

Confidentiality, Informed Consent, and Ethical Considerations in Reviewing the
Client's Psychotherapy Records

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Abstract

Ethical dilemmas that break the confidentiality of the client eventually test the psychologist's boundaries such that not taking action may place the patient in a position where they suffer, hurt themselves, or others. The effectiveness in obtaining a valid informed consent might depend upon the therapists training, experience, and sound judgement in conveying the extent of the therapy and limitations imposed by the information disclosed. Therefore, maintaining confidentiality during counseling while working with minors may pose unique scenarios in which the therapists must re-evaluate their approach to therapy. This paper reviews important ethical issues related to confidentiality, informed consent, the right to know, and HIPAA requirements fundamental to the therapeutic success of all parties involved.

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Sullivan, Ramirez, Rae, Peña Razo, and George (2002) asked "how do psychologists decide whether to break confidentiality in order to inform parents of risk-taking adolescent clients about the potential harm that may result from the adolescent's behavior" with an underlying theme that will "encourage open communication and trust during treatment" as they assure the clients that "confidentiality will be maintained." Ethical issues of confidentiality continue to move away from "paternalism (the doctor knows best) towards autonomy (the patient knows best)" in such a manner that trust becomes a focal point in the relationship between the clinician and the client (Weiner, 2001, p. 432).

Answering these types of questions are difficult, because Weiner (2001) suggests that confidentiality is not easily defined. There are subtle differences that include secrecy and privacy reflecting a "central paradox" in which the therapists' attitudes toward confidentiality are shown by the different reflections in their therapy notes (p. 436). Ethical dilemmas that break the confidentiality of the patient eventually test the psychologist's boundaries such that not taking action in protecting the patient may allow the patient to suffer, hurt themselves, or others.

Maintaining confidentiality during counseling while working with minors may pose unique scenarios in which the therapists must evaluate their approach to therapy from different therapeutic perspectives. According to Gustafson and McNamara (1987), minors have a greater dependency of trust and value the faithfulness of the clinician's agreement to maintain their privacy than adults, as it

becomes a fundamental reason why minor's participate in the therapeutic sessions. The *Ethical Principles of Psychologists and Code of Conduct* guidelines (American Psychological Association [APA], 1996), reminds the therapist that their primary responsibility and obligation is to protect the confidentiality of their clients.¹

As a minor seeks therapy for abuse (e.g., sexual and substance), or advise on issues of sexual activity (e.g., transmitted diseases, contraception, pregnancy, and birth control options) as an example, Gustafson and McNamara (1987) suggests that legal consent, consideration, and treatment of minors is allowed under most jurisdictions without parental consent (e.g., HIPAA, 2003, p. 19, §164.502).

Furthermore, exceptions related to "sufficient maturity", emancipation, treatment due to emergencies, and in cases where the court has ordered treatment, although designed to offer the minor additional options of choice, has left the clinician confused because the "exceptions are vague, [and] vary from state to state." The *Summary of California Laws Relating to the Practice of Psychology* (State of California Department of Consumer Affairs Board of Psychology, 2005) does clarify several exceptions, noting that a minor may consent to treatment under the following circumstances:

- (1) The minor is 15 years of age or older.
 - (2) The minor is living separate and apart from the minor's parents or guardian, whether with or without the consent of a parent or guardian and regardless of the duration of the separate residence.
 - (3) The minor is managing the minor's own financial affairs, regardless of the source of the minor's income.
- (b) The parents or

¹ See <http://www.apa.org/ethics/code1992.html#5.02>

guardians are not liable for medical care or dental care provided pursuant to this section. (c) A physician and surgeon or dentist may, with or without the consent of the minor patient, advise the minor's parent or guardian of the treatment given or needed if the physician and surgeon or dentist has reason to know, on the basis of the information given by the minor, the whereabouts of the parent or guardian (p. 71).

A factor in client confidentiality is the therapist's attitude toward informed consent. Beeman and Scott (1991) surveyed a group of therapists ($N = 255$) and found that while patients had clearly expressed the importance of protecting their confidentiality, the client was still quite vulnerable because the clinician invariably had less than an equal view similar to the patients. Rubanowitz (1987) additionally examined the appropriate confidentiality limits as perceived by the public. The results suggest that there should be a clear and concise operational definition for privacy, privileged communication, and confidentiality within the framework of the psychotherapist-client relationship. Furthermore, the patients seemed more interested in the practical matters related to the limits of confidentiality rather than the theory behind the ethical codes.

Although there is an indication from this sample of mental health professionals that protecting communication confidentiality was important, it continues to be an ever-pressing issue by various third party sources who request the release of the patient's records contrary to any confidentiality agreement already signed (Rubanowitz, 1987). This issue may stem from an underlying trend that presupposes the confidentiality, protection, safety, and welfare of the public as an overriding consideration. The results of this study, similar to those of Beeman and Scott (1991), suggest that the patients had a

reasonable expectation that the therapist should protect their privacy, however, they also recognized the value of protecting the public and as such, it would be appropriate to disclose the confidential information but in a manner considered professional in nature.

