DIFFERENCES IN REPORTING HIV STATUS BETWEEN PSYCHOLOGISTS AND PSYCHIATRISTS

by

Alan Asbridge

An Abstract
of a thesis submitted in partial fulfillment
of the requirements for the degree of
Master of Science
in the Department of Psychological Science
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May, 2013
ABSTRACT

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Alan Asbridge

The present research examined the relationship between profession and breaking confidentiality while working with patients who are HIV positive and having unprotected sex with a sexual partner, and are refusing to inform the partner of their HIV status. This study also examined the relationship between course of action (break or not break confidentiality) and scenario presented in the survey (intent to harm or no intent to harm). The sample consisted of licensed psychologists and psychiatrists practicing in the state of Missouri. Results showed no relationship between profession and the breaking of confidentiality, but did demonstrate a significant relationship between course of action and whether or not intent to kill was present. Results also suggest that the participants might be more familiar with the Tarasoff case than with Missouri law. Discussion focuses on the need for mental health professionals to better familiarize themselves with relevant state laws pertaining to HIV and “duty to warn” situations.
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Rationale

When treating patients, psychologists are often confronted with ethical dilemmas. Deciding on a course of action can often be very difficult because many times the psychologist will be dealing with a situation in which there are no clear options, or in which all available options are associated with potentially negative consequences (Fisher, 2008). Often in these situations the psychologist can simply decide to comply with the proper legal course of action, but this can also be problematic.

One particular ethical dilemma that has emerged for psychologists concerns the “duty to warn” situation. If a psychologist’s patient threatens to harm or kill an identifiable person, the psychologist might in some cases have the legal obligation to warn the potential victim (VandeCreek & Knapp, 2000). This poses an ethical dilemma because the psychologist is supposed to maintain confidentiality, but contacting the potential victim would entail breaking that confidentiality (Corey, Corey & Callanan, 2007). One well known case involving the “duty to warn” was the Tarasoff case of 1968 in which a psychologist was found liable for not warning a potential victim that his patient was planning to kill her (VandeCreek & Knapp, 2000).

Laws governing the proper course of conduct for psychologists dealing with dangerous clients may vary greatly from state to state (Vandecreek & Knapp, 2000). Also, state laws pertaining to a specific situation may be vague and ambiguous, offering no clear course of action at all, or a state may have no existing laws whatsoever dealing with a particular situation. When there is no clear legal course of action this could potentially create a serious problem for both the psychologist and the client. If the psychologist is not sure what to do she or he could be
vulnerable to possible malpractice liability or other legal consequences. Another problem that might exist when deciding on the proper course of action is that, in some cases, state laws could be different for psychologists, than for psychiatrists, or other types of mental health professionals in the exact same situation. If there were different legal obligations for psychologists and psychiatrists this could potentially lead to serious problems in the course of treating the client. A specific example of this would be in a state mental hospital setting in which the patient is being seen by a treatment team. If there were a psychologist and a psychiatrist on the treatment team, one could potentially envision a scenario in which the psychologist and the psychiatrist would be legally required to take opposing courses of action. Since the emergence of Acquired Immunodeficiency Syndrome (AIDS) psychologists have been presented with a new area of potential ethical dilemmas related to the “duty to warn”. When a patient is HIV positive and is having unprotected sex with others, the patient could be putting these individuals in mortal danger. In such cases, mental health professionals are faced with the dilemma of determining whether or not to breach the patient’s confidentiality in order to protect the patient’s sexual partner(s). In considering the complexities that arise in treatment settings involving a treatment team of mental health professionals (e.g., a team consisting of a psychologist, psychiatrist and a nurse), one could even envision a scenario in which one member of the team, knowing that the other members would be required (or inclined) to break the patient’s confidentiality, could possibly be inclined to conceal certain information about the patient from the other treatment team members to protect the patient’s confidentiality. Thus, the present study examined how psychologists and psychiatrists in the state of Missouri view breaking or maintaining the confidentiality of a hypothetical client who is HIV positive and is potentially endangering the lives of other people.
Purpose of the Study

The objective of this study was to determine whether psychologists and psychiatrists would differ in their course of action when a patient is Human Immunodeficiency Virus (HIV) positive and refuses to inform his or her sexual partner. In the state of Missouri, the law in section 191.656 states that the therapist, either a psychologist or a psychiatrist, may report a client’s HIV status and break confidentiality without facing civil liability if the client is putting other people in danger. However, the therapist is not required to do so. Therefore, there is no “duty to warn” with regard to a patient’s HIV status in the state of Missouri, and there appears to be no difference in required courses of action for psychologists and medical doctors in such cases. The decision over whether to break confidentiality and report a patient’s HIV status or maintain the patient’s confidentiality is entirely at the discretion of the therapist. This study is an important step to identifying scenarios in which psychologists and psychiatrists might handle an HIV status situation differently, and could also help identify the limitations to confidentiality a potential patient can expect when seeking mental health services. By examining how members of these two professions might handle a potentially life-threatening situation involving HIV, the researcher anticipated finding possible inconsistencies in how members of different professions would be inclined to handle such situations.

Hypotheses

It was hypothesized that there would be a significant difference in the way psychologists and psychiatrists would handle a hypothetical situation in which an HIV positive patient refused to inform his or her sexual partner of his/her HIV status. Specifically, it was predicted that psychologists would tend to keep strict confidentiality of the client and choose not to contact the partner or government agency, whereas psychiatrists would be more inclined to contact the sexual partner or report the client’s HIV status to an appropriate government agency. The
The researcher anticipated that the differences in the ethics codes of these two professions, differences in the culture of these two professions, and the judgments of courts in other states would lead to psychologists being more likely to maintain confidentiality. The researcher also expected that participants (both psychologists and psychiatrists) would be more likely to break confidentiality in a scenario in which the patient was not forthcoming about his HIV status with his sexual partner(s) because he was intentionally trying to kill his sexual partner versus in a scenario in which the patient was afraid to inform his sexual partner of his HIV status due to fears that the partner might end the relationship. That is, it was anticipated that the deliberate attempt to harm or kill a sexual partner would lead the respondents to be significantly more likely to break confidentiality.
Clinical psychologists practicing today have to deal with a variety of legal and ethical issues. For instance, one dilemma that a psychologist might encounter in the course of his or her career occurs when, during the course of therapy, a patient informs the psychologist of an intention to harm another person. When the patient discloses such an intention it can create a serious legal and ethical dilemma for the psychologist. The psychologist has to balance the need to protect the confidentiality of the patient with the obligation to protect the public from a potentially violent person (Donner, 2008). If the psychologist informs the intended victim of the threat or informs local law enforcement, the psychologist would most likely be violating the confidentiality of his or her patient and could possibly face civil liability charges for disclosing privileged information (Fisher, 2008).

The Critical Nature of Confidentiality

Confidentiality has been considered an essential part of mental health treatment for a long time, and is considered a critical factor in establishing the public’s trust in mental health practitioners (Fisher, 2008). Moreover, many psychologists consider maintaining patient confidentiality as their first and foremost responsibility, and thus believe that confidentiality must be maintained regardless of extenuating circumstances (Donner, 2008). Protecting a patient’s confidentiality not only involves refraining from disclosing sensitive information about a patient to other people, such as friends and family members, but also includes taking measures to ensure that records are kept confidential (Shah, 1970). Candid disclosure by the patient to the therapist is believed to be essential for therapy to be successful, and if the patient is concerned that what she or he says in therapy will not be held completely confidential, the patient will
likely be reluctant to disclose sensitive information (Woods & McNamara, 1980). Indeed, research has indicated that patients are more likely to be completely self-disclosing if confidentiality is assured at the beginning of the therapy session (Kobocow, Mcguire, & Blau, 1983). Other research has shown that psychologists are highly reluctant to breach or break confidentiality without the consent of the client, and the primary reasons that some psychologists cite for breaching confidentiality are to consult with other colleagues or to deal with a dangerous client (Baird & Rupert, 1987).

