HIV AND DUTY TO PROTECT: A SURVEY OF LICENSED
PROFESSIONAL COUNSELORS AND PHYSICIANS

DISSERTATION

Presented to the Graduate Council of the
University of North Texas in Partial
Fulfillment of the Requirements

For the Degree of

DOCTOR OF PHILOSOPHY

By

Laura K. Johnson, B.S., M.Ed.
Denton, Texas
May, 1995
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DISTRIBUTION

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This study was designed to investigate what course of action therapists and physicians report they would take in reconciling their conflicting duties to maintain confidentiality and protect third parties from harm in HIV-related situations. The physicians surveyed were licensed to practice medicine in Texas and board certified in Internal Medicine. The therapists surveyed were licensed professional counselors in Texas and members of one of three selected divisions within the Texas Counseling Association. A survey instrument developed by the researcher was mailed to 200 subjects randomly selected from each group.

The major findings of this study were as follows:

1. When an HIV positive client continues to engage in unprotected sex with an uninformed, identifiable third party, significantly more therapists and physicians reported they would inform the third party rather than maintain confidentiality or notify medical or law enforcement personnel. When the danger involved a needle-sharing partner, significantly more therapists would choose to inform the partner, while physicians would elect to notify authorities. However, when the client reports engaging in protected sex with a partner
unaware of his HIV-status, significantly more therapists and physicians would choose to maintain confidentiality.

2. Respondents in both groups reported "degree of dangerousness" as the most important factor to consider before breaching confidentiality. Ethical guidelines and state statutes were identified as the two most important resources to utilize when making such a decision.

3. The results demonstrated therapists are not knowledgeable that Texas law limits breaching confidentiality to medical or law enforcement personnel when third parties are endangered.

4. Twenty-four percent of therapists indicated they would hesitate treating HIV positive individuals. The most frequently cited reason for hesitation involved the lack of clear ethical guidelines and state statutes relevant to this issue.

5. The majority of therapists recommended that ACA develop ethical guidelines which specifically address confidentiality and the duty to protect in HIV-related cases.
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CHAPTER 1

INTRODUCTION

The Acquired Immune Deficiency Syndrome (AIDS) crisis has evolved into an extraordinary medical, legal, and social chronicle (Gray & Harding, 1988). AIDS has been relegated to the position of a plague and the most feared disease of present day (Bruhn, 1989; Price, 1990). Although mental health professionals and physicians who treat individuals who have tested positive for the Human Immunodeficiency Virus (HIV) face few legal and ethical issues that are truly new, AIDS complicates issues that are already ambiguous (Wood, Marks, & Dilley, 1990).

The AIDS epidemic has presented unsettling questions regarding the limits of confidentiality within the psychotherapeutic relationship (Knapp & VandeCreek, 1990). Mental health professionals and physicians must balance the individual's right to confidentiality and privacy against society's interest in protecting the public from harm (Erickson, 1993; Harding, Gray, & Neal, 1993; Hermann & Gagliano, 1989; Hughes & Friedman, 1994; Panem, 1988; Reamer, 1991a; Talbot, 1988; Waller, 1993; Watson, 1992). Regarding this issue, numerous authors have debated the controversial legal, ethical, and moral dilemmas regarding the application of "duty to warn" in cases involving clients who have tested positive for HIV or who have AIDS (Clark, 1991; Cohen, 1990;
To date no legal decision has been rendered regarding a therapist's duty to warn endangered third parties in a case involving HIV (Bernstein, 1990; Costa & Altekruse, 1994; Lynch, 1993; Silverman, 1993). However, many professionals in the mental health and medical fields argue that the ruling handed down in the precedent-setting Tarasoff v. Regents of the University of California (1976) case may be applicable to these situations in which a client who has tested positive for HIV willingly places identifiable persons at risk of contracting the virus (Bernstein, 1990; Costa & Altekruse, 1994; Dickens, 1988a; Edwards, 1989; Georgianna, 1992; Greve, 1990; Hopp & Rogers, 1989; Howe, 1988; Judd, Biggs, & Burrows, 1989; Lamb et al., 1989; Leong et al., 1992; Silverman, 1993; Spillane, 1990; Waller, 1993; Watson, 1992; Weiss, 1989; Zonana, 1989). As Gray and Harding (1988) stated:

In our opinion, a sexually active, seropositive individual places an uninformed sexual partner (or partners) at peril, and the situation therefore falls under the legal spirit of the Tarasoff case and the ethical tenets of “clear and imminent danger” (AACD, 1981, Section D.4). (p. 221)
In contrast, other authors have disputed the applicability of the Tarasoff ruling in AIDS-related cases (Girardi, Keese, Traver, & Cooksey, 1988; Turkington, 1989). Perry (1989) argued:

The vast majority of HIV-infected individuals have neither homicidal wishes nor intended victims. To compare them to the patient in the Tarasoff case is unjust, for it encourages widely held prejudices toward HIV carriers who are either practicing nonpathological sexual behaviors or are suffering from chemical dependence. They are not intent on harming anyone. (pp. 158-159)

One of many hypothetical scenarios illustrating such a case involves a married client who, after having an affair, tests HIV positive. The client refuses to inform his spouse, with whom he continues to engage in regular, unprotected sex, for fear of her learning of his infidelity.

Does the therapist have an ethical and/or legal obligation to breach the client's confidentiality and inform the spouse? One strategy strongly recommended for therapists facing this dilemma is a review of the literature (Bernstein, 1990). However, no consensus exists regarding whether "duty to warn" is a viable alternative in resolving this situation or in achieving the ultimate goal of minimizing the spread of AIDS.

On one hand, commentators in the medical and mental health fields have argued that the assurance of patient confidentiality is essential because control of the AIDS epidemic depends upon voluntary testing of persons who
are at high risk of contracting HIV. Limits on confidentiality may discourage these persons from participating in such testing as well as in necessary AIDS related research (Melton, 1991; Talbot, 1988). Disclosure requirements may also greatly hamper the psychotherapist-client relationship by either discouraging clients from revealing their HIV status or perhaps from seeking help altogether (Girardi et al., 1988). As Hughes and Friedman (1994) expressed, breaching confidentiality could result in harm to the client, causing extreme distress from the violation of trust.

Furthermore, AIDS also affects populations which have historically been disadvantaged and discriminated against (Werth, 1993; Ybarra, 1991). Thus, breaching confidentiality serves to increase opportunities for even further discrimination (Kain, 1988) which continues to be pervasive despite increasing antidiscrimination legislation (Edwards, 1989; Judd et al., 1989). Perry (1989) explored the issues of breaching confidentiality and "duty to warn" and concluded:

In the throes of this devastating epidemic we have within our therapeutic repertoire and within our resolve the capacity to help at-risk individuals reduce the transmission of HIV. We must therefore not place any potential barriers between ourselves and those in need by threatening to break an already fragile trust. (p. 161)

On the other hand, commentators have also argued that given the fact that AIDS is a fatal disease, the right of an endangered party to be informed
supersedes individual privacy rights and the obligation of confidentiality (Erickson, 1993; Gray & Harding, 1988). As Piorkowski (1987) stated, "A court probably would not conclude that an infected patient's right to privacy outweighs another individual's right to life" (p. 184). Furthermore, Spillane (1990) contended that failure to warn a third party of potential exposure cannot be justified on any basis, including the possibility of the patient experiencing discrimination. Regarding "duty to warn," Zonana (1989) stated:

Because AIDS is currently an incurable disease, a therapist who remains silent with the knowledge that a patient poses a potentially lethal danger to an identifiable person betrays his fiduciary responsibility to prevent the patient from destructive behavior and ignores the welfare of the community. (p. 164)

In summary, although a review of the literature would appear to assist mental health professionals and physicians in charting an appropriate course of action when facing this dilemma, it is apparent that the lack of consensus in the field may only contribute to their confusion and make their decision even more complex. As Werth (1993) noted, the conclusions and recommendations in the literature tend to contradict each other, which may begin to explain why the most common call for help to the American Psychological Association Office on AIDS involves concerns about confidentiality when a client who has tested HIV positive may be endangering others. Furthermore, Harding et al. (1993) summarized the issue by stating that "dialogue about whether or not a
helping professional may ethically and legally breach confidentiality has not
resolved the dilemma and, instead, has created more questions and
disagreements among various disciplines" (p. 297).

When examining ethical guidelines and state statutes, the issue of duty
to protect often becomes even more muddled. Kermani and Weiss (1989)
explained that state and federal legislatures, attempting to minimize the spread
of AIDS, have turned a worthy goal into an ethical minefield in trying to protect
individual rights while also attempting to protect society at large. The lack of
clarity in existing law on duty to disclose has left health professionals in a
quandary (Turkington, 1989).

Furthermore, attempting to reconcile ethical guidelines with state
statutes appears to be becoming increasingly difficult (VanHoose & Kottler,
1985). For example, a Maryland court failed to adopt Tarasoff in Shaw v.
Glickman (1980). The court ruled that, according to Maryland's privileged
communication laws, psychotherapists could not breach confidentiality even
when the lives of third parties are threatened (Knapp & VandeCreek, 1982).
However, the American Association for Counseling and Development (AACD)
Ethical Standards (1988) state that the member must take personal action or
inform authorities when a client poses clear and imminent danger to others.
This conflict places the mental health professional in a precarious legal/ethical
double bind. Also problematic is the fact that the American Counseling
Association (ACA) has yet to clearly define ethical standards related to HIV and the limits of confidentiality (Hughes & Friedman, 1994).

There are numerous legal and ethical issues that remain unanswered (Hawthorne & Siegel, 1988), and therefore, not surprisingly, psychotherapists are confused about their responsibilities concerning HIV-infected clients (Knapp & VandeCreek, 1990). As Totten et al. (1990) stated, "There are currently no available standards that provide guidelines to clinicians as to what factors to consider when breaking confidentiality in an AIDS-related psychotherapy situation" (p. 159).

Due to the discrepancy of opinion in the literature and the lack of clear guidelines provided by ethical standards and state statutes, it is difficult to predict what course of action mental health professionals and physicians would choose under such circumstances. Plausibly, this ambiguity and fear of potential liability could discourage these professionals from treating clients who have tested positive for HIV. As Erickson (1993) stated, "Until society responds, and clear legal and ethical guidelines are established, each mental health counselor must carefully consider all pertinent professional issues and then make an individual decision for appropriate action" (p. 130).

Furthermore, Reamer (1991a) contended that the AIDS crisis is testing the moral mettle of health professionals like no other health crisis has in the past. Researching, analyzing, and understanding the issues involved can contribute significantly to responding to critical questions regarding conflicts of
professional duty and delivery of services to persons who have tested HIV positive. As Friedman and Hughes (1994) stated, "Given the legal and ethical complexities, as well as the lack of comprehensive professional and legislative direction related to HIV, it is important that these issues are raised, examined, and debated" (p. 301).

With knowledge gained from this study, it may also be possible to ascertain what changes are necessary to provide therapists with clearer guidelines regarding their obligations to HIV positive clients and society at large. As a result, these changes would have the potential to reduce therapists' exposure to possible legal liability. In addition, by providing mental health professionals with a greater sense of security in treating these clients, essential services for this population may be more readily available.

Statement of the Problem

The problem addressed in this study is the assessment of the course of action licensed professional counselors and physicians report they would take in reconciling their ethical responsibility to maintain client confidentiality with their "duty to protect" uninformed, identifiable third parties from foreseeable harm in HIV-related cases. This research is designed to gather information regarding whether uniformity exists in the mental health and medical communities regarding how this dilemma is most appropriately resolved. In addition, the results of this study will help identify the particular factors that
therapists and physicians report they consider most important when deciding whether or not to disclose a client's HIV status to an endangered third party. Information obtained from this study could assist professional organizations in establishing clearer ethical guidelines for their members as well as demonstrate the need for more precise state statutes pertaining to the handling of confidentiality issues with individuals who have tested HIV positive.

Synthesis of Related Literature

The review of the literature focuses on six primary issues: (a) AIDS, (b) the Tarasoff decision, (c) right to confidentiality versus duty to protect, (d) related research, (e) ethical codes, and (f) state statutes.

AIDS

Acquired Immune Deficiency Syndrome (AIDS) was identified as a specific disease entity by the Center for Disease Control (CDC) in 1981 (Williams & Stafford, 1991). As of June 1994, statistics from the CDC revealed that 388,365 AIDS cases have been diagnosed in the United States (Centers for Disease Control [CDC], 1994). An additional 1.5 to 3 million Americans are estimated to be infected with the Human Immunodeficiency Virus (HIV). Many of these individuals are asymptomatic, and therefore, remain unaware of their HIV status (Ybarra, 1991). Regarding the percentage of HIV-infected individuals who will eventually develop AIDS, the literature initially reported estimates of 5%-10% (Lief, 1986) and 10%-50% (Faulstich, 1987; Norwood,
1987). However, researchers have since estimated that 99% of individuals who have tested positive for the causative agent HIV will eventually develop AIDS and die from an AIDS-related illness (Gray & Saracino, 1989).

The well-documented facts and statistics underlying the AIDS epidemic are alarming and grim. Although disproportionate numbers of homosexual or bisexual men and intravenous drug users have been afflicted by the disease, by moving into the heterosexual community, AIDS has become a threat to the entire population. Considering the fatality of AIDS, this threat has generated widespread fear and, at times, even hysteria or panic among certain segments of populations (Begg, 1989).

HIV, the presumed causative agent for AIDS, attacks cells primarily in the immune system which results in the body being unable to defend itself against opportunistic infections or cancers (Wood et al., 1990). HIV has been identified in blood, semen, vaginal secretions, tears, and saliva. However, the virus apparently has an insufficient concentration in tears and saliva to cause infection (Curran et al., 1988; Francis & Chin, 1987). HIV is predominantly transmitted through semen and vaginal fluid during sexual activity, through blood when sharing intravenous (I.V.) needles during drug use, and from mother to fetus during pregnancy and birth (Wood et al., 1990). HIV is detected primarily through two tests, the Enzyme-Linked Immunosorbent Assay (ELISA) and the Western Blot, which identify the presence of antibodies the body has produced in response to the infection. However, neither of these
tests are actually diagnostic or prognostic of AIDS itself, since the disease is not a discrete clinical entity. A diagnosis of AIDS is based on the presence of certain symptoms and opportunistic infections which indicate that the body's immune system has been rendered wholly or partially disabled by the HIV infection (Burroughs Wellcome, 1988; Price, 1990). Significantly, individuals who have tested positive for HIV are considered to be infectious, regardless of their stage of illness. Therefore, even asymptomatic, seropositive individuals are capable of transmitting the potentially fatal virus (Harding et al., 1993; Hoffman, 1991; Kleinman, 1991; Martin, 1989).

The Tarasoff Decision

The AIDS crisis raises challenging ethical and legal issues for mental health professionals and physicians (Hughes & Friedman, 1994). Particularly controversial, is the dilemma of reconciling the professional's duty to maintain a client's confidentiality with the duty to protect third parties from harm (Ensor, 1988; Gochros, 1988). The duty to protect is commonly argued to arise out of the precedent-setting case Tarasoff v. Regents of the University of California (1976) (Bernstein, 1990; Gehring, 1982; Keith-Spiegel & Koocher, 1985; Lewis, 1988; Spillane, 1990; Weiss, 1989). The facts of the case are as follows:

In Tarasoff, Prosenjit Poddar, an outpatient at the University of California hospital, informed his psychotherapist that he planned to kill an unnamed girl, readily identifiable as Tatiana Tarasoff, when she returned home after spending the summer in South America. The therapist
advised the university police department of this threat and requested that Poddar be detained. Poddar was taken into custody but soon released when he promised to stay away from Tatiana. Shortly after her return from Brazil, Poddar went to her place of residence and killed her. (VanHoose & Kottler, 1985, pp. 51-52)

Tarasoff's parents sued the therapist and state officials for their failure to detain Poddar and warn their daughter of his threat (Reamer, 1991b). The California Supreme Court ruled that the Tarasoffs stated a proper cause of action (Price, 1990). Although there is generally no legal duty imposed on an individual to control the conduct of another (Hanson, 1989), the court decided that the facts of the Tarasoff case satisfied the conditions necessary to impose a duty to protect. These three conditions included (a) a special, or fiduciary, relationship (i.e. the therapist-client relationship); (b) a reasonable prediction of conduct that constituted a threat; and (c) a foreseeable, identifiable victim (Costa & Altekruse, 1994; Gehring, 1982; Hughes & Friedman, 1994). In a controversial, landmark ruling the Tarasoff (1976) court concluded:

When a therapist determines or pursuant to the standards of his profession should determine, that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim against such danger. (p. 335)

Furthermore, the Tarasoff (1976) ruling stated:

We conclude that the public policy favoring protection of the confidential
character of patient-psychotherapist communications must yield to the extent to which disclosure is essential to avert danger to others. The protective privilege ends where public peril begins. (p. 337)

Bednar (1989) asserted, "In 1974, the door of legal liability opened wide to receive psychotherapists" (p. 261). Indeed, the Tarasoff decision elicited anxiety and confusion among mental health professionals (Beck, 1985; Fulero, 1988; Knapp & VandeCreek, 1982; Melella, Travin, & Cullen, 1987; Watson, 1992). This confusion was evidenced in a survey of psychotherapists conducted by Conte, Plutchik, Picard, and Karasu (1989). A questionnaire consisting of 103 items focused on six ethical issues: sexual conduct, socialization, confidentiality, harm to third parties and/or patients themselves, encouraging changes in patients’ personal lives during therapy, and use of the media. Therapists were asked to rate a number of behaviors related to psychotherapy as appropriate, inappropriate, unethical, or grounds for malpractice. The researchers found that the greatest discrepancy of opinion involved the issue of duty to warn. Responses to items related to this issue ranged from acceptable behavior to grounds for malpractice. The researchers concluded that a great deal of misunderstanding and discrepancy of opinion exists regarding duty to warn, and further clarification is required.

Furthermore, a research study conducted by Givelber, Bowers, and Blitch (1984) revealed that of the 90% of therapists surveyed who were aware of the Tarasoff ruling, nearly all believed that the only way to fulfill their legal
duty was to directly warn the endangered third party. In essence, it appears that therapists are unclear of the range of options available to them when discharging their duty to protect third parties (Slovenko, 1988).

Mental health professionals expressed concerns that, in light of legal rulings such as Tarasoff, confidentiality in the therapeutic relationship would continue to buckle under the pressure of legal mandates. Opponents of the duty to warn argued that without absolute confidentiality in the therapeutic situation, potential clients may not risk obtaining the help they need (DeKraai & Sales, 1982; Melella et al., 1987). Furthermore, Steere (1984) discussed the negative effects of breaching therapist-client confidentiality when warning a potential victim was involved. Steere contended that in cases in which the client decided not to carry out the intended threat, the breach of confidentiality may result in a loss of trust in the therapeutic relationship leading to the client terminating a potentially beneficial therapeutic process. Steere concluded, "The inability to help such people in therapy would in fact make them potentially more dangerous to society" (p. 78). Hence, the duty to warn has been attacked as the least desirable alternative in protecting third parties from harm (Hammond, 1980). Leong et al. (1992) also noted that from a clinical standpoint, no research has demonstrated that the duty to protect, as implemented by a warning to the potential victim or the police, actually serves its intended purpose.
A dissenting opinion in the Tarasoff case should also be noted. Justice William Clark argued that the ruling would inhibit people from seeking necessary psychiatric care and would interfere with therapy by restraining clients from making the revelations necessary for effective therapy, thus damaging the bond of trust upon which therapeutic relationships are based (Reiser, Bursztajn, Appelbaum, & Gutheil, 1987).

