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What Are the Confidentiality Rights of Collaterals in Family Therapy?

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The privacy rights of collateral family members constitute one of the most complex ethical issues in the field of family therapy. The author opens with four case studies which illustrate some of the dilemmas. The opening section reviews the APA Ethics Code on this topic, followed by an in depth analysis of confidentiality issues in marital therapy and the special ethical dilemmas of high conflict, child custody cases. The author reviews the scant case law on this topic and closes with a set of best practices guidelines for the clinician.

CASE #1

Psychologist X was the treating therapist for a 13 year old girl who had been the subject of an intense and bitter child custody dispute. Treatment was initiated by the mother. As part of the child's treatment, the psychologist met with the mother from time to time to provide feedback and recommendations. In some of these meetings, the mother disclosed that she was still struggling with her alcohol addiction. The father requested a meeting with the psychologist and asked for a complete copy of the daughter's treatment record. The psychologist refused on the grounds that he had to shield the mother's disclosures from the father. The father sought consultation from Psychologist Y about his rights. Psychologist Y advised the father that since he had joint legal custody of the daughter, he had a legal right to the entire record, including the mother's individual visits with Psychologist X. The father left Psychologist Y's office stating he intended to file a complaint against Psychologist X with the state licensing board.

Q. Does the father have a basis for a complaint against Psychologist X? Should Psychologist X have given the entire record to the father? If he

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had done so, and it had an adverse impact on the mother's custodial rights, would she have a basis for making a complaint against Psychologist X?

CASE #2

A couple was in the process of divorcing and were litigating over custody of their eight year old child. The father took the child to Psychologist B for treatment without the knowledge or consent of the mother. He hoped to establish that the mother was mentally unstable and that her condition put the child at risk in her care. The mother, in treatment with Psychologist Y, found out about this and asked what she should do about it. She was advised by Psychologist Y to seek a meeting with Psychologist B in which she would request the boy's diagnosis, the presenting problems, and the goals in treatment. Psychologist Y also advised her that she was well within her rights to ask for a copy of the child's records. The mother did so, but Psychologist B said he had met several times individually with the father in conjunction with the child's treatment, and that he had to consider how to release the child's records to her. He finally met with the mother and gave her a copy of the child's records but redacted (blacked out) all comments that the father made about himself in his meetings with Psychologist B, citing doctor-patient privilege.

The mother returned to treatment with Psychologist Y and asked, "Is this permissible for him to do this?" Psychologist Y advised the mother that under the law in the state she had a right to everything in the child's file, and that Psychologist B had acted improperly. The mother considered whether to file a formal complaint against Psychologist B, to demand the full record, and/or to advise Psychologist B to stop treatment of her son.

Q. Was Psychologist B correct in redacting the boy's records before releasing them to the mother? Should he have consulted an attorney? If he had not redacted the record, could he have exposed himself to a potential lawsuit by the father for failing to notify him that he had no privilege when he was being interviewed?

CASE #3

A woman sought treatment for depression with Psychologist Y, complaining of emotional distress about her marriage, especially with regard to the problem of her husband's drinking. Over a series of office visits, she detailed a pattern of behavior on the part of her husband that included withdrawal from the family on a nightly basis while he drank excessively. She also discussed his job losses due to his excessive drinking, losing his temper with the children when drinking, concerns about his drinking and driving with the children in the car, etc.

The husband then came in with his wife for a series of five conjoint marital sessions to try to address the marital problems and his use of alcohol. The marriage continued to deteriorate and the couple separated. The husband sought custody of the two minor children on the basis that his wife was mentally unstable. The wife sought custody of the children, alleging the father was unfit because of his drinking. The wife's attorney asked Psychologist Y to testify about her mental stability, her diagnosis, the treatment plan, and her prognosis.