Protecting the public may be difficult at times because Beeman and Scott (1991) report that the responsibilities of the psychologists can be ambiguous, and the ethical and legal concerns when counseling minors adds to the informed consent drama and the breach of confidentiality. Their experiment results indicated that nearly 30% of the clinicians failed to obtain a written consent from the minor. In addition, nearly 11% of the adolescents did not fully understand the consent form they signed or its implications. Furthermore, their study found that a primary reason why therapists did not offer a consent form to the minor was due to concerns that the minor might refuse therapy.

Patients with substance abuse dependencies pose additional challenges not otherwise considered in the adult population. McCrady and Bux (1999) suggest that it is commonplace for high-risk participants to sign informed consents while they are intoxicated or high on drugs. Therapist may need to wait for research, treatment, and intervention until the patient is sober and chemical free so as to not compromise the ethical, legal, and limits of confidentiality. The McCrady and Bux study ($N = 19,060$; clinical participants) found that substance abusers as generalized were a complex population that required thoughtful and creative methodologies in order to obtain a signed consent form that was not diluted by the patients intoxicated or drug high condition.

Taylor and Adleman (1998) supported these complex issues and found that 11.3% of the adolescents did not sufficiently comprehend the information on the consent form and another 11.6% refused to give permission at the time of therapy. Suggesting the informed consent refusals were partly due to a lack of understanding with respect to the session expectations, nature of the therapy, and the overall limits of confidentiality. Additionally, one could take into account that the average age of the minor was 12.8 years ($SD = 1.8$ yrs), which is below the 15 years of age consent consideration. Subsequently, counseling minors may place the therapists in a situation where they walk a fine line between "undermining the right to privacy and the benefits to the intervention process", when it comes to maintaining the confidentiality of the at-risk adolescent (Taylor & Adelman, 1998, p. 267).

However, this is not enough to ignore the serious nature of detrimental information that cause harm to the patient or others. Taylor and Adleman (1998) suggest that the right to privacy, exceptions to ethical considerations, informing minors about the limits of confidentiality, and making sure they clearly understand those limits is vital in a therapeutic relationship. In as much that, the researchers suggest there are times when parents need to know the information disclosed in confidence because they are part of the problem solving process.

VandeCreek, Miars, and Herzog (1987) study ($N = 116$, range 17 - 20 years of age) also surveyed adolescent participants to assess their attitudes toward therapist confidentiality expectations especially when the clinician had a dual role in therapy for both boy-girl friend problems. The overwhelming majority

of the clients had an expectation of continued privacy regardless of the scenario that might prompt the therapist to reveal personal information. The clients deemed it unethical and the clinician would clearly be violating their "trust and wishes."

VandeCreek et al. (1987) discussion found some major areas of concern in their study when addressing confidentiality issues by the "overall reactions of clients to disclosure of confidential communications, variations in reactions depending on presenting problems and potential recipients of information, differences between anticipations and preferences, and individual client differences in anticipation and preference (clusters)." Although clinicians should strive to provide a secure method in which the minor can freely express himself or herself, it is vitally important that the minor clearly understand it is in everyone's best interest that private and personal matters be resolved in an amicable fashion that is both confidential and professional. Such difficulties in therapeutic resolution become apparent when the request for help is from a teenager with unwanted pregnancy.

As commonplace as this may sound, clinicians who counsel minors, according to Ledyard (1998), face critical decisions regarding privileged communication, parental consent, informed consent, competency, and intervention that are critical in determining the outcome in similar types of counseling situations. Although Ledyard suggests that the counselor does not have an ethical obligation (depending upon the state) to inform the parents, understanding the level of competency, in a minor, is primary as an underlying

construct when complying with the American Counseling Association's (ACA, 2005) *Code of Ethics*.

Namely, that "clients have the freedom to choose whether to enter into or remain in a counseling relationship and need adequate information about the counseling process and the counselor. Counselors have an obligation to review in writing and verbally with clients the rights and responsibilities of both the counselor and the client...informed consent is an ongoing part of the counseling process, and counselors appropriately document discussions of informed consent throughout the counseling relationship" (p. 4, section A.2.a).

Similar issues in California's recent November 9, 2005 special election, which contained an informed consent ballot measure (i.e., Proposition 73, *Waiting Period and Parental Notification before Termination of Minor's Pregnancy. Initiative Constitutional Amendment*)² that was narrowly defeated (No = 52.6%, Yes = 47.4%).³ The main thrust of the initiative was to give parents or the legal guardian, 48 hours notice prior to a minor's intent to terminate (i.e., abort) an unwanted pregnancy except in a medical emergency.