Today, these same issues remain at the heart of the AIDS controversy. Confusion regarding the duty to protect third parties continues to proliferate in the mental health and medical communities (Costa & Altekruse, 1994; Ensor, 1988; Harding et al., 1993; Morrison, 1989). In addition, the consequences of professionals’ actions continue to be of paramount importance considering the fact that transmission of HIV-infection represents a danger to not only health, but life itself (Hirsh, 1990).

**Right to Confidentiality Versus Duty to Protect**

The lack of consensus in the literature surrounding the issue of duty to protect in HIV-related cases also illustrates the prevailing confusion this issue generates. Moreover, considering the complexity of HIV-related issues, it is not surprising that cogent arguments exist for maintaining a client’s right to privacy and confidentiality as well as protecting third parties from the foreseeable harm. Unfortunately, these arguments do not make the professional’s decision any less ambiguous.
Opponents of the duty to warn caution that disclosure of a patient's HIV status to third parties threatens the trust requisite for open communication and jeopardizes the integrity of the professional-patient relationship. Although third party notification may save lives in the short run, a loss of trust between professional and patient could deter persons from voluntary testing resulting in more HIV transmission and deaths in the long run (Turkington, 1989).

Kain (1988), Ross and Rosser (1988), and Hoffman (1991) also warned that seropositive clients enter counseling already having experienced the stigma associated with AIDS. Therefore, consequent to learning the limits of confidentiality, it would seem unlikely that these clients would speak freely about their antibody status or high-risk behaviors knowing such disclosures could result in even further stigmatization. Thus, by clients failing to disclose their condition, the disease may spread even faster (Kermani & Weiss, 1989). Hermann and Gagliano (1989) also pointed out that therapists may be hesitant to explore high risk behaviors posing danger to third parties if such exploration may lead to legal liability for their failure to warn those parties.

An additional argument for maintaining client confidentiality involves the devastating consequences of AIDS-related discrimination (Reamer, 1988; Richardson, 1988; Sanders, 1988; Werth, 1993). Those individuals bearing the stigma of AIDS have frequently been denied entry into schools, churches, and apartments; have been fired or forced to resign from their jobs; and have been refused insurance and adequate health care including emergency medical
treatment, simply because members of society fear them (Begg, 1989; Brandt, 1988; Bruhn, 1989; Chambers, 1992; Edmondson, 1992; Hermann, 1991; Mersky, 1989; Schoeman, 1991). The AIDS Task Force of the New York City Chapter of NASW (1986) stated that, due to the stigma attached to having the disease, there has been an erosion of fundamental human and civil rights of all people with AIDS-related illnesses. In addition, Ensor (1988) and Weiss (1989) noted that loss of reputation and destruction of relationships with family members and friends can be negative consequences of disclosure. North and Rothenberg (1993) also contended that due to the connection between domestic violence, drug abuse, and AIDS, women who have tested positive for HIV may be at risk of physical harm if their partners are informed that they have been exposed to possible infection.

In rebuttal to these arguments, advocates of the duty to warn assert that when the lives of third parties are in danger, failure to disclose cannot be justified on any basis including possible negative effects to the patient (Spillane, 1990). The possibility that an HIV positive individual may experience discrimination must be weighed against the significant risk that an unwarned individual may become infected and ultimately die (Erickson, 1993; Piorkowski, 1987). Considering the life threatening consequences of contracting HIV, Dickens (1988b) contended that breaching a client's confidentiality can be justified, and endangered third parties can be warned even without the client's consent.
Hirsh (1990) also contended that failure to advise third parties of foreseeable harm leaves professionals open to liability. While informing third parties of potential risk conflicts with the patient’s right to confidentiality, to not take action and allow an unknowing person to become infected with a deadly disease is unacceptable. Furthermore, the Presidential Commission on the Human Immunodeficiency Virus Epidemic stated:

In instances where a health care provider knows that an infected patient has refused to inform a sexual partner and continues to practice behaviors that place that person at risk of contracting HIV, stringent confidentiality should not be a bar to the health care provider’s ability to warn the unsuspecting sexual partner. (Eth, 1988, p. 574)

Although confidentiality is a venerated value in the medical and mental health professions, it is not an absolute legal right. These professionals have an obligation to protect the welfare of third parties in danger as well as the interests of individual patients (Gray & Harding, 1988; Kleinman, 1991; Talbot, 1988; Zonana, 1989).

An issue has also been raised as to the advantage of warning third parties who have engaged in sexual relations with an HIV-infected partner and have therefore already been exposed to the virus (Kermani & Weiss, 1989). Under these circumstances, Price (1990) suggested that notification would have little preventive effect, since many of these persons may have already contracted the virus, and because as of yet there is still no cure. Although this
is an argument posed against the duty to warn, Spillane (1990) stated that simply because individuals have been exposed to the virus, it cannot automatically be assumed that they have been infected. Even repeated exposure to the virus does not guarantee that a person will contract the infection.

Hearst and Hulley (1988) estimated that a single instance of penile-vaginal intercourse with an HIV-positive partner using a condom, has a 1-in-5,000 risk of infection, but 500 such instances have a 1-in-11 risk. Without using a condom, a single instance of penile-vaginal intercourse has an increased risk of 1-in-500, but 500 such encounters carry a 2-in-3 risk. Therefore, since condoms do not assure "safe sex," and it is impossible to determine when someone might become infected, the best protection comes from an informed partner who is aware of the risks (Kaplan, Sager, & Schiavi, 1985; Knapp & VandeCreek, 1990). Spillane (1990) contended that ultimately, disclosure safeguards individuals' rights by allowing them to make important choices, including whether to continue to engage in sexual relations with an individual who has tested positive for HIV. Even exposed individuals who have already contracted the virus have the right to make informed decisions about important issues such as pregnancy. In essence, it is argued that disclosure protects individuals' rights and would help minimize the spread of the disease by uninformed third parties.
One additional issue involves the application of the Tarasoff ruling to the professional's duty to protect in AIDS-related cases. Knapp and VandeCreek (1990) pointed out that, interestingly, the court's decision was based on previous cases involving the duty of physicians to warn third parties about their potential of contracting contagious diseases. In cases such as Davis v. Rodman (1921), Simonsen v. Swenson (1920), Skillings v. Allen (1919), and Wojcik v. Aluminum Company of America (1959), courts held that physicians had a duty to protect others when patients who had contagious diseases posed harm to others. Knapp and Vandecreek concluded:

Consequently, the application of the duty to protect cases involving HIV is not so much an extension of Tarasoff. Rather, Tarasoff is an extension of a long legal tradition dealing with the duty to warn third persons of infectious diseases. (p. 162)

In conclusion, although individuals who have tested positive for HIV are in a better position than physicians or therapists to warn third parties of potential risks (Piorkowski, 1987), sometimes they choose not to do so. As Hoffman (1991) stated, "Dishonesty to sexual partners regarding one's sexual history and infectious state appears to be common" (p. 529). When presented with this situation, health professionals are forced to choose between competing values of confidentiality and the welfare of others (Erickson, 1993). Each alternative has strong merit yet potentially severe negative consequences, which leaves physicians and therapists facing an extraordinary predicament.
Related Research

The literature has addressed very few research studies exploring the application of duty to protect to HIV-related situations in psychotherapy and medical practice. However, one reported study, conducted by Totten et al. (1990), investigated whether therapists employed two Tarasoff factors, dangerousness and identifiability of the victim, when deciding whether to breach confidentiality in AIDS-related psychotherapy situations. Subjects were randomly assigned to receive one of four hypothetical scenarios involving either a prostitute, IV drug user, homosexual, or bisexual client who has tested HIV positive. Within the scenario condition received, subjects were asked to review four cases in which degree of dangerousness (high vs. low) and identifiability of the victim (high vs. low) were systematically varied. Subjects were then asked to rate their likelihood of breaching confidentiality on a 7-point scale. A total of 241 questionnaires (24% of the total mailing) had usable data. Results indicated that therapists considered both factors, dangerousness and identifiability of victim, when deciding whether or not to breach confidentiality. However, degree of dangerousness was determined to be significantly more important than the identifiability of the victim.

An additional finding in this research study revealed that therapists who had experience with AIDS patients in psychotherapy were less likely to breach confidentiality than those without similar experience. Although the researchers admitted that the results do not provide much information to explain this
finding, they suggested that it is possible that those therapists who have already confronted an AIDS-related confidentiality dilemma may have successfully resolved the situation by utilizing strategies other than breaching confidentiality (Totten et al., 1990).

In addition, Silverman (1993) investigated whether registered members of the National Association of Social Workers in California would maintain client confidentiality or discharge their duty to warn when working with clients who tested positive for HIV and chose not to reveal their status to identifiable third parties. Regarding this issue, subjects were asked to rate eight statements on a 5-point Likert scale from strongly agree to strongly disagree. A total of 99 questionnaires (33% of the total mailing) was returned. Overall, 61% of the respondents either agreed or strongly agreed that it was their duty and professional responsibility to warn identified victims when the threat of HIV was established. Only 16% of subjects agreed that a client's HIV status should remain confidential regardless of the threat of exposure to a partner. Furthermore, 67% of respondents agreed that the current California ethical code of "Tarasoffing" should include notifying the partner in HIV-related situations, and 88% of subjects indicated it would be of professional help for the National Association of Social Workers (NASW) to specify a procedure to follow when working with HIV positive clients who refuse to disclose their status to identifiable at-risk third parties.
Georgianna (1992) conducted a research study to investigate the gay and lesbian community's view regarding a therapist breaching confidentiality to warn a third party about possible exposure to HIV. A total of 498 subjects were surveyed, and 89% of the respondents identified themselves as gay, lesbian or bisexual.

Overall, results of this study indicated that respondents viewed a therapist breaching confidentiality to warn a third party of possible exposure to HIV as unacceptable. Specifically, 80% of respondents reported that they would not disclose a client's diagnosis to the partner if they were the therapist, and 76% reported they would not recommend disclosure if someone else ("Other") was the therapist. In addition, the older, the more highly educated, and the greater number of seropositive individuals the respondents knew, the less likely they were to favor disclosure. Significantly, 61% of the respondents reported that they would initiate a lawsuit against their therapist if he or she breached confidentiality and disclosed their HIV status to their partner without their permission. Furthermore, 60% of respondents indicated they did not believe it was necessary for a law to be established to assist therapists in deciding when it may be appropriate to breach confidentiality and warn a partner of a client's HIV status; 58% did not favor individuals who have tested HIV positive being required by law to disclose their status to their partners; 75% did not favor therapists being required by law to warn a partner of their client's HIV status; and 58% indicated that they did not believe therapists
should have a choice of whether or not to warn a partner of the client’s HIV status. Georgianna (1992) concluded that these results are in direct conflict with current guidelines promulgated by the American Medical Association, the American Psychological Association, and the opinions of many practicing psychotherapists as documented in the current professional literature.

**Ethical Codes**

Keith-Spiegel and Koocher (1985) defined ethical codes as “principles specifying the rights and responsibilities of professionals in their relationships with each other and with the people they serve, as well as stating prescriptive, normative values reflecting the consensus of the profession” (p. 2). In essence, ethical codes are a set of guidelines that provide directions for conduct. Practitioners routinely refer to the ethical codes of their prospective professions when ethical dilemmas arise in professional activity. Thus, a review of the ethical codes pertaining to therapists and physicians is warranted when attempting to reconcile a professional’s duty to maintain confidentiality with the duty to protect. Regarding how to balance these duties, Zonana (1989) stated, “Professional organizations have a responsibility to reduce arbitrariness and idiosyncratic ethical decision making by providing guidelines about how to balance these obligations” (p. 164).

Addressing the ethical duty of therapists to maintain client confidentiality, the Association for Counseling and Development (AACD) *Ethical Standards* (1988) state: “The counseling relationship and information resulting therefrom
must be kept confidential, consistent with the obligations of the member as a professional person" (Section B.2).

The roots of the medical profession's obligation to protect patient confidentiality can be traced back prior to fourth century B.C. when the Hippocratic oath was first acknowledged. "The oath provided that everything learned by a physician during the course of a professional relationship with a patient that 'should not be published abroad' must remain confidential. This ethical standard is still in force today" (Weiss, 1989, p. 286). Furthermore, Principle IV of the Medical Ethics of the American Medical Association states, "A physician shall respect the rights of patients, of colleagues, and of other health professionals, and shall safeguard patient's confidences within the constraints of the law" (Hirsh, 1990, p. 28).

In conflict with the standard to protect client confidentiality, ethical codes also exist which mandate breaching confidentiality in certain circumstances. The AACD Ethical Standards (1988) state:

When the client's condition indicates that there is clear and imminent danger to the client or others, the member must take reasonable personal action or inform responsible authorities. Consultation with other professionals must be used where possible. The assumption of responsibility for the client's(s') behavior must be taken only after careful deliberation. The client must be involved in the resumption of responsibility as quickly as possible. (Section B.4)
Physicians also have an ethical responsibility to protect third parties who are at foreseeable risk of harm from their patients, and therefore, confidentiality is not absolute. A physician is allowed to reveal confidences if required to do so by law or if this action is necessary to protect the welfare of an individual or the community (Edmondson, 1992). The Judicial Council of the American Medical Association cited in McDonald (1989) stated:

The obligation to safeguard the patient's confidences is subject to certain exceptions which are ethically and legally justified because of overriding social considerations. When a patient threatens to employ serious bodily harm to another person, and there is a reasonable probability that the patient may carry out the threat, the physician should take reasonable precautions for the protection of the intended victim, including notification of law enforcement authorities. (p. 588)

Specifically related to AIDS issues, the AACD Governing Council approved a three-page position statement. This position statement very briefly addresses the issue of confidentiality as it relates to AIDS by directing members to: "Understand the ethical and legal issues raised by the AIDS epidemic and develop a framework for ethical decision-making, especially as it relates to issues of client confidentiality" (American Association for Counseling and Development, 1989, p. 28). As Harding et al. (1993) pointed out, this position statement asks members to develop a personal framework for ethical decision-making and fails to make clear ACA's priorities or provide the
practitioner with practical guidelines for the development of these decision making frameworks. Furthermore, Costa and Altekruse (1994) also acknowledged that the AACD Ethical Standards omit specific guidelines on therapists’ duty to warn responsibilities.

In contrast, the American Medical Association (AMA) Council on Ethical and Judicial Affairs (1988) addressed the ethical conflict between maintaining confidentiality and protecting third parties in HIV-related situations by providing the following guidelines for physicians:

Where there is no statute that mandates or prohibits the reporting of seropositive individuals to public health authorities and a physician knows that a seropositive individual is endangering a third party, the physician should (1) attempt to persuade the infected patient to cease endangering the third party; (2) if persuasion fails, notify authorities; and (3) if the authorities take no action, notify the endangered third party. (p. 1361)

However, the AMA statement, attributing equal significance to state statutes that mandate as well as prohibit the reporting of seropositive individuals endangering third parties, reflects the prevailing confusion. The question involving how a physician is to monitor whether or not the authorities have actually taken action regarding the physician’s report also remains unanswered (Price, 1990). McDonald (1989) contended that physicians treating patients who have tested positive for HIV and place third parties at risk
are forced to choose which course of action, disclosure or maintaining confidentiality, carries a greater likelihood of being sued.

It is also important to note that the AMA recommended the enactment of specific statutes which, while protecting patient confidentiality to the greatest possible extent,

(a) provide a method for warning unsuspecting sexual partners, (b) protect physicians from liability for failure to warn the unsuspecting third party but, (c) establish clear standards for when a physician should inform the public health authorities, and (d) provide clear guidelines for public health authorities who need to trace the unsuspecting sexual partners of the infected person. (AMA Council on Ethical and Judicial Affairs, 1988, p. 1361)

State Statutes

In addition to ethical guidelines, therapists and physicians look to the law for clarification of their obligations and restrictions in protecting endangered third parties (Harding et al., 1993). Laws frequently change and, therefore, incumbent upon practitioners is the responsibility to become completely familiar with the legal status of confidentiality in their particular jurisdiction (Berger, 1982; Costa & Altekruse, 1994; Silverman, 1993). In addition, these laws vary widely from state to state (Clark, 1991; Friedman & Hughes, 1994; Reamer, 1991b). Hence, to narrow the scope for the purposes
of this study, laws pertinent to therapists and physicians in the state of Texas will be examined.

The Texas Health and Safety Code, Title 7, Section 611.004 (1992) delineates the exceptions to the therapist-client privilege of confidentiality. In reference to danger posed to third parties, disclosure of confidential information is limited:

- to medical or law enforcement personnel if the professional determines that there is a probability of imminent physical injury by the patient to the patient or others or there is a probability of immediate mental or emotional injury to the patient. (p. 748)

This statute (Texas Health and Safety Code, Title 7, Section 611.004, 1992) was originally passed by the state legislature in 1979 as the Confidentiality of Mental Health Information of Individual Act (West, 1979). Shortly thereafter, some commentators surmised that by authorizing disclosure to medical and law personnel, rather than to potential victims, the statute appears to circumscribe the therapist's duty to warn (Green, 1980). Conversely, other commentators contended that it remains unclear if a literal reading of the statute would preclude mental health professionals from warning third parties (Hammond, 1980). As Costa and Altekruse (1994) stated, "This statute may actually prevent intended victims from being warned. These situations create confusion for mental health professionals who find their ethical codes and state laws at odds" (p. 346). Thus, for therapists in Texas, a double
bind exists when deciding whether to breach confidentiality and warn the victim, or risk being sued for negligence in failing to protect the potential victim (Hughes & Friedman, 1994). Furthermore, Hartsell and Bernstein (1994) advised that when a client potentially presents a danger to self or other, "the professional would be well advised to call the licensing board, the malpractice carrier and a lawyer. Professional advice should be received and digested before taking action of any type" (p. 4).

Hirsh (1990) also warned that case law suggests that the duty to warn cannot be satisfied by simply warning public health authorities. Hermann and Gagliano (1989) supported this contention and suggested that it seemed doubtful that ethical therapists would consider their duty to be satisfied by merely notifying health authorities. In summary, "Until legislation addressing these vital issues is promulgated, therapists facing this dilemma must depend on their ethical consciences to determine which course to follow" (Hermann & Gagliano, 1989, p. 76).

In the state of Texas, "health professionals" have an obligation to abide by state statutes which specifically address the confidentiality of test results for Acquired Immune Deficiency Syndrome and related disorders. Understanding the legal definition of both "health professional" and "test result" is of critical importance. "Health professional" is broadly defined as an individual whose:

(A) vocation or profession is directly or indirectly related to the maintenance of the health of another individual or animal; and
(B) duties require a specific amount of formal education and may require a special examination, certificate or license, or membership in a regional or national association. (Texas Health and Safety Code, Title 2, Section 81.003, 1992, p. 173)

Significantly, authors in the literature have commonly discussed statutes in this Act as if they were applicable only to physicians. However, based on how "health professional" is defined in the Act, it may be interpreted that the statutes apply to mental health professionals as well. Therefore, although physicians may take action in accordance with this Act, it remains unclear whether mental health professionals are even aware that these statutes may apply to them and thus, require them to act accordingly.

