The Limits of Confidentiality

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ANDREA'S STEPFATHER CALLS REQUESTING an appointment for her as soon as possible, stating he has just learned that her maternal grandfather has been sexually abusing her and her cousin. Andrea has been my patient on and off for many years and typically surfaces in August when her social phobia and anxiety escalate around the prospect of return to school. She is a pretty, shy 16 year-old girl of borderline intelligence who is not very verbal and has never been willing to stay with treatment beyond crisis intervention. She seems to manage to function well the other eleven months of the year, is popular, and keeps up academically.

I tell her step-father that I am a mandated reporter and agree to see Andrea the next day. She is accompanied by her mother who is furious with her father for molesting her "baby." She states adamantly that reporting won't be necessary because the family made dire threats to her father and ran him out of the state. Andrea is seen alone and painfully discloses details of the sordid abuse that began about 5 years earlier. Like many victims of abuse she dared not disclose because of the threats made to her by her grandfather. She pleads with me not to report. She just wants to forget about it and never see her grandfather again, let alone in court. Her concerns about reporting also relate to the fact that she lives in a small town and is worried that her peers will find out about the abuse. She doesn't think she could face them again if they knew about it.

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I meet with Andrea and her mother and explain to them that, while the grandfather may no longer pose a risk to Andrea, I am concerned about whom he will next victimize. Failure to protect does not seem to have been an issue in this family as the mother had no awareness of what was occurring when Andrea and her cousin visited their grandfather. I tell them I am obligated to report and will be calling the District Attorney's Office. Her mother expresses relief that I will not be involving child protective services. Andrea backs down some and says that, although she doesn't want to talk to the police, she will answer their questions and won't lie to them. She also agrees to return to see me and begins to speculate on whether the abuse might have something to do with her intense concerns about what others think of her and her discomfort around strangers. The DA's office is pleased to hear from me and is actively investigating the case having received 3 other complaints about the alleged perpetrator.

This is but one example of situations where we may need to breach confidentiality. Teens may pose a risk to themselves through substance abuse or suicidal behavior. They may endanger others with violent behavior or, in the case of those who are HIV positive, by practicing unprotected sex. The child and adolescent psychiatrist must weigh privacy interests versus the risk the patient poses to himself or others along with the impact that breach of confidence will have on the therapeutic relationship.

The AMA's *Principles of Medical Ethics* with Annotations especially Applicable to Psychiatry has recently revised Section 4, Annotation 8 which now reads: "When in the clinical judgement of the treating psychiatrist, the risk of danger is deemed to be significant, the psychiatrist may reveal confidential information disclosed by the patient." Thus, we are ethically protected when disclosures are made in good faith to protect the patient or others at risk. In the case of child abuse or sexual abuse, we are also protected by mandatory reporting laws. These laws also serve to protect us from unrealistic fantasies of being able to manage abusive families single handedly.

As part of laying ground rules with new patients, especially adolescents, it is wise to spell out the limits of confidentiality. When it is necessary to disclose confidential information to parents, the patient may be given the option of doing so himself or being present when the child and adolescent psychiatrist meets with the parents. A conjoint meeting allows the patient to know exactly what has been disclosed and may help overcome the child's wish to deny the problem. Whenever an abuse report has to be filed, the family should be informed of the intent to report and prepared for the investigatory steps that will follow. Some therapists fear that reporting will disrupt their therapeutic alliance with the family. Although reporting is distressing to all involved, it may be an effective way of setting limits and the crisis may be used to bring about changes in family functioning.

Beck, J. (1990): Confidentiality and the Duty to Protect: Foreseeable Harm in the Practice of Psychiatry. Washington: APPI.