Confidentiality and Disclosure Dilemmas in Psychotherapy with Adolescents

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Psychologists who provide mental health services to adolescents and their families must navigate complex ethical challenges with respect to confidentiality and disclosure decision-making. Therapy with adolescents may touch on a myriad of high-risk and health-compromising behaviors, such as alcohol and drug use, antisocial and potentially illegal behaviors, and sexual exploration. There may be situations in which the therapist believes that an adolescent is engaging in behaviors that raise the potential for harm, but are unsure as to what types of behaviors might warrant disclosure to adults, such as parents/guardians. In addition, clinicians may feel bound by promises of confidentiality or worry that the alliance between therapist and client will be harmed through disclosure. How do mental health clinicians develop confidentiality policies that serve to protect minors from serious harm, fulfill professional and legal responsibilities, and preserve the therapeutic relationship with the adolescent and parents/guardians?

Developing and communicating ethically responsible confidentiality and disclosure policies at the outset of the professional relationship may be one of the most effective ways of minimizing the possibility of future confusion, harm, and misunderstanding about the professional responsibilities of psychologists and the nature of the therapeutic relationship. Not surprisingly, adolescents entering therapy may be concerned that information discussed in session will be shared with others, such as parents, teachers, or even law enforcement officials. Like many adults, adolescents may also be confused about professional and legal confidentiality rules, including to whom psychologists may (or, in some cases, obligated) to disclose information.

Pitfalls of Promising Absolute Confidentiality

The trusting relationship developed between clinician and client is a critical tool in generating meaningful mental health improvement. Clinicians, in an attempt to encourage feelings of comfort and to establish a positive therapeutic alliance with an adolescent (who may be ambivalent or even hostile about seeing a therapist) may be tempted to promise absolute confidentiality (sometimes referred to as a "secrecy pact") to the adolescent. These promises, however, conflict with professional standards and state laws that may require therapist disclosure, such as in cases of reported child abuse, and may lead to irreparable damage of the therapeutic relationship if there's a situation in which the therapist determines that disclosure is ethically warranted.

Maintaining confidentiality reflects respect for the client's rights to and expectations of privacy, while disclosure of confidential information in certain circumstances may fulfill the clinician's obligation and duty to prevent harm. The moral principle of integrity calls for psychologists to be truthful in their work, including their ethical commitments and responsibility. Promising to maintain confidentiality in all circumstances in an attempt to build rapport and facilitate the provision of perhaps much-needed psychological services may, at first glance, appear to be in the service of the client, but doing so compromises the integrity of the therapist (and profession) by making promises that may not be able to be kept.

Moreover, although clinicians might assume that disclosures will always harm a therapeutic relationship or that minors prefer absolute confidentiality, research suggests that adolescents may, in fact, expect adults in positions of authority (including psychologists and researchers) to act to prevent harm, such as in situations of physical or sexual abuse or suicidal ideation (Fisher et al., 1996; O'Sullivan & Fisher, 1997).

Determining When to Disclose

Practicing psychologists are aware that confidentiality and disclosure decisions are informed by a number of sources, including the APA Ethics Code, institutional rules, state laws and federal regulations relevant to mandatory disclosures. For example, all 50 states have laws and regulations regarding child abuse and many states include duty to warn laws that require therapists to inform outside parties when a client may be a danger to themselves or others. When treating adolescents, however, how do mental health clinicians determine the extent to which certain risk behaviors, such as non-suicidal self-injury (e.g., superficial cutting), drug and alcohol use, and sexual risk behaviors1, may be seen as developmentally appropriate experimentation

or otherwise carry a low possibility of harm versus ones that may pose serious risk to the adolescent or others, warranting disclosure to parents/guardians or other adults?

Several researchers have conducted informative survey studies with mental health professionals assessing under which circumstances they might consider breaking confidentiality with adolescent clients. For example, Rae and colleagues have conducted some interesting surveys of pediatric psychologists (2002) and school psychologists (2009) assessing their likelihood to break confidentiality in response to a number of hypothetical adolescent risk behaviors that carry the possibility of harm, such as smoking, alcohol use, drug use, sexual activity, self-harm and antisocial behaviors. Results indicated that the intensity/magnitude and frequency/duration of the behavior were important determinants in the decision to break confidentiality. Surprisingly, there was a good deal of variation among professionals in terms of disclosure recommendations. In addition to intensity and frequency of the adolescent risk behavior, confidentiality recommendations also varied based upon the gender of both the professional responding to the survey and that of the hypothetical client, as well as the age of the client (respondents were more likely to recommend breaking confidentiality with younger hypothetical clients). These results are certainly revealing, but questions remain as to the actual behaviors of pediatric psychologists and mental health professionals who are confronted with these dilemmas on a regular basis.

Confidentiality and Disclosure Considerations2:

Below are some considerations with respect to confidentiality and disclosure policies and procedures that may be helpful:

During the informed consent process, engage in a frank discussion with both the adolescent and parents/guardians about their expectations regarding confidentiality, and the clinician's confidentiality policies and professional responsibilities, including the legal limitations of confidentiality in therapy settings and the types of information that would communicated to parents/guardians (and the types that would not). Although it's impossible to anticipate exactly what a client may disclose in future sessions, it may be helpful to provide general guidelines of what types of disclosures are legally required and/or otherwise may warrant notification to parents/guardians or other authorities.

It might prove helpful to discuss whether parents/guardians expect to receive regular feedback about therapeutic progress. Ideally and if appropriate, adolescents should be informed of these meetings, there should be agreement at the outset of the general nature of information that will be communicated, and clinicians should clarify their primary professional role (namely, by not becoming a therapist to a parent/guardian) (Koocher, 2008).

Rather than a one-time speech delivered in the initial session, adolescents and their families may benefit from discussions about and reminders of confidentiality and other policies throughout the therapeutic process. These discussions can also serve as opportunities for adolescent client and parents/guardians to learn more about the therapy process, the roles and responsibilities of the clinician, and continue to discuss expectations of each party.

When appropriate, therapists who plan to disclose confidential material should consider informing and discussing the reasons for disclosure with the adolescent client (Prout, DeMartino & Prout, 1999). If appropriate, encouraging the adolescent to lead or be a part of direct discussions with parents/guardians may also serve to empower adolescent client and facilitate open communication with family members.

Conclusion:

Confidentiality policies and disclosure decisions always require careful ethical analysis by clinicians. Disclosure dilemmas related to treatment with adolescents and their families may raise unique ethical concerns and seemingly competing moral principles. Therapists may understandably experience tension when confronted by difficult disclosure decisions that require consideration of both professional/legal obligations and the adolescent's expectation to privacy (as well as the potential impact to the therapeutic relationship that may be associated with disclosure). Therapist promises of absolute confidentiality, while intended perhaps to help clients and/or facilitate positive therapeutic change, may in actuality endanger the safety and well being of clients, threaten the integrity of the professional work, and place the psychologist at increased professional liability risk.

Notes

1 Psychologists should also be aware of laws and regulations in some states that protect professionals from being compelled to disclose certain information about a minor (such as records related to sexual health or substance use) to parents or others if they feel that the release of such information may negatively affect or harm the minor.

2 See Fisher (2014) for helpful disclosure-related decision-making considerations.

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