"Test result" is defined in the Act as:

any statement that indicates that an identifiable individual has or has not been tested for AIDS or HIV infection, antibodies to HIV, or infection with any other probable causative agent for AIDS, including a statement or assertion that the individual is positive, negative, at risk, or has or does not have a certain level of antigen or antibody. (Texas Health and Safety Code, Title 2, Section 81.102, 1992, p. 203)

The Texas Health and Safety Code, Title 2, Section 81.103 (1992) states, "A test result is confidential. A person that possesses or has knowledge of a test result may not release or disclose the test result or allow the test result to become known except as provided for by this section" (p. 205). The following
exceptions, provided for by this section, allow test results to be disclosed to:
(a) the Department of Health or local health authority under this chapter; (b) the Centers for Disease Control of the United States Public Health Service if reporting is required by federal law; (c) the physician or authorized person who ordered the test; (d) health care personnel who have a legitimate need to know the test result to provide for protection for themselves or the patient; (e) the person tested or a person legally authorized to give consent on the person's behalf; and (f) "the spouse of the person tested if the person tests positive for AIDS or HIV infection, antibodies to HIV, or infection with any other probable causative agent of AIDS" (Texas Health and Safety Code, Title 2, Section 81.103, 1992, p. 206).

As Hughes and Friedman (1994) summarized, this statute allows the release of HIV test result information to a spouse of the person tested by any person possessing the test result or having knowledge of the result. Therefore, it appears that mental health professionals, in addition to physicians, who have knowledge of the test result, may disclose the information to the spouse of the person tested. However, disclosure of the result may only be made to the spouse and not to any other partner. In fact, in Texas, unauthorized disclosure of HIV test results is a Class A misdemeanor. In addition to criminal charges, the person whose confidentiality is breached may also sue the individual for civil damages.
Moreover, the Texas statute permits the health professional to inform the spouse, yet it does not impose a duty to do so. Therefore, if the health professional decides not to breach confidentiality and inform the spouse of the test result, it appears that the professional could face a Tarasoff-type lawsuit (Hughes & Friedman, 1994).

Although this statute (Texas Health and Safety Code, Title 2, Section 81.103, 1992) refers to the confidentiality and exceptions to confidentiality of test results, it does not specifically address the issue of duty to protect. However, related articles in the literature have applied these exceptions in the Texas statute to Tarasoff and the duty to protect in AIDS-related cases. As Edwards (1989) stated, the Act neither addresses what health professionals must do when an HIV positive patient endangers third persons other than the spouse, nor the fact that a common law cause of action may exist in favor of a third party based on the Tarasoff ruling.

Furthermore, Piorkowski (1987) contended that case law supports the physician’s duty to warn third parties about the risk of HIV-infection. If the physician’s failure to warn was determined to be the proximate cause of the injury, then potential liability could exist and subsequently, damages be awarded. Moreover, Hirsh (1990) boldly asserted:

A physician’s freedom to inform others of a patient’s HIV status is complicated in states that have laws barring physicians from revealing a patient’s HIV status to anyone other than a spouse. But if what is
correct medically, morally, and reasonably outweighs what a state
legislature has ruled, then the physician may have to break the law.

Without question, physicians have the option to breach confidentiality to
protect the public. (p. 5)

In conclusion, despite outward appearances, state statutes addressing
the issues of confidentiality and duty to protect may not remove all doubts
concerning legal liability for disclosures or failures to disclose (Price, 1990).
Considering this high risk of potential liability and the lack of clear guidelines
provided by ethical standards and state statutes, Harding et al. (1993)
described the mental health professional's dilemma as "acute" (p. 300).

Summary

Every 17 minutes another American dies from AIDS. Presently, it is
estimated that 1 in every 100 men and 1 in every 800 women is HIV positive
(Centers for Disease Control [CDC], 1994). As the epidemic continues to
expand, therapists as well as physicians will be called on as service providers
to face the challenge of caring for those affected (Barret, 1989; Green &
Bobele, 1994; Hughes & Friedman, 1994; Robinson, 1994). Conceivably,
however, with the looming threat of potential liability and no clear consensus
on appropriate courses of action, increasing numbers of therapists and
physicians may hesitate to treat individuals with AIDS-related illnesses.
Therefore, those victimized by AIDS become victimized again, by the very
professionals who have the potential to help them the most. Pertinent research
is needed to determine what course of action therapists and physicians would choose to take when facing this dilemma, so that professional organizations and state legislatures can meet the challenge of providing clearer guidelines for the ethical and compassionate treatment of those suffering from AIDS-related illnesses.
CHAPTER 2

PROCEDURES

This chapter presents the purpose of the study, definition of terms, limitations, research questions, selection of subjects, demographic summary, instrumentation, collection of data, and procedures for analysis of data.

Purpose of the Study

This study utilized a written questionnaire to explore: (a) what course of action licensed professional counselors (hereafter referred to as therapists) and physicians in the state of Texas select when presented with four hypothetical scenarios in which a client who has tested positive for HIV poses harm to an identifiable third party; (b) whether uniformity exists in the course of action selected by members within each professional group as well as between professional groups; (c) what specific resources therapists and physicians report they would utilize, and what specific factors they consider most important when deciding whether or not to disclose a client’s HIV status to an at-risk third party; (d) how therapists recommend that state statutes be revised concerning their professional responsibilities when clients who have tested HIV positive continue to endanger identifiable third parties; and (e) how therapists
recommend the ACA Ethical Standards be revised to address issues related to confidentiality and the duty to protect in HIV-related cases.

Definition of Terms

**AIDS** is the acronym used to denote the Acquired Immune Deficiency Syndrome. AIDS is the late stage of an infection caused by the Human Immunodeficiency Virus (Bartlett & Finkbeiner, 1991). A diagnosis of AIDS is based on the presence of certain symptoms and opportunistic infections which indicate that the body's immune system has been rendered wholly or partially disabled by the HIV infection (Price, 1990).

**HIV** is the acronym for the Human Immunodeficiency Virus, previously called HTLV-III. Scientific authorities presently contend that HIV is the sole causative agent of AIDS (Bartlett & Finkbeiner, 1991).

**HIV status** refers to whether an individual has tested positive or negative for HIV.

**HIV positive** refers to the presence of antibodies in the bloodstream that the body has produced in response to HIV infection. The terms HIV positive and seropositive are used synonymously (Wood et al., 1990).

**Opportunistic infections** are illnesses which threaten individuals whose immune systems are no longer functioning normally (Baumgartner, 1985; Masi, 1990).
Asymptomatic refers to the absence of symptoms. An asymptomatic individual feels healthy (Bartlett & Finkbeiner, 1991).

Safer sex refers to sexual behaviors which reduce the risk of HIV transmission, such as utilizing condoms to prevent the exchange of bodily fluids (Hopp & Rogers, 1989).

Duty to Warn refers to the 1974 Tarasoff decision in which the Supreme Court of California ruled that psychotherapists have a duty to warn the intended victim, or other individuals likely to have contact with the victim, when the professional determines, or should determine, that such action is necessary to avert foreseeable danger (Lamb et al., 1989).

Duty to Protect refers to the 1976 Tarasoff decision in which the Supreme Court of California again heard the case on final appeal. The duty to warn was upheld by the court and broadened to duty to protect (Lamb et al., 1989). The court ruled that psychotherapists incur an obligation to use reasonable care to protect intended victims from foreseeable danger posed by their clients. The court stated that this duty may be discharged by taking one or more of several steps, including warning the intended victim, notifying the police, or taking any other steps reasonable under the circumstances (Tarasoff v. Regents of California, 1976).

Privacy refers to the freedom of individuals to determine the extent and circumstances under which their thoughts, feelings, behavior, opinions, and personal data are to be shared with others (VanHoose & Kottler, 1985).
Privacy is considered a basic right granted by the Fourth Amendment of the United States Constitution (Keith-Spiegel & Koocher, 1985; Thompson, 1983).

Confidentiality originates in professional codes of ethics and "indicates an explicit promise or contract to reveal nothing about an individual except under conditions agreed to by the source or subject" (Siegel, 1979, p. 251).

Privileged communication refers to the legal right which exists by state statute that protects clients from having their confidential communications revealed during legal proceedings without their permission. Privileged communication is a legal term that is narrower in scope than confidentiality (Herlihy & Sheeley, 1985; Shah, 1969).

Licensed Professional Counselor refers to an individual licensed as a professional counselor by the Texas State Board of Examiners of Professional Counselors.

Limitations

Considering the controversial and sensitive nature of the HIV-related issues explored in this survey, a social desirability bias could have occurred. Therapists and physicians may have responded based on how they think they "should" respond rather than how they would actually respond. Conversely, since subjects were asked to anticipate how they would respond to a situation they may have not yet encountered, their responses could be based on what they would prefer to do, based on their own moral convictions and beliefs,
rather than what they would actually do if they chose to seek consultation and legal advice.

Utilizing survey research methodology assumes the limitation that participants' responses may vary from participants who chose not to respond. However, the response rate achieved in this study augmented the statistical probability of a representative sample.

This study was also delimited to the state of Texas. Selection criteria required physicians to be licensed by the Texas State Board of Medical Examiners and be board certified in Internal Medicine. Therapists were required to be licensed by the Texas State Board of Examiners of Professional Counselors and be a member of the Texas Counseling Association (TCA). In addition, subjects in the therapist sample were also required to be a divisional member, within TCA, of the Texas Mental Health Counselors Association, the Texas Association for Counselor Education and Supervision, or the Texas Association of Marriage and Family Counselors. Therefore, the results of this study are not generalizable to all physicians and therapists in the state of Texas.

Research Questions

Due to the exploratory nature of this study, the following research questions were developed.
1. What course of action do therapists report they would take when presented with four hypothetical scenarios in which an HIV positive client poses harm to an identifiable third party?
   a. What percentage of therapists would choose to maintain client confidentiality?
   b. What percentage of therapists would choose to inform an endangered spouse?
   c. What percentage of therapists would choose to inform an endangered partner who is not a spouse?
   d. What percentage of therapists would choose to notify medical or law enforcement personnel?

2. To what extent do therapists' responses reflect agreement on the most appropriate course of action for each of the scenarios presented?

3. Do therapists select an internally consistent course of action when responding to the four scenarios (i.e., is their response the same for Scenarios "A," "B," "C," and "D")?

4. What course of action do physicians report they would take when presented with four hypothetical scenarios in which an HIV positive client poses harm to an identifiable third party?
   a. What percentage of physicians would choose to maintain patient confidentiality?
b. What percentage of physicians would choose to inform an endangered spouse?

c. What percentage of physicians would choose to inform an endangered partner who is not a spouse?

d. What percentage of physicians would choose to notify medical or law enforcement personnel?

5. To what extent do physicians' responses reflect agreement on the most appropriate course of action for each of the scenarios presented?

6. Do physicians select an internally consistent course of action when responding to the four scenarios (i.e., is their response the same for Scenarios "A," "B," "C," and "D")?

7. Does a significant difference exist between the course of action selected by therapists and the course of action selected by physicians in relation to the four scenarios presented?

8. What specific resources do therapists and physicians report they would utilize, and consider most important, when deciding whether or not to breach confidentiality and disclose a client's HIV status to an uninformed, identifiable third party (e.g., review relevant professional literature, consult with colleagues, consult with an attorney, review ethical standards, review state statutes, or others)?

9. What specific factors do therapists and physicians report they would consider most important before deciding to breach confidentiality in such a
case (e.g., degree of dangerousness that the client poses to a third party, identifiability of the third party, ethical considerations, legal issues, effects on the therapeutic relationship, or others)?

10. What percentage of therapists and physicians routinely inform patients of the limits of confidentiality at the onset of treatment?

11. Are therapists' knowledgeable of the fact that Texas statutes limit breaching confidentiality to medical or law enforcement personnel when third parties are endangered?

12. Are therapists who have had experience working with clients who have tested positive for HIV more or less likely to breach confidentiality and inform endangered third parties or medical or law enforcement personnel?

13. How would therapists recommend that current state statutes be revised in reference to breaching confidentiality when third parties are endangered in HIV-related cases?

   a. What percentage of therapists would recommend legally mandated confidentiality with immunity from prosecution for not notifying an at-risk third party?

   b. What percentage of therapists would recommend a legally mandated duty to protect which would provide immunity if the therapist acted in good faith and used reasonable care when notifying an endangered third party, but would also place the
therapist at risk for potential liability if the endangered party was not notified?

c. What percentage of therapists would recommend a discretionary duty which would provide immunity if a therapist chose either to breach or not to breach confidentiality to an at-risk third party provided that the therapist acted in good faith and within a reasonable standard of care within the profession?

d. What percentage of therapists would recommend no change in existing state statutes?

14. Considering the issues explored in this questionnaire, what percentage of therapists and physicians report that they would hesitate working with an individual who has tested HIV positive?

15. What specific reasons do therapists and physicians provide regarding why they may hesitate working with individuals who have tested HIV positive?

16. What percentage of therapists believe that the American Counseling Association (ACA) should develop ethical guidelines which specifically address confidentiality and the duty to protect in HIV-related cases?

17. How would therapists recommend that current ACA Ethical Standards be revised to address issues related to confidentiality and the duty to protect in HIV-related cases?
Selection of Subjects

For the purposes of this study, subjects were selected from two professional groups: therapists and physicians. Specific selection criteria were established for each of these sample groups.

Within the therapist sample, subjects were selected based on the following criteria. Each member of the subject pool must (a) be a licensed professional counselor in the state of Texas; (b) be a member of the Texas Counseling Association (TCA); and (c) within TCA, be a divisional member of the Texas Mental Health Counselors Association (TMHCA), the Texas Association for Counselor Education and Supervision (TACES), or the Texas Association of Marriage and Family Counselors (TAMFC).

The TMHCA, TACES, and TAMFC divisions were selected because they include TCA members most likely to confront the issue of duty to protect in HIV-related cases. Specifically, TMHCA works to support the role of therapists in private practice, hospital, business, and agency mental health settings. TMHCA also strives to improve the availability and quality of mental health counseling services through licensure and legislative action. Similarly, TACES emphasizes the need for quality education and supervision of counselors in all work settings. Members of TACES are typically engaged in the professional preparation of counselors or are responsible for supervision of counselors. TAMFC focuses on the issues, interests, and delivery of services within the area of marriage and family therapy.
The Texas State Board of Examiners of Professional Counselors publishes a roster of licensed professional counselors in Texas. In addition, the Texas Counseling Association publishes a directory of current members, which also specifies the divisional membership(s) of each member. Subjects who met the criteria established for this study were selected by cross referencing these publications.

Within the physician sample, subjects were selected based on the following criteria. The members of the subject pool must (a) be licensed by the Texas State Board of Medical Examiners, and (b) be board certified in Internal Medicine. The Internal Medicine specialty was selected for this study because, according to the Texas Department of Health, these physicians have the greatest likelihood of treating patients who have tested positive for HIV. Furthermore, physicians who specialize in Family Practice or General Practice typically refer patients who have contracted HIV to physicians who specialize in Internal Medicine.

The American Board of Medical Specialties (ABMS) publishes the Official ABMS Directory of Board Certified Medical Specialists which includes a list of physicians who are board certified in Internal Medicine in the state of Texas. This publication was utilized to select the subjects who met the aforementioned criteria.

A subject pool of members from the therapist and physician populations who met the criteria stated above comprised the sampling frame. According to
Slavin (1984), the most important principle in sampling is that each member of the population from which the sample is drawn should have an equal probability of being selected. Therefore, a random sampling procedure was utilized. In the therapist and physician sample pools, each subject was assigned a three digit number. A table of random numbers was then utilized to select 200 subjects from each sample pool.

In reference to selecting an appropriate sample size, Hinkle, Wiersma, and Jurs (1988) emphasized the importance of determining the desired level of power of a statistical test before collecting the data. In determining an acceptable level of power, the relationship between level of significance and power must be considered. Typically, for behavioral science studies a 4:1 ratio is recommended. Therefore, if the level of significance is established at .05, then the corresponding power is .80. Although the actual response rate could not be determined {emph}a priori, by selecting a sample size of 200 for this study utilizing Chi Square analysis, the probability of detecting an effect size of \( w = .5 \) would still yield a power of 83% even if the response rate was 40% (Cohen, 1977).

Hence, 200 subjects from each sample pool were mailed a survey instrument. Within the therapist subject group, a total of 150 questionnaires was returned, resulting in a response rate of 75%. Within the physician group, 109 questionnaires were returned, resulting in a response rate of 54.5% (see Table 1). Therefore, utilizing Chi Square analysis, the probability of detecting
an effect size of $w = .5$ yielded a power of 99% for the therapist subject group and 95% for the physician subject group.

Table 1

Response Rate

<table>
<thead>
<tr>
<th>Sample</th>
<th>Total Number of Subjects</th>
<th>Number of Respondents</th>
<th>Response Rate</th>
<th>Power</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapists</td>
<td>200</td>
<td>150</td>
<td>75.0%</td>
<td>99%</td>
</tr>
<tr>
<td>Physicians</td>
<td>200</td>
<td>109</td>
<td>54.5%</td>
<td>95%</td>
</tr>
<tr>
<td><strong>N=400</strong></td>
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<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Demographic Summary

Each subject was requested to complete a background information sheet (see Appendices A & B). A total of 148 therapists and 107 physicians provided the demographic information requested.

Within the therapist sample, 39% (58) of the respondents were male and 61% (90) were female. Within the physician sample, 79% (85) of respondents were male and 21% (22) were female (see Table 2).

Regarding the age of respondents, within the therapist sample, 50% of the subjects were between the ages of 46 and 55; 24% were over 56 years of age; 22% were between ages 36 and 45; and only 5% were ages 25 to 35. Within the physician sample, 50% of the subjects were between the ages of 36 and 45; 28% were ages 46 to 55; 12% were 25 to 35; and the remaining 9% were 56 or older (see Table 3).
Table 2

Gender of Subjects

<table>
<thead>
<tr>
<th>Gender</th>
<th>Therapist Sample</th>
<th>Percent of Total</th>
<th>Physician Sample</th>
<th>Percent of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>58</td>
<td>39%</td>
<td>85</td>
<td>79%</td>
</tr>
<tr>
<td>Female</td>
<td>90</td>
<td>61%</td>
<td>22</td>
<td>21%</td>
</tr>
</tbody>
</table>

Therapists N=148 / Physicians N=107

Table 3

Age of Subjects

<table>
<thead>
<tr>
<th>Age</th>
<th>Therapist Sample</th>
<th>Percent of Total</th>
<th>Physician Sample</th>
<th>Percent of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>25-35</td>
<td>7</td>
<td>5%</td>
<td>13</td>
<td>12%</td>
</tr>
<tr>
<td>36-45</td>
<td>32</td>
<td>22%</td>
<td>54</td>
<td>50%</td>
</tr>
<tr>
<td>46-55</td>
<td>74</td>
<td>50%</td>
<td>30</td>
<td>28%</td>
</tr>
<tr>
<td>56 or older</td>
<td>35</td>
<td>24%</td>
<td>10</td>
<td>9%</td>
</tr>
</tbody>
</table>

Therapists N=148 / Physicians N=107

Within the therapist sample, 60% of respondents held a Master’s degree, and 40% held a Doctoral degree (see Table 4). All physicians were required to have a medical degree, be licensed by the Texas State Board of Medical Examiners, and be board certified in Internal Medicine.

Years of counseling experience in the therapist sample varied considerably. The highest percentage of subjects (28%) reported between 11 and 15 years of professional experience. Years of medical practice was
similarly varied for physicians, with the highest percentage of subjects (27%) reporting 6 to 10 years of practice (see Table 5).

