognized that disclosing confidences impairs effective treatment of emotional disturbance, and thus is contrary to the best interest of society; therefore, the legislature enacted statutes to protect the confidentiality of psychotherapy.

The court responded that one must weigh the public
interest of supporting effective treatment of emotional disturbance, protecting the rights of patients to privacy and the importance of safeguarding confidential communications against the public interest and safety from violent assaults. They stated:

We conclude that the public policy favoring protection of the confidential character of the patient-psychotherapist communications must yield to the extent to which disclosure is essential to avert danger to others. The protective privilege ends where the public peril begins (p. 347).

The Tarasoff decision has resulted in proposals for new laws and additional court cases based on the same or a similar premise. A case in which an action was brought following Tarasoff involved parents suing a psychiatrist for negligence as he did not inform them that their daughter was suicidal and she ultimately killed herself (Bellah v. Greenson, 1977). The plaintiffs in this case cited Tarasoff in support of their cause of action; however the court noted that Tarasoff specifically addressed the issue of a duty when there is a danger to a third party and ruled that the psychotherapist does not have a similar duty, at least for which he can be held liable, when the person intends to injury him/herself. The court held that in inflicting injury to oneself, society's interest in confidentiality in psychotherapy was not sufficiently counterbalanced so that there should be a breach of confidentiality.

Confidentiality - Legal Cases: Most cases that have come before the court regarding confidentiality in
psychotherapy relate to the issue of whether psychotherapy communications are privileged, i.e., whether they can be used as evidence in a legal proceeding. Very few cases relate to the issue of privacy of psychotherapy outside of privileged communications or when the client is dangerous to himself or others.

One that does is Doe v. Roe (1973). In this case, an action was filed by a client of a psychiatrist to prevent publication of a book of her case history in which, although her name was disguised, information such as approximate age, religious affiliation, schools attended, profession and interest were not changed. The client was a social worker by profession and felt that she would be readily identified. The psychiatrist claimed the client had given consent to the publication of the case history eleven years previous, when she was still in psychotherapy, and that the book would advance scientific knowledge. The court found this prior consent to be inadequate as the client was still in psychotherapy and therefore may have been subject to unspoken pressures, if in fact this consent did exist, and indicated that the psychiatrist's commercial advertising of the book contradicted her claims of advancing scientific knowledge. The Supreme Court of New York ruled that the plaintiff had sufficient cause for a preliminary injunction to prevent publication and distribution of the book. The court stated that, although they were not
urging a common law right to privacy, every patient, and particularly those in psychotherapy, has the right to expect privacy (Stecher, 1977).

Another mental health privacy case of a vastly different nature involves the monitoring of the quality of mental health care. In Carey v. Affiliated Mid-West Hospital, Inc. (1977), a case originating in the circuit court of Cook County, Illinois, the State's Attorney's office sought access to the names and addresses of former patients at Chicago Lakeshore Hospital and insurance billings of these patients in order for the Grand Jury to investigate charges regarding the quality of care that patients received and possible violations of the Insurance Code. The State's Attorney wanted the names and addresses of former patients so that they could be contacted and asked about the quality of care they received while in Chicago Lakeshore Hospital. Records of insurance billings (which includes psychiatric diagnoses) would allow an evaluation of whether patients were hospitalized for inordinately long lengths of times for the purpose of "milking" the health insurance companies.

Attorneys representing two former patients of Chicago Lakeshore Hospital and a psychiatrist who saw patients at the hospital filed a petition to quash a subpoena for the above information. They stated that the release of such information would be a gross violation of
the right to seek psychiatric care in private. John Doe, one of the patients, is quoted as saying, "When I went in [Chicago Lakeshore Hospital], I had two main concerns; One, naturally, was to get well. The other, and almost as important, was that no one find out that I was there" (Chicago Tribune, Oct. 2, 1977, p. 5). Several other former patients contacted the Chicago Tribune and stated that, if they had experienced any abuse by their doctors or the hospital, they were quite capable of reporting it themselves.

The petitioners did not argue against the responsibility of society to see that patient abuse and/or insurance fraud do not occur and offered several alternative methods of conducting the investigation without infringing on the right to privacy in the psychiatrist-patient relationship, including, (1) having the hospital write all former patients, inform them of the investigation, and advise them to contact the State's Attorney's office if they wished, (2) interviewing past and present employees regarding hospital care and practices, and (3) conferring with investigators from the Department of Public Health and the Chicago Board of Health, two agencies already entrusted by the law to investigate patient abuse in mental health facilities.

The Circuit Court of Cook County sustained the motion to quash the subpoena. The State's Attorney took the
case to the Illinois Appellate Court, First District. The Appellate Court dismissed the case, meaning that the State's Attorney's office was unable to gain access to the hospital records through a subpoena.

This author was able to locate very few cases where either a client had sued for a breach of confidentiality or where confidentiality, rather than privileged communication was a significant issue. It should be noted that, in general, only cases that are appealed to a higher court are reported in the legal literature. Even those cases appealed may not be reported if they do not represent a new or different interpretation of the law or a reaffirmation of a rather significant point of law. For example, the information on Carey v. Affiliated Mid-West Hospital, Inc. (1977) was obtained through a newspaper story and the Illinois Association of Community Mental Health Agencies. This author could find no summary or discussion of this case in the legal literature.

One reason for the lack of cases regarding confidentiality may be that, once clients have informed their psychotherapists that they have learned of a breach of confidentiality and that they are displeased with it, unless the psychotherapists persist in divulging information, the clients would probably draw more attention to those very facts or items that they want kept private by suing in a court of law than by remaining silent.
Summary: The law regarding the privacy of psychotherapy is still in the making. Recent trends by legislatures and the courts have been toward greater awareness of the role of confidentiality in the therapeutic relationship, resulting in strict laws of confidentiality, but with a large number of carefully delineated exceptions. With so many exceptions, one wonders whether or not the privacy of psychotherapy has any real protection under the law. The laws would appear to protect clients from the unscrupulous, gossiping psychotherapist, but in other situations the legislature has allowed much leeway for individual judges to make decisions regarding confidentiality. The legislature has not allowed mental health professionals the same degree of professional judgment.

There is continuous legislative and court activity as to the validity of the exceptions to absolute confidentiality. It will take careful monitoring by mental health care professionals to see that the exceptions to confidentiality are not increased, stretched or abused so as to make the concept legally meaningless and at the same time not make the laws of confidentiality so rigid as to not allow room for professional, moral and ethical judgment.

Confidentiality - A Legal Perspective: Privileged Communication

The previous section focused on the legal development of the general concept of privacy in psychotherapy.
This section focuses on one specific aspect of privacy in psychotherapy, privileged communication. Privileged communication refers to those communications that are protected from use as evidence in a legal proceeding. Privileged communication is put into a separate section from privacy in psychotherapy as it represents the area under which there is likely to be the most public attention and conflict between the right of the individual to confidentiality in psychotherapy and the right or need for society to have certain information. It thus involves many issues in addition to the individual's everyday right to privacy.

**History of Privileged Communication:** Privileged communication was not formulated as a concept under common law until the 16th century because prior to that time, no person could be required to testify in a court of law. Soon after the enactment of the law requiring all persons to testify as ordered by a court, the attorney-client privilege, the oldest of the privileged relationships, was accepted into common law. Cases in the latter part of the 16th century prohibited an attorney from testifying as a witness, unless he had his client's consent. DeWitt (1958) notes that:

> The purpose of the privilege is to encourage the employment of professional advisors by persons in need of their services and to promote absolute freedom of consultation by removing all fear on the part of the client that his attorney may be compelled to disclose in court the communications made to, or the information acquired by, him in the course of his professional employment (p. 7).
This attorney-client privilege is generally accepted as common law and is protected by statute, as well, in nearly every state.

Confidential communications between a clergyman or priest and a parishioner are not considered privileged communications under common law and thus are only protected from disclosure in a legal proceeding by virtue of custom and/or statute. One reason offered to explain why communications in the attorney-client relationship were privileged, but not those in the clergyman-parishioner relationship, is that there was conflict between the Roman Catholic and the Anglican churches in England. The Roman Catholic church considered priest-penitent communications to be absolutely confidential and priests frequently refused to testify regarding their parishioners. The Anglican church was not so strict in this regard. It was generally considered that clergyman-parishioner privilege would show support for the Roman Catholic church and this was thus avoided. Roman Catholic priests still refused to testify or report what they heard in confession to authorities.

One of the first court cases involving the issue of privileged communication was the trial of Father Garnett, a Jesuit priest, who had been aware of a conspiracy known as the Gun Powder Plot, against King James and the members of Parliament in the early 1600's. He had learned of this
plot when hearing the confession of one of the conspirators and had not reported it to the authorities, thereafter being implicated as being a party to the treasonous plans. His defense was that he was bound by moral law not to disclose what he had learned from a penitent in confession. The judges found the act of the crime so immoral that they refused to accept a defense based on morality and Father Garnett was hanged (Stern, 1959).

Today the clergyman-parishioner relationship is generally accepted as privileged in the United States. Most of the states have statutes providing for this privilege. Those states that do not have such statutes have generally accepted the clergyman-parishioner privilege by custom.

The physician-patient relationship, like that of the clergyman-parishioner relationship, is not accepted as privileged under common law. The first recorded court case in which the issue of privileged communication was raised in regard to the physician-patient relationship was the trial of the Duchess of Kingston in 1776. She had been placed on trial for bigamy and when her physician was questioned, he had replied, "I do not know how far anything that has come before me in confidential trust in my profession should be discussed consistent with my professional honor" (Stern, 1959, p. 1074). In response, the judge ruled that it was indeed indiscrete to disclose secrets
learned in a professional capacity in most circumstances, but not when called to do so in a court of justice.

The question has frequently arisen as to why privilege is considered necessary for communications in the attorney-client relationship but not in the physician-patient relationship. Some have pointed out that, after all, many legislators and most judges are trained as attorneys and they are the ones who make this decision. DeWitt (1958) cites other authors who point out that the attorney-client privilege is intended to aid in the administration of justice, and that, although inviolable secrecy of communications between physician and patient may be in the interest of good and reliable medical care, it is not necessary in the interest of justice. He notes that most statutes in court cases regarding the physician-patient privilege see its primary purpose as:

To envoke and encourage the utmost confidence between the patient and his physician and to preserve inviolate, so that the patient will freely and frankly reveal to his physician all the facts, circumstances, and symptoms of his malady or injury, or lay bear his body for examination, and thus enable his physician to make a correct diagnosis of his condition and treat him more safely and efficaciously (p. 27).

There has been much controversy as to whether or not this is adequate cause for a physician-patient privilege. Wigmore, renowned for his monumental work on the laws of evidence, was strongly opposed to the physician-patient privilege. He stated that the following fundamental conditions must be present before communication may
be considered to have privileged status:

1) The communications must originate in a confidence that they will not be disclosed.

2) The element of confidentiality must be essential to the full and satisfactory maintenance of the relation between the parties.

3) The relation must be one which in the opinion of the community ought to be sedulously fostered.

4) The injury that would inure to the relation by the disclosure of the communications must be greater than the benefit thereby gained for the correct disposal of litigation.

(1940, p. 527)

Wigmore viewed the physician-patient relationship as meeting only the criteria that the relationship should be encouraged. He noted that people have sought medical care for years without the privilege and he saw nothing to be gained and much to be lost, in terms of truth and justice, if a physician-patient privilege was established.

During Wigmore's time privilege in psychotherapy was not examined as a legal issue distinct from the physician-patient relationship. He has been deceased for more than thirty years, and since his death, the practice of psychotherapy has grown and privilege in the psychotherapeutic relationship has been presented as a separate legal issue. Although Wigmore would not doubt still oppose a general physician-patient privilege, others have found the psychotherapist-patient relationship as meeting the criteria he set for privilege to exist.

Numerous states have enacted statutes providing for
privilege in the physician-patient relationship. In 1828, New York became the first state to establish the physician-patient privilege by statute. It stated simply that:

No person duly authorized to practice physic or surgery shall be allowed to disclose any information which he may have acquired in attending any patient, in a professional character, and which information was necessary to enable him to prescribe for such patients as a physician, or to do any act for him, as a surgeon (New York Revised Statutes, 1828, as quoted by DeWitt, 1958, p. 15-16).

Most states have since enacted statutes granting the physician-patient privilege, but there is considerable variation between states. The statutes provide for a number of different kinds of exceptions, and each state varies in the particular exceptions that it provides.

Lifschutz: A case which challenges these exceptions and raises several constitutional and therapeutic questions regarding confidentiality and privileged communication in psychotherapy is that of Lifschutz (1970). In this case, a man sued for damages in compensation for physical injuries, pain and suffering, and severe emotional stress as a result of an alleged assault. The plaintiff stated that he had received psychiatric treatment from Dr. Lifschutz about ten years earlier. Lifschutz was called in for a deposition and refused to give any information, even refusing to state whether or not the plaintiff had been a former patient of his. Lifschutz claimed a constitutional right as a psychotherapist to refuse to divulge such information. He was jailed for contempt of court.
Lifschutz then sued for a habeas corpus, i.e., a legal explanation of why he was jailed. The primary question at issue was whether the legislature had surpassed their constitutional limits by requiring that the right to privilege in psychotherapy is waived, in relevant matters, when a plaintiff brings his mental condition as an issue in litigation. This patient-litigant exception was very clearly spelled out in California statutes at the time and the court elected to follow the statutes; however, Lifschutz's arguments and the court's responses command attention.

One of the arguments of Dr. Lifschutz was that he was denied equal protection under the law as the legislature had allowed that clergymen were permitted to claim a privilege as above and he, as a psychiatrist, was not. He argued that given the purpose of clergyman-parishioner privilege, i.e., fostering a "sanctuary for the disclosure of emotional stress", that there was little real relevant distinction between the two professions on which to base a distinction in the law. The court found this argument reflected an inadequate understanding of the foundation of the privilege and cited Wigmore in support of the denial of the privilege:

Does the penitential relation deserve recognition and countenance? In a state where toleration of religion exists by law, where a substantial part of the community professes a religion practicing a confessional system, this question must be answered in the affirmative (1940, p. 378).
The court noted that a toleration of religious forms and practices is the foundation of this privilege. Obviously, the similar toleration for mental health care is not in the law. In addition, although psychotherapists may be strongly committed to the ethics and tenets of their professions, the court stated that this is reasonably distinguishable from religious conviction on which the clergyman-parishioner privilege is based.

Lifschutz also argued that, as a psychotherapist, he had a constitutional right to claim privilege based on the psychological needs and expectations of all patients, regardless of the wishes of a particular patient. He stated that he had the right to claim the privilege himself. The court noted that all prior cases dealing with physician-patient privilege have found that a constitutional right to privacy exists for the patients, but not for the physicians. They add that it is the patient's intimate revelations, even though the treatments may involve communication between the psychotherapist and the patient, that give rise to an interest in the privacy of the psychotherapeutic process.

Lifschutz also argued that any requirement that he reveal confidential communications between himself and a patient unconstitutionally impaired the practice of his profession. He based this argument on two legal contentions, (1) that the limitation on the capability to prac-
tice psychotherapy would be so severe that it represented a "taking" of valuable property, i.e., the psychiatrist's practice of psychotherapy, and (2) that since being required to testify would severely limit psychotherapy, it unconstitutionally limited the availability of medical care. The court indicated that they found Lifschutz's arguments in this regard to be somewhat exaggerated. They doubted that the profession of psychotherapy would be significantly impaired by his being required to testify, especially as in this and similar cases involving the patient-litigant exception, the only times the privilege of psychotherapeutic communications would not be followed are when the patients themselves introduce the issue of emotional distress and/or condition. The court added that "the practice of psychotherapy has grown, indeed flourished, in an environment of a nonabsolute privilege" (p. 11).

As to the statutes regarding the patient-litigant exception, the court upheld the statutes by requiring that Dr. Lifschutz testify regarding any communications relevant to the present suit. They found the statute to be a sound balance between the accepted need for confidentiality in the psychotherapeutic setting and the interest of the state to ascertain the truth in legal proceedings. The court noted that it is not fair to allow a plaintiff to make a claim, and then limit inquiry into the facts of the claim.
However, they very clearly asserted that all psychotherapeutic communications are not required to be disclosed under the patient-litigant exception and that any communications not directly relevant to the suit are considered privileged. The court briefly mentioned methods of evaluating the relevancy of confidential communications which would maintain respect for the plaintiff's privacy, including reviewing such materials in the judge's chambers or obtaining protective orders during discovery. They also concurred with the United States Supreme Court opinion (Griswold v. Connecticut, 1965) that the Constitution does guarantee "zones of privacy" and that psychotherapy falls into one of these zones, but that this does not guarantee an absolute privilege which would allow for no exceptions. The court concluded that:

Under a properly limited interpretation, the litigant-patient exception to the psychotherapist-patient privilege, at issue in this case, does not unconstitutionally infringe the constitutional rights of privacy of either psychotherapists or psychotherapeutic patients. As we point out, however, because of the potential of invasion of patients' constitutional interests, trial courts should properly and carefully control compelled disclosures in this area in light of accepted principles (p. 8).

An ironic fact about Lifschutz's case is that when it was decided that the psychiatrist did have to testify, once he stated that he had indeed seen the plaintiff ten years earlier, he was excused from any further testimony on the basis that it was irrelevant as it had taken place so many years previous to the suit (Grossman, 1978).
Illinois Law: In Illinois, the privilege of the psychotherapist-client relationship was apparently first recognized as based on common law in a trial court decision to excuse a psychiatrist from testifying (Binder v. Russell, 1952). This case involved an alienation of affections action by a husband whose wife was a client of the psychiatrist. The psychiatrist responded to questions with, "I can not reply in good conscience" (Northwestern University Law Review, 1952, p. 384). He was excused from testifying on the basis that psychiatrist-patient communications were privileged.

Since then, in Illinois, privacy in psychotherapy and the right to claim the privilege for communications in psychotherapy have followed parallel paths in state statutes. The general physician-surgeon statute enacted in 1959 (Appendix A) does not expressly state a privilege, but imposes an obligation of privacy except in specified situations, none of which is a subpoena or court order to testify.

The psychiatrist-patient statute of 1963 (Appendix A) expressly states a privilege in the psychiatrist-patient relationship, with three exceptions including relevant communications when, (1) a patient is determined to be in need of hospitalization, (2) there is a court ordered psychiatric examination, and (3) a patient or his/her heirs introduce the patient's mental condition as an element of claim or defense in a civil or administrative proceeding.
Cases of malpractice or when the patient is a complaining witness against a psychiatrist were added as a fourth exception in 1971. The wording of this statute would appear to grant the privilege to the psychiatrist as well as to the patient so that the psychiatrist could refuse to testify even if given permission or requested to do so by the patient.