**Limitations to Confidentiality**

Confidentiality is not absolute. Over the past few decades a major ethical and legal dilemma that has confronted the mental health professions involves the circumstances under which a therapist should breach the confidentiality of a client (Donner, 2008). Situations in which a therapist might consider breaching confidentiality include those involving potential child abuse or the abuse of an incapacitated adult, high risk taking behavior on the part of a minor, or dealing with a patient who could be in danger of harming him/herself or others (Fisher, 2008). Other possible situations which could require a therapist to disclose confidential information include being required to testify in court or turn over therapy records for patients involved in legal cases (Fisher, 2008). If a psychologist has a dangerous patient, but does not warn a potential victim or notify the appropriate law enforcement agencies, the therapist could be held liable if the patient commits a lethal crime that could have otherwise been prevented (Knapp & VandeCreek, 2003). In some cases (depending on local and state laws) a therapist will be required by law to break confidentiality and report certain information or turn over records to authorities (Fisher, 2008). To ethically deal with such limitations to confidentiality in clinical or counseling practice, therapists are admonished to discuss limitations to confidentiality as soon as
possible with the patient before therapy begins so the patient knows exactly what the limitations will be (Fisher, 2008). Unfortunately, despite the importance of confidentiality, research examining whether or not therapists inform their clients about the limitations of confidentiality has concluded that only about half of the therapists sampled discussed confidentiality with clients prior to initiating therapy (Baird & Rupert, 1987). If, at any time, the therapist feels the actions of a client are dangerous or serious enough to warrant breaching confidentiality, it is recommended that the therapist first try to convince the client to either cease the dangerous behavior or convince the client to inform the individuals who may be in danger. If the client continues to plan or engage in dangerous behavior and the therapist decides it is necessary to breach confidentiality, then it is recommended that the therapist inform the client that confidentiality must be breached and that appropriate authorities and potential victims will be notified (Ahia & Martin, 1993).

**The Tarasoff Case**

In the history of clinical psychological practice there is one case that has become a key precedent for balancing the duty of the psychologist to protect the confidentiality of his or her patient with the responsibility to protect the public; that case is the Tarasoff case of 1976 (Monahan, 1993). In 1969, a man named Prosenjit Poddar was receiving outpatient counseling at the Student Health Service at the University of California, Berkeley. In therapy Poddar confided to his psychologist that he intended to kill a woman when she returned from a trip abroad. Although the patient did not name the woman he intended to kill, she was readily identifiable as Tatiana Tarasoff (Corey, Corey, & Callanan, 2007). The psychologist assessed that Poddar was serious about his threat and thus should be considered dangerous and be admitted to a mental hospital for treatment and observation. The psychologist also contacted the campus police and
informed them of this patient’s intention to kill Tatiana Tarasoff. The police questioned Poddar and then decided he was not dangerous, and thus he was never admitted to a mental hospital. Subsequently, the psychologist sent a letter to the campus police expressing concern that this patient was dangerous and that the police needed to take appropriate action. However, prior to Tarasoff’s return to school, the psychologist’s supervisor asked that the letter to the campus police be returned, advised the psychologist to destroy his records of this case, and requested those involved that no further action be taken regarding this patient. Tarasoff and her family were never informed of the situation. When Tarasoff returned from her trip abroad, Poddar killed her, and a short time later her parents filed a lawsuit against the University of California for failing to notify the intended victim of a violent threat. The case eventually reached the California Supreme Court in 1976. In their ruling, the California Supreme Court stated that the therapist had acted professionally irresponsibly by not informing the potential victim, and that notifying the police, but not the victim, was not adequate to protect a potential victim (Lauren & Balken, 1984). The court also concluded that psychotherapists are required to take necessary actions to protect people from violent patients even if they have to break confidentiality to do so (Knapp & Vandecreek, 1982).

Since the decision in 1976, the Tarasoff case has arguably become the most well known legal case regarding the practice of clinical psychology (Monahan, 1993) and the name Tarasoff has symbolically come to stand for the dual and conflicting responsibilities that psychologists have for protecting the public and protecting the confidentiality of their patients (Monahan, 1993). The California Supreme Court’s decision has had an immense impact on clinical and counseling psychology. In particular, the court’s assertion that there are limitations to the confidentiality of the patient-therapist relationship (Shuman & Foote 1999), and that
psychologists have a “duty to warn” the potential victims of a crime have tremendous implications for professional psychologists. In the years following the Tarasoff decision, there has been much debate among mental health professionals over what constitutes a proper course of action when dealing with a Tarasoff-like situation. One suggestion that has been made is that the decision over whether or not to breach confidentiality should be made on a fact-based model that statistically analyzes the patient’s likelihood of committing a crime instead of relying on an intuitive assessment (Borum & Reddy, 2001). According to Stanard and Hazler (1995), “Each situation must be considered individually, with counselors continuing to use their own best professional judgment. That judgment should be based not only on the Tarasoff decision, but also on other issues such as autonomy, nonmalficence, beneficence, fidelity, judgement and confidentiality.” (p. 400). Since the landmark Tarasoff decision in 1976, the principles of the Tarasoff case have been applied to numerous state and federal jurisdictions (Folkman, 2000).

Differences in State Laws Regarding Tarasoff-Like Situations

The concept of “duty to warn” that emerged as a result of the Tarasoff case in California stipulated to psychologists that their responsibility to protect the public in some cases supercedes their responsibility to maintain the confidentiality of their clients (VandeCreek & Knapp, 1993). In some states, therapists are mandated by law to warn identifiable victims of the violent intentions of a dangerous patient (Knapp & VandeCreek, 2000). Some of the issues that have emerged in the aftermath of the Tarasoff decision center around uncertainty regarding the specific circumstances that will trigger the “duty to warn” potential victims. For instance, do the Tarasoff decision and “duty to warn” apply only to patients who state their intentions to kill another person, or are psychologists required to inform potential victims when a patient states an intention to commit another type of serious crime, such as non-lethal violent assault, sexual
assault, or violent destruction of property? Tarasoff-like principles have been applied to the negligent release of patients from hospitals, failure to properly supervise patients within hospitals, failure to commit patients to mental hospitals and improper supervision of patients in outpatient programs (VandeCreek & Knapp, 2001). According to Felthous and Kachigan (2001) the duty to warn and the duty to control patients to prevent violent acts were seen as separate legal concepts, and the Tarasoff case consolidated the two concepts into a single duty to protect (p. 355). Also, in some states, the “duty to warn” is now imposed on psychologists treating patients who have children when the patient’s children are at a highly increased likelihood of developing a mental illness. Some states now require psychologists to warn the children of potential problems in advance if the children are at a highly increased risk of psychiatric problems (Petrilla, 2001).

Another issue that has emerged as a result of the Tarasoff decision is uncertainty regarding which professionals are mandated to notify potential victims as a result of Tarasoff-like situations. The Tarasoff case centers around the proper course of action for a psychologist to take, but does the “duty to warn” precedent apply to medical doctors, social workers, nurses and other health professionals? Yet another issue that has emerged as a result of the Tarasoff decision is whether or not the “duty to warn” precedent established by the California Supreme Court will be imposed by other states. According to Striefel (2008), “Although the findings of a court are usually binding only in the state in which the court case was filed, such cases often serve as a precedent that is used in deliberating court cases in other states and in modifying the duty to warn and protect laws in other states” (p. 86). Since the Tarasoff decision was made at the state level, courts in other states might interpret the law differently, resulting in widely varying applications of the law from state to state. As a result of the Tarasoff case, there is a
relatively clearly defined “duty to warn” for psychologists practicing in the state of California; however, the “duty to warn” has not been upheld in some states. For instance, in 1999, the Texas Supreme Court ruled that psychologists are not required to break confidentiality when a patient threatens to harm another person (Streifel, 2008). According to Barbee, Combs, Eckleberry, and Villalobos (2007), “Texas does not adhere to the precedent set by Tarasoff. To the contrary, the opinion in Thapar v. Zezulka, rendered by the Texas Supreme Court in 1999, stipulated that mental health providers do not incur a duty to warn and protect” (p. 19). In some states the issues of Tarasoff liability and “duty to warn” have not been addressed by the legislature or the state supreme court and it will be difficult for mental health professionals practicing in those states to determine the proper course of action to take if a Tarasoff type situation occurs. As a result of the differences in how “duty to warn” laws are applied from state to state, it has become imperative that mental health professionals become familiar with the relevant laws and legal precedents of the state in which they practice (Striefel, 2008). Unfortunately, however, recent research examining the knowledge of psychologists regarding their state laws as related to Tarasoff-like situations revealed that 76.4% of psychologists did not properly understand the laws regarding “duty to warn” (Pabian, et al., 2009).