Proposition 73 proponents noted that a child under the age of eighteen cannot get a "flu shot, she can't go on a school trip, she can't have a tooth pulled, [and] she can't get her ears pierced" without parental or guardian consent, yet, the same thirteen year old girl can have an abortion.⁴ Opponents of Proposition 73 suggest that the "government cannot mandate good family communication"

² See http://voterguide.ss.ca.gov/prop73/title_summary.shtm.

³ 100% of the precincts reported <http://vote2005.ss.ca.gov>Returns/prop/00.htm>.

⁴ See <http://www.yeson73.net/>.

and mandatory notification laws will force teenagers into dangerous "back-alley or self-induced abortions" instead of seeking appropriate medical help.⁵

Proposition 73 was narrowed down to an abortion issue, and the passing of the initiative would have clearly defined abortion as causing the "death of the unborn child, a child conceived but not yet born"; instead of focusing on what could have been a parent's right-to-know and the minor's right-to-confidentiality. Morality constituents on both sides overshadowed these two issues (i.e., parents right-to-know and the minor's right-to-confidentiality), such that focusing on the parent-child communications reform in the initiatives was lost in the rhetoric. The lack of communication between parent and child is an essential variable that therapist would want to consider while outlining their approach in obtaining a valid informed consent.

These issues among others surrounding informed consent have continued to change over the past 15 years. Another is the consideration of appropriate ethical code concerns in client queries and a candid explanation of those concerns to the satisfaction of the patient and guardian. Pomerantz and Handelsman (2004) suggested that clinicians should approach informed consent, as an example, with the same fever and care as though the patient were one of their own "loved ones", with an expectation of taking the extra time and effort needed.

Such is the case, as in many states, children are not required to sign an informed consent form under the age of twelve according to Brewer and Faitak

⁵ See <http://www.noonproposition73.org/>.

(1989), and suggest that the clinician tends to become too lax in protecting the confidentiality of the minor in therapy. Furthermore, since the parents or legal guardian are frequently involved in the therapeutic sessions, the therapist must fully understand that a dual client relationship may exist and the rights of both parent and child require greater consideration, especially when the parents are not able to volunteer their time as required to successfully help complete the minor's therapy.

The researchers remind the clinician that parental involvement can be a two edged sword. One in which the parent is over-protective and acts as though they know what is best for child in therapy, while others have a nonchalant attitude and consider their attendance only a matter of duty. Brewer and Faitak (1989) urge parents to be active in the child's therapy by providing encouragement while fully understanding the skill and effectiveness of the therapist.

The effectiveness in obtaining a valid informed consent may depend upon the therapists training, experience, and sound judgement in conveying the extent of the therapy and limitations imposed by the information disclosed. Such is the case when counseling homeless adolescents, according to Rew, Taylor-Seehafer, and Thomas (2000). They found that providing therapy for the homeless adolescents required the clinician to reconsider additional ethical and legal ramifications that otherwise might go unnoticed in other populations.

Many homeless lack the legal capacity to authorize an informed consent according to Rew et al. (2000). Therefore, it is advisable to seek counsel from the

Institutional Review Board committee (IRB) as a viable alternative. The IRB's guidance can help the clinician define the research and therapeutic parameters that provide the assurance of confidentiality, anonymity, and protection of the adolescent's rights. While keeping in mind that the adolescent's confidentiality rights may cease when there is the potential for harm to themselves or others.

Chenneville (2000) supports this view and suggests that the responsibility to warn outweighs the therapist's breach of confidentiality. Such is the case when a therapist counsels those individuals with HIV/AIDS and the seriousness of the illness. There are difficult decisions in these types of cases, which include breach of confidentiality, deterioration of the relationship, and consideration for the various outcomes that may affect the well-being of the patient. Confidentiality is extremely important when therapists are counseling patients with HIV/AIDS, as when weighing the final decision and whether to release the private information may be worse than making it.

According to Chenneville (2000), effective decision-making methodologies also need additional consideration in order to protect the rights of the patient, clinician, and third parties. This includes determining if the disclosure of information is within the ethical guidelines of the individual state laws as they also play an important role in the confidentiality disclosure process. The perfect balance for this type of scenario may not exist, considering the responsibility imposed upon the psychologist after the Tarasoff ("Tarasoff v. Regents of the University of California ", 1976) ruling.

Court decisions such as *Tarasoff v. Regents of the University of California* (1976) and *Jaffee v. Redmond* ("Jaffee v. Redmond ", 1995) have influenced the fiduciary duties of the therapist. The burden to warn placed upon the clinician evolved from the Tarasoff decision. The result of the case decision now places the responsibility and duty to warn with the therapist to advise a potential victim, parents and or guardian, of an impending potential intended harm.