Table 4

Level of Education in Therapist Sample

<table>
<thead>
<tr>
<th>Degree Held</th>
<th>Number of Subjects</th>
<th>Percent of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Master's Degree</td>
<td>89</td>
<td>60%</td>
</tr>
<tr>
<td>Doctoral Degree</td>
<td>59</td>
<td>40%</td>
</tr>
</tbody>
</table>

N=148

Table 5

Years of Professional Experience

<table>
<thead>
<tr>
<th>Experience</th>
<th>Therapist Sample</th>
<th>Percent of Total</th>
<th>Physician Sample</th>
<th>Percent of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 years or less</td>
<td>12</td>
<td>8%</td>
<td>13</td>
<td>12%</td>
</tr>
<tr>
<td>6-10 years</td>
<td>27</td>
<td>19%</td>
<td>29</td>
<td>27%</td>
</tr>
<tr>
<td>11-15 years</td>
<td>40</td>
<td>28%</td>
<td>24</td>
<td>22%</td>
</tr>
<tr>
<td>16-20 years</td>
<td>35</td>
<td>24%</td>
<td>18</td>
<td>17%</td>
</tr>
<tr>
<td>21-25 years</td>
<td>15</td>
<td>10%</td>
<td>13</td>
<td>12%</td>
</tr>
<tr>
<td>26+ years</td>
<td>16</td>
<td>11%</td>
<td>10</td>
<td>9%</td>
</tr>
</tbody>
</table>

Therapists N=145 / Physicians N=107
Within the therapist sample, 76% of subjects earned their highest degree between 1970 and 1989. Similarly, 74% of physicians earned their medical degree between these same years (see Table 6).

Table 6

<table>
<thead>
<tr>
<th>Year Highest Degree Earned</th>
<th>Therapist Sample</th>
<th>Percent of Total</th>
<th>Physician Sample</th>
<th>Percent of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1990-94</td>
<td>20</td>
<td>15%</td>
<td>2</td>
<td>2%</td>
</tr>
<tr>
<td>1980-89</td>
<td>60</td>
<td>43%</td>
<td>37</td>
<td>37%</td>
</tr>
<tr>
<td>1970-79</td>
<td>46</td>
<td>33%</td>
<td>37</td>
<td>37%</td>
</tr>
<tr>
<td>1960-69</td>
<td>8</td>
<td>6%</td>
<td>18</td>
<td>18%</td>
</tr>
<tr>
<td>Before 1960</td>
<td>4</td>
<td>3%</td>
<td>7</td>
<td>7%</td>
</tr>
</tbody>
</table>

Therapists N=138 / Physicians N=101

Within both the therapist and physician samples, over 50% of the respondents reported that their primary work setting was private practice. The remaining therapists reported working in agencies, universities, schools, and hospitals. The remaining physicians were employed in universities, hospitals, clinics, and military and government installations (see Table 7).

Only 54% of responding therapists reported that they had ever received information related to the issue of HIV and the duty to protect third parties, while 46% had never received any information on the subject. Within the physician sample, only 35% of respondents reported having received
information on HIV and the duty to protect, while 65% reported they had never received any information regarding this issue (see Table 8).

Table 7

<table>
<thead>
<tr>
<th>Work Setting</th>
<th>Therapist Sample</th>
<th>Percent of Total</th>
<th>Physician Sample</th>
<th>Percent of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private Practice</td>
<td>116</td>
<td>58%</td>
<td>63</td>
<td>54%</td>
</tr>
<tr>
<td>Agency</td>
<td>14</td>
<td>7%</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>University</td>
<td>24</td>
<td>12%</td>
<td>25</td>
<td>21%</td>
</tr>
<tr>
<td>School</td>
<td>29</td>
<td>15%</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Hospital</td>
<td>11</td>
<td>6%</td>
<td>17</td>
<td>15%</td>
</tr>
<tr>
<td>Clinic</td>
<td>---</td>
<td>---</td>
<td>8</td>
<td>6%</td>
</tr>
<tr>
<td>Other</td>
<td>6</td>
<td>3%</td>
<td>4</td>
<td>3%</td>
</tr>
</tbody>
</table>

Therapists N=200 / Physicians N=117

Table 8

<table>
<thead>
<tr>
<th>Received Information</th>
<th>Therapist Sample</th>
<th>Percent of Total</th>
<th>Physician Sample</th>
<th>Percent of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>80</td>
<td>54%</td>
<td>37</td>
<td>35%</td>
</tr>
<tr>
<td>No</td>
<td>68</td>
<td>46%</td>
<td>70</td>
<td>65%</td>
</tr>
</tbody>
</table>

Therapists N=148 / Physicians N=107
The two most frequently cited sources of information related to HIV and duty to protect, received by therapists, were conferences and books or articles. Interestingly, for physicians, the two most frequently cited sources for this information were books or articles and professional organizations (see Table 9).

Table 9

Sources of Information Received on HIV and Duty to Protect

<table>
<thead>
<tr>
<th>Source</th>
<th>Therapist Sample</th>
<th>Percent of Total</th>
<th>Physician Sample</th>
<th>Percent of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Course work</td>
<td>18</td>
<td>10%</td>
<td>7</td>
<td>11%</td>
</tr>
<tr>
<td>Books or Articles</td>
<td>45</td>
<td>26%</td>
<td>22</td>
<td>34%</td>
</tr>
<tr>
<td>Conferences</td>
<td>58</td>
<td>34%</td>
<td>10</td>
<td>16%</td>
</tr>
<tr>
<td>Professional Organizations</td>
<td>32</td>
<td>19%</td>
<td>20</td>
<td>31%</td>
</tr>
<tr>
<td>Other</td>
<td>19</td>
<td>11%</td>
<td>5</td>
<td>8%</td>
</tr>
</tbody>
</table>

Therapists N=172 / Physicians N=64

Instrumentation

A written questionnaire was developed by the researcher to explore the research questions formulated for this study (see Appendices A & B). The initial section of the questionnaire consisted of four hypothetical scenarios. The number of scenarios were limited to four in order to secure the desired information while keeping the survey brief enough to increase response rate. The content of each scenario was derived from the AIDS primary exposure
categories delineated in the HIV/AIDS Surveillance Report (Centers for Disease Control [CDC], 1994). According to the CDC, 53% of persons with AIDS were exposed to HIV by male homosexual contact; 25% by I.V. drug use; 6% by male homosexual contact and I.V. drug use combined; 7% by heterosexual contact; 2% by blood transfusions; 1% by hemophilia/coagulation disorder; and 6% by undetermined contact. Hence, the scenarios developed for this study reflected the primary means in which HIV is transmitted.

In the survey instrument, Scenario "A" involved a married client (or patient) who tested positive for HIV and continued to engage in unprotected sex with his spouse. Despite encouragement from the therapist (or physician) to disclose his HIV status to his spouse, the client refused to do so. Scenario "B" was similar to Scenario "A," however the client posed harm to an identifiable partner who was not a spouse. Scenario "C" involved an HIV positive client who used I.V. drugs and continued to endanger her needle sharing partner. Finally, Scenario "D" involved a client who tested positive for HIV and engaged in protected sex (using a condom) with a partner who was unaware of his HIV status.

After reading each scenario, subjects were asked to select the course of action they believed they would take if confronted with this situation in actual practice. A three choice response format was utilized for each of the hypothetical scenarios. The possible courses of action included: (a) maintain confidentiality, (b) inform the spouse or partner of the potential harm, or (c)
notify medical or law enforcement personnel. Closed-ended questions were utilized to keep answers standardized across respondents and to minimize the opportunity for irrelevant responses.

The next section of the survey asked respondents: (a) what specific resources they consider most important to utilize when making the decision to maintain or breach confidentiality when a client who has tested HIV positive poses harm to an uninformed, identifiable third party; (b) what specific factors they consider most important when making such a decision; (c) if they routinely inform clients of the limits of confidentiality at the onset of treatment; (d) if they have had experience working with clients who have tested positive for HIV, and if so, how many; (e) if they have ever worked with an HIV positive client who posed harm to an uninformed, identifiable third party; and (f) if so, what action did they choose to take, how did they come to their decision, and what were the results of taking such action.

In addition, respondents were asked who they would disclose confidential information to if a client posed a probability of imminent physical injury to another person, according to Texas law. Respondents were also asked how they would recommend the current Texas statute be revised, if at all. A four choice response format was utilized for this question. Possible choices regarding state statute changes included: (a) legally mandated confidentiality with immunity from prosecution for not notifying an at-risk third party; (b) a legally mandated duty to protect which would provide immunity if
the therapist acted in good faith and used reasonable care when notifying an endangered third party, but would also place the therapist at risk for potential liability if the endangered party was not notified; (c) a discretionary duty which would provide immunity if a therapist chose either to breach or not to breach confidentiality to an at-risk third party provided that the therapist acted in good faith and used a reasonable standard of care; and (d) no change in existing statutes.

Finally, therapists and physicians were asked if, after considering the issues explored in this questionnaire, they would hesitate working with an individual who has tested HIV positive. For subjects who answered "yes," they were asked to state why. In addition, within the therapist sample group respondents were asked if they believed the American Counseling Association (ACA) should develop guidelines which specifically address confidentiality and the duty to protect in HIV-related cases. If subjects answered "yes," they were asked to state what type of guidelines they recommend ACA adopt.

The final section of the questionnaire elicited demographic information from the subjects including: (a) gender, (b) age, (c) highest degree earned, (d) year highest degree was earned, (e) number of years of experience delivering medical or psychotherapeutic services, and (f) work setting. Subjects were also asked if they had ever received information specifically related to the issue of HIV and duty to protect third parties, and if so, to identify the source of this information.
A brief cover letter accompanied each survey (see Appendix C). The cover letter explained the purpose and significance of the study, the importance of the subject’s participation, and the approximate time required to complete the survey. In addition, confidentiality of the subject’s responses was assured by informing the subjects that any reports of the research data would be based on group composites, not individual cases. The subjects were thanked in advance for their cooperation, and they were also offered a summary of the results of the study if so desired. A self-addressed, stamped return envelope was also included.

To ensure content validity, 10 licensed professional counselors who are members of the Dallas Metro Counseling Association, and 10 physicians who specialize in Internal Medicine were asked to complete the survey instrument developed for this study. Specifically, the subjects were also asked to evaluate the instrument in reference to (a) representativeness of the items, (b) clarity of directions, (c) clarity of the questions being asked, and (d) time required to complete the survey. The data collected from this pilot study was analyzed, and the results showed that the individual items did indeed yield the desired information in the appropriate form. The items also yielded the selected levels of measurement. Although subjects in the pilot study expressed interest in the issues presented and frequently requested a copy of the results, they did not recommend that any substantive changes be made to the survey instrument.
Collection of Data

Altschuld and Lower (1984) stated that obtaining a high percentage of returned and completed questionnaires is of critical importance in any research involving the use of a mailed survey instrument. Unless a high response rate is achieved, the results of the study may not be considered representative of the population from which the sample was selected, and the credibility of the study may be called into question. Therefore, appropriate follow-up procedures are considered an essential phase of any study which involves mailed survey instruments. Furthermore, follow-up procedures are also considered to be the most potent technique for increasing response rate (Berdie & Anderson, 1974).

The procedures utilized in this study involved three phases. The first phase involved the initial mailing of the cover letter and survey instrument to all subjects selected in the therapist and physician samples. Seven days after this initial mailing, a postcard was sent thanking each subject for participating in the study regardless of whether the subject had actually responded by this time (see Appendix D). The final phase of the follow-up procedure involved mailing a second cover letter and survey instrument to each subject who failed to respond (see Appendix E).

Subjects were not requested to identify themselves by name when completing the questionnaire. Instead, each survey instrument was assigned a four digit code. The first digit of the code identified whether the subject was a member of the therapist sample group or the physician sample group. The following three digit code identified the individual subject in the sample.
Subjects were informed that the identification codes would only be used by the researcher to determine which subjects had not yet responded so that additional follow-up procedures could be utilized.

Analysis of Data

Each response choice on the survey instrument was numerically coded according to the procedures required by the University of North Texas (UNT) Computing Center. The returned survey instruments were then submitted to the UNT Computing Center where they were keyed into the computer. The resulting data was then analyzed by the researcher using the SPSS Statistical Package.

Percentages were calculated for research questions 1, 4, 10, 11, 13, 14, and 16. The Log-linear model, which utilizes the Chi square goodness of fit test, was used to test for significant differences in questions 2, 3, 5, 6, 7, and 12. Questions 8 and 9 were evaluated by utilizing averaged ranks, and content analysis was used to evaluate questions 15 and 17. In all analyses of data utilizing Chi square, a .05 level of significance was used.
CHAPTER 3

RESULTS

This chapter presents a summary of the research findings, discussion, conclusions, and recommendations for further research.

Findings

Research question one examined the course of action therapists report they would take when presented with four hypothetical scenarios in which an HIV positive client poses harm to an identifiable third party. Percentages were utilized to analyze the data. Scenario "A" involved an HIV positive client who continues to engage in regular, unprotected sex with his spouse who is unaware of his HIV status. The results showed that 23% of therapists reported they would maintain client confidentiality; 47% would inform the spouse of the potential harm; and 25% would notify medical or law enforcement personnel. In addition, 6% reported they would inform the partner and notify medical or law enforcement personnel.

Scenario "B" involved a homosexual male who continues to engage in regular, unprotected sex with his partner who is unaware of his HIV status. In this scenario, 25% of therapists reported they would maintain confidentiality; 42% would inform the partner; 27% would notify medical or law enforcement personnel.
personnel; and 6% would inform the partner and notify medical or law enforcement personnel.

Scenario "C" involved a client who is an IV drug user, has tested HIV positive, and continues to share needles with her roommate who is unaware of the client's HIV status. In this scenario, 21% of therapists indicated they would maintain confidentiality; 44% would inform the roommate of the potential harm; 29% would notify medical or law enforcement personnel; and 5% would inform both the roommate and medical or law enforcement personnel.

Scenario "D" involved an HIV positive client who engages in protected sex (using a condom) with a partner who is unaware of his HIV status. In this scenario, 47% of therapists reported they would maintain confidentiality; 30% would inform the partner; 17% would notify medical or law enforcement personnel; and 5% would inform both the partner and medical or law enforcement personnel (see Table 10).

In addition, therapists were also requested to rate how confident they were of their responses to each of the four scenarios, "1" representing very little confidence and "10" representing a high level of confidence. Overall, the results indicated that respondents were moderately confident with the courses of action they selected. Furthermore, the mean confidence levels appeared relatively consistent across all four scenarios, only fluctuating between "6.7" and "7.1." Scenario "D," involving the client practicing 'protected' sex, received the lowest confidence rating (see Table 11).
Research question two evaluated the extent that therapists' responses reflected agreement on the most appropriate course of action for each of the four scenarios presented. The Log-linear model, which utilizes the Chi square
goodness of fit test, was used to test for significant differences. The results showed that therapists significantly chose one course of action in each of the four scenarios, reflecting agreement on the most appropriate course of action in each situation presented. For Scenarios "A," "B," and "C" therapists significantly chose to inform the at-risk third party directly rather than maintain confidentiality or notify medical or law enforcement personnel. Specifically, for Scenario "A," $X^2(2df)=15.569$, $p<.0004$; for Scenario "B," $X^2(2df)=7.625$, $p<.0221$; and for Scenario "C," $X^2(2df)=12.08$, $p<.0025$. However, in Scenario "D," involving the client practicing protected sex, subjects significantly chose to maintain client confidentiality, $X^2(2df)=21.16$, $p<.000025$, rather than notify the partner or medical or law enforcement personnel (see Table 12).

Table 12

Results of Chi Square Showing Therapists' Degree of Agreement on the Selected Course of Action for Each Scenario

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Observed Frequencies</th>
<th>Chi Square $X^2(2df)$</th>
<th>Level of Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;A&quot; Spouse</td>
<td>34</td>
<td>70</td>
<td>37</td>
</tr>
<tr>
<td>&quot;B&quot; homosexual</td>
<td>38</td>
<td>63</td>
<td>40</td>
</tr>
<tr>
<td>Partner</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&quot;C&quot; Needle</td>
<td>32</td>
<td>66</td>
<td>44</td>
</tr>
<tr>
<td>Sharing Partner</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&quot;D&quot; Safer Sex</td>
<td>71</td>
<td>45</td>
<td>26</td>
</tr>
<tr>
<td>(Condom)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

N=141 (Scenarios "A" & "B") / N=142 (Scenarios "C" & "D")
Research question three evaluated whether therapists selected an internally consistent course of action when responding to the four scenarios (i.e., is their response the same for Scenarios "A," "B," "C," and "D"). Again, the Log-linear model was utilized to test for significant differences. The results achieved statistical significance which indicates that therapists were internally consistent in the course of action they selected in the four scenarios, $X^2(6df) = 33.62864$, $p < .000001$. However, although the results were statistically significant, therapists did not select the same course of action in each of the four scenarios. In Scenarios "A," "B," and "C" they elected to inform the endangered third party, while in Scenario "D" they chose to maintain client confidentiality.

Research question four assessed what course of action physicians report they would take when presented with the same four hypothetical scenarios. In Scenario "A," involving the spouse, 15% of physicians reported they would maintain the patient's confidentiality; 47% would inform the spouse of the potential harm; 33% would notify medical or law enforcement personnel; and 6% would inform both the spouse and medical or law enforcement personnel.

In Scenario "B," involving a homosexual partner, 17% of physicians indicated they would maintain confidentiality; 40% would inform the partner; 37% would notify medical or law enforcement personnel; and 6% would inform both the partner and medical or law enforcement personnel.
In Scenario "C," which involves a needle sharing partner, 19% of physicians reported they would maintain confidentiality; 32% would inform the partner; 43% would notify medical or law enforcement personnel; and 6% would inform both the partner and medical or law enforcement personnel.

In Scenario "D," involving the HIV positive client practicing protected sex, 43% of physicians reported they would maintain confidentiality; 24% would inform the partner; 28% would notify medical or law enforcement personnel; and 6% would notify the partner and medical or law enforcement personnel (see Table 13).

Table 13

Physicians' Selected Courses of Action to the Scenarios

<table>
<thead>
<tr>
<th>Scenario</th>
<th>(a) Maintain Confidentiality</th>
<th>(b) Inform At-Risk Party</th>
<th>(c) Notify Medical or Law Personnel</th>
<th>(b &amp; c)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;A&quot; Spouse</td>
<td>15%</td>
<td>47%</td>
<td>33%</td>
<td>6%</td>
</tr>
<tr>
<td>&quot;B&quot; Homosexual Partner</td>
<td>17%</td>
<td>40%</td>
<td>37%</td>
<td>6%</td>
</tr>
<tr>
<td>&quot;C&quot; Needle Sharing Partner</td>
<td>19%</td>
<td>32%</td>
<td>43%</td>
<td>6%</td>
</tr>
<tr>
<td>&quot;D&quot; Safer Sex (Condom)</td>
<td>43%</td>
<td>24%</td>
<td>28%</td>
<td>6%</td>
</tr>
</tbody>
</table>

N=109
Physicians were also requested to rate their level of confidence in their responses to each of the four scenarios, again "1" represented very little confidence, and "10" represented a high level of confidence. Comparable to respondents in the therapist sample, physicians were moderately confident with the courses of action they selected, and similarly, the mean confidence level appeared relatively consistent across all four scenarios, fluctuating between "7.1" and "7.4." Scenario "D" received the lowest confidence rating of the four situations presented (see Table 14).