In pretrial motions, the husband's attorney requested that Psychologist Y be barred from disclosing any information from the conjoint visits, citing doctor-patient privilege. The mother's attorney argued that the husband was a collateral family member and thus had no privilege. The judge took it under advisement. One week later, the judge issued his ruling and sustained (agreed with) the husband's attorney's motion. The judge did so on the premise that the husband had the privilege because he "perceived that he was a patient" of Psychologist Y.

Q. Is a spouse in conjoint marital sessions a patient or a collateral family member? If the spouse is a collateral family member, does he own a privilege regarding his remarks?

CASE #4

Following a bitter custody battle, the court awarded care of A 15 year old boy to his father (see: Ellis, 2009). Treatment was initiated with Psychologist Y who then had one office visit with the father to obtain history, and two office visits with the adolescent. The mother then requested the therapist terminate treatment, and the psychologist complied. One year later the mother requested the boy's records in order to use them in a libel suit against the father. The father, consulting with the adolescent, said the boy didn't wish the records to be released, citing fear of reprisal from the mother. Psychologist Y attempted to strike several compromises with the mother, but was unsuccessful. The mother then filed a complaint against Psychologist Y with the state licensing board.

The board heard the case and ordered Psychologist Y to "turn over the boy's records" to another professional who would review them and pass them on to the mother. Psychologist Y complied but did not turn over the notes of the meeting with the father. Given the court's ruling in Case #3, concerned that the father may "perceive that he had a doctor-patient privilege," Psychologist Y interpreted the board's order narrowly. Psychologist Y reasoned that the court would have to issue a ruling on the status of the notes with the father, since they lie in a gray area before the law.

Four years later the mother filed a petition seeking notes of the meeting with the father, and any and all reports, journals, and documents the father may have given the psychologist. The boy, now 19, submitted a statement in

writing requesting that nothing from his file be released to his mother. The mother's attorney pushed forward with a subpoena to depose Psychologist Y and demand the records. Psychologist Y's attorney requested a hearing before a superior court judge, in order to obtain a ruling in the case. The judge heard arguments and ruled that the notes of the meeting with the father, and the documents given to the psychologist by the father, were not protected by the boy's privilege, and that they should be turned over to the mother. In effect, the court ruled that a collateral family member had no privilege and that a patient's privilege is limited only to direct communications between the doctor and the patient.

Q. Was the judge correct in her ruling? Can the patient assert the privilege over all materials contained in his/her file? Or is the privilege limited to only those direct communications between the patient and the psychologist?

INTRODUCTION

The privacy rights of patients and other family members in marital and family treatment cases is one of the most complex areas at the intersection of law and ethics. As the cases above indicate, psychologists do not have clear guidelines as to how to handle requests for records that involve notes by and about family members who participate in a patient's treatment. Taking a term from forensic psychology, we refer to these as "collateral" family members. Family therapists typically use their best judgment to arrive at a solution which they hope will appease various competing interests. In so doing, they easily run afoul of angry family members, licensing boards and the courts. Even judges, after researching legal precedents, may issue different rulings from one case to the next.

In general, most of the papers written on the subject of confidentiality rights in psychotherapy refer to individual, adult psychotherapy patients. The issue of who is the "patient" is simple and clear in those cases. The patient is the one who is requesting treatment, who is given a diagnosis and treatment plan, who signs the informed consent agreement, whose name is on the chart, whose name is on the insurance claim and on any bills which are mailed to the patient. When copies of records are requested, it is clear that only the patient can give permission to release them, unless compelled to do so by judicial order. Doverspike (2008); Knapp and VandeCreek (2003); and Bennett et al. (2006) are good general references in this area of ethics.

In the case of marital therapy, the issue of who is the patient, and thus who owns the privilege, is not as clear. One or both of the couple may be considered the "patient" in a clinical sense. Many clinicians may view the couple seeking treatment conceptually as a dysfunctional dyad, and the clinician will craft interventions with that perspective in mind. In fact, in this author's experience, many, if not most, couples who request marital

therapy do so with the expectation that “both of us” are the patient. They may use language such as “we need help.” This clinician has observed that many couples go so far as to put both names in the patient space on the application in order to be fair and balanced in their presentation.