The Jaffee case also affirmed additional responsibilities after the decision that suggested the courts now recognize there is a psychotherapist-patient relationship with privileged information protecting the confidentiality of the client's therapy. It would appear from similar court decisions such as these that the therapist must act with due diligence not only to safeguard the trusted relationship with the client, but to also consider the greater responsibility to act in an appropriate and professional manner that protects the safety of patient and others based upon the confidential information in the file.

Privacy, confidentiality, and safety issues as noted arise when third parties request the release of the patient's record information. Tranel (1994) suggest that a clinician must be aware of the broad scope of data others may access through court intervention and as such, a studious approach to note taking and ethical considerations become essential. It is a reminder that the sharing of information can be complex and a tricky terrain with severe professional and legal ramifications.

When submitting requested client record information, recognizing the value of the contents in the file can be a critical step in the process. Handwritten

notes as an example defined by HIPAA (2002) are, "notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. Psychotherapy notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date" (p.18, §164.501). Keeping this in mind, HIPAA provides protection for handwritten notes (p. 37, §164.508) as long as the data remains private (i.e., not share with others) and the notes in the file help the clinician recall the session content, reflection, or details related to conversations.

However, not all psychologists value the importance of the HIPAA requirements supported by the American Psychological Association (APA) and its membership. Membership is voluntary in the APA, and there are non-member psychologists who may feel they are not bound by or obligated to comply with and follow the APA ethical code guidelines according to Tranel (1994). This can be a perplexing dilemma for some patients in understanding the limitations they face when expectations of standardized ethical methodologies appear unenforceable.

In light of these and several other situations, the APA compiled nearly three years worth of research in response to the vast number of subpoenas and

court summons requiring therapists to testify regarding the release of client file information. The American Psychological Association's Committee on Legal Issues gathered the data to address the general confidentiality concerns of its members. The APA (1996) suggests that one may have to seek counsel to determine the "legally valid demand of sensitive test and client records" before complying with subpoena requests. Additionally, the APA laid the groundwork for the general principles of ethics suggesting that those failing to provide the court with the necessary subpoenaed information may find themselves in contempt of court facing stiff fines, penalties, or incarceration.

Hamberger (2000) suggest that 88% of their sample surveyed had a strong belief that their records should remain confidential, only 41% had signed release forms, according to their study, which allowed for the dissemination of their confidential information. The results of the study indicate that many clients do not know what data is in their patient file, nor the exact requested information sent to the third party companies.

Thus, the dissemination of data, which data may be part of the public domain, and recommendations for a course of action in the release of confidential and personal therapeutic information can be difficult for the therapist to comprehend. While the agreement between the therapists and the patient may suggest an explicit promise of confidentiality, Hamberger (2000) suggests there are additional scenarios that may compromise such a relationship. It appears the request for healthcare records of clients, as an example, may become a pressing issue for the clinician, including how much information to release, the frequency

of access to the client's records, and if the patient fully understands the extent to which their records may be distributed to third party individuals and companies.

Discussion

One cannot overlook the advancement in technology and e-transmission of confidential file information. Policies regarding the dissemination of the client records continue to lend it self towards the patients rights and the therapists responsibilities to ensure its protection. Jeffords (1999) suggests that the developing court decisions on confidentiality, protection of HIPAA rights, including steps and recommendations necessary to implement or theoretically guarantee the private health information of individuals, is nearly impossible since technology continues to outpace the technical training of the clinicians and their staff.

Furthermore, internet-mediated psychological services, chat rooms, video conferencing, and e-mail therapy continue to provide innovative therapeutic remedies that push the boundaries of the narrow application of web-based consultation services, notes Fisher and Fried (2003). Clarification on issues of competency, conflicts of interest, informed consent, privacy, confidentiality, and the implications of HIPAA and APA ethical code compliance still need considerable review by the clinician. They highlight the importance of additional training in specific internet based areas such as understanding the potential dangers while using e-mail or chat rooms in order to offer therapeutic services to the client. Lost and misrouted e-mails can be problematic if strict electronic methodological controls are not in place. Remedies might include using a return

receipt request on the e-mail, encrypting the correspondence to avoid unauthorized review of the information, and creating user ID and password-protected areas that require the patient to login may help.

Finding an acceptable middle ground for therapists where the field specialists are as diverse as those that practice, and a written commitment toward "personal values, moral dilemmas, high ideals, and overarching frameworks for analyzing moral problems" can be a difficult road to address as Knapp and VanderCreek (2003) cite. Although the Ethics Code may need more work, incorporating its core values into practice then providing feedback will help the profession find ways that benefit both clinician and client. Thus, protecting the client's personal psychotherapy records and the welfare and safety of all parties involved, becomes a primary responsibility the therapist must always consider. Remembering that the client has ultimately placed their faith and trust in the clinician may provide a pathway to psychological resolution in the therapeutic relationship that might otherwise remain unresolved.

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