That same year the Psychologist Registration Act (1963; Appendix A), which included a section on the prohibition and exceptions for disclosure of information by a psychologist, was passed. Although this act did not explicitly use the word "privilege" as did the act for the psychiatrist-patient relationship, it did not include a subpoena or court order in the five conditions under which a psychologist could disclose information. This act thus served to provide a strong privilege in the psychologist-client relationship. It stated as one of its exceptions that information may be disclosed with the express consent of the client and did not state that the psychologist may refuse to disclose when given this consent, so the privilege belonged strictly to the client and not to the psychologist. This act did not allow psychologists to testify when clients introduced their mental condition as an element of claim or defense in a civil suit unless the psychologists had the express consent of the client, i.e., there was no patient-litigant exception for psychologists.
The Social Worker's Registration Act of 1967 provided for a different kind of privilege than the acts for psychiatrists and psychologists. It allowed no privilege when there was a criminal trial and disclosure of information related directly to the facts or circumstances of the crime, but in civil cases it did not allow for a patient-litigant exception unless a client gave written consent to disclosure of information.

The variations in the laws for the different mental health professions certainly presents a confused picture. If their psychotherapist was a psychiatrist, clients could apparently discuss criminal acts, even murder, without fear that their psychiatrist would be forced to testify regarding these acts; however, a kleptomaniac could not seek help for habitual shoplifting from a psychotherapist who was a social worker without fear that the social worker may be required to testify to these discussions in the future. Regarding civil suits, clients whose psychotherapists were social workers or psychologists could merely sue and introduce their mental condition as part of a claim without allowing their psychotherapists to testify while clients whose psychotherapists were psychiatrists would automatically waive such a privilege.

As discussed in the previous section, the Illinois Mental Health and Developmental Disabilities Confidentiality Act (Illinois Revised Statutes, 1979; Appendix A),
which went into effect January 1, 1979, clears up a con-
siderable amount of confusion by setting forth the same
laws for privacy and privilege for all mental health pro-
fessions. The Confidentiality Act provides for a large
number of exceptions to the privilege of communications in
the psychotherapist-client relationship. Upon close exami-
nation, one sees that each exception is very carefully
delineated in order that communications may be kept as
private as possible and so that the absence of the priv-
ilege is not abused by the client's adversary.

For example, in the section dealing with the patient-
litigant exception, information may only be disclosed in a
civil or administrative proceeding if the clients introduce
their mental condition or any aspect of their mental health
care as an element of their claim or defense. The Act adds
that such disclosure may be made,

If any only to the extent the court finds, after in
camera [i.e., in the judge's chambers] examination of
testimony or other evidence, that it is relevant, pro-
bative, not unduly prejudicial or inflammatory, or
otherwise clearly admissible; that other satisfactory
evidence is demonstrably unsatisfactory as evidence of
the facts sought to be established by such evidence;
and that disclosure is more important to the interest of
substantial justice than protection from injury to
the therapist-recipient [of mental health services]
relationship or to the recipient or other whom disc-
closure is likely to harm (Illinois Revised Statutes
1979, p. 1491).

This section adds that no information other than the fact
that a person received treatment, the cost of such treat-
ment and the diagnosis may be disclosed unless a compelling
need is established for further disclosure. This section further limits the patient-litigant exception by providing that in any action brought in a marriage dissolution proceeding or any other action in which pain and suffering is an element of the claim, mental condition is not to be considered to be introduced unless a client or a witness on his behalf first testifies about the client receiving mental health care.

The above delineation of the patient-litigant exception prevents abuse of the privilege by allowing relevant information to be disclosed; however, it prevents abuse of the exception by limiting the information to be disclosed and defining the circumstances under which it may be disclosed. The other exceptions to the privilege, such as civil commitment, malpractice suits, or court ordered examinations are likewise very carefully explicated so that the interests of society can be served by allowing disclosure under specific conditions with minimal infringement on the privacy of the individual.

Even with the seemingly very clearly formulated law of the Illinois Confidentiality Act, controversies and disagreements still occur. An example is the case of Laurent v. Brelji (1979) in which the Illinois Department of Mental Health and Developmental Disabilities sought to discharge an employee for allegedly abusing a patient. In the civil service administration hearing, the patient
testified against the employee. The employee then requested that the patient's records be subpoenaed for use in his defense. Dr. Brelji, speaking for the Department of Mental Health and Developmental Disabilities, appealed the court order to bring the patient's records for in camera inspection on the basis that the Illinois Confidentiality Act does not allow for the disclosure of confidential information in an administrative hearing unless the recipient of mental health care introduces his mental condition or any aspect of his services received for such condition as an element of his claim or defense. Dr. Brelji noted that the patient was not making a claim, strictly defined as a cause of action, against the employee. If the employee was being sued on a personal injury action in the circuit court on the same charges, he could request an in camera investigation of the records for relevant information, but this was not the case.

The court ruled that a "claim" could be more broadly defined than as just a "cause of action." They stated that it was inconsistent that the records could be subpoenaed in a personal injury action, but not in an administrative procedure which was considering the same issues and allegations. The court added that this was especially true in light of the fact that the potential loss of the employee from the administrative proceeding is possibly greater than that in a civil suit.
A sidelight of this case was the fact that the legal brief prepared by the Department of Mental Health and Developmental Disabilities, which sought to protect the confidentiality of the patient, contained the patient's name, while the legal brief prepared by the attorneys of the employee very carefully referred to him as "Patient X" throughout.

Summary: The laws and practices regarding the privilege of communications between psychotherapists and clients vary from state to state. The current trend is toward increased acceptance by statute of such a privilege, but with carefully delineated exceptions. Even with these careful delineations, conflicts will arise. There are some who contend that there are so many exceptions as to make the privilege meaningless. Others contend that the amount of privilege granted by the statutes interferes with the administration of justice.

In attempting to come to a determination that is just to both the individual and society, the legal approach to decision making uses the principles of natural law as embodied in the common law. In addition, the legal approach considers and accommodates to other views including the principles of the Constitution, what is reasonable for the purposes and functions of the government and the practical needs of society. The courts operate on a case-by-case basis that does not facilitate an orderly or scientific
development of principles similar to the approach of psychologists. In the legal approach to decision making, the principles of moral absolutism are tempered by the mores of changing society.
CHAPTER III

INTEGRATION AND HYPOTHESES

Thus far we have explored the rationale for confidentiality in psychotherapy from a moral, theoretical and ethical perspective and the attempts of the legal system and the professions of psychotherapists to deal with this concept in an ordered society. As was discussed in the review of the literature, both theory and research regarding the practice and dynamics of psychotherapy suggest a central role for confidentiality in psychotherapy. The section on historical and moral aspects of confidentiality explicates how the Roman Catholic church, over a period of several hundred years, grappled with the controversy of absolute privacy and came to the decision that absolute secrecy in the confessional was essential to the maintenance of the sacrament of confession and therefore for the well-being of the church. The sections which discuss the laws and court rulings regarding privacy and privileged communication present sound social and legal arguments opposing absolute confidentiality and privileged communication in psychotherapy and serve at least partially to explain how the current laws came to be. This chapter is an effort to integrate these previous sections in a discussion of the effects of legal intervention on the tradi-
In order to explore the effects of legal intervention on the practice of psychotherapy, one must look at a number of variables including, but not limited to, (1) the overall effect of laws on confidentiality on the attitude and/or approach of the psychotherapist, (2) the effect of specific laws on the attitude and/or approach of the psychotherapist, (3) the effect of having revealed information on the subsequent attitude and approach of the psychotherapist, (4) the overall effect of the laws on confidentiality on the client's attitude and/or response in psychotherapy, (5) the effect of individual laws on the client's attitude and/or response in psychotherapy, and (6) the effects of having information revealed on the client's subsequent attitude and/or response in psychotherapy. The basic questions underlying each of the above variables involve: 1) a determination of whether the legal attempts to resolve issues of confidentiality help or hinder the practice of psychotherapy; 2) a determination of whether any resultant hinderance is in the best interest of society.

**Psychotherapist Reaction**

**Overall Effect of Laws:** As a whole, the laws on confidentiality must cause a mixed reaction in psychotherapists. On the positive side, they often offer definite, concrete guidelines for the psychotherapist to follow in deciding whether or not, and in what circum-
stances, information should be released. Such guidelines can certainly be a relief amongst all the controversy and ambivalence that surround disclosures of information. Jagim, Whittman and Noll (1978) and Mariner (1967) point out that a therapist who does not disclose confidential information to colleagues or other agencies may be viewed as uncooperative. The possibility of appearing uncooperative may inappropriately influence a decision regarding the release of confidential information.

The laws on confidentiality also serve to offer a means of protection, for both the client and the psychotherapists, from irresponsible or unreasonable requests for information. The psychotherapist in many cases now has the force of the laws to back up his ethical standards. Slovenko (1975) notes that "as in all areas of life, specific black letter rules [on confidentiality] are sought as though they were holy grail. They offer comfort and a sense of security" (p. 125). It is much easier to refuse to disclose information when the law states that you cannot. Then psychotherapists do not have to be concerned with the risks of appearing unreasonable or uncooperative as they are merely being good citizens and obeying the law.

The laws of confidentiality also reduce the possibility of misinterpretation when therapists refuse to release information. Mariner (1967) notes that many parties will assume that psychotherapists have negative infor-
mation if they refuse to disclose confidential communications. With strict laws on confidentiality such misinterpretation may be the exception rather than the rule.

Laws regarding confidentiality, however, do not only make the psychotherapist's job easier; they also complicate it. The laws very clearly spell out the fact that psychotherapy is not completely confidential, but the myth that it is still remains amongst both professionals and clients. Many psychotherapists wonder whether, in order to be totally ethical and responsible, they should give their clients Miranda type warnings at the onset of psychotherapy so that it is very clear to all parties what information will be confidential, and under what conditions, and what information will not be. Bersoff (1976) expresses concern that the failure of the therapist to fully inform a client of the limits of confidentiality, while the therapist has a duty to disclose certain kinds of information, may constitute entrapment. Freedman (1959) refers to disclosure of information after the client has been assured that psychotherapy would be confidential as "psychic entrapment." He states that a psychotherapist should either "warn his patient beforehand of the reservations he has concerning confidentiality or, having committed himself to secrecy he should maintain it" (p. 1080). Needless to say, to request full disclosure from clients on the one hand, and advise them that full disclosure may not be wise on the
other, must cause some discomfort in the psychotherapist.

Another fact about laws on confidentiality that can complicate the job of the psychotherapist is that the laws increase the awareness of the legal environment, with its increasing number of malpractice suits, in the therapy setting. Psychotherapists may feel a need to inform clients about the limits of confidentiality in order to protect the clients; they may also feel the need to do so in order to protect themselves from future law suits. An atmosphere in which a client is viewed as a potential adversary, which in these times may be the wisest approach for the legal protection of the psychotherapist, is probably not conducive to the most successful practice of psychotherapy. Roth and Meisel (1977) are concerned that an explanation to every patient of the limits of confidentiality "might prevent meaningful psychotherapy or even deter patients from therapy" (p. 510).

The laws very clearly define those conditions under which psychotherapists must release information, without any allowance for professional judgment, whether it is for the good of the individual and society or whether it actually serves no fruitful purpose. The psychotherapist, despite all his training, has lost the right to use professional expertise in deciding whether it is appropriate or in the interest of anyone to release information. This power now lies with the legislature and the courts, bodies
that do not necessarily have an understanding of the importance of confidentiality to the process of psychotherapy. Putting the power of decision-making into the hands of the court changes the disclosure of information from a therapeutic to a legal decision.

Many mental health professionals refuse to accept clients where it appears at all likely that the psychotherapist will be subpoenaed to testify in court. This is not merely a matter of time, convenience and money as those who testify as expert witnesses can generally charge and collect quite high fees for such testimony. Rather, it is a matter of being reluctant to enter a situation in which one is requested to offer professional judgment, but in the particular situation is limited in using professional judgment, i.e., in deciding what information is appropriate or not appropriate for disclosure, by the power of the court.

Even the client, by providing consent for the release of information, may interfere with the psychotherapist's professional judgment. Mariner (1967) proposes that psychotherapists not release information, even with client consent, except under very well considered circumstances. He notes that the client may inadvertently or unconsciously sabotage the therapeutic situation by trying to control what the psychotherapist says and to whom he says it. He believes that conflict regarding who is in
control of the therapeutic information may lead psychotherapists to do things they would ordinarily not do. Mariner offers the example of the nondirective psychotherapist, who would generally not give direct advice in the therapeutic setting, giving opinions and recommendations in response to a request for information from another agency or other source, when the client has provided written consent for the disclosure of information.

As a whole, the laws of confidentiality offer both relief and discomfort for psychotherapists as they provide clear guidelines, but may compel psychotherapists to act contrary to their professional and ethical training and judgment. Siegel (1979) notes that "It seems clear that in attempting to help people, psychotherapists have less difficulty with their principles, their patients, or their work than they do with the law" (p. 245). The laws thus, overall, may be viewed as both helping and hindering the practice of psychotherapy, depending on the particular law and the particular case.

**Effects of Specific Laws:** Specific aspects of the laws on confidentiality have distinct ramifications on how the psychotherapist conducts his/her practice. One area of particular concern is written records. There are significant questions, both legal and ethical, as to whether the record belongs to the client, the psychotherapist or the public. Several courts have ordered psychiatrists to bring
all records containing psychiatric history, as well as the thoughts, feelings, and fantasies of the client and the impressions and hypotheses of the psychotherapist, for in camera examination by the court (e.g., In re Lifschutz, 1970; Roberts v. Superior Court, 1973).

Keeping total records in psychotherapy has definite advantages. A primary purpose is to follow the progress of the client. Most progress takes place over a period of time. If one is forced to rely on the therapist's or the client's memory alone in order to assess progress or note patterns associated with extra- or intra-therapeutic events, much may be forgotten and the therapeutic process may be delayed. It can be quite helpful for the understanding of the client for psychotherapists to keep detailed records of sessions as well as their interpretations and hypotheses regarding the client's psychotherapy.

Complete records are also necessary when medication is used, when more than one professional at a clinic is involved with a client and for purposes of research. However, in keeping complete records one may also run the risk that such records will be subpoenaed for examination by a court or that clients or their guardians will demand to see the records. The Illinois Confidentiality Act, which is stricter than the statutes of most states, has several exceptions under which an in camera review of records by the court may be required. The court may decide
that information which is found to be relevant and/or necessary as evidence must be disclosed. In addition, the Confidentiality Act requires that clients and/or their guardians have complete access to their mental health records.

Client access to mental health records has been a significant issue in debates of the rights of mental health care recipients. It is discussed in the context of confidentiality as it seems only just and fair, to many, that clients should have the right to review and be aware of all information about them which is kept in records to which other people may have access. Many psychotherapists believe that keeping records open to clients enhances the feeling of psychotherapy being a cooperative project where the clients have certain rights and responsibilities (e.g., Brodsky, 1972; Fischer, 1972). These psychotherapists believe that such an atmosphere is conducive to progress in psychotherapy.

However, the fact that records may be subject to review by a court or the client certainly affects how a psychotherapist keeps records and what material is placed in these records. Freedman (1959) suggested that laws may be forcing psychotherapists "to keep scientifically inadequate records in order to be certain they will, under any circumstances, be able to maintain the patient's trust" (p. 1079).

A negative impact of client access or public and/or
client ownership of records may be that therapists, for the
benefit of the well-being of their clients, may greatly
limit the information, hypotheses and thinking that they
put in their notes. Aware that clients would be humil­
iated, embarassed or otherwise harmed if such hypotheses as
they may be latent homosexuals or they have love-hate
relationships with their mothers were mentioned in a court
proceeding or read by clients before they had come to the
point of exploring these concepts in their therapy, ethical
therapists would be greatly reluctant to write such hypo­
theses in their notes. They would, in justness and fair­
ness, limit their notes to quotes or vague or benign com­
ments. This limiting of notes is viewed as a danger to the
practice of traditional psychotherapy as when people are
limited in what they write on a subject, the result may be
a limiting of what is thought on the subject.

The Illinois Confidentiality Act tries to surmount
the problems which could lead to a psychotherapist having
very sparse records, for example dates and appointments
only, be defining records as excluding "the therapist's
personal notes, if such notes are kept in the therapist's
sole possession for his own personal use and are not dis­
closed to any other person, except the therapist's super­
visor, consulting therapist or attorney" (Illinois Revised
Statutes, 1979, p. 1489). This solution may be sufficient
for psychotherapists in private practice who do not provide
medication or have other people cover when they are unavailability. In such cases, "personal notes" could constitute the entire record of therapy sessions and would all be absolutely confidential. When a record was needed for any reason, the psychotherapists could submit only the fiscal records (record of appointments, dates, and payments) or sift through their "personal notes" and establish an official record for that particular case.

However, for psychotherapists who work in a mental health center or need to keep records to which other people have access, this calls for keeping two sets of records. One would be considered "personal notes" and could include conjecture, thoughts and hypotheses as well as facts about the client. The other official "record" would include appointments, diagnosis, medication, and any other information that another professional may need if the psychotherapist is not available. As most clinics, agencies and psychotherapists also have a fiscal record, this really means that to totally protect the confidentiality and still be able to think through a client's conflicts on paper, one would actually be required to keep three records. Most psychotherapists would agree that the paperwork required for the fiscal and official record alone is overwhelming, without the added burden of a third record.

If psychotherapists in a mental health clinic setting are constrained to keep more records that can be
viewed by a court or other party as allowed by law than a psychotherapist in a private practice, it would then appear that only the wealthy are in a position to receive psychotherapy in a truly private therapeutic relationship. It is not the intent of the law to allow for a different and possibly better kind of treatment for the wealthy than for the poor or middle class, but this certainly appears to be a possible result of recent laws on confidentiality.

Records present many thorny issues. With the new laws governing public, court and client access to records, it is possible that the results will be poor records which may lead to a poorer quality of treatment.

Another specific area of law on confidentiality that may have significant impact on the practice of psychotherapy is that addressed in Tarasoff v. The Regents of the University of California (1976). In this case the court ruled that a psychotherapist has a duty to protect a potential victim from foreseeable danger from a client, even if such a duty would require a breach of confidentiality. The decision in this particular case sent shockwaves through the mental health community, particularly as many clients have, in a moment of anger or frustration, expressed the wish to harm another person. A number of questions have been raised including: How is the psychotherapist to differentiate between a wish or a plan of action? How is a psychotherapist to predict how dangerous a client is? If a
client is not sufficiently dangerous to warrant commit-
ment, how can a psychotherapist justify a breach of con-
fidentiality?