Similarly, in family therapy, the therapist may refrain from designating a particular member of the family as a patient, and may convey the view to the family that the whole family, or perhaps some subsystem of the family—including stepparents and grandparents for example—is the patient in a clinical sense. This is often understandable and agreeable to the family. Many families requesting family therapy will make requests such as “we all need help getting along as a family.” Some request help for a subsystem, such as “My new husband needs help getting along with my teenage son.” Even more unclear but quite common are requests such as “My husband and I are sleepless, stressed, and fighting over how to handle our daughter who is using drugs again.” Some families will ask for multiple authorizations from the health insurance plan and fill out multiple patient applications “so we can all be the patient.”

While this may be desirable from a clinical perspective to regard couples, or dyads, or whole families as the therapeutic unit, and while it may fit with the perspective of the treatment requests, this collides with the realities of third party reimbursement and with the courts. From the perspective of the health insurance company, mental health billing must fit the medical model. Only one person in the room at the time the service is rendered is the patient. In order to be a patient, the person must request treatment if an adult (or one of the parents must request the treatment for the child, if the patient is a child), and the patient must have symptoms that warrant a DSM IV diagnosis that is covered by the plan. The treatment must be medically necessary, and a treatment plan for that individual must be in the patient’s chart.

In the case of marital therapy, the therapist must discuss the issue of who the patient is fully and openly with the couple in order to come to a mutual agreement. They must be informed that in order for the health insurance plan to cover their services, one person must be the patient and they must meet the above criteria set out by the health insurance plan. This step alone, done at the outset of treatment, may subtly change the dynamics of how couples therapy proceeds from that point forward. However, it is an essential part of the informed consent process. Likewise, the parents of a child who are requesting family therapy must agree that the child is the patient, and must be informed as to the child’s diagnosis and the treatment plan.

In an idealized setting where all clients pay for psychotherapy out of pocket, the therapist may draw up individualized informed consent agreements which specify that both marital partners (or life partners) have a privilege to the records of their couples treatment. In the case of family therapy, the parties may sign an agreement which specifies that all of the family members seen have equal rights to the confidentiality of their remarks in

the psychotherapy process and that no records can be released without the group consent of all the parties.

However, the reality of private practice is far from this ideal. In this author's practice in a middle class suburb of a large metropolitan area, a survey of the three practitioners indicated that less than 5% of their caseloads were private pay, and those were essentially the uninsured. Less than one percent of their patient population had private health insurance but chose to pay out of pocket rather than use their insurance. There are no large scale studies on the topic of what portion of psychotherapy patients are private paying patients. The economic reality is that probably the majority of patients are willing to agree on one person being designated the patient in order to make use of the health insurance benefits.

Most texts on ethics which address the issue of clarifying who the patient is simply recommend that the therapist discuss issues of confidentiality with family members before beginning treatment and to have the parties read and sign lengthy, detailed informed consent contracts which spell out who owns the privilege in these cases and who can access the records that accumulate from family treatment (Bennett et al., 2006; Doverspike, 2008; Knapp & VandeCreek, 2003). While this may seem to address the issue legally, it is a recommendation that is not practical or feasible from the perspective of one who runs a clinical practice. The early stages of treatment with a new patient must focus on rapidly identifying the patient's needs and establishing a rapport with the patient in the first 50 minutes by understanding, empathizing, clarifying the problem, setting goals, and offering hope of a positive outcome. A lengthy discussion of possible adverse legal outcomes is not what patients are expecting when they enter a psychologist's office requesting treatment.

In reality, the issue of who owns the rights to the treatment notes that are made when collateral family members participate in treatment is rarely an issue. This author (Psychologist Y) has seen perhaps 4,000 to 5,000 children and families in treatment, and no disputes over the records have arisen in cases where divorce conflicts were not part of the landscape. Even in cases where a couple who was seen for marital therapy is subsequently divorcing, it would be rare for them to request the records in those cases where they have no children under the age of eighteen. The opening four cases which occurred in the course of this author's practice over the last five years capture the types of cases in which these dilemmas arise.