Table 14

Mean Confidence Level of Physicians' Responses to the Scenarios

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Mean Confidence Level</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;A&quot; Spouse</td>
<td>7.4</td>
<td>2.64</td>
</tr>
<tr>
<td>&quot;B&quot; Homosexual Partner</td>
<td>7.3</td>
<td>2.71</td>
</tr>
<tr>
<td>&quot;C&quot; Needle Sharing Partner</td>
<td>7.4</td>
<td>2.65</td>
</tr>
<tr>
<td>&quot;D&quot; Safer Sex (Condom)</td>
<td>7.1</td>
<td>2.55</td>
</tr>
</tbody>
</table>

N=109

Research question five evaluated whether the physicians' responses reflected agreement on the most appropriate course of action for each of the four scenarios presented. The Log-linear model, which utilizes Chi square, was used to tested for significant differences. Overall, the results showed that
physicians significantly agreed on a specific course of action depending on the situation presented.

In Scenario "A," physicians significantly chose to inform the patient's spouse rather than maintain confidentiality or notify medical or law enforcement personnel, \(X^2(2df)=18.43, p<.0001\). This same pattern was evident in Scenario "B," in which the selected course of action, informing the partner of the potential harm, was statistically significant, \(X^2(2df)=11.023, p<.004\). However, in Scenario "C," physicians chose to notify medical or law enforcement personnel significantly more than informing the needle-sharing partner or maintaining the patient's confidentiality, \(X^2(2df)=8.60, p<.014\). Lastly, in Scenario "D," physicians significantly chose to maintain patient confidentiality rather than to notify the partner or medical or law enforcement personnel, \(X^2(2df)=9.765, p<.0076\) (see Table 15).

Research question six assessed whether physicians selected an internally consistent course of action when responding to the four scenarios (i.e., is their response the same for Scenarios "A," "B," "C," and "D"). Again, the Log-linear model was utilized to test for significant differences. The results showed that physicians' responses were not internally consistent. In Scenarios "A" and "B," the respondents significantly chose to inform the endangered third party; in Scenario "C," they chose to notify medical or law enforcement personnel; and in Scenario "D," they elected to maintain the patient's confidentiality, \(X^2(6df)=.85, p>.05\).
Table 15

Results of Chi Square Showing Physicians' Degree of Agreement on the
Selected Course of Action for Each Scenario

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Observed Frequencies</th>
<th>Chi Square x²(2df)</th>
<th>Level of Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(a) Maintain Confidentiality</td>
<td>(b) Inform At-Risk Party</td>
<td>(c) Notify Medical or Law Personnel</td>
</tr>
<tr>
<td>&quot;A&quot; Spouse</td>
<td>16</td>
<td>51</td>
<td>36</td>
</tr>
<tr>
<td>&quot;B&quot; Homosexual Partner</td>
<td>19</td>
<td>44</td>
<td>40</td>
</tr>
<tr>
<td>&quot;C&quot; Needle Sharing Partner</td>
<td>21</td>
<td>35</td>
<td>47</td>
</tr>
<tr>
<td>&quot;D&quot; Safer Sex (Condom)</td>
<td>47</td>
<td>26</td>
<td>30</td>
</tr>
</tbody>
</table>

N=103

Research question seven explored whether a significant difference exists between the course of action selected by therapists and the course of action selected by physicians in relation to the four scenarios presented. Utilizing the Log-linear model, the results showed that the difference between the two groups was not statistically significant for any of the four scenarios. Specifically, for Scenario "A," \(X^2(2df)=3.607, p>.05\); for Scenario "B," \(X^2(2df)=3.872, p>.05\); and for Scenario "D," \(X^2(2df)=3.79, p>.05\). However, the difference in responses between therapists and physicians for Scenario "C," involving the needle-sharing partner, approached statistical significance, \(X^2=4.9766, p>.05\).
Research question eight asked therapists and physicians to rank order five specific resources they would utilize and consider most important when deciding whether or not to breach confidentiality when a client who has tested HIV positive poses harm to an uninformed, identifiable third party (e.g., review relevant professional literature, consult with colleagues, consult with an attorney, review ethical standards, review state statutes, or others). Respondents were asked to rank order each of the five resources provided from one (most important) to five (least important). Averaged ranks were then utilized to analyze the data.

Therapists ranked "review ethical guidelines" as the resource they considered most important when deciding whether to breach confidentiality in such a situation. "Review state statutes" was ranked the second most important resource, followed by "consult with colleagues" and "consult with an attorney." "Review relevant professional literature" was ranked as the least important resource. In addition to the five resources provided, therapists listed "prayer," "personal morals and convictions," "consultation with HIV/AIDS services agencies," and "contacting the Texas Psychological Association Ethics Board" as other resources that they would also utilize.

Similarly, physicians also ranked "review ethical standards" as the resource they considered most important to utilize in such a situation, followed by "review state statutes," "consult with an attorney," and "consult with colleagues." Physicians also ranked "review relevant professional literature" as
the least important resource of those provided. Self-generated responses in
the physician sample included consultation with a variety of additional
resources such as "my malpractice carrier," "the Texas Department of Health
and public health officials," "infectious disease control policies at the hospital,
"the hospital Ethics Committee," and "an AIDS counselor." In addition,
physicians listed "common sense" and "use own judgment" as resources they
would utilize (see Table 16).

Table 16

<table>
<thead>
<tr>
<th>Resource</th>
<th>Averaged Rank (Therapists)</th>
<th>Averaged Rank (Physicians)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review ethical standards</td>
<td>1.98</td>
<td>2.51</td>
</tr>
<tr>
<td>Review state statues</td>
<td>3.03</td>
<td>2.58</td>
</tr>
<tr>
<td>Consult with colleagues</td>
<td>3.07</td>
<td>3.35</td>
</tr>
<tr>
<td>Consult with an attorney</td>
<td>3.36</td>
<td>3.34</td>
</tr>
<tr>
<td>Review relevant professional literature</td>
<td>3.78</td>
<td>3.54</td>
</tr>
</tbody>
</table>

Research question nine explored what specific factors therapists and
physicians report they consider most important before deciding to breach
confidentiality when a client who has tested HIV positive poses harm to an
uninformed, identifiable third party (e.g., degree of dangerousness that the
client poses to a third party, identifiability of the third party, ethical considerations, legal issues, effects on the therapeutic relationship, or others). The overall ranking of the five factors provided was identical for both therapists and physicians. The results indicated that respondents in both the therapist and physician sample groups considered "degree of dangerousness that the client poses to a third party" as the most important factor to consider before breaching confidentiality in such a situation. "Ethical considerations" was ranked as the second most important factor, followed by "legal issues" and "identifiability of the third party." "Effects on the therapist/client (or physician/patient) relationship" was ranked as the least important factor.

Within the therapist group, only two therapists listed additional factors they would consider. Both therapists commented that they would give notice to the client of their intent to breach confidentiality in order to give the client the opportunity to inform the endangered third party first. Self-generated responses from physicians included "the protection of patients and contacts" and "whether the third party would be likely to be influenced by the contact" (see Table 17).

Research question 10 determined what percentage of the therapists and physicians sampled routinely inform clients (or patients) of the limits of confidentiality at the onset of treatment. Within the therapist sample, 88% (132) of respondents indicated that they disclose the exceptions to confidentiality at the onset of treatment, and 12% (18) reported that they did not. In the
physician sample, only 26% (28) of respondents reported disclosing the limits of confidentiality, while 74% (81) indicated that they did not reveal this information (see Table 18).

Table 17

Rank Order of Factors

<table>
<thead>
<tr>
<th>Factor</th>
<th>Averaged Rank (Therapists)</th>
<th>Averaged Rank (Physicians)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Degree of dangerousness client poses to third party</td>
<td>1.84</td>
<td>2.10</td>
</tr>
<tr>
<td>Ethical considerations</td>
<td>2.41</td>
<td>2.69</td>
</tr>
<tr>
<td>Legal issues</td>
<td>3.00</td>
<td>2.90</td>
</tr>
<tr>
<td>Identifiability of the third party</td>
<td>3.61</td>
<td>3.45</td>
</tr>
<tr>
<td>Effect on therapist/client or physician/patient relationship</td>
<td>4.12</td>
<td>3.98</td>
</tr>
</tbody>
</table>

Therapists N=147 / Physicians N=107

Table 18

Disclosure of the Limits of Confidentiality

<table>
<thead>
<tr>
<th>Confidentiality Limits Disclosed</th>
<th>Therapist Sample</th>
<th>Percent of Total</th>
<th>Physician Sample</th>
<th>Percent of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>132</td>
<td>88%</td>
<td>28</td>
<td>26%</td>
</tr>
<tr>
<td>No</td>
<td>18</td>
<td>12%</td>
<td>81</td>
<td>74%</td>
</tr>
</tbody>
</table>

Therapists N=150 / Physicians N=109
Research question 11 assessed what percentage of therapists are knowledgeable of the fact that Texas statutes limit breaching confidentiality to medical or law enforcement personnel when third parties are endangered. Subjects were asked, according to Texas law, if they determine that a client poses a probability of imminent physical injury to another person, they: (a) may disclose confidential information to the person(s) at risk, (b) may disclose confidential information to medical or law enforcement personnel, or (c) must maintain the client's confidentiality.

The results showed that 47% of therapists reported that they believed Texas law permits them to disclose confidential information to both the person at-risk and to medical or law enforcement personnel. Twenty-one percent believed the law permits them to disclose confidential information only to the person at risk; 19% believed disclosure was limited to medical or law enforcement personnel; and 10% indicated they believed they were obligated by law to maintain the client's confidentiality. Of the remaining 2%, one respondent wrote in "I don't know," and one subject indicated that therapists may disclose confidential information to medical or law enforcement personnel, but they must also maintain the client's confidentiality. Another therapist checked all three responses (i.e., may disclose to the person at-risk, may disclose to medical or law enforcement personnel, and must maintain client's confidentiality) (see Table 19).
Table 19

**Therapists' Knowledge of Texas Law**

<table>
<thead>
<tr>
<th>Texas law states that the therapist:</th>
<th>Frequency</th>
<th>Percent of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a) may disclose confidential information to the person(s) at risk</td>
<td>32</td>
<td>21%</td>
</tr>
<tr>
<td>(b) may disclose confidential information to medical or law enforcement personnel</td>
<td>29</td>
<td>19%</td>
</tr>
<tr>
<td>(c) must maintain the client's confidentiality</td>
<td>15</td>
<td>10%</td>
</tr>
<tr>
<td>(a) &amp; (b)</td>
<td>71</td>
<td>47%</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>2%</td>
</tr>
</tbody>
</table>

N=150

Research question 12 assessed whether therapists who have had experience with HIV positive clients are more or less likely to breach confidentiality than those therapists who have not had such experience. Approximately half of all therapists sampled (51%) reported that they had not had experience with HIV positive clients, while 49% had such experience (see Table 20). Utilizing the Log-linear model, results showed no significant difference between the two groups in reference to whether therapists would maintain or breach confidentiality in the scenarios presented, $X^2(2df)=.17$, $p>.05$. 
Table 20

Therapists' Experience with HIV Positive Clients

<table>
<thead>
<tr>
<th>Have worked with HIV positive clients</th>
<th>Frequency</th>
<th>Percent of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>73</td>
<td>49%</td>
</tr>
<tr>
<td>No</td>
<td>77</td>
<td>51%</td>
</tr>
</tbody>
</table>

N=150

Regarding level of experience with clients who had tested HIV positive, 67% of respondents reported they had worked with 1 to 5 HIV positive clients, while the remaining therapists had worked with more than 5 but less than 50. Four respondents failed to report the number of HIV positive clients with whom they had experience (see Table 21).

Table 21

Therapists' Level of Experience with HIV Positive Clients

<table>
<thead>
<tr>
<th>Number of HIV Positive Clients</th>
<th>Frequency</th>
<th>Percent of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 - 5</td>
<td>46</td>
<td>67%</td>
</tr>
<tr>
<td>6 - 10</td>
<td>10</td>
<td>14%</td>
</tr>
<tr>
<td>11 - 25</td>
<td>9</td>
<td>13%</td>
</tr>
<tr>
<td>26 - 50</td>
<td>4</td>
<td>6%</td>
</tr>
<tr>
<td>More than 50</td>
<td>---</td>
<td>---</td>
</tr>
</tbody>
</table>

N=69
Research question 13 explored how therapists would recommend that current state statutes be revised in reference to maintaining or breaching confidentiality when third parties are endangered by clients who have tested HIV positive. The results indicated that therapists are primarily divided between wanting a discretionary duty and a legally mandated duty to protect. Specifically, 49% percent of respondents favored a discretionary duty which would provide immunity if a therapist chose either to breach or not to breach confidentiality to an at-risk third party provided that the therapist acted in good faith and within a reasonable standard of care within the profession. Yet, a similar number, 42% of respondents, favored a legally mandated duty to protect which would provide immunity if the therapist acted in good faith and used reasonable care when notifying an endangered third party, but which would also place the therapist at risk for potential liability if the endangered party was not notified. Only 3% of therapists recommended legally mandated confidentiality. Of the remaining 6%, 3% of respondents recommended no change in existing statutes, and 3% stated that they did not know what the current law dictates (see Table 22).

Research question 14 evaluated how many therapists and physicians, after considering the issues explored in this questionnaire, would hesitate working with an individual who has tested HIV positive. Within the therapist sample, 76% of respondents indicated that they would not hesitate working with an HIV positive client, while 24% reported that they would hesitate.
Respondents in the physician sample appeared less likely than therapists to hesitate working with HIV positive patients. Specifically, 90% of the physicians reported they would not hesitate working with an HIV positive individual, while 10% reported that they would hesitate (see Table 23).

Table 22

Therapists' Recommended Revision of Texas Statute

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legally mandated confidentiality</td>
<td>5</td>
<td>3%</td>
</tr>
<tr>
<td>Legally mandated duty to protect</td>
<td>63</td>
<td>42%</td>
</tr>
<tr>
<td>Discretionary duty</td>
<td>73</td>
<td>49%</td>
</tr>
<tr>
<td>No change in existing statute</td>
<td>5</td>
<td>3%</td>
</tr>
<tr>
<td>I don't know</td>
<td>4</td>
<td>3%</td>
</tr>
</tbody>
</table>

N=150

Table 23

Hesitation in Working with HIV Positive Individuals

<table>
<thead>
<tr>
<th>Would Hesitate</th>
<th>Therapist Sample</th>
<th>Percent of Total</th>
<th>Physician Sample</th>
<th>Percent of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>36</td>
<td>24%</td>
<td>11</td>
<td>10%</td>
</tr>
<tr>
<td>No</td>
<td>114</td>
<td>76%</td>
<td>98</td>
<td>90%</td>
</tr>
</tbody>
</table>

Therapists N=150 / Physicians N=109
Research question 15 explored the specific reasons therapists and physicians provided regarding why they may hesitate working with individuals who have tested HIV positive. Of the 36 therapists who indicated that they would hesitate working with these individuals, 24 respondents (67%) provided a specific explanation.

The most frequently cited reason for hesitation in working with HIV positive individuals involved concern and uncertainty regarding the ethical and legal issues involved. Over 50% of respondents specifically referred to the lack of clear ethical guidelines and state statutes, and fear of potential liability related to the conflicting duties of maintaining client confidentiality and the protection of third parties. As one respondent commented, "I would hesitate working with HIV positive individuals because to date there are no clear ethical standards or state statutes regarding this issue." Other therapists emphasized their concerns specifically related to the legal issues involved. For example, respondents explained their hesitation by stating: (a) "The unresolved status of this issue creates anxiety/uncertainty and the fear of potential liability;" (b) "It adds a dimension of responsibility which one may not be in an informed enough position to do the 'right' thing to avoid legal liability;" (c) "Unsure of legal liability due to the lack of ethical guidelines pertinent to this issue;" (d) "Because of legal ramifications;" (e) "Uncertainty about legal issues;" (f) "The law is not specific regarding my responsibilities on this issue;" and (g) "I would want more precise legal and ethical guidelines, and I would want to be assured..."
of my protection in whatever actions I would take as a therapist acting in good faith."

Other therapists stipulated that they would only work with HIV positive clients if they agreed not to pose harm to third parties. Examples of this position include: (a) "I would work with an HIV positive client only if he was willing to show (act) responsibly toward his possible victims;" (b) "Hesitate is the key word. I would want some commitment that they would not endanger others;" (c) "I would make treatment contingent upon the client's agreement to refrain from behavior(s) which endanger others;" and (d) "On one condition—that they have disclosed their HIV status to their partner and/or are not engaging in unsafe sex practices." The remaining respondents cited a variety of reasons to explain their hesitation in working with HIV positive individuals, including: (a) competence (e.g., "I have had little exposure to this issue. I believe others that emphasize this treatment as part of their practice would be better equipped"); (b) fear of contagion (e.g., "In spite of what all the published 'research' says, I am not convinced that AIDS could not easily mutate into a virus that could be spread by casual contact or air-born means. I am afraid of infected persons as a health risk"); (c) personal values and beliefs (e.g., "If a client is homosexual and/or drug addicted, prognosis for change is very weak and dismal. Based upon 15+ years of therapy experience inpatient and outpatient, neither of the above really want change and thus are limited of any motivation to change their lifestyle. Both are lifestyle addictions"); and (d)
personal preference (e.g., "It is my personal choice not to work with this population").

In comparison to the therapist sample group, fewer physicians reported hesitance in treating individuals who have tested HIV positive. Specifically, 11 physicians (10%) indicated that they would hesitate treating this population. Within this group, seven respondents provided a specific reason for their hesitation. In contrast to the therapists' responses, not a single physician attributed his or her hesitation to the lack of clear ethical guidelines. However, four physicians (67%) identified legal issues as the reason for their concern. For example: (a) "The legal issues are difficult to navigate;" (b) "Legal issues, because I carry no liability insurance;" (c) "Legal considerations;" and (d) "Legal crap." Similar to the therapists' responses, the remaining physicians also cited: (a) competence (e.g., "Because I am not familiar with this. I treat high blood pressure, heart disease, etc. I am quite familiar with what I do"); (b) fear of contagion (e.g., "I hesitate working with them not because of these issues--but because of the risk to myself and my family"); and (c) fears related to treating members of a stigmatized group (e.g., "Effect on my practice, i.e. in small towns ordinary patients do not wish to be in a clinic with HIV patients").

Overall, the results indicated that both therapists and physicians are concerned about the legal consequences involved in the treatment of HIV positive individuals. However, respondents in the therapist group indicated that they feel the additional burden of lacking clear ethical guidelines pertinent to this issue as well.
Research question 16 assessed whether therapists believe the American Counseling Association (ACA) should develop ethical guidelines which specifically address confidentiality and the duty to protect in HIV-related cases. The results showed that 84% of respondents believed ACA should take such action, while 16% believed they should not (see Table 24).

Table 24

<table>
<thead>
<tr>
<th>Therapists' Opinion on Whether ACA Should Develop Ethical Guidelines Which Address Confidentiality and Duty to Protect in HIV-Related Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ACA should develop specific guidelines</strong></td>
</tr>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
</tr>
</tbody>
</table>

N=150

Research question 17 asked therapists how they would recommend the current ACA Ethical Standards be revised to address issues related to confidentiality and the duty to protect in HIV-related cases. Content analysis was utilized to evaluate the therapists' responses.