As there are no clear answers to the above ques-
tions, Bersoff (1976) suggested that psychotherapists might
feel compelled to avoid the risk of civil liability, i.e.,
being sued, by warning potential victims even when the
likelihood of harm is negligible. If only the occasional
psychotherapist responds in this way, the general public
may still hear of the response. The knowledge that a
person with whom one is upset may be told of angry feelings
expressed to the therapist would certainly cause people to
be reluctant to seek psychotherapy if they had any inter-
personal difficulties at all (and what client does not
have some problems in relationships?) and definitely cause
people to be reticent in discussing certain kinds of feel-
ings once in psychotherapy.

Roth and Meisel (1977) express concern that requir-
ing the psychotherapist to give a warning may "lower the
threshold of dangerousness that will evoke actions from
therapists, thereby compromising the patient's confiden-
tiality and possibly his treatment" (p. 509).

Another approach psychotherapists may take to
protect themselves and the confidentiality of their clients
would be to interrupt and remind the clients of the limits
of confidentiality each time it sounds as if the clients
would be starting to say something very hostile or potentially violent towards another person. Such behavior would most definitely interfere with a client's train of thought and could approach a level of absurdity with a client who verbally expresses a lot of angry feelings.

Noll (1976) and Roth and Meisel (1977) raise a concern that a psychotherapist who breaches confidentiality by warning a potential victim of the threats or plans of a client may later be sued for invasion of privacy or defamation of character. In those cases where the psychotherapist decides that a client is not sufficiently dangerous to warrant warning a potential victim, Roth and Meisel note that the psychotherapist may still successfully be sued for failing to warn. They state that:

The vagueness of the standards determining when the psychiatrist must warn, taken in combination with the unpredictability of violence and the vagueness of the meaning of the term "dangerousness", may make the psychiatrist's decision appear questionable in retrospect no matter how he acts (p. 509).

The primary accomplishment of the Tarasoff rule against confidentiality seems to have been to raise the anxiety level of psychotherapists. It is doubtful that such a rule will save lives. It seems much more likely that it will add a deterrent to psychotherapy for potentially violent people, possibly resulting in greater loss of life. The only way the Tarasoff rule against confidentiality could save lives is if it were worded so that psychotherapists were permitted, not required, to warn potential
victims if, in their professional judgment, such a warning was necessary, appropriate and therefore therapeutic.

Another specific aspect of the Illinois Confidentiality Act which may cause difficulties is the one concerned with the enforcement of the rules for obtaining a Firearm Owners Identification Card. The Confidentiality Act allows the Department of Mental Health to verify whether or not individuals applying for such an identification card have been hospitalized for psychiatric reasons within recent years. The application of a person who has had a psychiatric hospitalization may be refused. This exception appears to be quite logical and in the interest of safe society. However, a possible result of this exception may be that people who have the desire or need to carry a weapon may be deterred from seeking mental health services.

Some psychotherapists who work in the area of law enforcement report great difficulty in providing adequate mental health care to police officers. A major source of this difficulty is found in the fear of the officers that psychotherapy or a psychiatric hospitalization could lead to the loss of their Firearm Owners Identification Card and therefore their job (Kelly, 1980).

Anyone who owns a gun should receive all the mental health care they need rather than be deterred from such care. It seems that character references could serve a comparable purpose to finding whether a person has had a
Another exception of the Illinois Confidentiality Act involves cases of child abuse or neglect. The law states that these must be reported to the Illinois Department of Children and Family Services. The Child Abuse Reporting Act adds the loss of professional license and/or registration as a consequence of the failure to report child abuse or neglect. Many mental health professionals have encountered the situation where a parent hit a child, realized the wrong and immediately sought help. Since the parent is already seeking help, embarrassment, inconvenience and loss of trust in the psychotherapist would probably be the only results of a report. The therapists in such a situation are put in a quandary. They may: (1) risk legal prosecution for failure to report, (2) interrupt and warn clients if it sounds as if they are going to make statements that would legally require a report, or (3) make the report and risk the therapeutic relationship. Once again, the law does not leave any room for professional judgment. It does not allow the psychotherapist to report only when it appears likely that more abuse and neglect will occur, but requires that the psychotherapist report all suspected abuse or neglect.

Another specific exception to confidentiality allowed by Illinois law is when the client consents to psychiatric hospitalization without the consequence of deterring some persons from seeking mental health care.
disclosure. The law does not grant psychotherapists the right to refuse to disclose information if they have the client's consent for disclosure (except in a court proceeding where psychotherapists may request that the judge hear their testimony in chambers even if the client has given consent for full disclosure in court). This area presents some issues related to those of records insofar as the determination of who "owns" the psychotherapist's impressions and evaluations of the client. To many, it seems only fair and just that people be able to determine the events of their own lives, and therefore, have the power to determine who is given what information about them. An unfortunate fact is that many people do not exercise good judgment in deciding with whom they would like their psychotherapist to talk openly. It is not unusual for clients to request that confidential and sensitive information be disclosed to such sources as employers and family members.

The particular exception of disclosure with client consent is generally easier for therapists to deal with than situations where they are required to report information to the court or a government agency. In the former case, there is the opportunity to discuss the wisdom of the consent to disclose with a client so that the consent may be either withdrawn or modified so that only limited information may be disclosed. All the other specific exceptions
to confidentiality discussed above require that the psychotherapist disclose information and do not allow for a compromise based upon professional judgment.

The specific aspects of the law on confidentiality that do not allow room for professional judgment would seem to hinder the process of psychotherapy. Since there are alternative ways of dealing with the situations in most of the specific laws discussed above (the psychotherapist using professional judgment to decide what aspects of client records should be disclosed, character references for the Firearm Owners Identification Card, involuntary hospitalization with the option of warning potential victims in cases when the client may be dangerous to others, professional judgment in reporting suspected child abuse), the specific laws that require the psychotherapist to disclose information appear not only to hinder psychotherapy but, in fact, are against the best interests of society.

Some ways that exceptions to the laws on confidentiality may be against the best interest of society are defined by Noll (1976) in a discussion of the implication of such laws on the practice of psychotherapy. Noll states:

(1) Greater numbers of patients will incriminate themselves and be subject to legal action, (2) psychotherapists may well have to defend themselves in courts of law for making allegations about patients, (3) a basically antagonistic relationship may develop between the patient and the psychotherapist, (4) psychotherapists acting in accordance with the principal of full and informed consent will deter patients from seeking their help, and (5) ultimately, fewer and fewer people
will avail themselves of psychotherapeutic services because of the fear that they may talk about the "wrong" things or express unacceptable feelings or desires (p. 1453).

It should be added that there is a valid rationale for each exception to the laws on confidentiality; however, in most cases there appears to be an alternate solution to the one which involves a breach of confidentiality.

**Effects of Disclosing Information:** A third consideration in this discussion of the effects of legal intervention on the practice of psychotherapy is the effect of having disclosed information on the psychotherapist's subsequent approach and attitude. This, logically, is going to depend on the results of the disclosure. An unfortunate experience with disclosure, e.g., one in which the disclosed material is handled inappropriately by others, can result in all the various responses to the laws discussed above, i.e., Miranda type warnings to clients, overly sparse records and/or interruptions and reminders of the limits of confidentiality during the psychotherapy. The only positive outcome of an unfortunate disclosure of information would be that psychotherapists may become more aware of the limits of confidentiality, warn their clients, and therefore not inadvertently deceive them into thinking that psychotherapy is totally confidential when it is not.

Psychotherapists who have had an unfortunate experience with disclosure of information may be more likely to refuse to see clients about whom it is probable that infor-
mation will have to be disclosed legally. They may refuse to disclose information on some occasions in the future. Some psychotherapists are reluctant to disclose any information to particular agencies and individuals, even with client consent, because of the lack of training of many workers regarding confidentiality of mental health records.

The psychotherapist is in the very uncomfortable position of wanting to promise absolute confidentiality, but not being able to do so realistically. One would expect that the act of disclosing confidential communications would result in the psychotherapist becoming more aware of the legal limits of confidentiality and more sensitive to the privacy of the therapeutic situation.

Most of the sources in the literature which address the issues of the psychotherapist’s attitude regarding and reaction to laws on confidentiality are limited to speculation rather than research. The present study explores the attitudes of psychologists regarding confidentiality in a number of situations.

Client Reaction

Overall Effect of Laws: The client is also going to have reactions to the fact that psychotherapy cannot be guaranteed to be absolutely confidential. Many psychotherapists have noted that an increasing number of clients are asking questions about confidentiality and mental health records. Frequently, a client will say "I would like to
tell you something, but I don't want it to go into my record." Although there appears to be increased concern expressed by clients about confidentiality, there are very few studies directly surveying the client's feelings about confidentiality or the lack of confidentiality. Such studies would be helpful in establishing ethical guidelines as well as understanding the therapeutic process. Whether or not reassurances by the psychotherapist and/or laws on confidentiality, including the exceptions to the law, affect the client's behavior in psychotherapy might be another area of research.

Most clients who voluntarily seek mental health care are very eager to disclose private thoughts, feelings and behaviors in psychotherapy; this is generally their first relationship where confidentiality is a key component of the relationship and they are frequently ready to "tell all." Even with more questions about confidentiality, clients are generally ready to be open and frank in the therapy setting except when the client is a mental health professional or student (therefore very aware of just how unprivate records frequently are) or when the client anticipates legal involvement, either criminal or civil. The apparent willingness of clients to disclose private information has been noted in the literature by a number of mental health professionals (e.g., Jung, 1975; Mowrer, 1961).
Despite this apparent willingness of clients to disclose private information in psychotherapy, there are studies which suggest that clients would prefer that such information not be disclosed beyond the therapist. Rosen (1976) divided clients at several different mental health clinics into two groups, the first of which was instructed to sign forms for the release of information to the state agency for mental health. The second group was additionally given a clear explanation of the fact that they would receive services whether or not they signed the form. In the first group, 100% of the clients signed the form. In the second group, between 20% and 41% of the clients signed the form, the amount varying among mental health clinics. This study concluded that many fewer clients would sign consent forms for the release of information if they clearly understood that it was not necessary to sign in order to receive services.

Most other studies regarding the clients' attitudes about confidentiality have involved college students. Lewis and Warman (1964), in a survey of college students who had been divided into groups as to whether they had received vocational counseling, personal counseling or no counseling, found that only one of the 29 personal counseling subjects thought information should be shared with housemothers, department heads or employers without consent and none of the personal counseling subjects thought infor-
mation should be shared without consent with teachers or fraternities and sororities. Twenty-one percent of students who had received personal counseling thought that information should be given to such sources as parents or advisors without the student's consent and only 34% of the students receiving personal counseling thought information should be shared with other counselors without the student's consent. In an open-ended question inquiring about the specific circumstances under which it might be all right for a counselor to release a summary report of testing and counseling, the personal counseling subjects place "considerable stress...on the importance of strict confidentiality of information" (p. 10).

Students were asked what sources they would consent to be given detailed information. The only sources that over half of the personal counseling students would allow to have information were the counselors seen (97%), other counselors (76%), advisors (62%), and parents (62%). Only 17% of personal counseling subjects would consent to the counseling center releasing information to teachers and 28% would allow the release of information to employers. The personal counseling subjects as a whole were more concerned with confidentiality than the vocational counseling or no counseling subjects.

In a follow-up study at a different university, Anderson and Sherr (1969) additionally inquired about the
release of specific kinds of information. They found that their sample of college students was more willing to release information than the students in Lewis and Warman's study. They noted that the students discriminated among the types of information which they would allow to be released. Students who had been in counseling did not wish information about personal problems to be released to employers without their consent (only 18% indicated that this was acceptable), but had much less objection to the release of information regarding discipline/behavior (56% indicated this was acceptable) or grades (67%) to employers without their consent.

Students who had been in counseling were more willing to have information released to their parents than to employers without their consent, but still discriminated between kinds of information. For example, 65% of counseled subjects indicated that it was acceptable to inform parents of a student's personal problems without consent, compared to 71% for discipline/behavior information and 89% for grades.

Anderson and Sherr additionally note that students were reluctant to allow information to be shared with other counselors. For example only 23% of counseled subjects indicated that it was acceptable to release information on personal problems to other counselors without their consent, apparently unaware of the amount of supervision and
consultation that takes place within a counseling center. Anderson and Sherr suggest that this indicates a marked difference between standard counseling practices and the expectations of college students.

Simmons (1968) explored the approval that college students at a counseling center would give if certain kinds of information were released to certain people without their explicit consent. The material to be released included vocational, personal adjustment and danger-to-self-or-others information. The possible recipients of information included parents, the dean's office, the student health service or other counselors. Simmons found that two-thirds of the responses were favorable to the release of information without explicit consent, many more than in the previous studies. However, Simmons did not report how many clients were seen for personal counseling versus vocational counseling. Simmons also found that the kinds of information as well as the potential recipient of information had a significant relationship to approval of its release without explicit consent. He noted that there was not an interaction between kind of information and recipient, suggesting that college student counselees were selective in both the kinds of information that they did not want released to anyone and the people that they did not want to receive any information about them.

The above studies suggest that clients are inter-
ested, in varying degrees, in the maintenance of confidentiality in the therapeutic relationship. Clients, for the most part, experience relief from the laws in Illinois on confidentiality and psychotherapy. Most clients are reassured by the fact that a psychotherapist must obey laws regarding confidentiality and could be punished under the law for disclosing information to the client's friends, relatives or employers.

**Effects of Specific Laws:** Clients, with some exceptions, appear to be content with the specific aspects of the law on confidentiality as well, primarily because they do not anticipate having occasion to fall under one of the exceptions to confidentiality. Noll (1974, 1976) has noted that even when clients are informed of the limits of confidentiality, they are not fully aware of the consequences of the release of information. It is logical to assume that people who do fall under one of the exceptions would be more hesitant to seek mental health care and have greater difficulty being frank and open once in psychotherapy.

This is aptly demonstrated by the difficulty a law enforcement psychotherapist has in involving officers of the law in psychotherapy. The officers clearly state that they fear that if they follow through when referred, they could end up losing their guns and their jobs. This is true even when the referral for psychotherapy does not
reflect on the officer's ability. For example, if officers kill a person in the line of duty, they may be referred for psychotherapy so that they do not overreact, hold their fire too long in a subsequent situation and end up getting themselves killed (Kelly, 1980).

As discussed previously, the Tarasoff rule which would require a psychotherapist to warn a potential victim of possible danger may deter potentially dangerous people from seeking mental health care to learn to deal with their feelings and impulses. Bersoff (1976) discusses this concern and adds that such a law may result in mental health professionals becoming more identified with law enforcement, therefore discouraging even clients who would not be potentially dangerous from seeking professional help.

There is the same concern that people may be discouraged from seeking mental health care in regard to the exception to confidentiality that requires psychotherapists to report all cases of suspected child abuse or neglect to a state agency, regardless of the potential likelihood of continued abuse or neglect. Parents who abuse their children often view themselves very negatively. The anticipation of telling the psychotherapist of these negative qualities may already deter many from seeking help. The knowledge that a psychotherapist may then have to report them seems likely to be an even greater deterrent to seek-
ing professional help. Some clients who are not very likely to continue abusing or neglecting their children have a psychological need to be reported so that they can be "punished," cleanse themselves of past wrongs and start a new life in terms of their identity as parents. In such cases, it is generally most therapeutic if the clients call the state agency and report themselves rather than be reported by the therapist. The reporting then becomes a constructive, responsible act that the client has taken on the way to "good" parenting.

Clients are generally quite pleased to learn that they have the right to examine their records. However, clients generally are not interested in actually reviewing the record, but wish to maintain the right to do so.

It appears that the specific aspects of the laws on confidentiality do not hinder the average person from seeking psychotherapy; however, they do hinder those that fall under the exceptions. These people falling under the exceptions would include those who have a need or desire to carry a gun, people who have concerns about violent impulses against others and parents who are concerned about how they handle their children. These are obviously three groups of people that society would not want to deter from seeking psychotherapy. It seems that it is not in the best interest of society to have specific exceptions in the laws on confidentiality that would add such a deterrent.
Effect of Having Information Disclosed: The final point for consideration in examining the effect of legal intervention on confidentiality is the effect of having information revealed on the client's subsequent attitude and/or response in psychotherapy. Bersoff (1976), Noll, (1976) and Roth and Meisel (1977) express concern that statutory requirements that the psychotherapist disclose certain kinds of information in certain circumstances will not only deter people from seeking psychotherapy, but create an antagonistic relationship between the client and the psychotherapist.

One would expect that clients would feel betrayed and angry about an unconsented disclosure, especially if they were not informed that the release of information would occur. Although feelings of anger and betrayal can be worked through by the psychotherapists, and this working through could even enhance the therapy, it seems likely that such feelings would more often result in the client becoming reluctant to be frank and open and/or dropping out of therapy.

Clients generally are pleased when the psychotherapist refuses to disclose information without consent. This seems to be especially true for low-income clients who are involved in a number of other types of social service agencies and who have come to accept the fact that information is often informally shared among these agencies with-
out the client's consent. These people frequently experience a lack of respect for their privacy and are pleased to learn that the psychotherapist will not divulge confidential information without consent. The psychotherapist's refusal to disclose information without consent for such clients can be a real turning point in the therapeutic process in that the clients may recognize new areas of responsibility and control over their own lives. This prospect of growth when the psychotherapist refuses to disclose information is also present for clients who have been overprotected by others, such as family or friends, and the psychotherapist is the first person to refuse to disclose confidential information to the overprotectors.

It is recommended that the client's attitude and response to psychotherapy following a disclosure of information be further explored in surveys of clients or surveys of the experiences of psychotherapists.

Hypotheses

There has been minimal research in regards to psychotherapists' attitudes on confidentiality. Jagim, Whittman and Noll (1978) surveyed mental health professionals in North Dakota. They reported that 98% of those responding to the survey indicated that they viewed confidentiality as "essential to maintaining a positive therapeutic relationship." When given explicit situations, the therapists departed from the ideal of absolute confidentiality, i.e.,
only 20% responded that they would emphasize confidentiality in respect to state laws such as those requiring the reporting of child abuse, only 14% responded that they would emphasize confidentiality over the safety of a threatened third-party as in *Tarasoff v. Regents of the University of California*, and only 59% responded that they would risk a citation for contempt of court before disclosing confidential information. This survey only presented situations involving potential danger or a contempt of court citation. It does not address day-to-day situations such as those in which an employer, family member or third-party payer requests the release of confidential information.