**Tarasoff-Like Situations and Human Immunodeficiency Virus Status**

Since the proliferation of Acquired Immunodeficiency Syndrome (AIDS) in the early 1980’s an entirely new area of challenges has emerged for clinical and counseling psychologists with regards to balancing patient confidentiality with the duty to protect the public in meeting the legal obligations of the “duty to warn” precedent established by the Tarasoff decision. If a patient is Human Immunodeficiency Virus (HIV) positive, it is likely a deeply personal issue for the patient. Therefore, when a patient discloses the fact that he or she is HIV positive in therapy,
the psychologist will have ample reason to maintain the confidentiality of that information
(Donner, 2008). If the psychologist were to break confidentiality and warn potential sexual
partners, the psychologist could do substantial harm to the patient. For instance, the patient’s
sexual partner could decide to end the relationship as a result, causing the patient considerable
distress and anxiety. Also, the patient could be subjected to scorn and embarrassment from
friends, and/or family members, and could be discriminated against in the work-place or by other
members of the community. Another reason for state laws to favor maintaining patient
confidentiality in such cases is to protect the patient with AIDS from the possible prejudices of a
psychologist who might not personally approve of the patient’s lifestyle and sexual orientation
(Lamb et al., 1989). For instance, research conducted with psychologists in the state of Florida
determined that psychologists were significantly more likely to breach confidentiality in
situations in which the client/patient was HIV positive and possibly placing another person at
risk if the psychologist was homophobic (McGuire et al., 1995).

Despite concerns raised regarding the breaching of confidentiality, if a patient is HIV
positive and engages in certain behaviors, such as unprotected sexual intercourse or intravenous
needle sharing, which could lead to the infection of other people with HIV, he or she could be
putting the lives of other people in possible mortal danger. This has created a new ethical and
legal dilemma for psychologists and other mental health professionals. That is, it is unclear
whether an HIV positive patient who discloses in therapy that he or she is engaging in behavior
likely to infect others with HIV should be considered dangerous in the same manner as a patient
who discloses the intention to kill someone with a gun or other weapon. In other words,
clinicians are left to decide whether a patient’s HIV status could lead to a situation requiring the
same legal “duty to warn” as those involving a threatened act of violence. Another complexity
associated with this issue is whether or not the patient who is HIV positive is intentionally exposing others to HIV. Mental health professionals will have to evaluate whether there is a difference between an HIV positive patient who is having unprotected sex with his or her sexual partner and who refuses to disclose his or her HIV status to the partner because of fear the partner will end the relationship, versus a patient who is HIV positive, having unprotected sex with a partner and who refuses to disclose his or her HIV status to the partner because the patient is deliberately trying to infect the partner with HIV in an attempt to kill him or her. Thus, it is unclear whether the same legal obligation of “duty to warn” would exist in the case of the patient who was knowingly putting a partner at risk while not intending to do harm as it would for a patient who was intentionally trying to use HIV as a way to kill his or her sexual partner (Knapp & Vandecreek, 2000).

Some researchers have suggested that clinicians should follow a systematic model regarding whether or not to breach the confidentiality of an HIV positive patient who could be putting others at risk of infection (Melchert & Patterson, 1999). The model suggests that confidentiality should be maintained unless the patient is knowingly putting someone else at risk and refuses to either cease the risky behavior or inform the potential victim, or if the patient is intentionally trying to infect another person (Melchert & Patterson, 1999). Laws regarding “duty to warn” in relation to HIV status vary from state to state, and just as some states have not yet established a clear “duty to warn” for patients who threaten violence, many states have not provided a ruling on how Tarasoff-like cases involving HIV should be handled (Knapp & Vandecreek 1990). According to Knapp and Vandecreek (2000), “State laws regarding reporting HIV status differ considerably from those regarding patients who threaten to assault others. Psychotherapists in some states are prohibited from warning identifiable victims of persons who
are HIV positive.” (p. 1341). This would indicate that, in many states, the psychologist is not required to report HIV status to an identifiable victim as part of the “duty to warn” obligation and could even be held liable for breaching client confidentiality in such cases. Not all courts have applied the duty to warn to cases involving HIV infection, and thus therapists’ legal responsibility for protecting sexual partners of HIV-positive clients remains unclear in many cases (Lauren & Balken, 1984). In general, laws regarding duty to warn and HIV status tend to favor maintaining strict confidentiality for situations in which the client/patient is seeing a licensed psychologist, although this is still somewhat unclear, and can vary from state to state (VandeCreek & Knapp, 2000). In research conducted to determine whether or not psychologists would breach confidentiality in AIDS related situations, the results showed that psychologists were most likely to breach confidentiality when a combination of factors emerged (Totten et al., 1990). The factors that led most psychologists to state they would breach confidentiality were the perceived dangerousness of the client and the identifiability of the potential victim (Totten et al., 1990). Other research examining whether or not psychologists would breach confidentiality if an HIV positive client were putting a sexual partner at risk has concluded that many psychologists differed in their opinion on breaching confidentiality and on the proper way to manage such breaching (Simone & Fulero, 2001). This research also revealed that only 62% of psychologists surveyed could correctly identify their relevant state laws pertaining to HIV and confidentiality (Simone & Fulero, 2001).

Mental Health Services Provided by Physicians and Other Professionals

Often times, a person in need of mental health services will receive services from professionals who were not trained as psychologists. For instance, mental health patients might receive services from a treatment team, including for instance, a psychiatrist who is trained as a
physician (Bray, 2010). Also, mental health patients often work with nurses or social workers whose training varies from that of a psychologist (Monahan, 1993). It is conceivable that members of these different professions could have different ethical guidelines as well as different legal standards to follow concerning how HIV status relates to the duty to warn. Often, psychiatrists see patients who not only exhibit behavioral problems, but also have very low mental functioning and are unable to take care of their basic needs on a day to day basis (Macklin, 1991). If this type of low functioning psychiatric patient were HIV positive, he or she could be unknowingly putting other people in danger (Macklin, 1991). According to Macklin (1991), “the obligation of protecting the public supercedes a patient’s right to confidentiality if the patient is infected with HIV and is clearly placing other people in danger” (p. 19). Also, if an HIV infected patient with a low level of mental functioning is not cognizant of the consequences of his or her actions and does not realize that his or her actions are endangering a sexual partner, the mental health professional might be less concerned with maintaining the patient’s confidentiality and more concerned with protecting the public, thus increasing the likelihood of breaking confidentiality (Macklin, 1991).

Knapp and Vandecreek (2000) noted, “Physicians have been held liable for failing to notify identifiable victims of the HIV status of their patients.” (p. 1341). This would suggest that a psychiatrist who is trained as a medical doctor might be required by law to warn the sexual partner of a patient’s HIV status if the patient refused to inform the partner. Therefore, the legal standards and/or ethical guidelines governing the expected action of psychologists and psychiatrists could differ a great deal in some cases. This potential difference in how members of these two professions might deal with the issue of duty to warn and HIV status could cause a variety of problems. For instance, while receiving treatment in a mental hospital, a patient will
often be assigned to a treatment team which could include nurses, social workers, psychologists, and a psychiatrist (Bray, 2010). Considering that the legal standards (or ethical guidelines) for the duty to warn and protect in some states could be quite different for psychologists versus psychiatrists regarding a patient’s HIV status, a situation could develop in which two professionals serving on a patient’s treatment team could be legally (or ethically) required to take different courses of action. As one could imagine, such a situation could result in a variety of problems. It is even conceivable that a psychologist could discover the HIV status of a patient during therapy and decide not to inform the rest of the treatment team out of concern that other members of the treatment team would be required to disclose the patient’s HIV status to others. This could open up a number of serious problems for the patient and seriously diminish the effectiveness of treatment.