PSYCHOLOGISTS' ETHICAL GUIDELINES

The APA Ethics Code (2002) offers no specific guidelines on the privacy rights of collateral family members in family therapy. In section 3.10 "Informed Consent," the psychologist who is engaged in counseling or psychotherapy

is advised to obtain the informed consent of the “individual or individuals” using language which is understandable to that adult or child. In section 10.01 “Informed consent to therapy,” this principle is reiterated but made more specific to patients who are in a treatment setting. Most informed consent agreements are tailored toward the concept that only one individual is a patient. In couples therapy, the identified patient signs the consent form. The other partner may not even review it or be aware of it. When working with children, it is the parent who presents a child for treatment who typically reviews and signs the informed consent agreement. The other parent may not be present and thus may not review it. In cases where parents are divorced, it is predominantly the parent with primary physical custody who initiates treatment and who reviews and signs the informed consent agreement. The other parent, who may even live out of state, may not be aware of it, or see it, much less sign it.

In section 4.02 “Discussing the limits of confidentiality,” the psychologist is advised to “discuss with persons. . . (1) the relevant limits of confidentiality and (2) the foreseeable uses of the information generated through their psychological activities.” For example, standard informed consent contracts typically notify the patient that in the event that the person poses an imminent danger to himself or a clear risk of harm to an identifiable person, or in the event that the patient discloses acts of abuse toward a child or elderly person, confidentiality must be waived. Most informed consent agreements also include language that notifies the patient that in the event of a personal injury lawsuit, the psychotherapy records will likely be requested and must be released for the suit to proceed.

Section 10.02 “Therapy involving couples or families,” addresses the complex nature of confidentiality when several persons are involved in the patient’s treatment. This section advises the psychologist to “clarify at the outset (1) which of the individuals are clients/ patients and (2) the relationship the psychologist will have with each person.” This includes the psychologist’s role and “the probable uses of the services provided or the information obtained . . .” In this section, most clinician’s notify the patient that certain kinds of information will be sent to the patient’s insurance plan, for example.

Some family therapists have the “patients” sign a contract in which they agree to have the records sealed in the event of a divorce or litigation and that they will not subpoena the therapist to testify for or against either one in a legal matter (Doverspike, 2008; Ellis, 2006). Such agreements, while noble in aspiration, are not legally enforceable. Under HIPAA, Section 164.524, the identified patient is entitled to his/her entire record. The person who is the patient in couples therapy owns the legal rights to the records. If the patient is a child or adolescent, and if the parents are married to each other, the parents are joint custodians of the child’s records and both may be entitled to a copy of the entire record. If the parents are divorced, the most recent

court order regarding the custodial rights of the parents will govern who has access to the records. The exceptions may be where the adolescent is a “mature minor” (age 15 or older), and where the parent is not acting in the child’s best interests and thus not entitled to act as the child’s representative under HIPAA (Section 164.502, para.s (g) 5, I and ii). Seeking the child’s records specifically for use in a child custody proceeding has been defined, by some courts, as not acting in the child’s best interests. Exceptions are also made in states where adolescents’ rights to their treatment records have prevailed in the courts (see: Ellis, 2009, for a fuller discussion).

SPECIAL ISSUES IN COUPLES THERAPY

The issue of who is the patient and who is the collateral family member in couples therapy is complex and controversial. In the past the advice from ethics experts was to see couples together in all visits and advise them that no information will be released from their file without the written consent of both parties (Harris, 1997). This policy was endorsed and reiterated by Doverspike (2008, p. 134) when discussing policies on release of information. What is lacking here is the recognition that only one person, legally, is the patient. Thus, this agreement is not binding. In fact, Doverspike (2008) contradicts this position in his discussion on identifying “Who is the client?” Here he suggests that when bringing a collateral family member into a client’s session, “it is important to obtain informed consent of the collateral after clarifying the collateral’s role” (p. 94). He suggests the reader use the APAIT Outpatient Services Agreement for Collaterals available at <http://www.apait.org>.