In addition to there being very few studies exploring the attitudes of psychotherapists regarding confidentiality, there are few studies exploring actual psychotherapists' practices in disclosing information. Those studies available explore the practices of school counselors (e.g., Boyd, Tennyson & Erickson, 1973, 1974) and therapists in a college counseling center setting (e.g., Nugent & Pareis, 1968; Sherwood, 1974). Nugent and Pareis found that about 40% of the 461 responding college counseling center directors (67% return rate) reported releasing information about counselees without the student's permission. Sherwood found that only 76% of 4-year college counselors and 63% of 2-year college counselors always obtained the student's permission before releasing information. Because of the
college counseling center setting and the fact that these results may reflect release of vocational and academic information as well as personal problem information, these results cannot be generalized to other mental health professionals.

The present study is intended to fill in some of the gaps in information noted above regarding client and therapist attitudes about confidentiality in psychotherapy. It surveyed opinions regarding the release of information by psychotherapists when they do not have the permission of the client in greater depth than previous studies by explicitly presenting the subjects with concrete situations that do not involve a client who is an immediate danger to self or others. Additionally, this study attempted to replicate the findings of Jagim et al. (1978), using six of their eleven questionnaire items. This survey was given to mental health professionals, mental health care recipients and Illinois State's Attorneys. Illinois State's Attorneys were included in this study as they are in the unique position of trying to discover and present the truth in a court of law and at the same time must prosecute for any breach of the Illinois Confidentiality Act.

Although this study is primarily exploratory in nature, several hypotheses based on past experience and the literature are offered. A high Opinion Index on 35 Likert-type questions will suggest disapproval of the release of
information by a psychotherapist without the client's clear consent. A low Opinion Index will indicate approval of the disclosure of information without the client's clear consent.

1) It is hypothesized that all three subject groups agree with statements regarding the importance of confidentiality in psychotherapy and a therapist's professional/ethical obligation regarding confidentiality.

2) It is hypothesized that fewer psychotherapists (than in the first hypothesis) actually disapprove of the release or approve of the nonrelease of information when confronted with concrete situations, whether or not the client is potentially dangerous. This prediction is based on the awareness that even in day-to-day decisions regarding confidentiality in psychotherapy, there does not always appear to be a clear choice between right and wrong.

3) It is hypothesized that there is a significant difference in the Opinion Index dependent on the type of information to be disclosed. Specifically, it is hypothesized that disclosure of information directly related to psychotherapy is most strongly disapproved by all subject groups, i.e., personal problems and psychiatric diagnosis have a significantly higher Opinion Index than the other three types of information.

4) As educational and vocational information are generally viewed as nonsecret, it is hypothesized that it
has the lowest Opinion Index of all types of information.

5) It is hypothesized that there is a significant difference in the Opinion Index dependent on the recipient of information. Specifically, based on studies in college counseling centers, it is hypothesized that the release of information to employers has a significantly higher Opinion Index than other possible recipients of information.

6) It is hypothesized that physicians have the lowest Opinion Index of any of the possible recipients of information.

7) It is hypothesized that in regard to confidentiality the mental health professional is more concerned with ethical standards than the client, i.e., that the mental health professional has a significantly higher Opinion Index than the mental health care recipient. This hypothesis is based on a study concerned with ethical standards in research when using human subjects which indicated that the research psychologist is generally far more concerned with the protection and nondeception of the experimental subjects than are the subjects themselves (Sullivan & Deiker, 1973).
CHAPTER IV

METHODS

Subjects

The subjects were drawn from three populations, (1) mental health clients at the Springfield Mental Health Center, Springfield, Illinois, (2) registered psychologists in central and southern Illinois, and (3) Illinois State's Attorneys.

Surveys were sent to the State's Attorneys in each county in Illinois (N=102). Forty-two (41%) surveys were returned by State's Attorneys. Eight of these were not used in the statistical analysis as they were not complete (N=34; 33%). Responding State's Attorneys ranged in age from 25 to 70 years, with a mean age of 34.8 years and a standard deviation of 9.33 years. One State's Attorney was female, 28 were male and five did not indicate their sex.

Registered psychologists with zip codes in central and southern Illinois were randomly selected from a listing provided by the Illinois Department of Registration and Education (N=102). A total of 68 (67%) surveys were returned, one indicating that the psychologist was deceased. Two psychologists did not fill out the survey as they were retired and no longer practicing. Two other surveys were not usable as they were incomplete, leaving a total of 63.
(62%) surveys for the statistical analysis. Responding psychologists ranged in age from 27 to 64 years with a mean age of 43.6 years and a standard deviation of 12.53 years. Fourteen responding psychologists were female, 45 were male and four did not indicate their sex.

The first 102 mental health clients 18 years of age or older keeping appointments at the Springfield Mental Health Center during the week of October 22, 1979, were selected as subjects. Many clients request that mail from the mental health center not be sent to their homes because they do not wish others to know they are coming to the mental health center. Therefore, in the interest of privacy, the additional criterion of having previously been sent a bill for services was used in selecting clients. This may have eliminated some subjects who pay their bills at each appointment and those who, due to poor financial circumstances, are not charged a fee. Fifty-one (50%) clients returned surveys. One was incomplete, leaving 50 (49%) surveys for statistical analysis. Responding clients ranged from 18 to 59 years of age, with a mean age of 33.8 years and a standard deviation of 8.63 years. Thirty-three responding clients were female, 11 were male and six did not indicate their sex.

All responding subjects indicated that their race was Caucasian. Subjects were promised a copy of the results if they indicated the desire for such on a separate card.
Design Overview

The design for the analysis of the Survey of Opinion was a 3 x 5 x 7 (Subjects x Information x Recipients) analysis of variance with repeated measures on the last two factors. The three subject groups were psychologists, State's Attorneys and mental health clients. The five types of information were educational/vocational information, the fact that a person is a client, psychiatric diagnosis, personal problems and financial information. The seven recipients of information were the client's physician, the Department of Mental Health, legal authorities, the client's relatives, the client's insurance company, the client's employer and the client's friends. The dependent variable was the Opinion Index, a measure of the approval of the disclosure of information by a psychotherapist without client consent.

Materials

The primary source of data was the Survey of Opinion consisting of 35 Likert-type items designed to assess attitudes about psychotherapists disclosing or not disclosing specific kinds of information to specific sources about clients who are not an immediate danger to themselves or others (see Appendix B). The five kinds of specific information addressed in the survey are educational/vocational, the fact that a person is a client, psychiatric diagnosis, a client's personal problems and financial
information. Educational/vocational information was selected as a variable as it is generally considered public information that people disclose readily (Jourard, 1959). Financial information was selected as a variable as such information is usually not readily disclosed (Jourard, 1959), but it is not directly related to psychotherapy. The fact that a person is a client was selected as a type of information because being a client is an open and public act, but many people may still want such information kept private. Personal problems and psychiatric diagnosis were selected for the survey as they are two kinds of sensitive information directly related to psychotherapy.

The seven possible recipients of information on the survey are the client's physician, the Department of Mental Health, legal authorities, the client's relatives, the client's insurance company, the client's employer and the client's friends. The Department of Mental Health was selected as a variable as, in Illinois, a diagnosis and demographic information must be submitted to the Department for each client by agencies receiving Department of Mental Health funding (it should be noted that no identifying information, such as name or social security number is required). The client's insurance company was selected to represent the category of third-party payers who require a client's psychiatric diagnosis before paying for mental health care services. The other five possible recipients
of information are included in the survey as they frequently request information about clients, with intentions that may or may not be beneficial to the client.

Two forms of the survey were developed in order to avoid response bias. The like numbered items on each form address the same combination of kind of information and recipient of information, but on one form the item is worded negatively and on the other it is worded positively, i.e., on one form the item asks about a "psychotherapist disclosing information without a client's clear consent" and on the other form the item asks about a "psychotherapist not disclosing information because he does not have a client's clear consent to disclose." Form A was structured by first pairing the kind of information and recipient in random order and then flipping a coin to decide if each item, 1 through 18, would be worded the positive or negative way. Items 19 through 35 were worded the opposite way of items 1 through 17, respectively, so that each form is balanced for the number of items worded each way. The items on Form B are in the same order as Form A but worded in the opposite manner.

A value was assigned to each of the five points of the 35 Likert-type questions so that a score of 1 indicates that the subject strongly approves of the psychotherapist releasing information without the client's clear consent and/or strongly disapproves of the psychotherapist not
releasing information because the client has not given clear consent. The value increases by one at each point until at the other end of the continuum of opinion, a value of 5 indicates that the subject strongly disapproves of the psychotherapist releasing information without the client's clear consent and/or strongly approves of the psychotherapist not releasing information because a client has not given clear consent.

A total Opinion Index was tabulated for each subject by averaging the value of the responses indicated on each of the 35 items. A high Opinion Index indicates that the subject disapproves of a psychotherapist releasing information without the client's clear consent and a low Opinion Index indicates that the subject approves of a psychotherapist releasing information without the client's clear consent. An Information Opinion Index was tabulated for each type of information by averaging the value of the responses on items regarding the release of each respective type of information. The Information Opinion Index was tabulated for all subject combined, for each group of subjects and for each possible recipient of information. A high Information Opinion Index indicates that subjects disapprove of the release of the particular type of information without the client's clear consent and a low Information Opinion Index indicates that subjects approve of the release of the particular type of information without the
A Recipient Opinion Index was tabulated for each recipient of information by averaging the value of the responses on items regarding the release of information to each respective recipient. The Recipient Opinion Index was tabulated for all subjects combined, for each subject group and for each type of information. A high Recipient Opinion Index indicates that subjects disapprove of the release of information to the particular recipient without the client's clear consent and a low Recipient Opinion Index indicates that subjects approve of the release of information to the particular recipient without the client's clear consent.

The Survey of Opinion was followed by a form requesting demographic information including age, sex, race, religion, education and occupation. This form included six Likert-type questions used by Jagim et al. (1978) in a survey of the attitudes of mental health professionals regarding confidentiality and four additional questions regarding the subject's personal experience with psychotherapy and regarding confidentiality. A sample questionnaire is included in Appendix B.

Procedures

All subjects were sent the same letter of explanation, Survey of Opinion, form requesting demographic information and additional questions (see Appendix B). A stamped, self-addressed envelope was enclosed for returning the
survey. A stamped, self-addressed postcard was included so that subjects could indicate the fact that they had completed the survey as well as their desire for a copy of the results.

On the Survey of Opinion subjects were requested to mark the space on a five point Likert-type scale from "Approve" to "Disapprove" that best reflected their opinion about the situations presented in the survey items.

In order that subjects could be assured anonymity and their surveys could be divided readily into the three groups, State's Attorneys were sent surveys printed on blue paper, clients on yellow paper and psychologists on white paper. The surveys were mailed out in early November of 1979. A reminder letter with an additional survey was sent out in February of 1980 to those who had not returned a postcard following the first mailing.
CHAPTER V

RESULTS

Manipulation Check

A simple t-test indicates no significant difference between the Opinion Indices of subjects completing Form A and the Opinion Indices of subjects completing Form B, \( t(144) = 1.00, p > .30 \). This result suggests that both forms measure the same variable and that wording half of the questions positively and half negatively effectively eliminated bias due to response style.

Evaluation of Hypotheses

The first hypothesis is that a majority of all three groups of subjects agree with statements regarding client's expectations of confidentiality in psychotherapy, the therapist's professional/ethical obligation regarding confidentiality and the importance of confidentiality in psychotherapy (see Appendix B, items A, B, C). This prediction is supported by data. As the three statements address general issues of confidentiality, they are combined for statistical analysis. The three general statements regarding confidentiality are supported by an average of 96.8% of the psychologists, 95.8% of the clients and 75.6% of the State's Attorneys. A one-way analysis of variance indicates a significant difference between subject groups, \( F(2,144) = 151 \)
9.870, \( p < .001 \). Due to an unequal number of subjects in the three groups, t-tests are used for further analysis. The t-test for differences between independent means indicates that psychologists supported the statements significantly more than State's Attorneys, \( t \) (89) = 4.090, \( p < .001 \) and that clients supported the statements significantly more than State's Attorneys, \( t \) (76) = 3.676, \( p < .001 \). There was no significant difference between psychologists and clients, \( t \) (107) = .204, \( p > .50 \).

The second hypothesis is that fewer psychotherapists (than in the first hypothesis) actually disapprove of the release or approve of the nonrelease of information when confronted with concrete situations, whether or not the client is potentially dangerous. The data support this hypothesis in situations where there is a legal requirement to disclose information (28.1% endorsed confidentiality), where the client is potentially dangerous to others (15.8% endorsed confidentiality) and where the psychotherapist is in risk of receiving a contempt of court citation (49.1% endorsed confidentiality; see Appendix C, items, G, H, I). A simple sign test indicates that the endorsement of confidentiality was significantly stronger for the three general statements regarding confidentiality than for the three concrete situations named above, \( z = 6.930, p < .0001 \).

The second hypothesis is not supported by the data in day-to-day situations in which the client is not an
immediate danger to himself or others. An average of 96.8% of the psychologists endorsed each of the general statements while an average of 93.2% of the psychologists supported confidentiality in each of the concrete situations. A test for the significance between two proportions indicates that this difference is not significant, \( z = 1.305, p > .05 \).

All main effects and interactions in the analysis of variance are significant (see Table 1). All simple effects analyzed are significant as well as most t-test comparisons of means. A close look at the data indicates that very small differences are significant. This is attributed to an unusually high number of degrees of freedom and to the fact that the results are highly skewed. For example, on a five-point scale, the average total Opinion Index of the psychologists for the individual questions on the survey was 4.71.

The skewed distribution and high number of degrees of freedom result in data that are numerically almost identical being statistically highly significantly different. In order to limit the discussion to results that may be psychologically meaningful and significant as well as statistically significant, only those data which show a difference of at least .5 (on the five-point scale) and are also statistically significant in their difference will be discussed.

The first part of the third hypothesis is that there
Table 1
Analysis of Variance Summary Table for Type of Information and Recipient of Information for Psychologists, Clients and State's Attorneys

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>MS</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between Subjects</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>2</td>
<td>398.60</td>
<td>30.29**</td>
</tr>
<tr>
<td>S(A)</td>
<td>144</td>
<td>13.16</td>
<td></td>
</tr>
<tr>
<td>Within Subjects</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>4</td>
<td>27.08</td>
<td>27.22**</td>
</tr>
<tr>
<td>AB</td>
<td>8</td>
<td>6.26</td>
<td>6.29**</td>
</tr>
<tr>
<td>S(A)B</td>
<td>576</td>
<td>1.00</td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>6</td>
<td>126.73</td>
<td>66.44**</td>
</tr>
<tr>
<td>AC</td>
<td>12</td>
<td>28.36</td>
<td>14.87**</td>
</tr>
<tr>
<td>S(A)C</td>
<td>864</td>
<td>1.91</td>
<td></td>
</tr>
<tr>
<td>BC</td>
<td>24</td>
<td>2.71</td>
<td>4.51**</td>
</tr>
<tr>
<td>ABC</td>
<td>48</td>
<td>1.05</td>
<td>1.74*</td>
</tr>
<tr>
<td>S(A)BC</td>
<td>3456</td>
<td>.60</td>
<td></td>
</tr>
</tbody>
</table>

Note. Factor A refers to subjects, B to type of information, C to recipient of information and S to error.

* p .005
** p .0001
is a significant difference in the Information Opinion Index dependent upon the type of information to be disclosed. This hypothesis is supported by the data. An analysis of variance indicates that the type of information to be disclosed has a highly significant effect on whether or not the subjects approve of the disclosure, $F(4, 576) = 27.22, p < .0001$.

However, despite the high level of significance, an examination of the data in graphical form indicates negligible differences for all subjects combined dependent upon the type of information to be disclosed (see Figure 1). The biggest difference, between educational/vocational information and financial information is less than .3. This suggests that, for all subjects combined, the type of information to be disclosed, while having some effect, does not have a meaningful part in determining whether the disclosure will be approved. All subjects combined tend to disapprove of disclosing and approve of not disclosing all information regardless of the type of information. The first part of the third hypothesis is supported statistically, but not when the criterion of psychological significance is applied.

The second part of the third hypothesis is that the disclosure of information directly related to psychotherapy is most strongly disapproved in all subject groups, i.e., it is hypothesized that personal problems and psychiatric
Figure 1. Mean Information Opinion Indices for each type of information for each subject group and all subjects combined.
diagnosis have a significantly higher Information Opinion Index than the other three types of information. The data do not support this prediction using either statistical or psychological criteria. A planned comparison of the means of the Information Opinion Indices of personal problems and psychiatric diagnosis versus the means of the Information Opinion Indices of information that a person is a client, financial information, and educational/vocational information does not even approach significance, $F (1,576) = .003, p > .20$.

A post hoc comparison of means indicates that subjects approve of the disclosure of financial information significantly less than the other four types of information, $F (4,576) = 2.37, p < .05$, but, as can be seen in Figure 1, for all subjects combined financial information differed from the other types of information by less than .3. All subjects combined did not discriminate between financial information and the other four types of information to a meaningful degree.

The fourth hypothesis is that educational/vocational information is generally viewed as nonsecret, i.e., it is hypothesized that educational/vocational information has the lowest Information Opinion Index of all types of information. The data support this hypothesis statistically. A planned comparison of the mean Opinion Index of educational/vocational information versus the mean Opinion Indices of
the other four types of information indicates that subjects approve of the disclosure of educational/vocational information significantly more than other types of information, $F (1,576) = 4.851, p < .05$. However, the negligible difference in Figure 1 suggests that this is not a meaningful difference. Apparently, all subjects combined did not discriminate between educational/vocational information and other types of information in deciding whether or not to approve the disclosure of information. The fourth hypothesis is supported statistically, but not when the criterion of psychological significance is applied.

The first part of the fifth hypothesis is that there is a significant difference in the Recipient Opinion Index dependent upon the recipient of information. This hypothesis is supported by the data. An analysis of variance indicates that the recipient of information has a highly significant effect on whether or not subjects approve of the disclosure of information, $F (6,864) = 66.44, p < .0001$. An examination of the data in graphical form suggests that the result is meaningful as well as statistically significant (see Figure 2). The mean Recipient Opinion Index for all subjects combined ranges from 3.81 when the recipient is the client's physician to 4.78 when the recipient is a friend of the client. The order of the Recipient's Opinion Index for all subjects combined ranging from lowest to highest is the client's physician (3.81), the Department of
Figure 2. Mean Recipient Opinion Indices for each recipient of information for each subject group and all subjects combined.
Mental Health (4.04), legal authorities (4.19), the client's relatives (4.42), the client's insurance company (4.61), the client's employer (4.69) and the client's friends (4.78).