Another factor that could cause additional complications for mental health professionals could occur when the law dictating the proper course of action in a certain situation is ambiguous and does not provide a clear course of action, or when no laws exist for such a situation. Often, state legislatures do not create laws to deal with problems until a problem develops, but rather implement laws only after a problem has occurred (VandeCreek & Knapp, 2000). If a mental health professional were practicing in a state that does not provide a clear course of action mandated by law, the mental health professional will have to act in the manner which he or she feels is most appropriate for the situation (Fisher, 2008). This ambiguity could lead to a variety of problems. One potential problem is that a patient could disclose sensitive information to one therapist who would be inclined to maintain the patient’s confidentiality, and then that same patient might later see another mental health provider who would be inclined to break confidentiality and report the patient’s HIV status to law enforcement or other government
agencies. This type of ambiguous situation could create confusion and general distrust of mental health professionals, as well as greater liability for mental health professionals (VandeCreek & Knapp, 2000). The American Medical Association (AMA, 2001) has recommended guidelines for physicians treating HIV positive clients who are putting third parties at risk while practicing in a state that does not have a clear legal course of action. The guidelines clearly state that if an HIV positive client is endangering another person, the physician should first try to convince the patient to cease the behavior that is placing other people at risk; if the patient refuses, then the physician should notify the proper authorities and the endangered third party (Kermani & Weiss, 1989).

The State of Missouri and “Duty to Warn” with HIV Positive Patients

As discussed earlier, in the state of California there is a clear “duty to warn” for mental health professionals, dating back to the Tarasoff case of 1976, whereas, in Texas the state supreme court has not only rejected the concept of “duty to warn” for mental health professionals, but it has clearly stated that confidentiality must be kept at all times and under all circumstances. In the state of Missouri, the law lies somewhere between those of Texas and California. In Missouri, mental health professionals can report a patient’s HIV status and break confidentiality but are not required to do so. According to Missouri state statutory law, section 337.055, “Any communication made by any person to a psychologist during therapy is deemed privileged communication and the psychologist shall not be made to testify or be examined without prior consent of the client.” However, section 191.656 of the Missouri statutory code states, “No person shall be held liable for disclosing HIV ---unless the person acted in bad faith or with conscious disregard, no person shall be liable for violating any duty or right of confidentiality established by law for disclosing the results of an individual’s HIV testing to: a)
the department of health and senior services, b) healthcare personnel working with patient, g) victim of a crime—once charges are filed.” Section 191.656 also states, “The Department of Health and Senior Services and its employees shall not be held liable for disclosing an HIV-infected person’s HIV status to individuals with whom the person has had sexual intercourse,” and, “There will be no civil liability to any health care provider making a good faith report to the Department of Health and Senior Services regarding a person’s HIV status, or by court order for testing.” Therefore, in the state of Missouri, the law stipulates that mental health professionals will not be held liable for breaking confidentiality regarding their patients’ HIV status, including reporting a patient’s HIV status to the Missouri Department of Health and Senior Services. However, there is nothing in Missouri’s statutory code that states mental health professionals or other health care providers are legally required to report a patient’s HIV status even if the patient is deliberately trying to infect another person.

In summary, essentially there is no “duty to warn” currently on the books in the state of Missouri with regard to a patient’s HIV status. With the way the law is currently written in Missouri, if a patient were to disclose that he or she were HIV positive and were having unprotected sex with a sexual partner, it leaves the decision whether or not to report the situation to the individual judgment of the therapist. According to Missouri state statutory law, section 191.656 “The reporting of HIV status to health care personnel or the subject’s spouse shall not be construed in any court to impose any duty on a person to disclose the results of an individual’s HIV testing to a spouse or health care professional or other potentially exposed person, parent or guardian.” Therefore, with no legally mandated “duty to warn” in the case of a possible HIV infection in the state of Missouri, it is unclear how mental health professionals should respond to a situation in which a patient could be putting sexual partners at risk by having unprotected sex
with them. It is also unclear whether there would be differences in how psychologists and psychiatrists would be inclined to handle such situations. It is possible that Missouri’s mental health professionals would respond based on how mental health professionals in similar situations have been judged by courts in other states (e.g., assuming that state laws would require medical doctors to break confidentiality and warn potential victims, but not require psychologists to warn potential victims). It is also possible that mental health professionals in Missouri would respond differently to this type of situation based on the culture and background of their specific profession or based on the environments in which they practice. In short, it is conceivable that there could be differences in how psychiatrists and psychologists practicing in the state of Missouri would handle such a situation. The current situation in the state of Missouri provides an opportunity to examine the potential differences in how members of these two professions would handle an HIV related Tarasoff-like situation.

The purpose of this study was to examine how mental health professionals in the state of Missouri would be inclined to handle a situation in which an HIV patient could potentially be putting sexual partners at risk by having unprotected sex with them. Specifically, this study examined how psychologists and psychiatrists in the state of Missouri would handle such a situation. For instance, based on the literature reviewed previously, it seems plausible that psychologists might be more likely to maintain strict confidentiality, whereas psychiatrists might be more likely to break confidentiality. The American Psychological Association’s Ethical Principles of Psychologists and Code of Conduct (APA, 2002, hereinafter referred to as the APA Ethics Code) states in section 4.05b, “Psychologists disclose confidential information without the consent of the individual only as mandated by law for the valid purpose such as (3) protect the client/patient, psychologist, or others from harm,” (p.7). This part of the APA Ethics Code
implies that psychologists should abide by a legally-imposed duty to warn but does not refer specifically to situations involving a client’s HIV status. Also, Missouri statutes provide no legal mandate to break confidentiality in such situations. Therefore, a psychologist practicing in Missouri could very likely decide that confidentiality should not be breached if the psychologist were seeing an HIV positive client putting identifiable others at risk. The American Medical Association’s Ethical Principles of Physicians and Code of Conduct (AMA, 2001, hereinafter referred to as the AMA Ethics Code) takes a different stance than the APA Ethics Code on patients who could cause harm to others. Section 5.05 of the AMA Ethics Code states “The physician should not reveal confidential information without the express consent of the patient, subject to certain exceptions which are ethically justified because of overriding considerations. When a patient threatens to inflict serious physical harm to another person or to him or herself and there is reasonable probability that the patient may carry out the threat, the physician should take reasonable precautions for the protection of the intended victim, which may include notification of law enforcement authorities” (section 5.05, confidentiality). The AMA Ethics Code suggests that a physician should report a patient who is endangering the life of another person to the proper authorities, whereas the APA Ethics Code is more ambiguous and leaves the decision to break confidentiality up to the individual psychologist. Finally, the American Psychiatric Association’s Principles of Medical Ethics (ApA, 2009, hereinafter referred to as the American Psychiatric Association’s Ethics Code) reflects a similar viewpoint as the AMA Ethics Code. Section 4.2 of the American Psychiatric Association’s Ethics Code states, “A Psychiatrist may release confidential information only with the authorization of the patient or under proper legal compulsion. The continuing duty of the psychiatrist is to protect the patient, including fully apprising him/her of the connotations of waiving the privilege of privacy” (p. 6). Morever,
section 4.8 of the American Psychiatric Association’s Ethics Code states, “When, in the clinical judgment of the treating psychiatrist, the risk of danger is deemed to be significant, the psychiatrist may reveal confidential information disclosed by the patient.” (p. 7). Again, much like the AMA Ethics Code, the American Psychiatric Association’s Ethics Code is fairly clear that psychiatrists can breach confidentiality without consent of the patient if they feel the patient is dangerous to others whereas the APA Ethics code seems to encourage psychologists to maintain confidentiality, unless disclosure of confidential information is mandated by law.

One might argue that the AMA and the American Psychiatric Association’s Ethics Codes, as compared to the APA Ethics Code (2002), are written in a manner that might compel psychiatrists to be more likely than psychologists to break confidentiality in situations in which a patient is HIV positive and putting other people at risk. However, this remains to be empirically studied. For instance, as mentioned earlier, in some states, psychologists have not been held liable for failing to warn identifiable victims of an HIV positive patient while psychiatrists and other physicians (members of the medical profession), have been held liable for not warning potential victims (VandeCreek & Knapp, 2000). Although there is no difference in Missouri law between how psychiatrists (and other physicians) and psychologists are required to handle the case of an HIV positive patient who is endangering other people, it is possible that psychologists might choose to maintain strict confidentiality of the patient based on discipline-specific ethical guidelines as well as court rulings in other states, whereas psychiatrists might choose to breach confidentiality in HIV Tarasoff-like situations based on the ethical guidelines of their profession as well as court rulings in other states.