A total of 75 respondents provided recommendations on how they would like ACA to address this issue. Although a variety of recommendations was offered, 75% of all responses could be categorized into two primary groups. The largest group, 45% of respondents, stated that they believed therapists should have an ethical duty to breach confidentiality and warn third
parties of potential harm in HIV-related cases. The following are examples of these recommendations: (a) "ACA needs to produce a form that in HIV cases the client would read and sign at the outset informing the client that the counselor has an ethical duty to alert the partner and others;" (b) "Therapists should have an ethical duty to inform. This is not a political issue, it is a health--life issue;" (c) "Mandated duty to protect the endangered party;" (d) "I think, since HIV is potentially lethal, it should be included in the duty to warn--mandated warning given to anyone the client poses harm;" and (e) "That ACA develop ethical guidelines stating that a therapist must breach confidentiality because such clients are threatening another person's life, even though the threat is passive."

Furthermore, other respondents who also advocated a duty to protect recommended that HIV situations be treated like other threats to life or safety. Hence, these individuals suggested that ethical guidelines established for child abuse, homicide, and suicide should also apply to danger posed by HIV positive clients. Finally, the remaining therapists within this group emphasized the importance of the client being informed before treatment begins about the specific limits to confidentiality. In addition, they recommended that the client be given an opportunity to inform the at-risk party of the danger prior to the therapist taking any action. However, if the client refuses to disclose his or her HIV status then the therapist would inform the third party. As one respondent stated:
When a client reveals physical conditions that are contagious and/or life threatening to others with whom the client is intimate, the therapist has a duty to inform the client of concerns and request a conjoint session with involved parties. If the client refuses, the therapist has a duty to protect by informing affected others to allow them to take precautionary, preventative measures as soon as possible. In my view, the client forfeits his/her rights to confidentiality when he/she decides to engage in activities that endanger another person's health/life.

The second primary group consisted of 30% of respondents. Unlike the first group which recommended a specific type of guideline that ACA adopt related to this issue, this group of respondents simply emphasized the need for ACA to acknowledge the dilemma that therapists face and provide clear guidelines on an appropriate course of action. For example, respondents stated: (a) "It is critical that ACA provide clear guidelines that straightforwardly and thoroughly take into account the multiple complexities of HIV-related situations;" (b) "Specific guidelines that explain in detail how to deal with relevant situations like the ones in this questionnaire;" (c) "Duty to inform vs. duty to warn vs. duty to protect!!! Clarify our ethical responsibilities!" (d) "ACA should develop clearer and more specific guidelines for such cases;" and (e) "Provide explicit guidelines on recommended steps for therapists to follow as to how to deal with third parties in HIV situations."

In addition, respondents within this group requested that ACA provide guidelines as other professional
organizations have already done. As one respondent stated, "It is difficult to understand why the AMA and APA have already provided their members with direction on this issue and why ACA has failed to follow suit." Furthermore, another respondent echoed similar discouragement with ACA by commenting, "I am a member of ACA, however they are not an effective unit."

The next largest group of respondents (9%) recommended that ACA establish ethical guidelines in which therapists have a discretionary duty which would permit them to either maintain confidentiality or disclose a client's HIV status to an at-risk third party depending on the individual circumstances in a case and provided that the therapist acted in good faith. As one respondent stated, "Therapists should have a discretionary duty to report, with therapist immunity, and with reporting guided by therapeutic goals and within established standards of practice."

The remaining recommendations were diverse, including: (a) the protection of therapists (e.g., "Guidelines must be provided that protect therapists, as well as clients and partners"); (b) termination of therapy (e.g., "Interruption or termination of counseling sessions until client informs endangered third party"); (c) no duty whatsoever (e.g., "No duty to counsel such individuals. AIDS is a politicized infectious disease. Infectious persons should probably be quarantined"); and (d) simply "Not sure."

Significantly, in analyzing and categorizing all responses, not one therapist recommended that ACA adopt ethical guidelines which mandate
maintaining a client’s confidential disclosures in HIV-related situations. Furthermore, in reference to those who did not recommend that ACA address this issue, several respondents provided an explanation for their position. These respondents questioned whether ACA is the appropriate body to develop such guidelines since laws vary considerably between states. Therefore, they suggested that perhaps it would be more suitable for state counseling associations and licensing agencies to establish ethical guidelines congruent with state statutes.

Discussion

This study utilized a written questionnaire to explore issues related to how therapists and physicians reconcile their conflicting duties to maintain confidentiality and protect at-risk third parties in HIV-related situations. Subjects within the therapist and physician sample groups were presented with four hypothetical scenarios in which a client who tested HIV positive posed harm to an unsuspecting, identifiable third party. Within the therapist sample group, the results showed that one selected course of action in each scenario reached statistical significance, reflecting agreement on a specific course of action depending on the situation. In the first three scenarios, the endangered third party was either a spouse, a sexual partner, or a needle sharing roommate. In these scenarios, the results showed that significantly more
therapists chose to inform the at-risk third party rather than maintain client confidentiality or notify medical or law enforcement personnel.

Although therapists significantly chose to inform the at-risk third party in the first three scenarios, in the fourth scenario, in which the client engaged in protected sex with a partner who was unaware of his HIV status, significantly more therapists elected to maintain confidentiality rather than notify the partner or medical or law enforcement personnel. Furthermore, although therapists deviated from their selected course of action in Scenario "D," the results still reached statistical significance regarding internal consistency of responses (i.e., do therapists respond the same in Scenarios "A," "B," "C," and "D").

It is also important to point out that although one selected course of action in each scenario reached statistical significance, a notable number of therapists chose an alternative course of action. For example, in Scenario "A," although 47% of respondents chose to inform the spouse, 23% indicated they would maintain confidentiality, 25% reported they would notify medical or law enforcement personnel, and 6% chose to inform the at-risk third party and medical or law enforcement personnel. Therefore, it is apparent that an overwhelming consensus of opinion does not exist in reference to how therapists report they would react to such situations.

Therapists were also asked to rate how confident they were of the course of action they selected in each of the situations depicted. As stated earlier, the mean confidence level was relatively consistent across the four
scenarios, ranging from "6.7" to "7.1." Interestingly, Scenario "D," which involved a client engaging in protected sex with a partner who was unaware of his HIV status, received the lowest confidence rating.

One possible explanation for this finding involves the issue of degree of dangerousness that the client poses to a third party. In the first three scenarios, a medically established degree of dangerousness exists in that an HIV positive individual poses a threat of infecting a third party through sexual intercourse or intravenous drug use. Therefore, therapists may believe it is their ethical obligation to notify the uninformed, identifiable third party. However, in the fourth scenario, in which the client reports engaging in protected sex, the degree of dangerousness is significantly reduced. This may explain why a significant number of therapists deviated from their selected course of action in the first three scenarios and chose instead to maintain the client's confidentiality. Yet, because protected sex reduces but does not eliminate the possibility that the third party can contract HIV, this may explain why therapists were not as confident with their selection. In essence, therapists may believe that the possibility still remains that a person could become infected and cause potential adverse consequences for the therapist who did not inform the third party at risk. As Kaplan et al. (1985) and Knapp and VandeCreek (1990) contended, since condoms do not assure "safe sex," and it is impossible to determine when someone might become infected, the best protection comes from an informed partner who is aware of the risks.
Overall, based on responses to the scenarios, therapists appeared to agree that they have an obligation to protect third parties at risk of contracting HIV. These results appear to confirm contentions in the literature that there seems to be growing support among mental health professionals for active disclosure when danger is posed to third parties in HIV situations (Costa & Altekruse, 1994). In addition, these findings are consistent with a study conducted by Silverman (1993) in which 61% of respondents, who were registered members of the National Association of Social Workers in California, reported that they either agreed or strongly agreed that it was their duty and professional responsibility to warn identified victims when the threat of HIV was established.

However, these results directly conflict with findings from a study conducted by Georgianna (1992) which investigated the gay and lesbian community’s view regarding a therapist breaching confidentiality and warning a third party about possible exposure to HIV. In this study, 80% of respondents reported they would not disclose a client’s diagnosis to an at-risk third party if they were the therapist, and 76% indicated they would not recommend disclosure if someone else (“Other”) was the therapist. One possible explanation for these disparate findings may involve the fact that the subjects in the Georgianna study were asked to “assume” the role of therapist. It is likely that individuals unfamiliar with the therapist role may not be aware of their ethical and legal responsibilities to protect third parties endangered by their
clients. In addition, these respondents may view confidentiality in therapy as absolute, and any breach of this trust may be considered unethical and a violation of their right to privacy.

Comparable to therapists, within the physician sample group, the results showed that one selected course of action in each scenario reached statistical significance, again reflecting agreement on the most appropriate course of action depending on the situation depicted. However, the results also indicated that physicians' responses were not internally consistent across the four scenarios. Significantly more physicians chose to inform the at-risk third party in Scenarios "A" and "B" which involved a spouse or sexual partner. Yet in Scenario "C," involving a needle-sharing roommate, physicians elected to notify medical or law enforcement personnel, while in Scenario "D," which involved a patient engaging in protected sex, significantly more physicians reported they would maintain confidentiality.

Physicians were also asked to rate how confident they were of their responses to each of the scenarios. The results indicated that physicians were moderately confident of their responses. Furthermore, their mean confidence levels were relatively consistent across the four scenarios, ranging from "7.1" to "7.4," which is only slightly higher than the mean confidence levels for therapists which ranged from "6.7" to "7.1." Again, like therapists, Scenario "D" received the lowest confidence rating, plausibly for the same reasons stated for the therapist group.
Furthermore, the results showed that no statistical difference existed between the course of action selected by therapists and the course of action selected by physicians in any of the four scenarios presented. However, in Scenario "C," involving the needle-sharing roommate, the difference in responses between the two sample groups approached statistical significance. In this scenario, significantly more physicians chose to notify medical or law enforcement personnel, whereas therapists significantly chose to inform the roommate of the potential harm. In fact, numerous physicians stated they would contact the Texas Department of Health. A possible explanation for this discrepancy in selected course of action could be that physicians are more knowledgeable and have greater experience working with public health authorities who may manage drug-related situations including individuals sharing contaminated needles. In addition, therapists may consider this scenario only in terms of a "duty to warn" the third party, whereas physicians may view such conduct as a violation of law, thus requiring them to notify proper authorities.

Therapists and physicians were asked to rank, in order of importance, five specific resources they would utilize when deciding whether or not to breach confidentiality when a client (or patient) who has tested HIV positive poses harm to an uninformed, identifiable third party. Within the therapist sample, respondents ranked the resources provided as follows: (1) "review ethical guidelines;" (2) "review state statutes;" (3) "consult with colleagues;" (4)
"consult with an attorney;" and (5) "review relevant professional literature." The overall ranking by physicians was similar to that of therapists. However, physicians ranked "consult with an attorney" as more important than "consult with colleagues."

Interestingly, therapists and physicians ranked "review ethical guidelines" as the most important resource to utilize in such a situation. However, unlike the American Medical Association (AMA), the American Counseling Association (ACA) has yet to address confidentiality issues pertinent to HIV situations, so therefore, no ethical guidelines even exist. This may also explain why some therapists stated that they would seek direction from the Texas Psychological Association and the AMA. As Reamer (1991b) stated,

Although ethicists have not produced definitive guidelines to resolve enduring issues related to every complex dilemma, and should not be expected to, there can be no doubt that their assessments have done much to illuminate critical issues and to suggest practical options and alternatives. (p. 11)

Increasing the complexity of the situation even further, therapists and physicians ranked "review state statutes" as the second most important resource to utilize, yet again, presently no state statutes exist which specifically address the issue of HIV and duty to protect. Furthermore, considering the lack of clear ethical guidelines and relevant state statutes, as well as the discrepancy of opinion present in the literature, it remains questionable how
beneficial it would be for therapists to consult with colleagues or an attorney.

In summary, considering the limited number of resources available, Knapp and VandeCreek (1990) appear correct in their view that it is not surprising psychotherapists are confused about their responsibilities to HIV-infected clients and at-risk third parties.

Additionally, therapists and physicians were asked to rank five specific factors they would consider most important before deciding to breach confidentiality when a client (or patient) who has tested HIV positive poses harm to an uninformed, identifiable third party. The overall ranking of the five factors provided was identical for both groups. Specifically, therapists and physicians ranked the factors as follows: (1) "degree of dangerousness that the client (or patient) poses to a third party;" (2) "ethical considerations;" (3) "legal issues;" (4) "identifiability of the third party;" and (5) "effects on the therapist/client (or physician/patient) relationship."

The therapists' ranking of these five factors is consistent with a study conducted by Totten et al. (1990). In this study, subjects were asked to review cases in which degree of dangerousness (high vs. low) and identifiability of the victim (high vs. low) were systematically varied. The results indicated that although therapists considered both of these factors when deciding whether to breach confidentiality, degree of dangerousness was significantly more important than identifiability of the victim. Subjects were also requested to generate factors they would consider most important when deciding to breach
Respondents most frequently listed "degree of dangerousness" (36%), followed by "legal and ethical considerations" (25%), "psychological diagnosis/state" (19%), and "sexual practices" (17%). "Identifiability of the victim" was only listed by 8% of the respondents.

Obviously, therapists and physicians place prominence on the degree of dangerousness that an individual poses to a third party. As stated earlier, this finding may explain why therapists and physicians chose to inform the spouse and the sexual partner in Scenarios "A" and "B," while they elected to maintain confidentiality in Scenario "D." In this scenario, the level of dangerousness was significantly reduced by the individual using a condom during sexual activity. Further research is needed to investigate how therapists and physicians individually evaluate degree of dangerousness in order to understand how these personal assessments directly affect the course of action selected in such situations.

On several questions in the survey, therapists and physicians frequently commented that they believed breaching confidentiality and notifying at-risk third parties was ethically permissible only if clients or patients were made aware of this possibility at the onset of treatment. However, the majority of physicians (74%) reported they do not disclose the limits of confidentiality before treatment begins. Although 88% of therapists reported that they disclose the exceptions to confidentiality to clients at the onset of treatment, 12% indicated that they did not.
The circumstances under which a client's confidential disclosures should, if ever, be disclosed remains a matter of some controversy (Siegel, 1979). However, as Keith-Spiegel and Koocher (1985) stated, there appears to be uniform agreement on one point; the client has the right to know the parameters of the therapeutic relationship including the limits of confidentiality. According to Hughes and Friedman (1994), given the possibilities for discrimination and stigmatization, it is of critical importance that HIV positive clients be informed of the limits of confidentiality and the disclosure policies of the provider. Such a discussion should include specific information on state laws pertinent to the disclosure of HIV test results and HIV positive status as well as how the provider complies with such state statutes.

Un fortunately, situations may arise in which clients continue to refuse to inform at-risk third parties of their HIV status. When confronted with such a case, Gray and Harding (1988) recommended that to protect the therapeutic relationship, therapists should first inform clients of their intent to breach confidentiality before taking any action. Overall, Reamer (1991b) concluded, "Clients should understand from the beginning of the relationship that although confidentiality is a sacred professional value, it is limited by law and professional ethics" (p. 58).

Also incumbent upon practitioners is the responsibility to be completely familiar with the legal status of confidentiality in their particular state (Berger, 1982; Costa & Altekruse, 1994). However, subjects within the therapist sample
do not appear to be knowledgeable that Texas statutes limit breaching confidentiality to medical or law enforcement personnel when third parties are endangered. Specifically, the Texas Health and Safety Code, Title 7, Section 611.004 (1992) limits the disclosure of confidential information "to medical or law enforcement personnel if the professional determines that there is a probability of imminent physical injury by the patient to the patient or others" (p. 748).

Remarkably, the results indicated that only 19% of respondents within the therapist sample were knowledgeable of what the law stipulates regarding breaching confidentiality when a client poses harm to a third party. The majority of therapists (47%) believed that Texas law permits them to disclose confidential information to both the person(s) at risk and to medical or law enforcement personnel, while 21% believed confidential information could only be disclosed to the person(s) at-risk. In addition, 10% of respondents indicated that it was their understanding that they are obligated by law to maintain client confidentiality, and the remaining 2% admitted that they did not know what the law stipulated.

This apparent lack of knowledge regarding legal limits of the disclosure of confidential information could possibly explain why significantly more therapists chose to inform the at-risk third parties in Scenarios "A," "B," and "C." For example, in Scenario "B," 42% of respondents reported they would inform the partner; 27% would notify medical or law enforcement personnel; 25%
would maintain client confidentiality; and 6% would inform the third party and notify medical or law enforcement personnel. In this scenario, 48% of respondents reported they would take action in violation of present state statutes.

One possible explanation for these findings may involve therapists’ awareness of the Tarasoff case in California. As previously explained, in a landmark ruling the Tarasoff (1976) court concluded:

When a therapist determines or pursuant to the standards of his profession should determine, that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim against such danger. (p. 335)

Interestingly, several therapists made reference to the Tarasoff case when responding to the scenarios. Although these notations do not provide a clear explanation of how therapists’ understanding of the Tarasoff ruling may have influenced their responses, at least two possible conclusions could be made to help explain why significantly more therapists chose to inform the at-risk third parties in the first three scenarios. First, some therapists may believe that if a legal decision is rendered in Texas involving a therapist’s duty to protect a third party at risk of contracting HIV, the court may cite the Tarasoff ruling and find the therapist liable on a case law basis. Hence, respondents may have elected to breach confidentiality and inform the third parties in the first three scenarios to avoid this type of potential legal liability.
On the other hand, some respondents may believe that the Tarasoff ruling has already been adopted in Texas. Therefore, this mistaken belief may explain, in part, why some therapists assume the law permits disclosure to third parties and why significantly more therapists chose to inform the at-risk third parties in the first three scenarios. Possibly, the Tarasoff ruling and its progeny are taught in graduate counseling programs. However, students may not be cognizant of the fact that Tarasoff has yet to be adopted in many states including Texas. Hence, this finding illustrates the need for students to recognize the limited applicability of court rulings in other states. Most significantly, considering only 19% of therapists demonstrated knowledge of the legal limits of the disclosure of confidential information, counselor educators must recognize the critical importance of teaching students statutes relevant to their particular state.

Furthermore, these findings appear to support a study conducted by Givelber et al. (1984). The results in this study showed that of the 90% of therapists surveyed who were aware of the Tarasoff ruling, nearly all believed the only way to fulfill their legal duty was to directly warn the endangered third party. In essence, it appears that therapists may be unclear of the range of options available to them when discharging their duty to protect third parties (Slovenko, 1988).

Moreover, in reference to the law, therapists and physicians were asked how they would recommend that current state statutes be revised in reference
to breaching confidentiality when third parties are endangered by clients or patients who have tested HIV positive. Within the therapist sample, 49% of respondents favored a discretionary duty which would provide immunity if the therapist chose either to breach or not to breach confidentiality to an at-risk third party, provided that the therapist acted in good faith and within a reasonable standard of care. However, a similar number of therapists (42%) preferred a legally mandated duty to protect which would provide immunity if the therapist acted in good faith, but which would also place the therapist at risk for potential liability if the endangered party was not notified.

Surprisingly, only 3% of therapists recommended legally mandated confidentiality, which appears contradictory to the number of articles in the literature which promote maintaining confidentiality in HIV situations (Kain, 1988; Kermani & Weiss, 1989; Perry, 1989; Posey, 1988). One possible explanation for this finding may be that therapists are not familiar with such articles nor the rationale of authors who advocate maintaining confidentiality under such circumstances. Furthermore, therapists' recommendations on changes in state law may also be influenced by their personal opinion on the most appropriate course of action in such situations. It appears that the overwhelming majority of therapists view maintaining client confidentiality as unacceptable when a third party is in jeopardy of contracting HIV.