The first part of the fifth hypothesis is supported when applying both statistical and psychological criteria.

The second part of the fifth hypothesis is that subjects approve the least of releasing information to employers, i.e., it is hypothesized that employers have a significantly higher Recipient Opinion Index than other possible recipients of information. This hypothesis is supported by the data. A planned comparison of the mean Recipient Opinion Index for employers versus the Mean Recipient Indices of the other six recipients of information indicates that subjects approve of the disclosure of information to employers significantly less than the disclosure of information to the other six recipients, \( F(1, 864) = 13.270, \ p < .001 \). Subjects approve the disclosure of information to friends less than to employers, although not meaningfully less. As can be seen in Figure 2, employers as recipients differ from the client's friends, insurance company and relatives by less than .5, but differ from legal authorities, the Department of Mental Health and the client's physician by more than .5. This suggests that subjects approve of the disclosure of information to employers to a meaningfully lesser degree than to the client's physician, the Department of Mental Health and legal authorities.
The sixth hypothesis is that subjects approve the most of releasing information to physicians, i.e., it is hypothesized that physicians have a significantly lower Recipient Opinion Index than other possible recipients of information. This hypothesis is supported by the data. A planned comparison of the mean Recipient Opinion Index for physicians versus the mean Recipient Opinion Indices of the other six recipients of information indicates that subjects approve of the disclosure of information to physicians significantly more than to the other six recipients, $F(1,874) = 45.270, p < .001$. As can be seen in Figure 2, for all subjects combined, physicians as recipients differ from the Department of Mental Health and legal authorities by less than .5, but differ from the other four possible recipients of information by more than .5. This suggests that subjects are willing to have information disclosed to physicians to a meaningfully greater degree than to a client's relatives, insurance company, employer or friends.

The final hypothesis is that psychologists are more concerned with confidentiality than clients, i.e., it is hypothesized that psychologists have a significantly higher Opinion Index than clients. This hypothesis is supported by the data. The analysis of variance indicates a highly significant difference between subject groups, $F(2,144) = 30.29, p < .0001$. A Newman-Keuls test of the difference between all pairs of means indicates that psychologists
approve of the disclosure of information significantly less than clients. The critical expected value at the .01 level of significance is .329 and the observed value is .338, $p < .01$. The Newman-Keuls test additionally indicates that psychologists approve of the disclosure of information significantly less than State's Attorneys. The critical expected value at the .01 level of significance is .373 and the observed value is .677, $p < .01$. Clients also approve of the disclosure of information significantly less than State's Attorneys. The critical expected value at the .01 level of significance is .373 and the observed value is 1.015, $p < .01$.

As can be seen in Figures 1 and 2, the Opinion Index of psychologists is consistently higher than that of clients, although generally less than .5 different. The only variable on which the Opinion Index of psychologists is more than .5 greater than the Opinion Index of clients is when the recipient of information is a physician. Clients approve of the disclosure of information to physicians without client consent to a meaningfully greater degree than psychologists.

Despite the fact that the Opinion Index of psychologists is less than .5 higher than the Opinion Index of clients, the fact that the Opinion Index of psychologists was consistently higher than the Opinion Index of clients, regardless of recipient or type of information, is regarded
as a meaningfully significant result. This finding adds to previous research that suggests that psychologists are more concerned than are clients or subjects in assuring that clients or subjects are treated humanely and ethically.

The Opinion Index of psychologists is more than .5 higher than the Opinion Index of State's Attorneys for all five types of information and for five out of the seven recipients (client's physician, the Department of Mental Health, legal authorities, relatives and the client's employer). The Opinion Index of psychologists is less than .5 higher than the Opinion Index of State's Attorneys when the recipient is the client's insurance company or friends. This result suggests that State's Attorneys are significantly more approving than psychologists of the disclosure of information without client's consent except when the recipient of information is the client's insurance company or friends. This finding suggests that in day-to-day situations, State's Attorneys find more reason for information about psychotherapy to be disclosed without client consent than do psychologists.

The Opinion Index of clients is more than .5 greater than the Opinion Index of State's Attorneys for all types of information except financial (Figure 1) and for all recipients except the client's insurance company and friends (Figure 2). This indicates that, as a whole, clients approve of disclosing information to a meaningfully
less degree than do State's Attorneys. Clients and State's Attorneys are not meaningfully different when the information is financial or the recipient is the client's insurance company or friends, primarily because in these three situations State's Attorneys are more disapproving of disclosing information than in other situations, so their Opinion Indices are closer to the Opinion Indices of clients.

Other Findings of Interest

A 3 x 7 x 5 (Subjects x Information x Recipients) analysis of variance with repeated measures on the last two factors indicates that all main effects are highly significant (see Table 1). Again, the three subject groups are psychologists, State's Attorneys and mental health clients. The five types of information are educational/vocational information, the fact that a person is a client, psychiatric diagnosis, personal problems and financial information. The seven recipients of information are the client's physician, the Department of Mental Health, legal authorities, the client's relatives, the client's insurance company, the client's employer and the client's friends.

The analysis of variance indicates that there is a Subjects x Information interaction, $F(8,576) = 6.29$, $p < .0001$, a significant Subjects x Recipient interaction, $F(12,874) = 14.87$, $p < .0001$, a significant Information x Recipient interaction, $F(24,3456) = 4.51$, $p < .0001$, and a significant Subjects x Information x Recipient interaction,
As all main effects and interactions are significant, simple effects were explored. Only those simple effects and differences between means that meet the criteria of both statistical and psychological significance are reported below.

All simple effects related to the Subjects x Information interaction are statistically significant. Within each group of subjects, there is a statistically and psychologically significant effect on the approval of disclosure of information dependent upon the type of information to be disclosed only for State's Attorneys, \( F(4,132) = 161.66, p < .0001 \). For each type of information there is a statistically and psychologically significant effect on the approval of disclosure depending upon the subject group; educational/vocational, \( F(2,144) = 125.33, p < .0001 \); fact that a client, \( F(2,144) = 228.80, p < .0001 \); diagnosis, \( F(2,144) = 258.17, p < .0001 \); personal problems, \( F(2,144) = 196.15, p < .0001 \); financial, \( F(2,144) = 56.675, p < .0001 \).

The t-test was used to compare differences between each subject group for each type of information. Each subject group is significantly different from both other subject groups on each type of information. The data is presented in graphical form in Figure 1.

For educational/vocational information, psychologists have a significantly higher Information Opinion Index
than State's Attorneys, $t_{144} = -5.06$, $p < .0001$, and clients have a significantly higher Information Opinion Index than State's Attorneys, $t_{144} = -3.07$, $p < .005$. For the fact that a person is a client psychologists have a significantly higher Information Opinion Index than State's Attorneys, $t_{144} = -8.26$, $p < .0001$, and clients have a significantly higher Information Opinion Index than State's Attorneys, $t_{144} = -5.54$, $p < .0001$. For a person's diagnosis, psychologists have a significantly higher Information Opinion Index than State's Attorneys, $t_{144} = -8.53$, $p < .0001$, and clients have a significantly higher Information Opinion Index than State's Attorneys, $t_{144} = -5.78$, $p < .0001$. For information about personal problems, psychologists have a significantly higher Information Opinion Index than State's Attorneys, $t_{144} = -8.44$, $p < .0001$, and clients have a significantly higher Information Opinion Index than State's Attorneys, $t_{144} = -5.45$, $p < .0001$. For financial information, psychologists have a significantly higher Information Opinion Index than State's Attorneys, $t_{144} = -4.33$, $p < .0001$.

In Figure 1, the curves for psychologists and clients parallel the curve of all subjects combined and, despite statistical significance, do not show a meaningful difference in approval of disclosure dependent on type of information. For both psychologists and clients the biggest difference is between educational/vocational infor-
information and financial information. This difference is less than .4 for both groups. This indicates that psychologists and clients endorse confidentiality in psychotherapy without regard to the type of information that may be disclosed. This also suggests that psychologists and clients expect a certain degree of privacy, clients expecting somewhat less privacy than psychologists, of all communications in the psychotherapeutic relationship.

State's Attorneys have a meaningful difference in approval of disclosure dependent upon the type of information, but only for financial information (see Figure 1). State's Attorneys do not have a meaningful difference in approval of disclosure among educational/vocational information, information that a person is a client, diagnosis and personal problems. State's Attorneys approve of not disclosing and disapprove of disclosing financial information more than any other of the other four types of information.

The analysis of variance indicates that there is a highly significant Subjects x Recipients interaction, $F_{(12,864)} = 14.87$, $p < .0001$, and the simple effects of this interaction were explored. Within each group of subjects, there is a statistically significant effect on the approval of disclosure of information dependent upon the recipient of the information, but this effect is psychologically significant only for clients, $F_{(6,294)} = 82.27$, $p < .0001$. 
and State's Attorneys, $F(6, 198) = 300.98, p < .0001$.

An analysis of variance on simple effects shows a statistically and psychologically significant effect on the approval of disclosure of information for five of the seven recipients of information dependent upon the subject group; physician, $F(2, 144) = 272.57, p < .0001$; Department of Mental Health, $F(2, 144) = 196.95, p < .0001$; legal authorities, $F(2, 144) = 221.74, p < .0001$; relatives, $F(2, 144) = 75.30, p < .0001$; employer, $F(2, 144) = 32.36, p < .0001$.

The t-test was used to compare differences between each subject group for each recipient of information. The data is presented in graphical form in Figure 2.

When a physician is the recipient of information, psychologists have a significantly higher Recipient Opinion Index than clients, $t(144) = -3.66, p < .0005$, and State's Attorneys, $t(144) = -8.20, p < .0001$, and clients have a significantly higher Recipient Opinion Index than State's Attorneys, $t(144) = -4.73, p < .0001$. When the Department of Mental Health is the recipient of information, psychologists have a significantly higher Recipient Opinion Index than State's Attorneys, $t(144) = -6.79, p < .0001$, and clients have a significantly higher Recipient Opinion Index than State's Attorneys, $t(144) = -4.63, p < .0001$. When legal authorities are the recipients of information, psychologists have a significantly higher Recipient
Opinion Index than State's Attorneys, $t_{(144)} = -7.92$, $p < .0001$, and clients have a significantly higher Recipient Opinion Index than State's Attorneys, $t_{(144)} = -5.58$, $p < .0001$. When relatives are the recipients of information, psychologists have a significantly higher Recipient Opinion Index than State's Attorneys, $t_{(144)} = -5.61$, $p < .0001$, and clients have a significantly higher Recipient Opinion Index than State's Attorneys, $t_{(144)} = -4.07$, $p < .0005$. When an employer is the recipient of information, psychologists have a significantly higher Recipient Opinion Index than State's Attorneys, $t_{(144)} = -5.24$, $p < .0001$, and clients have a significantly higher Recipient Opinion Index than State's Attorneys, $t_{(144)} = 4.09$, $p < .0005$.

As can be seen in Figure 2, psychologists were consistent in tending to disapprove the disclosure of information without consent regardless of the recipient. The biggest difference, between the physician and friends of the client, was less than .4, and did not meet the criteria for psychological significance.

In Figure 2, the curve for clients closely parallels the curve for all subjects combined. For clients, physicians as recipients differ only from the Department of Mental Health by less than .5, and differ from the other five recipients of information by more than .5. This result suggests that clients approve of the disclosure of
information to physicians to a meaningfully greater degree than to legal authorities, relatives, the client's insurance company, the client's employer and the client's friends.

State's Attorneys have the greatest variation in response due to recipient of information. The Recipient Opinion Index ranges from a low of 2.64 for physicians as recipients to a high of 4.74 for friends. For State's Attorneys, the Recipient Opinion Indices for physicians, the Department of Mental Health and legal authorities are less than .5 from each other, but more than .5 lower than the other four recipients. This result suggests that State's Attorneys approve of the disclosure of information to physicians, the Department of Mental Health and legal authorities to a meaningfully greater degree than to the client's relatives, insurance company, employer or friends. For State's Attorneys, relatives are in the middle as recipients of information, being more than .5 different from all other recipients. The client's insurance company, employer and friends are over .5 higher than the other four recipients of information indicating that State's Attorneys approve of the disclosure of information to these three recipients to a meaningfully less degree than to relatives, legal authorities, the Department of Mental Health and the client's physician.

The analysis of variance indicates that there is a
significant Information x Recipient interaction, $F(24,3456) = 4.51, p < .0001$, and the simple effects of this interaction were explored. For each type of information there is a statistically and psychologically significant difference in approval of disclosure of information dependent upon the recipient of information; educational/vocational, $F(6,876) = 22.39, p < .0001$; fact that a client, $F(6,876) = 30.95, p < .0001$; diagnosis, $F(6,876) = 31.36, p < .0001$; personal problems, $F(6,876) = 28.11, p < .0001$; financial, $F(6,876) = 8.689, p < .0001$. For each recipient of information there is a statistically and psychologically significant difference in approval of disclosure of information dependent on the type of information only when the recipient is the client's physician, $F(4,584) = 24.42, p < .0001$.

Despite these levels of statistical significance, an examination of the data in graphical form suggests little meaningful interaction (see Figure 3). Except for when the recipient is the client's physician, the five types of information differ by less than .5 for each recipient. When the recipient is the client's physician, financial information has an Opinion Index over .5 higher than the other four types of information. This result indicates that all subjects combined disapprove of disclosing financial information more than any of the other four types of information to physicians.
Figure 3. Mean Recipient Opinion Indices for each recipient of information for each type of information.
The analysis of variance indicates that there is a significant Subjects x Information x Recipients interaction, $F(48,3456) = 1.74$, $p < .005$. This interaction is not considered meaningfully significant and will not be discussed. The F-value for this interaction was only statistically significant because of the high number of degrees of freedom in both the numerator and denominator of the F ratio.
This survey demonstrates that psychologists, mental health clients and, to a lesser degree, State's Attorneys all support the basic concept of confidentiality being an important component of the psychotherapeutic relationship. In addition, all three groups agree that a client has expectations of confidentiality and that a psychotherapist has a professional and ethical obligation regarding confidentiality in psychotherapy. This finding is in accord with the moral obligation of natural law not to reveal a committed secret, the emphasis put on confidentiality in the psychological literature and the statements of the courts regarding the importance of confidentiality in psychotherapy, whether or not the particular court ultimately decided to allow absolute confidentiality.

Psychologists

When concrete situations involving a legal requirement to disclose information or the psychotherapist being in risk of receiving a contempt of court citation are introduced to psychologists, support for confidentiality drops significantly. This is viewed as representing a conflict between the psychotherapeutic principle or ideal of absolute confidentiality and the pressures of the out-
side world or society. Natural law and the Ethical Standards of Psychologists suggest that absolute confidentiality in the psychotherapeutic relationship must be maintained unless there is a risk of danger to others. The situation in which the psychologist risks receiving a contempt of court citation if he does not divulge confidential communication is generally not one in which there is a risk of harm to others, yet only 49.1% of the psychologists endorse confidentiality in this situation.

The reasons for the apparent conflict between the principle of confidentiality and the pressures of society are numerous. In situations where there is a risk of danger to an individual or society, a psychologist may feel morally bound by natural law to reveal information and prevent harm. In situations where there is not a risk of danger to others, the response of divulging information may indicate a lack of training in ethical practices and in the importance of confidentiality in psychotherapy. In situations where there is not a risk of danger to others the psychologists may not view ethical principles as emanating from natural law, but rather as basic rules of thumb from which to operate, a breach of such rules being a "decision" rather than an "immoral act." It may be that some psychologists would choose to violate the confidence of a client rather than suffer the consequences of society's reaction by refusing to do so.
It is most probable that many psychologists have not adequately thought through the implications of divulging information, even under court order, on the practice of psychotherapy and the profession as a whole. Without a thorough understanding of the importance of confidentiality for psychotherapy and an incorporation of the natural law that would require confidentiality into one's value system, it would be expected that psychologists would follow the will of the society of which they are members.

Psychologists additionally show less support for confidentiality when the client is potentially dangerous to others. Although this decreased support may contradict the ideal of absolute confidentiality, it is in accordance with both the Ethical Standards for Psychologists and the teachings of natural law.

One must comment on the average of 3.2% of the psychologists who did not endorse statements regarding the importance of confidentiality in psychotherapy. The fact that any psychologist does not support confidentiality in general should be of great concern to the profession as such an opinion is a direct affront to the Ethical Standards of Psychologists. This 3.2% represents two out of the 63 psychologist subjects. This small percentage and number could hopefully be the result of misreading the question or mismarking the item. It may also be that all psychologists do not accept all the principles of the Ethical Standards
for Psychologists.

In situations that did not involve a legal requirement to disclose information, a contempt of court citation or a potentially dangerous client, psychologists approve quite strongly of not disclosing information or disapprove quite strongly of disclosing information without the client's clear consent. This finding is interpreted as indicating that psychologists agree with the principles of their ethical code and natural law. A number of the situations involved the disclosure of what might appear to be harmless information to persons who were often likely to be already in possession of such information. Regardless of the type of information or the recipient of the information, the psychologists strongly endorse confidentiality. This is readily apparent in the graphs of Figures 1 and 2.

This endorsement of confidentiality in day-to-day situations is much stronger than expected. This finding suggests that psychologists, contrary to what was previously suggested, have been well trained in ethical practices and/or follow the principles of natural law. It also suggests that psychologists have learned through training and experience that confidentiality in psychotherapy, as well as other ethical considerations, is important for the profession and practice of psychotherapy.

A clue to a reason for the stronger than expected endorsement of confidentiality may be found in the candid
comment of one psychologist subject who wrote,

I must respond in regard to my belief that information should not be disclosed--my rating[s] respond to this belief. If you had asked if I had ever broken confidence [in these situations] my responses would have been very different.

It is recommended that future studies explore both opinions and actual practices regarding confidentiality.

Type of Information

The results indicate that for psychologists, clients and all subjects combined there is no meaningful difference in approval of the disclosure of information dependent upon the type of information. Subjects as a whole simply did not discriminate among types of information in deciding what could be disclosed without consent and what could not. This result suggests that psychologists, clients and all subjects combined have a high regard for the confidentiality of all information in psychotherapy.