Another reason to anticipate differences in how psychologists and psychiatrists would handle confidentiality in HIV related “Tarasoff-like” situations relates to the different
background and training of the two professions. Psychiatrists, who are members of the medical profession, are trained to do what they can to stop the spread of communicable disease and will do so when faced with the choice of protecting the patient’s confidentiality or protecting the public’s health (Macklin, 1991). In the training of a psychologist, however, there is a greater emphasis on serving the emotional needs of the client regardless of whether the client is doing something contrary to the public good; as a result, a psychologist might be more likely than a psychiatrist to maintain confidentiality (VandeCreek & Knapp, 2001). For these and other reasons specified previously, the author expected to find that psychologists versus psychiatrists would report differences in how they would handle a hypothetical situation involving a Tarasoff-like situation involving an HIV positive patient. Specifically, it was anticipated that psychiatrists would be more likely to breach confidentiality in such a situation than would psychologists.
CHAPTER 3
METHODOLOGY

Participants

Surveys were mailed to 150 licensed psychologists and 150 licensed psychiatrists practicing in the state of Missouri at the time of the study (300 total participants). Three hundred participants was deemed an appropriate number of participants because the researcher believed that 300 participants would provide a good sample size and be a manageable number of participants both financially and from a time standpoint. The psychologists were randomly selected from a list of those who were practicing in the state of Missouri listed on the state of Missouri’s professional licensing website (pr.mo.gov). The psychiatrists were randomly selected from a list of those who were practicing in the state of Missouri. The list for psychiatrists was obtained from the web-site ucomparehealthcare.com. After selecting the participants from the professional registration and ucomparehealthcare websites, the researcher conducted an internet search to determine whether the psychologist or psychiatrist was currently seeing patients. If, based on the results of this search, the individual did not appear to be engaged in clinical practice, his or her name was eliminated from the list of potential participants. Psychiatrists and psychologists who were working in the VA hospital system or in any other mental health facility administered by the United States federal government were removed from the participant list. This was done because the purpose of this study was to examine how mental health professionals practicing under the laws governing the state of Missouri respond to the given scenarios presented in the vignettes. The laws that mental health professionals practicing in federal facilities may adhere to could be different than those of the state of Missouri and therefore could lead the participants to provide responses very different than the participants practicing under
Missouri law, and as a result distort the results of the study. Of the 300 total surveys that were mailed, a total of 43 were returned by a participant, (14% response rate), and 46 were returned by the post office due to an incorrect address. Of the 43 participants who responded, 15 were psychiatrists and 28 were psychologists. Also, among the 43 respondents, 38 indicated a course of action to either break or maintain the confidentiality of the patient in the scenario, while 5 did not indicate any such course of action. Of the 5 that did not indicate any course of action, 2 were psychiatrists and 3 were psychologists. The 5 respondents that did not indicate a course of action were removed from further analysis. Therefore, the statistical analysis was based on data provided by 38 total respondents (13 psychiatrists and 25 psychologists).

Of the 14 psychiatrists who provided useable age information, the mean age was 54.57 years ($SD = 12.07$). The gender breakdown for psychiatrists was 9 men and 5 women. The ethnic background for psychiatrists was 10 white/caucasian, 2 black/african american, 1 indian, and 1 mixed race. The primary practice setting of the psychiatrist participants included: 7 in publically funded facilities, 6 in private practice, and 1 stated he had worked for the Missouri Department of Mental Health.

Of the 28 psychologists who responded, all provided useable demographic information, except for one psychologist who did not provide her age. Of the 27 psychologists who provided their age, the mean age was 58.81 years ($SD = 7.49$). The gender breakdown for psychologists was 10 men and 18 women. The ethnic breakdown for psychologists was 27 white/caucasian, and 1 black/african american. The primary practice setting for psychologists included: 22 in private practice, 2 who worked for non publically funded hospitals, 2 who worked for non profit agencies, 1 who worked for a locally funded public facility, and 1 who worked for a school of medicine.
Materials

To address the proposed research question, surveys were administered to a group of psychiatrists and psychologists. Participants were asked to provide demographic information such as whether the participant was a psychologist or a psychiatrist and what type of setting the participant worked in (e.g. private practice or a publically funded facility). The survey included two short vignettes. One vignette contained a scenario in which a patient was intentionally trying to kill his sexual partner (the ‘kill” vignette). The other vignette contained a scenario in which a patient was afraid his sexual partner would end the relationship (the “break-up” vignette). The vignettes were followed by a series of questions regarding what the participants would do under the circumstances presented in each vignette. To avoid any order effects, the order of the two vignettes was presented in reverse order for half of the participants. Half of the psychologist and half of the psychiatrist participants received surveys with the patient intentionally trying to kill his partner listed first and the other half received the same scenario listed second. Participants were also invited to elaborate on their responses in the space provided (see Appendix A). The surveys were mailed directly to the address of the participants as indicated on the Missouri licensing board and the ucomparehealthcare.com website. Anonymity concerns were addressed in the informed consent form (see Appendix B). Respondents received a pre-paid addressed envelope to be used to return their responses. The researcher did not send reminder cards to the potential participants to complete the survey if they did not reply.
**Hypotheses**

The researcher expected to find a significant difference in how psychologists versus psychiatrists would handle a situation involving a patient who is HIV positive who refused to inform his or her sexual partner. Specifically, the researcher expected to find that psychologists would tend to keep strict confidentiality of the client and not contact the partner or government agency, whereas the psychiatrists would be more likely to contact the partner or report the client’s HIV status to an appropriate government agency. The researcher also expected that there would be a significant difference in which vignette the sample as a whole was more likely to break confidentiality in. Specifically, the researcher expected that the participants would be more likely to break confidentiality in the scenario where the patient wants to kill his sexual partner, (the “kill” scenario) than in the scenario where the patient is afraid his sexual partner will end the relationship (the “break-up” scenario).

**Planned Analyses**

The results of this study were examined quantitatively and qualitatively. The quantitative analysis consisted of two chi-squared tests. The first chi-squared test examined the responses of psychologists versus psychiatrists in terms of whether or not they would break the confidentiality of a client in each scenario. The possible responses (i.e., courses of action the participants were able to choose from) included: *contact the police or other law enforcement agency, contact the patient’s sexual partner, contact the Missouri Department of Health and Senior Services, and not contact anyone and maintain confidentiality*. The first three response options involved a choice to break confidentiality, whereas the final choice would be to maintain confidentiality. The second chi-squared test examined if the participants (regardless of whether they were psychologists or psychiatrists) would be more likely to break confidentiality in the scenario
presented in the vignette in which the patient was intentionally trying to kill his sexual partner than in the vignette in which the patient was afraid his sexual partner would end the relationship. The researcher also analyzed qualitatively the comments that each of the respondents provided after responding to the questions following each vignette.
CHAPTER 4
RESULTS

Of the 300 surveys that were sent to potential participants, 43 were returned by participants, 46 were returned by the post office due to an incorrect address, and 211 were not returned by participants (response rate of 14% of the 300 sent, response rate of 16.9% when excluding those returned due to an incorrect address). Of the 43 participants who responded, 15 were psychiatrists and 28 were psychologists. Also, among the 43 respondents, 38 indicated a course of action to either break or maintain the confidentiality of the patient in the scenario, while 5 did not indicate any such course of action. Of the 5 that did not indicate any course of action, 2 were psychiatrists and 3 were psychologists. The 5 respondents that did not indicate a course of action were removed from further analysis. Therefore, the statistical analyses were based on the data provided by 38 total respondents (13 psychiatrists and 25 psychologists).

The first hypothesis was that there would be a significant difference between psychiatrists and psychologists in whether or not to break confidentiality in the two vignettes presented. The first analysis was done to determine if there was a significant difference between psychiatrists and psychologists in their responses to the two scenarios included in the survey, the “kill” scenario and the “break-up” scenario. For the “kill” scenario, all 38 respondents (13 psychiatrists and 25 psychologists) indicated they would break confidentiality. A chi square test of independence showed no relationship between profession (psychologist or psychiatrist) and course of action (break or not break confidentiality), \( \chi^2 (1) = 0, p > .05 \). For the “break-up” scenario, 11 psychiatrists indicated they would break confidentiality while only 2 indicated they would not break confidentiality, and 22 psychologists indicated they would break confidentiality while only 3 indicated they would not break confidentiality. A chi square test of independence
showed no relationship between profession (psychologist or psychiatrist) and course of action (break or not break confidentiality), $\chi^2 (1) = .507, p > .05$. The results therefore indicated that, among the participants in the present sample, there was no significant difference between psychiatrists and psychologists in whether they would break confidentiality in either the “kill” or the “break-up” scenarios.