Bennett et al. (2006) are more direct about who is the client or patient and who is the collateral contact. In a case study which they present, a wife is seen for individual therapy and her husband joins her for couples sessions. The psychologist is advised to explain to the husband at the outset that the wife is the patient and that the husband is there “as a collateral contact only, to further the treatment of the wife.” (p. 90). Presumably this would offer the spouse an opportunity to ask questions about whether his remarks would be privileged.

This is the same scenario as that presented in Case #3. Psychologist Y could have notified the husband that he was a collateral contact and thus had no basis to assume that his remarks were confidential. In fact, some legal experts (Corey, Corey, & Callanan, 2007) assert that confidentiality is lost at any point where there is a third party in the consulting room (the patient and the therapist being the first and second parties). The husband and wife in Case #3 both heard the remarks of the other and both were free to testify to the court as to what was disclosed in the office visits. The husband might have disclosed less information about his drinking habits had he been put

on notice. However, it is equally likely that he did not anticipate a divorce, much less a child custody dispute, and would have freely disclosed such information, even if he had been given advance notification.

In a recent newsletter article, APA's ethics expert, Jeff Younggren, and attorney Stephen Hjelt (2010), addressed the issue of collaterals in marital therapy. They argue that marital therapy is properly an endeavor in which both parties are seen together, neither is the identified patient, thus no claim is filed with a health plan, and both parties are joint custodians of the record. In fact, Younggren and Hjelt go so far as to assert that if the therapist identifies one of the parties as a "patient," and upgrades their symptoms to the level of a clinical diagnosis, so that the marital therapy is covered by the health plan, then the health insurance company has been deceived into paying for a "non covered service." Thus, it has adequate grounds to charge the therapist with fraud and professional misconduct and take legal action.

Younggren and Hjelt assert that the practice of identifying one person in couples therapy as the patient also runs the risk of encountering ethical dilemmas regarding the privacy rights of the non-patient in marital therapy. If one person is identified as the patient, and the other is designated a non-patient, then the patient has sole access to the records. If the marital therapy process fails, and the couple proceeds toward divorce, the identified patient can use the records against the non-patient of the couple. If the non-patient thus loses the protections afforded in traditional individual treatment and thus loses control of his/her records, Younggren and Hjelt argue that the therapist's conduct could be seen as a "violation of professional standards and of the duty owed to the client/patient," thus opening the door for the non-patient collateral to file a lawsuit against the therapist.

While Younggren and Hjelt's model for marital therapy is ideal, it is not realistic. This psychologist would argue that only a small, affluent minority of clients would seek marital therapy and be willing to pay the therapist's fee out of pocket. The vast majority of middle class couples seeking marital therapy fully intend to use their health insurance plan to cover the services, and demand that the service be offered to them in that manner. Typically, at least one of the parties meets criteria for a DSM IV diagnosis of Adjustment Disorder, and that person may qualify as the identified patient. What Younggren and Hjelt consider fraud—seeing the couple together, identifying one as the patient, and filing the claim with the patient's health insurance plan—is likely the prevailing norm in clinical practices today. The only part of the process that may be fraudulent is fabricating a diagnosis for one of the parties in couples therapy in order to obtain coverage for a service that would not otherwise be covered.