State's Attorneys had a significantly lower regard for confidentiality in psychotherapy than all subjects combined for all types of information except financial. State's Attorneys endorsed the confidentiality of financial information to a significantly greater degree than the other four types of information. There are several possible reasons as to why State's Attorneys apparently regard financial information as more private than other types of information. Educational/vocational information is commonly regarded as nonprivate (Jourard, 1971). Information
related to mental health care, i.e., the fact that a person is a mental health client, the person's diagnosis and information on personal problems may provide important facts for the State's Attorney to use in prosecuting a criminal case and recommending a sentence. A person's financial status should have no effect on a criminal trial. Another reason that State's Attorneys may disapprove of the disclosure of financial information more than information related to mental health care may be that attorneys, in their schooling and practice, have more experience with confidential financial information and understand the reasons why a person would want to keep such information private. Although many attorneys are also engaged in advocacy, the average attorney may not have such frequent occasion to be aware of the reasons for confidentiality of information related to psychotherapy.

Psychologists and clients also endorsed the confidentiality of financial information more strongly than the other four types of information, but not to a significantly greater degree. Although financial information was intentionally included in the survey as it is considered private, but not related to mental health, this finding was unexpected. A possible reason for the strong endorsement is apparent in the graph of the Information x Recipient interaction (Figure 3). This graph suggests that several of the recipients, for example, physicians and the Depart-
ment of Mental Health, may have been deemed appropriate to receive mental health information but not financial information, and there were not comparable recipients, such as lending institutions, to be appropriate recipients of financial information.

**Recipient of Information**

All subjects combined approve of the disclosure of information to physicians to a meaningfully greater degree than to the client's relatives, insurance company, employer or friends. There are several possible reasons for this finding. The fact that a person is a client, the psychiatric diagnosis and personal problems are an aspect of a patient's health. Physicians generally want and/or need to be aware of all health problems of their patients. Many clients discuss their problems with their physicians first and then are referred for mental health care. In addition, physicians are expected to uphold a certain degree of confidentiality and may therefore be considered trustworthy recipients of information.

The Department of Mental Health ranks second to physicians in receiving approval as recipients for confidential information. This finding is probably due to subjects viewing such an agency as the appropriate keeper of records of mental health information. It may also be due to the fact that it is standard practice for agencies receiving funding from the Illinois Department of Mental
Health to submit the diagnosis, financial information and other information (without identifying information) of each client to the Illinois Department of Mental Health. The Illinois Department of Mental Health also keeps a central record, with names and diagnoses, of all patients hospitalized in Department of Mental Health facilities and all persons hospitalized in private facilities but for whom the Illinois Department of Mental Health pays the hospital bill. These record keeping practices appear to meet with the approval of most subjects in this survey.

The finding that all subjects combined approve the disclosure of information to employers less than to physicians, the Department of Mental Health and legal authorities suggest that these latter three recipients are viewed more as having good reason to need and/or want information about a mental health client than are employers. Physicians may need information to provide adequate medical care, the Department of Mental Health is the primary keeper of mental health records and legal authorities may want information to provide better protection to society. It is also possible that subjects fear repercussions from employers more than from the other three named recipients.

Subjects least approve of the disclosure of information to friends. This result is not a surprise as friends would have less reason than any other recipient to have access to confidential information. Friends may
request such information in an effort to help, but are generally not in a situation to be making decisions regarding the client or the client's future, other than whether or not they want to remain a friend.

The degree to which psychologists, clients and State's Attorneys all disapprove of the disclosure of information to the client's insurance company without clear consent is of significance. This is especially true when one considers the fact that, according to the Illinois Confidentiality Act, insurance companies are the only sources who can legally obtain complete psychiatric records with a general consent form. With a general consent for access to a client's medical records, insurance companies have unlimited access to psychiatric records. It is obvious that the psychologists, mental health clients and State's Attorneys in the present study disapprove of this exception. The degree of disapproval demonstrated in this study may suggest the recommendation that the legislature review the exception to confidentiality that allows insurance companies such relatively easy access to records.

Psychologists do not show a meaningful difference in approval of disclosure of information dependent upon the recipient of information. Reasons for this finding may be that psychologists have received thorough training in ethics and the importance of confidentiality in psychotherapy and expect a certain degree of confidentiality in
psychotherapy regardless of who may request information.

Clients show a meaningfully greater degree of approval of disclosure of information to physicians than to legal authorities, the client's relatives, the client's insurance company, the client's employer or the client's friends. A reason for this result is that clients may regard their physicians as safe and trustworthy recipients of information. Clients may also view physicians as working collaboratively with the mental health professional for the client's best health or view the psychotherapist as a specialist, not unlike the cardiologist, who routinely sends reports to the primary physician. It may be that the concepts of physician and psychotherapist are not distinct and separate categories in the minds of the clients.

Clients also show a significantly greater degree of approval of disclosure of information when the recipient of information is the Department of Mental Health than when the recipient is the client's friends or employer. This finding is probably due to clients viewing the Department of Mental Health as the appropriate keeper of mental health records, as discussed above.

State's Attorneys have the greatest variation in response due to recipient of information. State's Attorneys approve of the disclosure of information to physicians, the Department of Mental Health and legal authorities to a significantly greater degree than to the other four recip-
ients of information. There is probably greater approval of the disclosure of information to physicians and the Department of Mental Health for the same reasons as clients and all subjects combined, discussed above. However, the relatively high approval of the disclosure of information to legal authorities may reflect State's Attorneys' own interest in obtaining psychiatric records to aid in their work.

While psychologists appear consistently to follow their ethical standards and the tradition of privacy in confidentiality by not having a meaningful difference in approval of disclosure of information dependent upon recipient, State's Attorneys appear to evaluate the appropriateness of each recipient separately. The approach of the State's Attorneys is viewed as reflecting the approach of the legal system which, while setting laws to govern behavior generally, in theory evaluates each situation individually, based on its merits, regardless of ethical codes or principles of natural law. This approach also does not try to establish scientific principles across a number of situations as does that of the psychologist.

Subjects

The present study demonstrates that psychologists consistently show more regard for confidentiality in psychotherapy than clients. Although this finding is consistent, and is therefore considered meaningful, the only
condition in which the Opinion Index of psychologists was more than .5 higher than clients was when the recipient of information was the client's physician.

A reason for the finding that the Opinion Indices of psychologists show less than .5 more support for confidentiality than the Opinion Indices of clients may be related to the subject pool from which clients were drawn. Only those clients who had received a bill for services at the Mental Health Center through the mail were sent a survey. This procedure eliminated client subjects whose fees are paid by such sources as Public Aid and subjects who, because of poor financial circumstances, are not assessed a fee. Assuming that income is correlated with education, one might deduce that the client subjects were more knowledgeable of the importance of confidentiality in psychotherapy and sophisticated insofar as how confidential information can be used and/or misused than an average group of clients. This deduction is supported by the fact that the mean years of education for client subjects was 13.79, nearly two years beyond high school.

The fact that psychologists consistently support confidentiality more than clients may be due to their training in ethical principles and the experiences of the psychologists that reinforce the importance of the concept of confidentiality. It may also be due to the psychologists' awareness of state laws and the legal penalties they may
incur by breaking the laws.

This study demonstrates that psychologists consistently show more regard for confidentiality in psychotherapy than State's Attorneys. Reasons for the difference between psychologists and State's Attorneys may be that the training and experience of psychologists have given them a better understanding of the importance of confidentiality in psychotherapy; psychologists may view themselves as serving the individual client while State's Attorneys may view mental health care as a service to society, in which case State's Attorneys would see the disclosure of information as benefiting society in many circumstances; and psychologists and State's Attorneys may have used a different approach in answering the survey questions, psychologists asking themselves which response best reflects their ethical principles and State's Attorneys asking which response is most helpful and fair for all parties involved.

This study demonstrates that clients show more regard for confidentiality in psychotherapy than do State's Attorneys. This finding makes sense in that clients have a personal stake in keeping information confidential which State's Attorneys, except for those who have been clients, do not have. It is likely that in most circumstances, clients are responding to items in terms of what is acceptable in their individual case while State's Attorneys are
responding in terms of what would be most helpful and fair to society as a whole. This reflects a personal interest in confidentiality on the part of the clients.

The finding that psychologists, of the three subject groups, show the highest regard for confidentiality in psychotherapy indicates a high degree of awareness of the importance of confidentiality and a knowledge of general ethical principles and/or of the laws of Illinois regarding confidentiality. This finding also may reflect a vested interest that psychotherapists have in maintaining confidentiality in psychotherapy, i.e., if psychologists are not able to maintain confidentiality, they will probably not be able to continue to practice psychotherapy in the traditional manner and their livelihood may suffer. Psychologists have a personal interest in conducting themselves in a manner that benefits the profession as a whole.

The finding that clients strongly supported confidentiality, although to a lesser extent than the psychologists, suggests a strong desire for privacy in the psychotherapeutic setting. This finding adds support to previous studies, all conducted using college student counselees as subjects, which indicate that clients expect confidentiality in psychotherapy.

The finding that State's Attorneys have the least regard, of the three subject groups, for confidentiality in psychotherapy indicates a lack of understanding of the
essential role of privacy in the therapeutic setting. This conclusion is of utmost concern as State's Attorneys are elected officials who have contacts and influence with other elected officials, e.g., legislators, who formulate the laws. State's Attorneys also frequently become judges later in their careers, thereby being in a position to interpret the law.

The responses of the State's Attorneys in the present study also suggests either a lack of knowledge of current Illinois law regarding confidentiality in psychotherapy or disagreement with the law. Under current Illinois law, releasing information in all 35 of the situations posed in the Survey of Opinion is illegal (except for insurance companies when only a general consent to medical records is required). The study specifically surveyed "opinion" and not knowledge. However, one can not deduce whether State's Attorneys answered in terms of opinion or according to their knowledge of the law. With either approach to responding to the survey, the results are disturbing. State's Attorneys, who have the responsibility of determining whether or not there is adequate evidence for prosecuting someone who has committed a criminal act, such as divulging confidential communications, do not strongly endorse confidentiality in psychotherapy. They are either not familiar with the law on confidentiality in psychotherapy or disagree with it.
Conclusions and Recommendations

Recent Illinois legislation, designed to extend the protection of confidentiality in psychotherapy, has at least 19 separate exceptions and actually results in making it more difficult for psychotherapists to assure confidentiality to their clients. Psychotherapists have, in nearly all cases, been stripped of the opportunity to use professional judgment in deciding whether or not confidential information should be disclosed. The results of the Survey of Opinion indicate that, when allowed to use professional judgment, psychologists strongly favor refusing to disclose information without client consent unless the client is a danger to himself or others. However, nearly one-half of the psychologists indicated they would disclose confidential information if there was a risk of a contempt of court citation; such a citation would be possible in most of the 19 exceptions to confidentiality. One must conclude that the new Confidentiality Act will result in more situations where confidential communications will be disclosed.

One area of the law of particular concern is that which allows insurance companies to use a general consent form, which any person applying for a policy or making a claim is required to sign, to obtain access to "any and all" psychiatric records. The results of the Survey of Opinion indicate that all subjects would be opposed to such
a law. It is recommended that further research explore this particular exception to confidentiality.

Other areas of concern in the law are those which require a disclosure of confidential information with no allowance for professional judgment when there is no danger to the client or others, especially when other sources are available for obtaining information. The results of the Survey of Opinion suggests that there is sufficient opposition to the disclosure of information without client consent when the client is not dangerous to self or others to consider a reexamination of the exceptions to confidentiality. For example, it is recommended that there be research to explore the feasibility of the Department of Law Enforcement requiring character references before issuing Firearm Owner's Identification Cards rather than requiring the Department of Mental Health to report whether individuals applying for identification cards have had a psychiatric hospitalization. It is recommended that studies examine methods that would allow the psychotherapist, rather than a judge, to decide what confidential information, if any, is relevant and necessary for disclosure in a court of law. It is recommended that the entire Confidentiality Act be reevaluated so that decisions on confidentiality can be made in a therapeutic rather than legal manner.

When there is the possibility of a client being
dangerous to self or others, it is recommended that re-
search investigate approaches that would permit the psy-
chotherapist to use professional judgment in deciding how
to approach the problem. This recommendation is made
with the philosophical and moral attitude that it is in the
therapeutic interest of clients to do whatever is neces-
sary, but only what is necessary, to keep them from hurting
themselves or others. For example, when a client threatens
a third party, the psychotherapist should be permitted to
use professional judgment, 1) to decide if the threat is
likely to be carried out, and 2) to decide how to respond
to a serious threat. Ennis and Litwack (1974) point out
that the psychiatric literature indicates that mental
health professionals are very poor predictors of danger-
ousness. They cite numerous studies suggesting that mental
health professionals over-predict dangerousness, leading
one to conclude that, if permitted to use professional
judgment, psychotherapists would tended to err in the inter-
est of society. When making a decision as to how to re-
spond to a serious threat, psychotherapists need to be able
to sue alternatives that best fit the situations. In some
cases, seeing a client for more frequent appointments will
be helpful. In others, the psychotherapist may determine
that hospitalization is necessary. Only in cases where the
law interferes with psychotherapists' efforts to do what is
best for their clients, e.g., Tarasoff would it be neces-
sary to disclose information to a threatened third party.

It is recommended that studies explore the feasibility of psychotherapists being permitted to use professional judgment in reporting child abuse so that only cases where there is ongoing abuse or a risk of danger to the child would be required to be reported. Reporting child abuse can drastically disrupt the therapeutic relationship, especially if such a report is not necessary.

It is recommended that further research be accomplished regarding ethical issues, specifically confidentiality. Lewis and Warman noted in 1964 that, "a search of the literature reveals few, if any attempts to clarify the issues pertaining to the problem of confidentiality through research rather than speculation" (p. 7). This statement is still true today.

It is specifically recommended that there be research exploring both the opinions and actual behavior of psychologists in regard to confidentiality. Such research could provide helpful information for use in planning training programs in ethics for psychologists, for enumerating and clarifying ethical issues and for reaching a better understanding of the concept of confidentiality in psychotherapy. Some more careful exploration of the variety of situations and pressures that are brought on psychologists to disclose information would provide data that could aid in the above as well. In addition to assessing attitudes,
it would be useful to do more assessment of psychologists' knowledge of ethical codes and laws regarding confidentiality. This information would be most helpful for training and continuing education purposes.

It is recommended that there be more research exploring client attitudes regarding confidentiality. This information would be useful in pinpointing areas of potential conflict, confusion or friction. For example, the results that clients strongly disapprove of the disclosure of information to insurance companies without clear consent provides information and data that may be useful in facilitating a modification of the general consent insurance companies are not able to use. A replication of these results would provide reliability for the present data.

It is recommended that psychologists continue their education and training in ethics and confidentiality in psychotherapy. It is also recommended that psychotherapists attempt to provide more and better training for laymen regarding ethics and confidentiality in psychotherapy. In view of the survey results, it is especially recommended that psychotherapists attempt to educate attorneys and legal authorities regarding the role of confidentiality in the traditional practice of psychotherapy and the importance of confidentiality in the psychotherapeutic relationship.
SUMMARY

This dissertation explores the issue of confidentiality in psychotherapy from a moral and historical, psychotherapeutic and legal perspective. The moral and historical section discusses the similarities between current debates on confidentiality and the writings on the Seal of Confession of 13th through 17th century Roman Catholic theologians. The works of major theorists-practitioners, basic texts and manuals on psychotherapy, psychological research and codes of ethics are discussed as they pertain to confidentiality. The legal section examines privacy in terms of tort and constitutional law, current Illinois law and recent legal cases regarding privileged communication and confidentiality in psychotherapy.

The moral, scientific and legal approaches to the resolution of conflicts are contrasted throughout the dissertation. The impact of legal intervention regarding confidentiality on the traditional practice of psychotherapy is discussed in terms of possible psychotherapist and client reactions to specific laws on confidentiality and to the disclosure of confidential information.

The present study surveyed the opinions of psychologists, mental health clients and State's Attorneys on psychotherapists disclosing specific kinds of information.
to specific sources about clients who are not an immediate
danger to themselves or others. The five kinds of informa-
tion addressed in the survey are educational/ vocational,
the fact that a person is a client, psychiatric diagnosis,
a client's personal problems and financial information.
The seven possible recipients of information on the survey
are the client's physician, the Department of Mental
Health, legal authorities, the client's relatives, the
client's insurance company, the client's employer and the
client's friends.

The results indicate the psychologists, clients
and all subjects combined have no significant difference
in approval of disclosure of information dependent upon
type of information. State's Attorneys have a higher
regard for financial information than for all other types
of information. Psychologists show no significant differ-
ence in approval of disclosure of information dependent on
recipient of information. Clients, State's Attorneys and
all subjects combined show a significant degree of differ-
ence in approval of disclosure dependent on recipient of
information. The results demonstrate that psychologists
consistently show more regard for confidentiality than
clients or State's Attorneys. State's Attorneys show the
least regard for confidentiality in psychotherapy.

Further research is recommended regarding ethical
issues, specifically confidentiality.
REFERENCES


Carey v. Affiliated Mid-West Hospitals, Inc., Circuit Court of Cook County, Chancery Division, No. 77 CH 4888, 1977.


Himelstein, P. & Lubin, B. Relationship of the MMPI K scale and a measure of self-disclosure in a normal population. Psychological Reports, 1966, 19, 166.


Regan, R. E. The moral principles governing professional secrecy with an inquiry into some of the more important professional secrets. Washington, D.C.: Catholic University of America Press, 1941.


Siegal, M. Privacy, ethics and confidentiality. Professional Psychology, 1979, 10, 249-257.


Yoeckel v. Samonig, 75 N.W. 2d 925 (1956).
REFERENCE NOTES


5.1 Physician-patient relationship. § 5.1. No physician or surgeon shall be permitted to disclose any information he may have acquired in attending any patient in a professional character necessary to enable him professionally to serve such patient, except only (1) in trials for homicide when the disclosure relates directly to the fact or immediate circumstances of the homicide, (2) in actions, civil or criminal, against the physician for malpractice, (3) with the expressed consent of the patient, or in case of his death or disability, of his personal representative or other person authorized to sue for personal injury or of the beneficiary of an insurance policy on his life, health, or physical condition, (4) in all civil suits brought by or against the patient, his personal representative, a beneficiary under a policy of insurance, or the executor or administrator of his estate wherein the patient's physical or mental condition is an issue, (5) upon an issue as to the validity of a document as a will of the patient, (6) in any criminal action where the charge is either murder by abortion, attempted abortion or abortion or (7) in actions, civil or criminal, arising from the filing of a report in compliance with the "Abused and Neglected Child Reporting Act", enacted by the 79th General Assembly.
5.2 Psychiatrist-patient relationship.] § 5.2.
In civil and criminal cases, in proceedings preliminary thereto, and in legislative and administrative proceedings, a patient or his authorized representative and a psychiatrist or his authorized representative have the privilege to refuse to disclose, and to prevent a witness from disclosing, communications relating to diagnosis or treatment of the patient's mental condition between patient and psychiatrist, or between members of the patient's family and the psychiatrist, or between any of the foregoing and such persons under the supervision of a psychiatrist in the accomplishment of the objectives of diagnosis or treatment.