The second hypothesis was that there would be a significantly greater overall number of participants who chose to break confidentiality in the “kill” vignette than in the “break-up” vignette. The second analysis performed was to determine if there was a significant difference in the combined responses of all the respondents between the “kill” and the “break-up” scenario. Again, 38 of 38 respondents indicated that they would break confidentiality in the “kill” scenario, whereas in the “break-up” scenario, 32 respondents indicated they would break confidentiality, while 5 indicated that they would not break confidentiality. One participant indicated a response in the “kill” scenario, but did not indicate a response in the “break-up” scenario. Therefore, that participant’s response for the “break-up” scenario was removed from the statistical analysis. A chi square test of independence showed a relationship between course of action taken (break or not break confidentiality) and scenario presented in the vignette (“kill” or “break-up”), $\chi^2 (1) = 5.34, p < .05$. The results indicated a significant difference in how the participants in the sample would respond between the two scenarios presented in the vignettes.

Due to the significant difference in breaking confidentiality between the “kill” and “break-up” scenarios, a subsequent statistical analysis was performed on the responses that indicated a course of action to break confidentiality to determine if there was a significant difference in the choices the respondents made in how they would break the confidentiality of the patient. There were four possible choices for the participant to break confidentiality: (1) to
contact the police or other law enforcement, (2) to contact the patient’s sexual partner, (3) to contact the Missouri Department of Health and senior services (MDHSS), and/or (4) to select multiple responses. A chi square goodness of fit was performed on the 38 responses in the “kill” scenario that indicated breaking confidentiality. In the “kill” scenario, 1 respondent selected the option of contacting law enforcement, 13 chose the option of contacting the sexual partner, 3 indicated they would contact MDHSS, and 21 selected multiple response options. A chi square goodness of fit test showed a significant difference among the four response option categories, $\chi^2 (3) = 27.19, p < .05$. The results indicated that in the “kill” scenario, the participants were significantly more likely to choose multiple response options.

In the “break-up” scenario, 32 participants indicated they would break confidentiality. Of these 32, none indicated that they would contact law enforcement, 18 indicated they would contact the sexual partner, 7 indicated they would contact MDHSS, and 7 selected multiple response options. A chi square goodness of fit test showed a significant difference among the four response option categories, $\chi^2 (3) = 20.75, p < .05$. The results indicated that, in the “break-up” scenario, the participants were significantly more likely to choose the option of contacting the sexual partner.

The statistical assumptions for using a chi square test were met for the assumption of mutually exclusive groups, as each participant’s response could be only used in one cell in running the statistics. However, for the assumption of expected frequencies being 5 per cell, none of the 5 chi square tests performed in this analysis met this assumption due to small sample size, and therefore the results of this statistical analysis should be interpreted with caution.
The first hypothesis was that there would be a difference between psychiatrists and psychologists in whether they would break the confidentiality of a patient in both the “kill” and “break-up” scenarios presented in the survey. That is, it was anticipated that psychiatrists would be more likely to report that they would break confidentiality under both conditions than would psychologists. The results of the study did not support the first hypothesis, as there was no difference between psychiatrists versus psychologists in either the ”kill”, or the “break-up” vignette. In the “kill” vignette, the results of the study showed that not only was there no significant difference between the responses provided by psychiatrists versus psychologists, but also both groups unanimously indicated that they would break confidentiality. In the “break-up” vignette, results again showed no significant difference between psychiatrists and psychologists. In fact, the responses of the two groups were not only not significantly different, but they were almost identical, with 11 of 13 (84.6%) psychiatrists indicating an intention to break confidentiality and 22 of 25 psychologists (88%), reporting an intention to break confidentiality.

The second hypothesis was that the participants would be significantly more likely to break confidentiality in the “kill” versus “break-up” scenario. The results of the study supported this hypothesis, in that participants from both professions were more likely to break confidentiality in the “kill” versus “break-up” scenario. These results likely indicate that an important factor in Tarasoff-like situations involving an HIV positive client is the intentionality on the part of the patient, with regard to the possibility of harming another human being.

As a result of the significant results of the chi square to test the second hypothesis, subsequent chi square analyses were performed for each of the vignettes to determine if there
was a significant difference among the choices participants selected for breaking confidentiality. For the “kill” vignette the participants were significantly more likely to choose multiple courses of action. This suggests that when mental health professionals encounter a patient who intends to harm or kill another person, the psychologist or psychiatrist is likely to break confidentiality and report the situation to multiple sources. By choosing to report the intent to harm another to multiple sources, a mental health professional could be indicating an immediate and urgent desire to stop the patient from harming others. For the “break-up” vignette, the participants were significantly more likely to choose the option of only contacting the sexual partner. This suggests participants might have felt less urgency in stopping the actions of the patient. These results also might indicate a widespread knowledge of the Tarasoff case among the participants (Monahan, 1993). In the Tarasoff case, the psychologist was deemed negligent for not warning the potential victim. The researcher feels that a significant number of participants choosing only to inform the sexual partner may indicate the participant’s familiarity with the Tarasoff case, and taking action consistent with the Tarasoff ruling. The Tarasoff case, and the issues involved with the Tarasoff case, have been the subject of many articles published in peer reviewed literature. It is possible that some of the participants in this study are familiar with some of these articles, and through these articles are very familiar with the Tarasoff ruling.

It is also possible that the results of the “break-up” scenario could indicate a lack of familiarity with the specifics of Missouri law among the participants, due to the fact that the Tarasoff case was a state of California ruling and does not apply to the state of Missouri. It is possible that the participants may not have known that Missouri does not have a “duty to warn” law such as California has, and some of them assume that mental health professionals are bound to the precedent of the Tarasoff ruling, when mental health professionals practicing in the state of
Missouri are not. To further illustrate this point, of the 43 individuals whose data were analyzed in the study, 13 respondents mentioned the term “duty to warn” or referred to the Tarasoff case in the comment section of the survey, even though the terms “duty to warn” or “Tarasoff” case were never mentioned in the survey. This may indicate a widespread familiarity with the Tarasoff case but less familiarity with the law in the state of Missouri, and therefore could explain the high frequency of participants only choosing the “contact the sexual partner” option in the “break-up” scenario. It is likely that the participants in this study, as well as mental health professionals throughout the state of Missouri need to better familiarize themselves with the specifics of Missouri law so they can make decisions for their patients that are consistent with Missouri law (Pabian, Welfel, & Beebe, 2009). If mental health professionals in the state of Missouri made decisions based on the Tarasoff decision and California law instead of Missouri law, patients in Missouri could be more likely to encounter psychologists and psychiatrists who will break patient confidentiality because they may feel that they are bound to the “duty to warn” of the Tarasoff decision. This could result in Missouri practitioners feeling compelled to break confidentiality of the patient in certain “gray area” situations when it is not necessary to do so. In the state of Missouri there is no “duty to warn” and mental health practitioners have discretion as to whether or not to break the confidentiality of an HIV positive patient. With no “duty to warn” Missouri practitioners who are making decisions based on Missouri law may be more likely to maintain the confidentiality of the patient in appropriate situations.

Research indicates that only 23.6% of mental health practitioners are aware of the relevant state laws pertaining to the confidentiality of potentially dangerous clients (Pabian, Welfel, & Beebe, 2009). Mental health practitioners can become better informed of the relevant confidentiality laws of their state by actively looking up such laws on their state’s revised statute
Reporting HIV Status

website. Other ways psychologists can become better informed are to read published research related to confidentiality issues, and to consult with the APA Ethics Committee or their malpractice attorneys to get a clearer understanding of the laws regarding confidentiality and potentially dangerous clients in their state. It would be wise for mental health practitioners to familiarize themselves with the confidentiality laws of their state in advance of a problem, rather than wait until an ethical or legal dilemma arises to discern the proper legal and/or ethical course of action.

In the comment section of the survey, many participants indicated a desire to consult with others before making a final decision on the proper course of action to take. Of the 43 surveys returned, 15 included statements indicating that the participants would consult with others. Some of the potential consultation sources that were mentioned included liability insurance companies, the APA Ethics Committee, attorneys, other colleagues, the risk management office of the facility (state facility), HIPPA compliance office, Missouri Psychological Association (MOPA), supervising psychologists, and the mental health coordinator of the hospital.