This finding also appears discrepant with the 21% to 25% of therapists who elected to maintain confidentiality in the first three scenarios. However, it
is possible that although these respondents chose to maintain confidentiality in the situations presented, they would prefer to have a choice, or discretionary duty, when deciding whether or not to breach confidentiality when third parties are threatened. Overall, this finding suggests that when HIV-related situations such as those presented in the questionnaire are confronted in actual practice, therapists do not believe absolute confidentiality is warranted. Depending on the specific circumstances of a case, therapists appear to favor having the legal discretion to protect endangered third parties.

Furthermore, the results indicated a greater consensus among physicians than therapists regarding recommendations on how state statutes be revised. Specifically, 63% of physicians favored a discretionary duty, while 23% advocated a legally mandated duty to protect. Similar to therapists, only 5% of physicians recommended legally mandated confidentiality, and 6% preferred no change in existing statutes.

Overall, these results conflict with a study conducted by Georgianna (1992) which assessed the views of the gay and lesbian community regarding breaching confidentiality in HIV situations. The results showed that 60% of respondents did not believe it was necessary for a law to be established to assist therapists in deciding when it may be appropriate to breach confidentiality and warn a partner of a client's HIV status. Furthermore, 75% of respondents did not favor therapists being required by law to warn a partner in
such situations, and 58% indicated they did not believe therapists should even have a choice of whether or not to warn a partner at risk of contracting HIV.

The reason for these discrepant findings remains unclear. Perhaps, when confronted with such a situation, therapists believe they have an ethical, legal, or even moral duty to protect another individual from foreseeable harm. Therapists may also fear legal reprisal from unsuspecting individuals who eventually contract HIV from their clients. On the other hand, gays and lesbians have had to confront the AIDS epidemic more frequently than any other segment of the population. They may view a therapist breaching confidentiality and warning a third party as an unacceptable breach of trust. These individuals may fear stigmatization, discrimination, and the destruction of relationships with family and friends. Therefore, they may place ultimate importance on safeguarding the disclosure of their HIV status to anyone. Perhaps they may also believe it is their undeniable right to decide when, how, and even if others are ever informed. In summary, further research would be useful in understanding the distinct differences between how therapists and gays and lesbians believe such situations are best resolved.

Regarding whether subjects had experience with HIV positive patients, 49% of therapists reported having such experience, while 51% reported they had no experience with this population. The number of HIV positive clients with whom therapists had treated ranged from 1 to 50, with the majority of therapists (67%) reporting having experience with 1 to 5. Within the physician
sample group, 94% of respondents reported having treated HIV positive patients, while only 6% indicated having no such experience. Level of experience varied considerably with physicians reportedly having worked with anywhere from 1 to more than 1000 HIV positive patients. The largest percentage of physicians (31%) reported having treated between 100 and 500 patients who are HIV positive.

These characteristics of the sample groups may help to explain the difference in response rate between therapists and physicians. Within the therapist sample, 75% of subjects returned the questionnaire compared to 54.5% of physicians. Since approximately half of the therapists reported experience with HIV positive clients and half did not, this lack of experience did not appear to deter therapists from returning the questionnaire. However, some physicians returned an uncompleted questionnaire and explained that they did not work with HIV-related illnesses. Since 94% of physicians reported experience with HIV positive patients, it is possible that physicians with no such experience may have felt they lacked the necessary expertise to respond.

Furthermore, it was investigated whether therapists or physicians who had experience with HIV positive patients were more or less likely than those professionals without such experience to breach confidentiality and inform endangered third parties. No statistical difference was found between these two groups.
This finding contradicts results found by Totten et al. (1990). In this study, clinicians who had contact with AIDS patients in psychotherapy were less likely to breach confidentiality than those without similar experience. To explain this finding, the researchers surmised that it was possible that those clinicians who have already confronted an AIDS-related confidentiality dilemma may have successfully resolved the situation by utilizing strategies other than breaching confidentiality. Although approximately half of the therapists surveyed in the present study had experience treating HIV positive clients, only 10% had actually confronted a situation in which an HIV positive client posed harm to an uninformed, identifiable third party. Therefore, conceivably this segment of the sample was insufficient to elicit significant differences. Presently, research has only investigated differences between therapists who have had experience with HIV positive clients and those who have not had similar experience. Perhaps it would be useful, instead, to study differences between therapists who have actually confronted such a situation in actual practice and those who have not to determine whether a discrepancy in maintaining or breaching confidentiality actually exists between these two groups.

In the present study, 10% of therapists reported that they have faced the situation in which an HIV positive client posed harm to an uninformed, identifiable third party. Although respondents were asked to explain the action they chose to take, how they came to their decision, and the results, no
particular pattern emerged regarding how such situations are best resolved. In addition, a number of therapists described the action they chose to take but failed to report the results.

Examples of action taken by therapists confronted with this situation included: (a) "I did not inform the partner because testing positive for HIV does not pose an imminent physical, mental, or emotional injury to another person. It remains an important therapeutic issue for my client, however, who hopefully will inform his partner in the future;" (b) "I maintained client confidentiality, but gave generic warnings to those people involved with the client on how to avoid the risks of contracting the disease;" (c) "Contacted the medical center and discussed the matter with the doctor who was able to be sure the parties were informed;" (d) "I convinced them to reveal their status to their partner;" (e) "Told client if he didn't reveal his status or take necessary precautions with his partner I would be forced to disclose information. He terminated treatment;" (f) "The client refused to inform his partner but agreed to begin using a condom;" and (g) "The client eventually told his partner, and the parties separated. It was learned 6 months later that the party had now tested positive to HIV. The client continued in therapy until entering the hospital for the final time."

As noted earlier, compared to therapists, a much higher percentage of physicians reported having treated HIV positive patients. Overall, they also reported working with greater numbers of patients that are HIV positive. Therefore, it is surprising to note that only 7% of physicians, compared to 10%
of therapists, indicated that they had ever faced a situation in which an HIV positive patient posed harm to an uniformed, identifiable third party. Interestingly, numerous physicians commented that they there were never informed of such a situation or that these issues were not "presented." As one physician stated, "I don't routinely ask whether a patient plans to inform those he may be placing at risk." Another respondent stated, "My medical consultation is unrelated to social behaviors." Based on the respondents' comments, it may be possible that some physicians choose not to ask patients about their behaviors which may endanger third parties. As Hermann and Gagliano (1989) concluded, health care professionals may be deterred from making specific inquiries about high risk behaviors of patients if such exploration may lead to legal liability for failure to warn those parties.

Seven physicians who have been confronted with this situation provided an explanation of the course of action they chose to take. Examples included: (a) "HIV+ patient posed imminent risk to his sexual partner and his partner was informed. Patient was angry for awhile;" (b) "Hemophiliac male married to second wife. She wants children. I told the wife in front of the patient. She became angry at me and refused to believe there were any risks to her or baby;" (c) "Husband refused to inform wife. I did so after informing husband of my planned action and counseled her in my office. She requested testing and was HIV+;" and (d) "The USAF HIV Program performs anonymous contact tracing via local health departments. If an HIV+ patient names a sexual
contact, we notify the health department who, in turn, notifies the contact person that they have had sexual contact with an HIV+ person. We do not tell the contact the identity of the HIV+ person. This system works very well."

After considering the issues explored in this questionnaire, respondents were asked if they would hesitate working with individuals who have tested HIV positive. The majority of therapists (76%) reported they would not hesitate working with HIV positive individuals. However, 24%, or almost 1 in 4 therapists, indicated that they would hesitate. The reason most frequently cited for cause for hesitation specifically involved the lack of clear ethical guidelines and state statutes, and fear of potential liability related to the conflicting duties of maintaining client confidentiality and the protection of third parties. As one respondent stated, "I refuse to work with HIV positive individuals, because ACA has provided no direction on what to do when clients place others at risk. It is my understanding that the potential exists for me to be sued by my client if I breach confidentiality, and by the third party if I fail to do so. I have no desire to be the precedent-setting case in the state of Texas."

In reference to the issue of HIV and duty to protect, Harding et al. (1993) summarized, "Disparity exists within the legal community, among ethical positions taken by helping professions, and with authors debating this confidentiality dilemma" (p. 303). However, although debate has been rigorous in the literature, results of this study confirm that the uncertainty and confusion this issue generates affects therapists in actual practice. Most significantly, the
results also verify that some mental health professionals are consciously choosing not to work with HIV positive individuals due to the unresolved status of the ethical and legal issues involved.

Apparently, therapists' uncertainty and fear of potential liability is not unfounded. Georgianna (1992) surveyed 498 subjects identifying themselves as gay, lesbian, or bisexual concerning their views about therapists breaching confidentiality and informing third parties at risk of contracting HIV. Significantly, 61% of respondents reported that they would initiate a lawsuit against their therapist if he or she breached confidentiality and disclosed their HIV status to their partner without their permission. This finding may help explain therapists' hesitation in treating individuals who have tested HIV positive, particularly in light of the fact that ethical guidelines and state statutes have yet to be adopted to mitigate the opportunity of potential litigation.

In comparison to therapists, fewer physicians (10%) reported hesitance in treating HIV positive individuals. Several reasons may serve to explain this difference. First, as stated earlier, 94% of respondents in the physician sample reported having worked with HIV positive individuals. Therefore, if physicians have decided to include the treatment of HIV-related illnesses in their practice, they may have already acknowledged and accepted the potential complexities inherent in such cases. Second, physicians' hesitation may also be lessened because the AMA has provided its members with specific ethical guidelines that address the protection of third parties in HIV-related situations. Third, as
stated earlier, physicians may choose not to explore whether a patient is presenting a risk to an identifiable partner. Fourth, physicians may be more knowledgeable than therapists about available resources, such as partner notification programs, which can lessen the burden when confronted with such situations. Fifth, physicians have an ethical responsibility to treat HIV positive individuals. As the AMA Council on Ethical and Judicial Affairs (1988) stated,

A physician may not ethically refuse to treat a patient whose condition is within the physician’s current realm of competence solely because the patient is seropositive. Persons who are seropositive should not be subjected to discrimination based on fear or prejudice. (p. 1361)

The majority of physicians who reported that they would hesitate working with HIV positive individuals identified legal issues and fear of legal liability as the reasons for their concern. In contrast to therapists, no respondents in the physician sample attributed their hesitation to the lack of clear ethical guidelines. However, this result illustrates the point that ethical guidelines in and of themselves are not sufficient. Relevant state statutes are also essential. Although the AMA has established ethical guidelines pertinent to confidentiality and the protection of third parties in HIV-related situations, it appears that these guidelines have not provided physicians with confidence that the action they take will protect them from potential legal liability.

Understandably, considering therapists’ reported frustrations with the lack of direction relevant to this issue, 84% of respondents recommended that
ACA develop ethical guidelines which specifically address confidentiality and the duty to protect in HIV-related cases. This finding is consistent with a study conducted by Silverman (1993) in which 88% of the social workers surveyed indicated that it would be helpful if the National Association of Social Workers Code of Ethics specified a procedure to follow when working with HIV positive clients who do not wish to disclose their status to an at-risk, identifiable third person.

Therapists generated a variety of recommendations on how ACA should address this issue. The highest percentage of respondents, approximately 45%, stated that they believed therapists should have an ethical duty to breach confidentiality and inform third parties of potential harm in HIV-related cases. The finding appears consistent with Silverman (1993) who found that 67% of the social workers surveyed agreed that the current California ethical code of "Tarasoffing" should include notifying the partner in HIV-related situations.

In contrast to this group of respondents who advocated that ACA adopt a specific course of action, the next largest group of therapists (30%) simply emphasized the need for ACA to acknowledge the dilemma therapists face and provide direction on the most appropriate course of action. Apparently, these respondents simply prefer that the issue be addressed regardless of the course of action recommended. Other respondents (9%) advocated a discretionary duty which would permit the therapist to choose whether or not to breach confidentiality depending on the individual circumstances in a case.
Remarkably, no therapist advocated that ACA establish guidelines which mandate maintaining a client's confidential disclosures in HIV-related situations. Again, this finding directly conflicts with the number of articles found in the literature which advocate maintaining client confidentiality in such situations (Kain, 1988; Kermani & Weiss, 1989; Perry, 1989; Posey, 1988).

Specific comments provided by respondents also suggested that some therapists maybe be losing confidence in ACA's ability to address controversial issues pertinent to the profession in a timely manner. Respondents reflected their sense of discouragement by commenting that since ACA has failed to confront this issue, they would be forced to seek direction from other professional organizations such as the American Medical Association, the American Psychological Association, or the Texas Psychological Association.

In reference to therapists (16%) who did not recommend that ACA address this issue, several respondents offered an explanation for their position. These respondents emphasized that statutes pertaining to confidentiality and the duty to protect vary considerably from state to state. Therefore, they recommended that rather than national organizations addressing this issue, perhaps it would be most advantageous for state counseling associations to adopt ethical guidelines congruent with relevant state law. In summary, therapists overwhelmingly agreed that ethical guidelines pertinent to HIV and duty to protect need to be established.
However, like physicians, therapists also recommended that state statutes be enacted which would reduce their exposure to legal liability in HIV situations.

Finally, only 54% of therapists reported that they had ever received information related to the issue of HIV and the duty to protect third parties. Of the 46% of therapists that had never received any information on the subject, 37% indicated they had treated HIV positive clients. Even more significantly, within the physician sample only 35% of respondents reported having received such information. Of the 65% of physicians that indicated they had never received this information, 63% reported having treated HIV positive patients.

The two most frequently cited sources of information pertinent to this issue for therapists were conferences and books or articles, while physicians most frequently reported having received such information from books or articles and professional organizations.

These results demonstrate that an alarming number of therapists and physicians treat HIV positive patients without ever even being exposed to or educated on the issue of HIV and duty to protect third parties. This finding also appears to confirm that many therapists and physicians are completely unfamiliar with numerous articles in the literature that debate the limits of confidentiality in HIV-related situations.

Surprisingly, however, no significant difference existed in the mean confidence levels for those therapists and physicians who had received information relevant to this issue compared to those who had not received
such information. For therapists who had received such information, the mean confidence levels in relation to the four scenarios presented ranged from "6.9" to "7.4." For therapists who had not received such information, the mean confidence levels ranged from "6.5" to "7.0." For physicians who had received information, mean confidence levels ranged from "7.5" to "8.0," compared to "6.8" to "7.3" for physicians who had not received such information.

These results indicate that the information therapists and physicians have received on HIV and duty to protect has failed to significantly increase their confidence in resolving situations similar to those presented in the various scenarios. Apparently, debate in the literature and exposure to others' professional opinions regarding this issue is not sufficient in effectively raising levels of confidence regarding the most appropriate course of action in such circumstances. Perhaps, confidence is best enhanced by therapists and physicians knowing they are acting in accordance with ethical guidelines and state statutes which specifically address the limits of confidentiality in HIV situations.

Conversely, it is important to note that confidence levels did not appear to be adversely affected when respondents reported they had never received information on HIV and duty to protect third parties. Therefore, this finding may indicate that therapists and physicians do not base their level of confidence on how informed they are about this subject, but rather on their personal beliefs regarding how such situations are best resolved. Further
research is needed to gain an understanding of what factors promote confidence in choosing the most appropriate course of action in such situations.

Conclusions

Based upon the findings of this study, the following conclusions were reached.

1. When a client who has tested HIV positive poses harm to an uninformed, identifiable third party, therapists appear to agree that they have an obligation to inform the third party. However, the assessment of the degree of dangerousness that a client poses appears to be an important factor before therapists decide whether or not to breach confidentiality. If a client refuses to inform the partner of his or her HIV status and continues to engage in high risk activities such as unprotected sex or sharing needles, then therapists agree that confidentiality should be breached and the third party be informed. On the other hand, if the degree of dangerousness is substantially reduced, for example if the client is engaging in protected sex, then significantly more therapists choose to maintain confidentiality. Furthermore, once the degree of dangerousness is established, therapists appear to agree that confidentiality should be breached regardless of whether the endangered third party is a spouse, a sexual partner who is not a spouse, or an individual with whom the client shares needles. Also, significantly more therapists elect to inform the
endangered third party directly rather than notify medical or law enforcement personnel.

2. Consistent with therapists, physicians also significantly agreed that confidentiality should be breached when an HIV positive patient poses harm to an uniformed, identifiable third party. In situations in which a spouse or sexual partner is in jeopardy of contracting the virus, physicians chose to inform the at-risk third party. However, in a case involving a needle-sharing partner, significantly more physicians reported they would notify medical or law enforcement personnel. Physicians also appeared to evaluate the degree of dangerousness that a patient poses to a third party before deciding what action to take. Like therapists, physicians chose to maintain confidentiality when the level of dangerousness was reduced by the patient using a condom during sexual activity.

3. The results also specifically confirmed the importance given to assessing the degree of danger an HIV positive client poses to another person. When asked to rank order five factors provided that they would utilize and consider most important, respondents in both sample groups ranked "degree of dangerousness" highest, followed by "ethical considerations," "legal issues," "identifiability of the third party," and "effects on the therapist/client (or physician/patient) relationship."

4. Therapists and physicians emphasized the need for specific ethical guidelines and state statutes relevant to the issue of HIV and duty to protect.
When asked to rank in order of importance the five resources provided that they would utilize when deciding whether or not to breach confidentiality in such a situation, the results showed that therapists ranked "review ethical guidelines" as the most important resource followed by "review state statutes," "consult with colleagues," "consult with an attorney," and "review relevant professional literature." The overall ranking for physicians was similar to therapists, however they ranked "consult with an attorney" as more important than "consult with colleagues."

These results confirm that if therapists were confronted with an HIV situation in which they were forced to choose between competing values of maintaining client confidentiality and protecting a third party from harm, they would refer to their professional ethical codes for direction. However, since the American Counseling Association (ACA) has yet to establish ethical guidelines which address this issue, therapists must make a decision without this guidance. Furthermore, therapists and physicians considered state statutes to be an important resource in their decision-making process. Yet, again, presently Texas law does not address the issue of protection of third parties in HIV situations. In summary, considering the complexity of the issues involved and the lack of resources available, perhaps the time has come for therapists to actively advocate that professional organizations address this issue and pertinent state legislation be enacted in order to clarify mental health professionals' responsibilities and limit potential liability in such situations.
5. The majority of therapists do not demonstrate that they are knowledgeable that Texas law limits breaching confidentiality to medical or law enforcement personnel when a client poses danger to a third party. Evidently, education is critically needed so that therapists can make informed decisions that will not place them at risk for legal liability in such situations.

6. Therapists do not advocate that state statutes be enacted which mandate maintaining an HIV positive client's confidential disclosures when they pose danger to third parties. Instead, the majority of therapists are divided in recommending either a discretionary duty or a mandated duty to protect. This recommendation is also consistent with therapists' selected courses of action in the scenarios presented. Furthermore, if therapists lobbied to ensure legislation relevant to this issue was passed, perhaps it would be helpful for ACA, like the AMA, to develop model statutes in an attempt to keep state laws congruent with ethical guidelines, assuming that such guidelines are eventually established.

7. Therapists who have had experience with HIV positive clients are no more likely than therapists without such experience to breach confidentiality when a client poses harm to a third party.