There is no privilege under this Section for any relevant communications

(a) when a psychiatrist, in the course of diagnosis or treatment of the patient, determines that the patient is in need of hospitalization, provided that such communications shall be admissible only with respect to issues relating to the need for such hospitalization;

(b) if the judge finds that the patient, after having been informed that the communications would not be privileged, has made communications to a psychiatrist in the course of a psychiatric examination ordered by the court, provided that such communications shall be admissible only with respect to issues involving the patient's mental condition;

(c) in a civil or administrative proceeding in which the patient introduced his mental condition as an element of his claim or defense or, after the patient's death, when his mental condition is introduced by any party claiming or defending through or as a beneficiary of the patient; the provisions of this paragraph (c) shall not apply to preclude the assertion of the privilege in any action brought or defended under the "Illinois Marriage and Dissolution of Marriage Act", as now or hereafter amended, unless the patient or the psychiatrist on behalf of the patient first testifies as to such communications;

(d) in any proceeding brought by the patient against his psychiatrist, including but not limited to any malpractive proceeding, and in any criminal or license revocation proceeding in which the patient is a complaining witness and in which disclosure is relevant to the claim or defense of the psychiatrist.
5306. Disclosure of information by psychologist
--Prohibition--Exceptions.] § 6. No psychologist shall
disclose any information he may have acquired from persons
consulting him in his professional capacity, necessary to
enable him to render services in his professional capa-
city, to such persons except only: (1) in trials for
homicide when the disclosure relates directly to the fact
or immediate circumstances of the homicide, (2) in all
proceedings the purpose of which is to determine mental
competency, or in which a defense of mental incapacity is
raised, (3) in actions, civil or criminal, against the
psychologist for malpractice, (4) with the expressed
consent of the client, or in the case of his death or
disability, of his personal representative or other person
authorized to sue or of the beneficiary of an insurance
policy on his life, health or physical condition, or (5)
upon an issue as to the validity of a document as a will
of a client.
§ 20. No social worker may disclose any information he may have acquired from persons consulting him in his professional capacity which was necessary to enable him to render services in his professional capacity of those persons except: (1) to his employer, (2) in a criminal trial when the disclosure relates directly to the fact or immediate circumstances of the crime, (3) in actions, civil or criminal, against the social worker for malpractice, or (4) with the written consent of the client, or in the case of his death or disability, of his personal representative or other person authorized to sue or of the beneficiary of an insurance policy on his life, health, or physical condition.
MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES CONFIDENTIALITY ACT

AN ACT to protect the confidentiality of records and communications of recipients of mental health or developmental disability services, and to amend and repeal certain Acts and Sections herein named in connection therewith.

Be it enacted by the People of the State of Illinois, represented in the General Assembly:

ARTICLE I

Section 1. This Act shall be known and may be cited as the "Mental Health and Developmental Disabilities Confidentiality Act".

Section 2. The terms used in this Act, unless the context requires otherwise, have the meanings ascribed to them in this Section.

(1) "Confidential communication" or "communication" means any communication made by a recipient or other person to a therapist or to or in the presence of other persons during or in connection with providing mental health or developmental disability services to a recipient. Communication includes information which indicates that a person is a recipient.

(2) "Guardian" means a legally appointed guardian or conservator of the person.

(3) "Mental health or developmental disabilities services" or "services" includes but is not limited to examination, diagnosis, evaluation, treatment, training, pharmaceuticals, aftercare, habilitation or rehabilitation.

(4) "Personal notes" means:

(i) information disclosed to the therapist in confidence by other persons on condition that such information would never be disclosed to the recipient or other persons;

(ii) information disclosed to the therapist by the recipient which would be injurious to the recipient's relationships to other persons, and

(iii) the therapist's speculations, impressions, hunches, and reminders.

(5) "Parent" means a parent or, in the absence of a parent or guardian, a person in loco parentis.

(6) "Recipient" means a person who is receiving or has received mental health or developmental disabilities services.
(7) "Record" means any record kept by a therapist or by an agency in the course of providing mental health or developmental disabilities service to a recipient concerning the recipient and the services provided. Record does not include the therapist's personal notes, if such notes are kept in the therapist's sole possession for his own personal use and are not disclosed to any other person, except the therapist's supervisor, consulting therapist or attorney. If at any time such notes are disclosed, they shall be considered part of the recipient's record for purposes of this Act. Record does not include testing material used in the course of providing services if the disclosure of such material would compromise the objectivity or fairness of the testing process.

(8) "Record custodian" means a person responsible for maintaining a recipient's record.

(9) "Therapist" means a psychiatrist, physician, psychologist, social worker, or nurse providing mental health or developmental disabilities services or any other person not prohibited by law from providing such services or from holding himself out as a therapist if the recipient reasonably believes that such person is permitted to do so. Therapist includes any successor of the therapist.

Section 3. (a) All records and communications shall be confidential and shall not be disclosed except as provided in this Act.

(b) A therapist is not required to but may, to the extent he determines it necessary and appropriate, keep personal notes regarding a recipient. Such personal notes are the work product and personal property of the therapist and shall not be subject to discovery in any judicial, administrative or legislative proceeding or any proceeding preliminary thereto.

Section 4. (a) The following persons shall be entitled, upon request, to inspect and copy a recipient's record or any part thereof:

(1) the parent or guardian of a recipient who is under 12 years of age;

(2) the recipient if he is 12 years of age or older;

(3) another person on such recipient's behalf if the recipient so authorizes in writing;

(4) the parent or guardian of a recipient who is at least 12 but under 18 years, if the recipient is informed and does not object or if the therapist does not find that there are compelling reasons for denying such access. The parent or guardian who is denied access by either the recipient or the therapist may petition a court for access to the record; or

(5) the guardian of a recipient who is 18 years or older.

(b) Assistance in interpreting the record may be provided without charge and shall be provided if the person inspecting the record is under 18 years of age. However, access may in no way be denied or limited if the person inspecting the record refuses such assistance. A reasonable fee may be charged for duplication of a record.

(c) Any person entitled to access to a record under this Section may
submit a written statement concerning any disputed or new information, which statement shall be entered into the record. Whenever any disputed part of a record is disclosed, any submitted statement relating thereto shall accompany the disclosed part. Additionally, any person entitled to access may request modification of any part of the record which he believes is incorrect or misleading. If such request is refused, the person may seek a court order to compel modification.

(d) Whenever access or modification is requested, the request and any action taken thereon shall be noted in the recipient's record.

Section 5. (a) Except as provided in Sections 6 through 11 of this Act, records and communications may be disclosed only with the written consent of:

(1) the parent or guardian of a recipient who is under 12 years;
(2) both the parent or guardian of a recipient who is at least 12 but under 18 years and the recipient. If only the recipient refuses to consent there shall be no disclosure unless the therapist finds that such disclosure is in the best interests of such recipient. If the parent or guardian refuses to consent, disclosure shall not be made; or
(3) the recipient if he is 18 years or older or his guardian if he has been adjudicated incompetent.

(b) Every consent form shall be in writing and shall specify the following:

(1) the person or agency to whom disclosure is to be made;
(2) the purpose for which disclosure is to be made;
(3) the nature of the information to be disclosed;
(4) the right to inspect and copy the information to be disclosed;
(5) the consequences of a refusal to consent, if any; and
(6) the fixed period of time for which the consent is valid; and
(7) the right to revoke the consent at any time.

The consent form shall be signed by the person entitled to give consent and the signature shall be witnessed by a person who can attest to the identity of the person so entitled. A copy of the consent and a notation as to any action taken thereon shall be entered in the recipient's record.

(c) Only information relevant to the purpose for which disclosure is sought may be disclosed. Blanket consent to the disclosure of unspecified information shall not be valid. Advance consent may be valid only if the nature of the information to be disclosed is specified in detail and the duration of the consent is indicated. Consent may be revoked in writing at any time; any such revocation shall have no effect on disclosures made prior thereto.

(d) No person or agency to whom any information is disclosed under this
Section may redisclose such information unless the person who consented to the disclosure specifically consents to such redisclosure.

(e) Except as otherwise provided in this Act, records and communications shall remain confidential after the death of a recipient and shall not be disclosed unless the recipient's representative, as defined in the Probate Act of 1975, approved August 7, 1975, as now or hereafter amended, and the therapist consent to such disclosure or unless disclosure is authorized by court order after in camera examination and upon good cause shown.

(f) Paragraphs (a) through (e) of this Section shall not apply to and shall not be construed to limit insurance companies writing Life, Accident or Health insurance as defined in Section 4 of the Illinois Insurance Code, as now or hereafter amended, and Non-Profit Health Care Service Plan Corporations, writing Health Care Service contracts, under The Non-profit Health Care Service Plan Act, as now or hereafter amended, in obtaining general consents for the release to them or their designated representatives of any and all confidential communications and records kept by agencies, hospitals, therapists or record custodians, and utilizing such information in connection with the underwriting of applications for coverage for such policies or contracts, or in connection with evaluating claims or liability under such policies or contracts, or coordinating benefits pursuant to policy or contract provisions.

Section 6. Such information from a recipient's record as is necessary to enable him to apply for or receive benefits may be disclosed with consent obtained pursuant to Section 5 of this Act. Disclosure may be made without consent when despite every reasonable effort it is not possible to obtain consent because the person entitled to give consent is not capable of consenting or is not available to do so. The recipient shall be informed of any disclosure made without consent. The information disclosed without consent under this Section may include only the identity of the recipient and therapist and a description of the nature, purpose, quantity, and date of the services provided. Any request for additional information shall state with particularity what further information is needed and the reasons therefor. Refusal to consent to the disclosure of more information than is necessary to apply for or receive direct benefits shall not be grounds for in any way denying, limiting, or cancelling such benefits or refusing to accept an application or renew such benefits. Such information shall not be redisclosed except with the consent of the person entitled to give consent.

Section 7. When a therapist or agency which provides services is being reviewed for purposes of funding, accreditation, audit, licensure, statistical compilation, research, evaluation, or other similar purpose, a recipient's record may be used by the person conducting the review to the extent that this is necessary to accomplish the purpose of the review, provided that personally identifiable data is removed from the record prior to the use. Personally identifiable data may be disclosed only with the consent obtained pursuant to Section 5 of this Act. Funding, accreditation, licensure, and the like may not be withheld or withdrawn for failure to disclose personally identifiable data if consent is not obtained.
Section 8. In the course of an investigation, a regional human rights authority of the Guardianship and Mental Health Advocacy Commission created by the Guardianship and Mental Health Advocacy Act enacted by the 80th General Assembly may inspect and copy any recipient's records in the possession of a therapist or agency which provides services. However, a regional authority may not inspect or copy records containing personally identifiable data which cannot be removed without imposing an unreasonable burden on the therapist or agency which provides services, except as provided herein. The regional authority shall give written notice to the person entitled to give consent for the identifiable recipient of services under Section 4 that it is conducting an investigation and indicating the nature and purpose of the investigation and the need to inspect and copy the recipient's record. If the person notified objects in writing to such inspection and copying, the regional authority may not inspect or copy the record. The therapist or agency which provides services may not object on behalf of a recipient.

Section 9. (a) In the course of providing services, a therapist may disclose a record or communications without consent to:

(1) the therapist's supervisor, a consulting therapist, members of a staff team participating in the provision of services, a record custodian, or a person acting under the supervision and control of the therapist;

(2) persons conducting a peer review of the services being provided; and

(3) an attorney or advocate consulted by a therapist or agency which provides services concerning the therapist's or agency's legal rights or duties in relation to the recipient and the services being provided.

Information may be disclosed under this Section only to the extent that knowledge of the record or communications is essential to the purpose for which disclosure is made and only after the recipient is informed that such disclosure may be made. A person to whom disclosure is made under this Section shall not redisclose any information except as provided in this Act.

Section 10. (a) Except as provided herein, in any civil, criminal, administrative, or legislative proceeding, or in any proceeding preliminary thereto, a recipient, and a therapist on behalf and in the interest of a recipient, has the privilege to refuse to disclose and to prevent the disclosure of the recipient's record or communications.

(1) Records and communications may be disclosed in a civil or administrative proceeding in which the recipient introduces his mental condition or any aspect of his services received for such condition as an element of his claim or defense, if and only to the extent the court in which the proceedings have been brought, or, in the case of an administrative proceeding, the court to which an appeal or other action for review of an administrative determination may be taken, finds, after in camera examination of testimony or other evidence, that it is relevant, probative, not unduly prejudicial or inflammatory, or otherwise clearly admissible; that other satisfactory evidence is demonstrably unsatisfactory as evidence of the facts sought to be established by such evidence; and that disclosure is more important to the interests of substantial
justice than protection from injury to the therapist-recipient relationship or to
the recipient or other whom disclosure is likely to harm. No record or
communication between a therapist and a recipient shall be deemed relevant for
purposes of this subsection, except the fact of treatment, the cost of services
and the ultimate diagnosis unless the party seeking disclosure of the communica-
tion clearly establishes in the trial court a compelling need for its production.
However, for purposes of this Act, in any action brought or defended under the
"Illinois Marriage and Dissolution of Marriage Act", approved September 22,
1977, as now or hereafter amended, or in any action in which pain and
suffering is an element of the claim, mental condition shall not be deemed to be
introduced merely by making such claim and shall be deemed to be introduced
only if the recipient or a witness on his behalf first testifies concerning the
record or communication.

(2) Records or communications may be disclosed in a civil proceeding
after the recipient’s death when the recipient’s physical or mental condition has
been introduced as an element of a claim or defense by any party claiming or
defending through or as a beneficiary of the recipient, provided the court finds,
after in camera examination of the evidence, that it is relevant, probative, and
otherwise clearly admissible; that other satisfactory evidence is not available
regarding the facts sought to be established by such evidence; and that
disclosure is more important to the interests of substantial justice than protec-
tion from any injury which disclosure is likely to cause.

(3) In the event of a claim made or an action filed by a recip-
ient, or, following the recipient’s death, by any party claiming as a beneficiary
of the recipient for injury caused in the course of providing services to such
recipient, the therapist and other persons whose actions are alleged to have been
the cause of injury may disclose pertinent records and communications to an
attorney or attorneys engaged to render advice about and to provide represent-
tation in connection with such matter and to persons working under the
supervision of such attorney or attorneys, and may testify as to such records or
communication in any administrative, judicial or discovery proceeding for the
purpose of preparing and presenting a defense against such claim or action.

(4) Records and communications made to or by a therapist in the course
of examination ordered by a court for good cause shown may, if otherwise
relevant and admissible, be disclosed in a judicial or administrative proceeding
in which the recipient is a party or in appropriate pretrial proceedings, provided
such court has found that the recipient has been as adequately and as effectively
as possible informed before submitting to such examination that such records
and communications would not be considered confidential or privileged. Such
records and communications shall be admissible only as to issues involving the
recipient’s physical or mental condition and only to the extent that these are
germane to such proceedings.

(5) Records and communications may be disclosed in a proceeding
under the Probate Act of 1975, approved August 7, 1975, as now or hereafter
amended, to determine a recipient’s competency or need for guardianship,
provided that the disclosure is made only with respect to that issue.
(6) Records and communications may be disclosed when such are made during treatment which the recipient is ordered to undergo to render him fit to stand trial on a criminal charge, provided that the disclosure is made only with respect to the issue of fitness to stand trial.

(7) Records and communications of the recipient may be disclosed in any civil or administrative proceeding involving the validity of or benefits under a life, accident, health or disability insurance policy or certificate, or Health Care Service Plan Contract, insuring the recipient, but only if and to the extent that the recipient's mental condition, or treatment or services in connection therewith, is a material element of any claim or defense of any party, provided that information sought or disclosed shall not be redisclosed except in connection with the proceeding in which disclosure is made.

(8) Records or communications may be disclosed when such are relevant to a matter in issue in any action brought under this Act and proceedings preliminary thereto, provided that any information so disclosed shall not be utilized for any other purpose nor be redisclosed except in connection with such action or preliminary proceedings.

(b) Before a disclosure is made under this Section, any party to the proceeding or any other interested person may request an in camera review of the record or communications to be disclosed. The court or agency conducting the proceeding may hold an in camera review on its own motion. When, contrary to the express wish of the recipient, the therapist asserts a privilege on behalf and in the interest of a recipient, the court may require that the therapist, in an in camera hearing, establish that disclosure is not in the best interest of the recipient. The court or agency may prevent disclosure or limit disclosure to the extent that other admissible evidence is sufficient to establish the facts in issue. The court or agency may enter such orders as may be necessary in order to protect the confidentiality, privacy, and safety of the recipient or of other persons. Any order to disclose or to not disclose shall be considered a final order for purposes of appeal and shall be subject to interlocutory appeal.

Section 11. Records and communications may be disclosed, (i) in accordance with the provisions of the Abused and Neglected Child Reporting Act, approved June 26, 1975, as now or hereafter amended; (ii), when, and to the extent, a therapist, in his sole discretion, determines that such disclosure is necessary to initiate or continue civil commitment proceedings under the laws of this State or to otherwise protect the recipient or other person against a clear, imminent risk of serious physical or mental injury or disease or death being inflicted upon the recipient, or by the recipient on himself or another; (iii) when and to the extent such is, in the sole discretion of the therapist, necessary to the provision of emergency medical care to a recipient who is unable to assert or waive his rights hereunder and there is no relative or other third party available to give consent; and (iv) in commitment proceedings under the "Mental Health and Developmental Disabilities Code", enacted by the 80th General Assembly, and proceedings and investigations preliminary thereto, to the State's Attorney for the county of residence of a person for whom involuntary or judicial admission is sought, or in which such person is found, or in which the facility is
located, provided that the information so disclosed shall not be utilized for any other purpose nor be redisclosed except in connection with such proceedings or investigations. Any person, institution, or agency, under this Act, participating in good faith in the making of a report under the Abused and Neglected Child Reporting Act, approved June 26, 1975, as now or hereafter amended, or in the disclosure of records and communications otherwise in accordance with this provision, shall have immunity from any liability, civil, criminal or otherwise, that might result by reason of such action. For the purpose of any proceeding, civil or criminal, arising out of a report or disclosure in accordance with this provision, the good faith of any person, institution, or agency so reporting or disclosing shall be presumed.