There were a number of noteworthy responses in the comment section of the surveys. One psychologist, who indicated that he would not break confidentiality in the “break-up” scenario, stated that “HIV is not a death sentence, it is treatable, people with HIV do not necessarily die from AIDS and often live long mostly normal lives.” Another psychologist, who indicated she would not break confidentiality in the “break-up” scenario, stated that she “would point out to the patient that if the partner gets HIV and dies the relationship would eventually end anyway.” She then went on to state that she would “break confidentiality in the “kill” scenario because of the fact that “the intent to harm” was clear even though HIV might not be the best weapon.” A third psychologist, who indicated that she would not break confidentiality in the
“break-up” vignette, stated that “the patient’s sexual partner was a consenting adult who should know that there are risks for his or her behavior.” However, all three of these psychologists stated they would break confidentiality in the “kill” vignette.

Additional comments worth noting include one from a psychologist who commented, “situations like this are why I am not in private practice.” Another psychologist stated in the comment section, “AIDS is completely curable” and also attached a medical research study that suggests there is a new treatment to cure AIDS. One psychiatrist stated that he would consider immediate hospitalization in response to the “kill” vignette.

Based upon the results of the statistical analyses of the data as well as participants’ open ended comments, it appears that these practitioners take the confidentiality of their patients very seriously. However, based on the fact that the majority of participants indicated they would break confidentiality in both vignettes, it seems clear that the participants are aware of the limitations to confidentiality that can arise when a patient is putting other people in danger. The participants’ comments also indicated a high level of familiarity with the Tarasoff case; in fact, based on their open ended comments, the participants appeared to be much more familiar with the precedent set in the Tarasoff case than they were with Missouri statutory law regarding a patient’s HIV status and “duty to warn.”

Based upon the analyses of both the quantitative and qualitative data, it seems reasonable to conclude that participants’ decisions with regard to whether or not to break confidentiality were strongly motivated by whether or not a patient has an intent to harm or kill another person. That is, participants (both psychiatrists and psychologists) overwhelmingly chose to break the patient’s confidentiality when the scenario involved a patient who wanted to intentionally harm or kill another person (i.e., as in the “kill” vignette). When the patient did not express an intent
to harm or kill another person, such as in the “break-up” vignette, the majority of participants still chose to break the confidentiality of the patient; however, a substantial number of participants indicated that under these circumstances, they would choose not to break confidentiality.

Recommendations for further research in this area would be to include conducting a replication study that includes a larger and more representative sample, including practitioners from states other than Missouri. Another suggestion for future research would be to include a survey that questioned participants on knowledge of their respective state laws in “Tarasoff-like” situations. Another possibility to examine in future research would be to include analysis on whether the participant’s primary practice is in a private setting or is in a publicly funded institution. It could be possible that the mindset of practitioners in private practice is different than practitioners working for publically funded facilities. This possible difference between practitioners in public versus private practice could be the case if private practitioners feel that their patients are customers and they are working for the patient, and that their first responsibility is to protect the patient. While practitioners in public facilities may feel they are working for their community as a whole and their first responsibility is to protect the community. Thus private practitioners might be more likely to maintain confidentiality in HIV related “Tarasoff-like” situations. Perhaps an interesting analysis of participant ethnic background could examine whether the participant was born in an individualistic culture (such as the United States), or was born into a collectivist culture (such as Japan). Mental health professionals might be more likely to maintain confidentiality if raised in an individualistic culture, while more likely to break confidentiality if raised in a collectivist culture as the result of different social values that develop in different cultures (Guimond, et al., 2007). Another possible suggestion for further
research into this area of inquiry would be to inform the participants of the relevant Missouri laws in advance and then let them respond to the survey. Another possibility for future research would be to assess the participants’ knowledge of their relevant state laws based upon their responses on the survey.

**Limitations**

One of the primary limitations of this study is the small sample size and low response rate. Since there are about two thousand psychologists and psychiatrists currently licensed in the state of Missouri, with the small number of participants that responded to this study (43), the findings might not generalize to all psychiatrists and psychologists currently practicing in the state of Missouri. Due to the small sample size, this investigation could be viewed as a pilot study, and a more extensive project with a larger sample of participants should be undertaken in the future. Other similar survey studies examining psychologists’ attitudes about patients with HIV included sample sizes of 643 with a response rate of 36% (McGuire, et. al, 1995); another had a sample size of 84, with a response rate of 21% (DiMarco & Zoline, 2004); a third had a sample size of 300, with a 30% response rate (Pabian, Welfel, & Beebe, 2009); and another had a sample size of 253, with a response rate of 49% (Simone & Fulero, 2001). Survey response rates of the type used in this study typically range from 24% to 54% (Simone & Fulero, 2001). Sample sizes from practicing psychologists have ranged from 39 to 4,097 (Weathers, Furlong, & Solorzano, 1993). Larger survey samples are recommended to be able to more confidently generalize the results of a study to a larger population of mental health practitioners (Anderson, Doherty, & Freidrich, 2008).

Some possible methods for obtaining a larger sample size in future research might include the pre-notification of potential participants that they will be sent a survey, including a
monetary or other inducement, making the request to participate in the study more personal in nature, sending follow up notification to potential participants, and selecting participants that might be highly interested in the results of the study (Anseel et. al., 2010). Monetary inducements have been found to increase response rates from 50% to 78% (Huck & Gleason, 1974). Personalization of the cover letter has been found to improve response rate from 68% to 77% (Weathers, Furlong, & Solorzano, 1993). Sending a follow up notification has been found to increase survey response rate from 38% to 59% (Etzel & Walter, 1974), and pre-notification of potential participants has been found to increase response rate from 20.5% to 68.2% (Jolson, 2010). Other factors that can affect response rate is the manner in which the participant responds. The method of response in this study was by postal mail. Other possible methods of responding to survey research include e-mail response, web-based responses, or facsimile responses. Wogalter, Yarbrough, and Martin (2000) found that mail surveys had a higher rate of return than did e-mail or fax surveys (p. 583), while McMinn et. al. (2011) had a response rate of 54.7% through postal mail and only 12.9% by using e-mail (p. 176). Other research into the response rates of different return methods found that web-based survey responses had a 44% response rate, postal mail survey methods had a 26% response rate, while the fax response rate was 17% (Cobanoglu, Warde, & Moreo, 2001). Another possibility to increase sample size would be to approach mental health practitioners to be participants for a research study while they are attending professional conventions.

If another attempt at this study were made, this researcher would attempt to obtain a larger sample size by sending out many more surveys, more thoroughly checking the correct address and contact information of potential participants, pre-notifying the potential participants that they would be contacted to participate in the study, sending follow-up notification to the
participants after the survey has been mailed out, and offering some sort of incentive or inducement for the potential participant to return the survey. Also participation could be increased by approaching potential participants at professional conventions. Another method for increasing response rate could include giving potential participants the options of mail response, e-mail response, web-based response, or fax response. Another possibility to increase the number of participants in future studies of this nature would be to contact and work in conjunction with the Missouri Psychological Association and the Missouri Psychiatric Association.

The small sample size may affect the representativeness of the data, since the small number of participants may not reflect the views of the larger population of psychologists and psychologists practicing in the state of Missouri. Perhaps those who responded to this survey were more likely to work in a particular type of setting (private practice or public facility) and participants’ work settings might have had an impact on their response. Perhaps the participants who responded were enthusiastic about contributing to academic research, and perhaps these participants were more likely to respond a certain way. Also, it is possible that the participants who responded have strong feelings about HIV related issues in psychotherapy, and this might have affected their responses as well as the representativeness of the findings. There were also about twice as many psychologists versus psychiatrists that responded to the survey. Therefore, the results are based on a larger number of psychologists’ responses. With twice as many psychologists as psychiatrists in this sample, the representativeness of the findings could be affected. Psychologists may be more likely to respond to academic research studies because psychologists likely had to perform extensive research in order to obtain their doctoral degrees and therefore could be more sympathetic to graduate students’ efforts to conduct research.
Psychiatrists, who are trained as medical doctors, likely have less experience with conducting research and therefore could be less likely to respond to academic research surveys. The fact that almost twice as many psychologists, versus psychiatrists, participated in this should be considered a limitation of this study.