8. The majority of therapists and physicians reported they would not hesitate treating an individual who is HIV positive. However, 1 in 4 therapists admitted they would hesitate. Significantly, the most frequently cited reason for hesitation specifically involved the lack of clear ethical guidelines and state
statutes resulting in a fear of potential liability. These results confirmed that some therapists are making a conscious decision not to treat HIV positive individuals. Therefore, as the AIDS epidemic continues to expand it becomes imperative that any barriers to treatment be removed so that therapists can meet this challenge.

9. An overwhelming majority of therapists recommended that ACA develop ethical guidelines which address confidentiality and the duty to protect in HIV-related cases. Specifically, the greatest number of respondents reported that they believed therapists should have an ethical duty to breach confidentiality in order to avert danger to third parties in such situations. The second largest group of therapists did not provide a specific recommendation but strongly emphasized the need for ACA to acknowledge this confidentiality dilemma and provide direction on the appropriate course of action. Other therapists advocated a discretionary duty. No therapist advocated a mandated duty to maintain client confidentiality in such situations.

Recommendations for Further Research

Based on the results and conclusions of this study, the following recommendations for further research are suggested.

1. Replication of this study in states other than Texas would be desirable to determine whether these results are specific to the state of Texas or are generalizable to a national level.
2. In the absence of ethical guidelines and state statutes pertinent to the issue of HIV and duty to protect third parties, further research is requisite in achieving a deeper understanding of how therapists decide what is the most appropriate course of action in such situations.

3. In the present study, degree of dangerousness and identifiability of the victim were established in each of the scenarios. However, further research is warranted to examine what course of action therapists and physicians would select in more difficult cases, for example, when the at-risk third party is not readily identifiable or when the client has been exposed to HIV but refuses to be tested.

4. Research is needed to identify effective intervention strategies which promote personal responsibility by facilitating the exploration of issues such as fear of rejection, abandonment, and isolation, which may inhibit clients from self-disclosing their HIV status to at-risk third parties.

5. AIDS forces mental health professionals to confront their own values. Therefore, research which clarifies how therapists' values, attitudes, fears, and biases may influence their decision-making process when confronting such situations is crucial. Understanding and clarifying these factors would increase the likelihood of mental health professionals providing quality care.

6. Working with clients who have tested HIV positive requires specialized knowledge, skills, and understanding of the ethical, legal and treatment issues involved. Therefore, research evaluating how mental health
professionals are being prepared to meet this challenge is critical. Such studies could serve as the impetus for further training on HIV-related issues in graduate programs.

7. Research is also necessary to determine the efficacy of alternative resources, such as partner notification programs, self-notification programs, and contact tracing, which promote the protection of individuals who are unaware of their exposure to HIV. Utilization of such resources could help prevent further erosion of the fundamental principle of confidentiality in psychotherapy.

8. Disclosure of confidential information in the state of Texas is limited to medical or law enforcement personnel. Research is needed to determine what specific action is taken after such reports are made to authorities to ascertain if the therapist’s duty to protect third parties is indeed fulfilled.

9. Research would be beneficial which examines differences in personality characteristics and situational factors between those individuals who adopt safe sex practices and those who continue to place others at risk.
APPENDIX A

THERAPIST SURVEY
PRIVACY GUIDELINES

1. Your participation is voluntary.

2. PLEASE DO NOT PUT YOUR NAME ON THIS QUESTIONNAIRE. Your participation is strictly confidential. Your responses will be processed by the University of North Texas Computing Center. Any reports on the research data will be based on group composites, not individual cases.

3. Your effort in answering all items is appreciated.

4. Please indicate that you have read and understood these privacy guidelines by placing an "X" in the box below.

THANK YOU FOR YOUR PARTICIPATION!
HIV: CONFIDENTIALITY VERSUS DUTY TO PROTECT

PLEASE CHECK THE COURSE OF ACTION YOU BELIEVE YOU WOULD TAKE IF CONFRONTED WITH THE FOLLOWING SCENARIOS.

1. Client A informs you that, after having an affair, he has tested HIV positive. Despite your encouragement, the client refuses to inform his spouse, with whom he continues to engage in regular, unprotected sex, for fear of her learning of his infidelity.
   If confronted with this situation, would you:

   (a) _____ Maintain the client's confidentiality
   (b) _____ Inform the spouse of the potential harm
   (c) _____ Notify medical or law enforcement personnel

   On a scale from 1 to 10, please rank how confident you are of your response (1 = very little confidence, 10 = highly confident): _____

2. Client B is a homosexual male who has been in a monogamous relationship with a man he has lived with for five years. After recently applying for health insurance, he reveals to you that he tested HIV positive. Although you have encouraged him to reveal his status to his partner, with whom he continues to engage in regular, unprotected sex, the client refuses to do so, fearing that his partner will leave him.
   If confronted with this situation, would you:

   (a) _____ Maintain the client's confidentiality
   (b) _____ Inform the partner of the potential harm
   (c) _____ Notify medical or law enforcement personnel

   On a scale from 1 to 10, please rank how confident you are of your response: _____
3. Client C is an IV drug user who informs you that she has tested HIV positive yet continues to share needles with her roommate. Although you have repeatedly encouraged the client to stop sharing needles with her roommate and inform her of her HIV status, the client refuses to take such action. If confronted with this situation, would you:

(a) _____ Maintain the client’s confidentiality
(b) _____ Inform the roommate of the potential harm
(c) _____ Notify medical or law enforcement personnel

On a scale from 1 to 10, please rank how confident you are of your response: ____

4. Client D has informed you that he has tested positive for HIV. He lives with his partner and is sexually active. Although you have encouraged him to inform his partner of his HIV status, he has refused to do so. However, he assures you that whenever they engage in sexual activity he wears a condom.

If confronted with this situation, would you:

(a) _____ Maintain the client’s confidentiality
(b) _____ Inform the partner of the potential harm
(c) _____ Notify medical or law enforcement personnel

On a scale from 1 to 10, please rank how confident you are of your response: ____

FOR QUESTIONS 5 AND 6, PLEASE RANK ORDER THE RESPONSES FROM MOST IMPORTANT (1) TO LEAST IMPORTANT (5).

5. What specific resources would you consider most important to utilize when making the decision to maintain or breach confidentiality when a client, who has tested HIV positive, poses harm to an uninformed, identifiable third party? (Please rank order responses from 1 to 5.)

(a) _____ Review relevant professional literature
(b) _____ Consult with colleagues
(c) _____ Consult with an attorney
(d) _____ Review ethical standards
(e) _____ Review state statutes
(f) _____ Other, please specify: ______________________________
6. If you would consider breaching confidentiality in such a case, what specific factors would you consider most important before taking such action? (Please rank order responses from 1 to 5.)

(a) _____ Degree of dangerousness that the client poses to a third party
(b) _____ Identifiability of the third party
(c) _____ Ethical considerations
(d) _____ Legal issues
(e) _____ Effects on the therapeutic relationship
(f) _____ Other, please specify: ________________________________

PLEASE ANSWER THE FOLLOWING QUESTIONS BY CHECKING THE APPROPRIATE BLANK.

7. Do you routinely inform clients of the limits of confidentiality at the onset of therapy?

_____ Yes  _____ No

8. According to Texas law, if a therapist determines that a client poses a probability of imminent physical injury to another person, the therapist: (check all that apply)

(a) _____ may disclose confidential information to the person(s) at-risk;
(b) _____ may disclose confidential information to medical or law enforcement personnel;
(c) _____ must maintain the client's confidentiality.

9. Have you worked with clients who have tested HIV positive?

_____ Yes  _____ No

If so, how many? _____
10. Have you worked with a client(s) who is HIV positive and posed harm to an uninformed, identifiable third party?

    _____ Yes    _____ No

If so, please explain what action you chose to take, how you came to this decision, and what were the results of taking this action.

11. How would you recommend that current state statutes be revised in reference to maintaining or breaching confidentiality when third parties are endangered by clients who have tested HIV positive? Would you recommend:

    (a) _____ legally mandated confidentiality with immunity from prosecution for not notifying an at-risk third party;
    (b) _____ a legally mandated duty to protect which would provide immunity if the therapist acted in good faith and used reasonable care when notifying an endangered third party, but which would also place the therapist at risk for potential liability if the endangered party was not notified;
    (c) _____ a discretionary duty which would provide immunity if a therapist chose either to breach or not to breach confidentiality to an at-risk third party provided that the therapist acted in good faith and within a reasonable standard of care within the profession;
    (d) _____ no change in existing statutes.
12. Considering the issues explored in this questionnaire, would you hesitate working with an individual who has tested HIV positive?

_____ Yes  _____ No

If yes, please state why:__________________________________________

_________________________________________________________________

13. Do you believe the American Counseling Association should develop ethical guidelines which specifically address confidentiality and the duty to protect in HIV-related cases?

_____ Yes  _____ No

If yes, what type of guidelines would you recommend that ACA adopt?

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________
**BACKGROUND INFORMATION**

Please answer the following questions by checking the appropriate blank.

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<tr>
<th>Gender:</th>
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<th>Female</th>
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Year highest degree was earned: _____

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<th>Number of years of counseling experience:</th>
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</tr>
<tr>
<td></td>
<td>University</td>
<td>Other (Please specify: ____________)</td>
</tr>
</tbody>
</table>

Have you ever received information specifically related to the issue of HIV and the duty to protect third parties?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

If yes, what was the source of this information? (Check all that apply.)

| Course work | Books or articles | Conferences, seminars, or workshops | Professional organizations | Other (please specify: ____________) |
SUMMARY OF RESULTS

If you are interested in receiving a summary of the results of this research study, please complete the following information. To maintain your confidentiality, please detach this page and mail it in a separate envelope to:

Laura Johnson
2601 Belmeade Drive
Carrollton, Texas 75006

Name: ____________________________________________________________

Address: __________________________________________________________

_________________________________________________________________

THANK YOU AGAIN FOR YOUR PARTICIPATION!
APPENDIX B

PHYSICIAN SURVEY
PRIVACY GUIDELINES

1. Your participation is voluntary.

2. PLEASE DO NOT PUT YOUR NAME ON THIS QUESTIONNAIRE. Your participation is strictly confidential. Your responses will be processed by the University of North Texas Computing Center. Any reports on the research data will be based on group composites, not individual cases.

3. Your effort in answering all items is appreciated.

4. Please indicate that you have read and understood these privacy guidelines by placing an "X" in the box below.

THANK YOU FOR YOUR PARTICIPATION!
HIV: CONFIDENTIALITY VERSUS DUTY TO PROTECT

PLEASE CHECK THE COURSE OF ACTION YOU BELIEVE YOU WOULD TAKE IF CONFRONTED WITH THE FOLLOWING SCENARIOS.

1. Patient A has tested positive for HIV. Despite your encouragement, the patient refuses to inform his spouse, with whom he continues to engage in regular, unprotected sex, for fear of her learning of his infidelity. If confronted with this situation, would you:

(a) _____ Maintain the patient's confidentiality
(b) _____ Inform the spouse of the potential harm
(c) _____ Notify medical or law enforcement personnel

On a scale of 1 to 10, please rank how confident you are of your response (1 = very little confidence, 10 = highly confident): ____

2. Patient B is a homosexual male who has been in a monogamous relationship with a man he has lived with for five years. After recently applying for health insurance, he reveals to you that he tested HIV positive. Although you have encouraged him to reveal his status to his partner, with whom he continues to engage in regular, unprotected sex, the patient refuses to do so, fearing that his partner will leave him. If confronted with this situation, would you:

(a) _____ Maintain the patient's confidentiality
(b) _____ Inform the partner of the potential harm
(c) _____ Notify medical or law enforcement personnel

On a scale of 1 to 10, please rank how confident you are of your response: ____
3. Patient C is an IV drug user and has tested HIV positive, yet she continues to share needles with her roommate. Although you have repeatedly encouraged the patient to stop sharing needles with her roommate and inform her of her HIV status, the patient refuses to take such action. If confronted with this situation, would you:

(a) _____ Maintain the patient’s confidentiality
(b) _____ Inform the roommate of the potential harm
(c) _____ Notify medical or law enforcement personnel

On a scale of 1 to 10, please rank how confident you are of your response: ____

4. Patient D has tested positive for HIV. He lives with his partner and is sexually active. Although you have encouraged him to inform his partner of his HIV status, he has refused to do so. However, he assures you that whenever they engage in sexual activity he wears a condom. If confronted with this situation, would you:

(a) _____ Maintain the patient’s confidentiality
(b) _____ Inform the partner of the potential harm
(c) _____ Notify medical or law enforcement personnel

On a scale of 1 to 10, please rank how confident you are of your response: ____

FOR QUESTIONS 5 AND 6, PLEASE RANK ORDER RESPONSES FROM MOST IMPORTANT (1) TO LEAST IMPORTANT (5).

5. What specific resources would you consider most important to utilize when making the decision to maintain or breach confidentiality when a patient, who has tested HIV positive, poses harm to an uninformed, identifiable third party? (Please rank order responses from 1 to 5.)

(a) _____ Review relevant professional literature
(b) _____ Consult with colleagues
(c) _____ Consult with an attorney
(d) _____ Review ethical standards
(e) _____ Review state statutes
(f) _____ Other, please specify: _____________________________________________
6. If you would consider breaching confidentiality in such a case, what specific factors would you consider most important before taking such action? (Please rank order responses from 1 to 5.)

(a) _____ Degree of dangerousness that the patient poses to a third party
(b) _____ Identifiability of the third party
(c) _____ Ethical considerations
(d) _____ Legal issues
(e) _____ Effects on physician/patient relationship
(f) _____ Other, please specify: _________________________________

PLEASE ANSWER THE FOLLOWING QUESTIONS BY CHECKING THE APPROPRIATE BLANK.

7. Do you routinely inform patients of the limits of confidentiality at the onset of treatment?

_____ Yes  _____ No

8. According to Texas law, if a physician determines that a patient poses a probability of imminent physical injury to another person, the physician:
   (check all that apply)

(a) _____ may disclose confidential information to the person(s) at-risk;
(b) _____ may disclose confidential information to medical or law enforcement personnel;
(c) _____ must maintain the patient’s confidentiality.

9. Have you worked with patients who have tested HIV positive?

_____ Yes  _____ No

If so, how many? _____
10. Have you worked with a patient(s) who is HIV positive and posed harm to an uninformed, identifiable third party?  

- Yes  
- No

11. If so, please explain what action you chose to take, how you came to this decision, and what were the results of taking this action.

- 
- 
- 

12. How would you recommend that current state statutes be revised in reference to maintaining or breaching confidentiality when third parties are endangered by patients who have tested HIV positive? Would you recommend:

(a) _____ legally mandated confidentiality with immunity from prosecution for not notifying an at-risk third party;
(b) _____ a legally mandated duty to protect which would provide immunity if the physician acted in good faith and used reasonable care when notifying an endangered third party, but which would also place the physician at risk for potential liability if the endangered party was not notified;
(c) _____ a discretionary duty which would provide immunity if a physician chose either to breach or not to breach confidentiality to an at-risk third party provided that the physician acted in good faith and within a reasonable standard of care within the profession;
(d) _____ no change in existing statutes.

13. Considering the issues explored in this questionnaire, would you hesitate working with an individual who has tested HIV positive?  

- Yes  
- No

If yes, please state why: _____________________________________________

- 

BACKGROUND INFORMATION

Please answer the following questions by checking the appropriate blank.

Gender: _____ Male _____ Female

Age: _____ 25 - 35 _____ 46 - 55
      _____ 36 - 45 _____ 56 - up

Number of years in medical practice:

      _____ 0 - 5 _____ 16 - 20
      _____ 6 - 10 _____ 21 - 25
      _____ 11 - 15 _____ 26 - up

Year medical degree was earned? _____

Work Setting: _____ Private Practice _____ Clinic
          _____ Hospital _____ Other (please specify: ___)
          _____ University

Have you ever received information specifically related to the issue of HIV and the
duty to protect third parties?

      _____ Yes _____ No

If yes, what was the source of this information? (Check all that apply.)

      _____ Course work
      _____ Books or articles
      _____ Conferences, seminars, or workshops
      _____ Professional organizations
      _____ Other (please specify: ______________)
SUMMARY OF RESULTS

If you are interested in receiving a summary of the results of this research study, please complete the following information. To maintain your confidentiality, please detach this page and mail it in a separate envelope to:

Laura Johnson  
2601 Belmeade Drive  
Carrollton, TX 75006

Name: ________________________________

Address: __________________________________
________________________________________
________________________________________

THANK YOU AGAIN FOR YOUR PARTICIPATION!
APPENDIX C

COVER LETTER
Dear Colleague:

You have been selected to participate in a research study which explores the course of action therapists and physicians select when confronted with a client who has tested HIV positive and poses harm to an identifiable third party. The results of this study will help distinguish specific factors which play a role in the health professional’s decision-making process. In addition, information obtained from this study could assist professional organizations and the state legislature in establishing new ethical guidelines and state statutes relevant to this issue.

The enclosed questionnaire is very brief and will require approximately ten minutes of your time. Your participation will contribute significantly to the compilation of accurate information.

The questionnaire has been coded to permit follow-up on forms not returned. Your responses will remain completely confidential, and the results of this study will only be presented in a group format. You are encouraged to complete and return the last page of the questionnaire if you are interested in receiving a summary of the results.

A self-addressed, stamped envelope is provided. Your cooperation in responding to the questionnaire and its prompt return is deeply appreciated. If you have any questions, please feel free to contact me at (214) 418-9367.

Sincerely,

Laura Johnson, M.Ed.
Doctoral Candidate

Byron Medler, Ed.D.
Coordinator, Counselor Education Program
APPENDIX D

FOLLOW-UP POSTCARD
Dear Colleague:

Recently, you were mailed a questionnaire entitled "HIV: Confidentiality Versus Duty to Protect." If you have returned the questionnaire, thank you for your prompt reply. If you have not yet had the opportunity to complete it, please do so now and return it in the postage-paid envelope supplied.

Your response is very important, and your cooperation is much appreciated. Thank you again for your participation.

Sincerely,

Laura Johnson, M.Ed., L.P.C.
APPENDIX E

FOLLOW-UP COVER LETTER
Dear Colleague:

Recently you received a survey entitled "HIV: Confidentiality Versus Duty to Protect." Your input is of critical importance to the validity of the results of this research study. Information obtained from this study could assist professional organizations and the state legislature in establishing new ethical guidelines and state statutes relevant to confidentiality issues and the duty to protect third parties in HIV-related situations.

The enclosed questionnaire is very brief and will require approximately ten minutes of your time. Your responses will remain completely confidential, and the results of this study will only be presented in a group format. In addition, you are encouraged to complete and return the last page of the questionnaire if you are interested in receiving a summary of the results.

A self-addressed, stamped envelope is enclosed. Your cooperation in responding to the questionnaire and its prompt return is deeply appreciated. If you have any questions, please feel free to contact me at (214) 418-9367.

Sincerely,

Laura Johnson, M.Ed.  Byron Medler, Ed.D.
Doctoral Candidate  Coordinator, Counselor
Education Program
REFERENCES


*Davis v. Rodman*, 227 S.W.614 (1921).


Simonsen v. Swenson, 177 N.W.2d 831 (1920).


Texas Health and Safety Code, Title 2, Sec. 81.003 (1992).

Texas Health and Safety Code, Title 2, Sec. 81.102 (1992).

Texas Health and Safety Code, Title 2, Sec. 81.103 (1992).

Texas Health and Safety Code, Title 7, Sec. 611.004 (1992).