Section 12. (a) If the United States Secret Service requests information from the Department of Mental Health and Developmental Disabilities relating to a specific recipient and the Director of the Department determines that disclosure of such information may be necessary to protect the life of a person under the protection of the Secret Service, only the following information may be disclosed: the recipient's name, address, and age and the date of any admission to or discharge from a Department facility.

(b) The Department of Mental Health and Developmental Disabilities and all private hospitals are required, as hereafter described in this subsection, to furnish the Department of Law Enforcement only such information as may be required for the sole purpose of determining whether an individual who may be or may have been a patient is disqualified because of that status from receiving or retaining a Firearm Owner's Identification Card under subsection (e) of Section 8 of ‘‘An Act relating to the acquisition, possession and transfer of firearms and firearm ammunition’’, approved August 3, 1967, as amended. Any such information disclosed under this subsection shall remain privileged and confidential, and shall not be redisclosed nor utilized for any other purpose. The method of requiring the providing of such information shall guarantee that no information is released beyond what is necessary for this purpose. One acceptable method is that of periodically providing lists to the Department of Mental Health and Developmental Disabilities or any private hospital of Firearm Owner's Identification Card applicants on which the Department or hospital shall indicate the identities of those individuals who are to its knowledge disqualified from having a Firearm Owner's Identification Card for reasons described herein. The Department may provide for a centralized source of information for the State on this subject under its jurisdiction.

For purposes of this subsection (b) only, the following terms shall have the meaning prescribed:

(1) '‘Hospital’’ means only that type of institution which is providing full-time residential facilities and treatment for in-patients and excludes institutions, such as community clinics, which only provide treatment to out-patients.

(2) '‘Patient’’ shall mean only a person who is an in-patient or resident of any hospital, not an out-patient or client seen solely for periodic consultation.
Section 13. Whenever disclosure of a record or communication is made without consent pursuant to this Act or whenever a record is used pursuant to Sections 7 and 8 of this Act, a notation of the information disclosed and the purpose of such disclosure or use shall be noted in the recipient's record together with the date and the name of the person to whom disclosure was made or by whom the record was used.

Section 14. Any agreement purporting to waive any of the provisions of this Act is void.

Section 15. Any person aggrieved by a violation of this Act may sue for damages, an injunction, or other appropriate relief. Reasonable attorney's fees and costs may be awarded to the successful plaintiff in any action under this Act.

Section 16. Any person who knowingly and wilfully violates any provision of this Act is guilty of a Class A misdemeanor.

Section 17. The Director of the Department of Mental Health and Developmental Disabilities shall adopt rules and regulations to implement this Act.

This Act takes effect January 1, 1979.

This Act amends the following:
Chapter 51, Evidence, par. 5.1
Chapter 23, Charities and Public Welfare, "Social Workers Registration Act", par. 5320 (Note: Transferred to Ch. 111, Professions and Occupations).
Chapter 91½, Mental Health, "Psychologists Registration Act", par. 406 (Note: Transferred to Ch. 111, Professions and Occupations).

This Act repeals par. 5.2 of Chapter 51, Evidence.
Dear Madam or Sir:

Enclosed please find a survey and questionnaire regarding confidentiality in psychotherapy. The Mental Health Center of Sangamon-Menard Counties is sponsoring this research in an effort to provide data that will be helpful in determining policy and to lawmakers. In addition, I will be using the results in a Doctoral Dissertation for the fulfillment of the Ph.D. requirements at Loyola University of Chicago.

All responses to the survey and questionnaire will be kept confidential. It is not necessary to put your name on the survey or questionnaire. If there are any questions which you feel may identify you, please feel free to skip them.

Please fill out the enclosed postcard when you return the questionnaire. This will enable me to send reminder letters only to those who have not returned the postcard.

If you wish to receive a summary of the results and conclusions, please indicate this on the postcard.

Thank you in advance for your time and consideration. They are very much appreciated.

Sincerely,

Helen P. Appleton, M.A.
SURVEY OF OPINION

Form A

Directions: Please mark the space that best reflects your opinion of each of the following situations. Assume that the client is not an immediate danger to himself or others.

1. A psychotherapist not disclosing a client's education and vocation to the Department of Mental Health because he does not have the client's clear consent to disclose.
   Approve __________ Disapprove

2. A psychotherapist disclosing a client's financial situation to the client's employer without the client's clear consent.
   Approve __________ Disapprove

3. A psychotherapist disclosing a client's psychiatric diagnosis to the client's physician without the client's clear consent.
   Approve __________ Disapprove

4. A psychotherapist disclosing that a person is a client to the client's insurance company without the client's clear consent.
   Approve __________ Disapprove

5. A psychotherapist not disclosing that a person is a client to the client's friends because he does not have the client's clear consent to disclose.
   Approve __________ Disapprove

6. A psychotherapist not disclosing a client's financial situation to legal authorities because he does not have the client's clear consent to disclose.
   Approve __________ Disapprove

7. A psychotherapist disclosing a client's education and vocation to the client's physician without the client's clear consent.
   Approve __________ Disapprove

8. A psychotherapist not disclosing a client's personal problems to the Department of Mental Health because he does not have the client's clear consent to disclose.
   Approve __________ Disapprove

9. A psychotherapist disclosing that a person is a client to the client's employer without the client's clear consent.
   Approve __________ Disapprove

10. A psychotherapist not disclosing a client's psychiatric diagnosis to the client's insurance company because he does not have the client's clear consent to disclose.
    Approve __________ Disapprove

11. A psychotherapist not disclosing a client's personal problems to the client's relatives because he does not have the client's clear consent to disclose.
    Approve __________ Disapprove

12. A psychotherapist not disclosing a client's education and vocation to the client's friends because he does not have the client's clear consent to disclose.
    Approve __________ Disapprove

13. A psychotherapist not disclosing a client's financial situation to the client's relatives because he does not have the client's clear consent to disclose.
    Approve __________ Disapprove

14. A psychotherapist disclosing that a person is a client to the Department of Mental Health without the client's clear consent.
    Approve __________ Disapprove

15. A psychotherapist not disclosing a client's financial situation to the client's insurance company because he does not have the client's clear consent to disclose.
    Approve __________ Disapprove

16. A psychotherapist disclosing a client's personal problems to the client's physician without the client's clear consent.
    Approve __________ Disapprove

17. A psychotherapist not disclosing that a person is a client to legal authorities because he does not have the client's clear consent to disclose.
    Approve __________ Disapprove

18. A psychotherapist disclosing a client's psychiatric diagnosis to the client's employer without the client's clear consent.
    Approve __________ Disapprove

19. A psychotherapist disclosing a client's personal problems to the client's physician without the client's clear consent.
    Approve __________ Disapprove
19. A psychotherapist disclosing
a client's education and vocation
without the client's clear consent.
Approve ___ ___ ___ ___ Disapprove

20. A psychotherapist not disclosing
a client's financial situation
to the Department of Mental Health
because he does not have the client's
clear consent to disclose.
Approve ___ ___ ___ ___ Disapprove

21. A psychotherapist not disclosing
a client's personal problems
to the client's insurance company
because he does not have the client's
clear consent to disclose.
Approve ___ ___ ___ ___ Disapprove

22. A psychotherapist not disclosing
a client's education and vocation
to the client's employer
because he does not have the client's
clear consent to disclose.
Approve ___ ___ ___ ___ Disapprove

23. A psychotherapist disclosing
a client's personal problems
to legal authorities
without the client's clear consent.
Approve ___ ___ ___ ___ Disapprove

24. A psychotherapist disclosing
a client's personal problems
to the client's friends
without the client's clear consent.
Approve ___ ___ ___ ___ Disapprove

25. A psychotherapist not disclosing
that a person is a client
to the client's physician
because he does not have the client's
clear consent to disclose.
Approve ___ ___ ___ ___ Disapprove

26. A psychotherapist disclosing
a client's psychiatric diagnosis
to legal authorities
without the client's clear consent.
Approve ___ ___ ___ ___ Disapprove

27. A psychotherapist not disclosing
a client's personal problems
to the client's employer
because he does not have the client's
clear consent to disclose.
Approve ___ ___ ___ ___ Disapprove

28. A psychotherapist disclosing
a client's education and vocation
to the client's relatives
without the client's clear consent.
Approve ___ ___ ___ ___ Disapprove

29. A psychotherapist disclosing
that a person is a client
to the client's relatives
without the client's clear consent.
Approve ___ ___ ___ ___ Disapprove

30. A psychotherapist disclosing
a client's psychiatric diagnosis
to the Department of Mental Health
without the client's clear consent.
Approve ___ ___ ___ ___ Disapprove

31. A psychotherapist disclosing
a client's psychiatric diagnosis
to the client's friends
without the client's clear consent.
Approve ___ ___ ___ ___ Disapprove

32. A psychotherapist not disclosing
a client's education and vocation
to legal authorities
because he does not have the client's
clear consent to disclose.
Approve ___ ___ ___ ___ Disapprove

33. A psychotherapist disclosing
a client's psychiatric diagnosis
to the client's relatives
without the client's clear consent.
Approve ___ ___ ___ ___ Disapprove

34. A psychotherapist not disclosing
a client's financial situation
to the client's friends
because he does not have the client's
clear consent to disclose.
Approve ___ ___ ___ ___ Disapprove

35. A psychotherapist disclosing
a client's financial situation
to the client's physician
without the client's clear consent.
Approve ___ ___ ___ ___ Disapprove
Directions: Please mark the space that best reflects your opinion of each of the following situations. Assume that the client is not an immediate danger to himself or others.

1. A psychotherapist disclosing a client's education and vocation to the Department of Mental Health without the client's clear consent.
   Approve ______ ______ ______ ______ Disapprove

2. A psychotherapist not disclosing a client's financial situation to the client's employer because he does not have the client's clear consent to disclose.
   Approve ______ ______ ______ ______ Disapprove

3. A psychotherapist not disclosing a client's psychiatric diagnosis to the client's physician because he does not have the client's clear consent to disclose.
   Approve ______ ______ ______ ______ Disapprove

4. A psychotherapist not disclosing that a person is a client to the client's insurance company because he does not have the client's clear consent to disclose.
   Approve ______ ______ ______ ______ Disapprove

5. A psychotherapist disclosing that a person is a client to the client's friends without the client's clear consent.
   Approve ______ ______ ______ ______ Disapprove

6. A psychotherapist disclosing a client's financial situation to legal authorities without the client's clear consent.
   Approve ______ ______ ______ ______ Disapprove

7. A psychotherapist not disclosing a client's education and vocation to the client's physician because he does not have the client's clear consent to disclose.
   Approve ______ ______ ______ ______ Disapprove

8. A psychotherapist disclosing a client's personal problems to the Department of Mental Health without the client's clear consent.
   Approve ______ ______ ______ ______ Disapprove

9. A psychotherapist not disclosing that a person is a client to the client's employer because he does not have the client's clear consent to disclose.
   Approve ______ ______ ______ ______ Disapprove

10. A psychotherapist disclosing a client's psychiatric diagnosis to the client's insurance company without the client's clear consent.
    Approve ______ ______ ______ ______ Disapprove

11. A psychotherapist disclosing a client's personal problems to the client's relatives without the client's clear consent.
    Approve ______ ______ ______ ______ Disapprove

12. A psychotherapist disclosing a client's education and vocation to the client's friends without the client's clear consent.
    Approve ______ ______ ______ ______ Disapprove

13. A psychotherapist disclosing a client's financial situation to the client's relatives without the client's clear consent.
    Approve ______ ______ ______ ______ Disapprove

14. A psychotherapist not disclosing that a person is a client to the Department of Mental Health because he does not have the client's clear consent to disclose.
    Approve ______ ______ ______ ______ Disapprove

15. A psychotherapist disclosing a client's financial situation to the client's insurance company without the client's clear consent.
    Approve ______ ______ ______ ______ Disapprove

16. A psychotherapist not disclosing a client's personal problems to the client's physician because he does not have the client's clear consent to disclose.
    Approve ______ ______ ______ ______ Disapprove

17. A psychotherapist disclosing that a person is a client to legal authorities without the client's clear consent.
    Approve ______ ______ ______ ______ Disapprove

18. A psychotherapist not disclosing a client's psychiatric diagnosis to the client's employer because he does not have the client's clear consent to disclose.
    Approve ______ ______ ______ ______ Disapprove
19. A psychotherapist not disclosing a client's education and vocation to the client's insurance company because he does not have the client's clear consent to disclose.

Approve __________ Disapprove

20. A psychotherapist disclosing a client's financial situation to the Department of Mental Health without the client's clear consent.

Approve __________ Disapprove

21. A psychotherapist disclosing a client's personal problems to the client's insurance company without the client's clear consent.

Approve __________ Disapprove

22. A psychotherapist disclosing a client's education and vocation to the client's employer without the client's clear consent.

Approve __________ Disapprove

23. A psychotherapist not disclosing a client's personal problems to legal authorities because he does not have the client's clear consent to disclose.

Approve __________ Disapprove

24. A psychotherapist not disclosing a client's personal problems to the client's friends because he does not have the client's clear consent to disclose.

Approve __________ Disapprove

25. A psychotherapist disclosing that a person is a client to the client's physician without the client's clear consent.

Approve __________ Disapprove

26. A psychotherapist not disclosing a client's psychiatric diagnosis to legal authorities because he does not have the client's clear consent to disclose.

Approve __________ Disapprove

27. A psychotherapist disclosing a client's personal problems to the client's employer without the client's clear consent.

Approve __________ Disapprove

28. A psychotherapist not disclosing a client's education and vocation to the client's relatives because he does not have the client's clear consent to disclose.

Approve __________ Disapprove

29. A psychotherapist not disclosing that a person is a client to the client's relatives because he does not have the client's clear consent to disclose.

Approve __________ Disapprove

30. A psychotherapist disclosing a client's psychiatric diagnosis to the Department of Mental Health because he does not have the client's clear consent to disclose.

Approve __________ Disapprove

31. A psychotherapist not disclosing a client's psychiatric diagnosis to the client's friends because he does not have the client's clear consent to disclose.

Approve __________ Disapprove

32. A psychotherapist disclosing a client's education and vocation to legal authorities without the client's clear consent.

Approve __________ Disapprove

33. A psychotherapist not disclosing a client's psychiatric diagnosis to the client's relatives because he does not have the client's clear consent to disclose.

Approve __________ Disapprove

34. A psychotherapist not disclosing a client's psychiatric diagnosis to the client's friends because he does not have the client's clear consent to disclose.

Approve __________ Disapprove

35. A psychotherapist not disclosing a client's financial situation to the client's physician because he does not have the client's clear consent to disclose.

Approve __________ Disapprove
Please Note: Although the following demographic information is requested, if you believe that it may identify you, it is not necessary for completion of the survey.

Age _______ Sex _______ Race _______ Religion _______

Education (last year completed) _______ Occupation _______

Directions: The following questions are separate from the previous Survey Of Opinion. Please make an effort to consider them individually and not in relation to the previous questions.

A. Most patients/clients expect that communications with mental health professionals will remain confidential.
   Agree ____ ____ ____ ____ ____ Disagree

B. A therapist has a professional/ethical obligation to keep information concerning a client/patient confidential.
   Agree ____ ____ ____ ____ ____ Disagree

C. How important is confidentiality in maintaining a positive therapeutic relationship?
   Essential ____ ____ ____ ____ ____ Nonessential

D. Have you ever consulted a mental health professional? _______
   If yes, for what length of time? ______________________________

E. Have you ever hesitated to consult a mental health professional because you were not certain that it would remain confidential? _______

F. Have you ever had confidentiality broken by a psychotherapist? _______
   If yes, please explain.

Directions: The following questions should only be completed by mental health professionals.

G. In certain cases, there is a legal requirement to disclose information to a third party (e.g., reports of child abuse). In making a decision, should the emphasis be placed on confidentiality or the legal requirements?
   Confidentiality ____ ____ ____ ____ ____ Legal requirement

H. In a recent California case (Tarasoff), the California Supreme Court ruled that the psychologist was responsible for warning a threatened third party. In your opinion, which would you emphasize in making a decision - confidentiality or the legal requirements or safety of third party?
   Confidentiality ____ ____ ____ ____ ____ Third party

I. If a court made a ruling to the effect that you would receive a contempt-of-court citation if you did not disclose confidential information, which would you choose - contempt citation or disclosure?
   Contempt citation ____ ____ ____ ____ ____ Disclosure

J. Please list or briefly describe situations in which confidentiality has presented the greatest difficulty for you.
Dear Madam or Sir:

In November, 1979, you were sent a copy of the enclosed survey and questionnaire and our records indicate that we have not yet received a reply. It would be greatly appreciated if you would fill out this survey regarding confidentiality in psychotherapy so that this study may be completed this spring. The Mental Health Center of Sangamon-Menard Counties is sponsoring this research in an effort to provide data that will be helpful in determining policy and to lawmakers. In addition, I will be using the results in a Doctoral Dissertation for the fulfillment of Ph.D. requirements at Loyola University of Chicago.

If you have completed and returned the first copy of this survey, please simply fill out the postcard indicating that you have already replied. Several more surveys than postcards have been received in response (perhaps the smaller postcards were lost in the mail). In such cases, I apologize for the intrusion of this reminder letter.

All responses to the survey and questionnaire will be kept confidential. It is not necessary to put your name on the survey or questionnaire. If there are any questions which you feel may identify you, please feel free to omit them.

Please fill out the enclosed postcard when you return the questionnaire. This will enable me to send second reminder letters only to those who have not returned the postcard. If you wish to receive a summary of the results and conclusions, please indicate this on the postcard.

Thank you in advance for your time and consideration. They are very much appreciated.

Sincerely,

Helen P. Appleton, M.A.
The dissertation submitted by Helen Pugacz Appleton has been read and approved by the following committee:

Dr. James E. Johnson, Director
Associate Professor, Psychology, Loyola

Dr. Eugene C. Kennedy
Professor, Psychology, Loyola

Dr. LeRoy A. Wauck
Professor, Psychology, Loyola

The final copies have been examined by the director of the dissertation and the signature which appears below verifies the fact that any necessary changes have been incorporated and that the dissertation is now given final approval by the Committee with reference to content and form.

The dissertation is therefore accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy.

December 12, 1980
Date

James E. Johnson
Director's Signature