Another potential limitation relates to the survey used in this study. The survey was developed by the researcher specifically for the purpose of this study, and thus was the first time it had ever been used. Therefore, there was no prior validity or reliability information for the survey. Another potential limitation of the survey includes the possibility that participants might have interpreted the scenarios presented in the vignettes differently from how they were intended to be interpreted. An example of this would be if a participant read the scenario and didn’t understand the researchers’ intent that all options to get the patient to stop his behavior had been completely exhausted and the only two choices remaining were to break confidentiality or to maintain confidentiality knowing that the patients’ sexual partner would almost certainly end up being infected with HIV. Another limitation that is common in research that utilizes survey data is the possibility that the participants would act differently from how they indicated in their survey response. That is, people’s responses to a hypothetical scenario might not accurately represent how they would truly behave under real-life circumstances.

Implications of Research

Research into legal and ethical dilemmas, such as issues that were examined in this study, have important implications for mental health professionals who are treating patients now and in the future. Based on the varying responses of the participants in the present sample, and the wide variety of opinions regarding confidentiality and “duty to warn” in the existing literature, it is recommended that all professionals who might have to deal with the conflict between patient
confidence and protecting the public be more proactive in determining the proper course of action as well as what the relevant state laws are, should such a situation ever arise. It is the opinion of this researcher that all graduate clinical, counseling, and school psychology and medical school programs should include coursework in legal and ethical issues such as those explored in the present study. Also, post-doctoral and medical residency programs should include training that deals with confidentiality and duty to protect the public as they relate to potentially dangerous patients. Also, practicing mental health professionals would be wise to familiarize themselves with confidentiality and “duty to warn” issues as part of their continuing education requirements. Another step that would be helpful would be for the American Psychological Association, and the American Psychiatric Association to actively clarify what the relevant laws are for their practicing members in each state, and what the proper course of action would be in “Tarasoff-like” situations for each legal jurisdiction for both HIV and non HIV situations.

It is the opinion of the researcher that a future study with a much larger sample size that could be more strongly generalized to all mental health professionals practicing in the state of Missouri would yield similar results to this study. In summary, the results of this study suggests that the primary factor in determining whether or not Missouri mental health practitioners will break a patient’s confidentiality in an HIV related “Tarasoff-like” situation is not based on differences between the professions (e.g., psychologist versus psychiatrist) but rather appears to be based on whether or not the patient expresses a clear intent to harm or kill someone else. In a scenario in which a patient expresses a clear intent to harm or kill, both psychiatrists and psychologists will overwhelmingly break confidentiality. In a situation in which the patient has no clear intention to harm or kill another person, but is still endangering another person by
possibly exposing the person to HIV infection, the majority of psychologists and psychiatrists indicate that they would still break confidentiality; however, in this situation a substantial number of practitioners will still choose to maintain the strict confidentiality of the patient.
REFERENCES


APPENDIX A
QUESTIONNAIRE

Which of the following best describes your primary practice: Please check one of the following:

<table>
<thead>
<tr>
<th>Publicly Funded Facility:</th>
<th>Private Practice</th>
<th>Other (please specify)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local ____</td>
<td>____</td>
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<tr>
<td>State ____</td>
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<tr>
<td>Federal ____</td>
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Age (In Years) ______

Gender: (Please circle one) Male Female

Ethnicity: (Please circle one) White/Caucasian Black/African American Hispanic/Latino(a) Asian/Pacific Islander Native American Middle Eastern Indian Mixed race

Other (please specify) ________________________________
After reading the following vignettes, please respond to the questions that follow

1. Imagine that you are seeing a male patient who is HIV positive and who is engaged in a sexual relationship with a partner who is unaware of your patient’s HIV status. You implore the patient to inform his sexual partner but the patient refuses, saying he wants to kill his partner by infecting the partner with HIV. You believe that all efforts to get your patient to either inform the partner of the situation, use a condom, or abstain from sex have been exhausted and that your patient will continue having sex with the partner until the partner is infected with HIV. You know where the patient’s partner lives and have a phone number by which you are able to contact the partner.

What course of action would you take?

Please check all courses of action that you would take:

____ I would contact the police or other law enforcement agency

____ I would contact the patient’s sexual partner and inform that person of the patient’s HIV status.

____ I would contact the Missouri Department of Health and Senior Services.

____ I would not contact anyone, and would strictly maintain the confidentiality of my patient.

____ Other (please specify) ________________________________________________

If you would like to discuss or clarify your answers to the vignette further, please feel free to do so in the space that follows.
2. Imagine that you are seeing a male patient who is HIV positive and who is engaged in a sexual relationship with a partner who is unaware of your patient’s HIV status. You implore the patient to inform his sexual partner but the patient refuses saying he is afraid that if the partner finds out he has HIV the partner will end the relationship. He does not want to infect his partner, but won’t inform the partner of the situation even if it means putting the partner at risk. You believe that all efforts to get your patient to either inform the partner of the situation, use a condom, or abstain from sex have been exhausted and that your patient will continue having sex with the partner until the partner is infected with HIV. You know where the patient’s partner lives and have a phone number by which you are able to contact the partner.

What course of action would you take?

Please check all courses of action that you would take:

_____ I would contact the police or other law enforcement agency

_____ I would contact the patient’s sexual partner and inform that person of the patient’s HIV status.

_____ I would contact the Missouri Department of Health and Senior Services

_____ I would not contact anyone, and would strictly maintain the confidentiality of my patient.

_____ Other (please specify) _____________________________________________

If you would like to discuss or clarify your answers to the vignette further please feel free to do so in the space that follows.
APPENDIX B
INFORMED CONSENT FORM

Identification of researchers: This research is being conducted by Alan Asbridge, a graduate student in the Department of Psychological Science at the University of Central Missouri, as a requirement for the completion of his master’s degree. This work is being supervised by Kim Stark-Wroblewski, Professor of Psychological Science.

Purpose of the Study: The purpose of this study is to determine the practices of various mental health professionals in the state of Missouri regarding decisions pertaining to confidentiality when an HIV positive patient could be putting others at risk of HIV infection.

Request for Participation: We are inviting you to participate in a study examining how various mental health professionals might handle a situation in which an HIV positive patient could be putting others at risk of infection. It is up to you whether you would like to participate. If you decide not to participate, you will not be penalized in any way. You can also decide to discontinue your participation at any time without penalty. If you do not wish to answer any of the questions, you may simply skip them. You may withdraw your data at the end of the survey. If you wish to do this, simply do not return the survey to us. Once you mail the survey back to us, we will not be able to separate your data from others’ responses, as your responses will be anonymous and we will have no way to identify which survey is yours.

Exclusions: You must be at least 18 years of age to participate in this study.

Description of Research Method: Your participation in this study would involve the completion of a very brief survey, which might take up to 8 minutes for you to complete. The survey will ask you to provide information regarding your age, gender, ethnic background, professional background and your primary practice setting. The survey will then ask you to respond to two short vignettes that describe a situation in which a patient could potentially be putting another person at risk of HIV infection, and will ask you to select from a list of options what course of action you would take under those circumstances. You will have space to discuss your answers further if you wish to do so.

Privacy: All of the information we collect will be anonymous. We will not record your name or any information that could be used to identify you.

Explanation of Risks: The only physical risks associated with this study are the risks of doing everyday paperwork. Other risks could include the possibility of revealing a course of action with which others (e.g., your colleagues or the institution for which you work) might disagree, although the data will be anonymous. There is virtually no physical risk of injury and there will be no compensation or medical treatment provided by the researchers.
**Explanation of Benefits:** The benefits of participating in this study include the knowledge that your participation could help contribute to a better understanding of how Missouri’s mental health professionals view issues pertaining to patient confidentiality.

**Questions:** If you have any questions about this study, please contact Alan Asbridge at (573)-446-9055 or alanasbridge@hotmail.com, or Kim Stark-Wroblewski at (660)-543-4982 or stark@ucmo.edu. If you have any questions about your rights as a research participant, please contact the Human Subjects Protection Program at (660) 543-4621 or at humansubjects@ucmo.edu.

If you would like to participate simply fill out the survey and return it in the envelope provided. By filling out the survey and returning it you will be giving your informed consent to participate in the study.

Thank you for considering my request to participate in this study.

Sincerely,

Alan Asbridge