Younggren and Hjelt's paper generated "questions and concerns" from many readers. In a follow-up article, Younggren and Harris (2011) clarified their position. They acknowledge that if the identified patient actually did meet criteria for a DSM IV diagnosis (Axis 1-IV), then this billing practice

would be acceptable. However, their position as to who owns the privilege in this case is unclear. They state that “confidentiality issues are matters of concern with this type of treatment.” (p. 9). In “true couples therapy” the protection of privacy of both parties is crucial for success. They suggest that in this model of couples therapy—where one person is the identified patient and the partner is the collateral contact—issues of informed consent should be discussed at the outset “along with the fact that no information about or records of the treatment will be released without both parties’ permission” (p. 9). In reality, if the identified patient requests his or her records, they must be granted, regardless of the wishes of the spouse or partner. HIPAA strengthened the patient’s rights to obtain their records, not in part, but in their entirety. Younggren and Harris state that “a majority of states would respect the privilege of both parties equally,” but give no citation. They acknowledge that some states, such as New York, and Washington, “may be different.”

SPECIAL ISSUES IN TREATING CHILDREN FROM HIGH CONFLICT FAMILIES

Treating children who come from high conflict families is a complex and high risk endeavor (Bennett et. al, 2006). Unlike typical families who may present the child for treatment, and who both have the same goal—reduction of the child’s symptoms—parents in high conflict families often have not only different agendas, but competing agendas (Ellis, 2006). One parent may exaggerate the child’s symptoms in order to portray the other parent as a poor caregiver. Likewise, one parent may minimize the child’s symptoms and even deny symptoms, in an effort to put forth a positive picture of themselves as good caregivers, and to “look good” at trial. One parent may not be seeking treatment, but intends to use the professional to gather information about what goes in the other parent’s home and to document a pattern of abuse or poor judgment by the other parent. It is common for one parent to seek treatment for the child without the knowledge or permission of the other parent. In all these cases, the unstated goal is to use the documentation to the parent’s advantage in a court proceeding. In many of these cases, the parent also intends to subpoena the family therapist to testify at a subsequent trial. In some cases, the parents have been court ordered to participate in family therapy. They have followed the court order with bitterness and resentment and have no interest in furthering any goals in treatment.

In cases where a couple is contemplating divorce, or where parents are in the midst of divorce, or have litigated over child custody in the past, or those who are re-litigating post-divorce due to a change of circumstances, the risk of a dispute over the records may be fairly high. The psychotherapy notes can be requested specifically for the purpose of gaining legal advantage over a family member. Parents who have joint legal custody of their children

jointly own the privilege and can demand copies of the child's records in most states, including the notes of meetings with collateral family members and any and all materials that were given to the child's therapist. These records may include the parent's personal journal of events that had occurred with the child. They may include statements the parent may have made to the therapist which, if revealed, would be very detrimental to their case legally. Examples would be the parent's statement that he or she intended to block the other parent from having contact with the child, or that they intended to go into hiding with the child. They may include damaging self disclosures such as the parent's admission that his or her current marriage is deteriorating, that he or she consumed too much alcohol in the child's presence, or lost their temper with the child and became verbally abusive.

These kinds of disclosures can be devastating to a parent's position in child custody litigation. Some psychotherapists may decline to release the records to a parent, citing the child's confidentiality. However, this is not defensible. Most state laws uphold parents' rights to their children's records. In fact, HIPAA (the Health Insurance Portability and Accountability Act) also strengthened the rights of parents to all of the materials in their child's treatment files (see: HIPAA, Privacy Rule, Section 164.502).

There is very little case law on the legal rights regarding collateral family members who are seen as part of a child's treatment. The Georgia case of *Mrozinski v. Pogue* (1992) has a direct bearing on this issue. In this case Mr. Mrozinski's 14 year old daughter was in treatment with Dr. Pogue, an Atlanta psychiatrist, for drug addiction and other mental health problems while she was a resident of an inpatient psychiatric program. The drug use began while she was in her mother's care, and the court had intervened and placed her in the custody of the father. The father participated in family therapy while the daughter was hospitalized. Upon release, the mother obtained the discharge summary. Dr. Pogue also gave the mother an affidavit which contained negative remarks about Mr. Mrozinski's relationship with his daughter and recommending custody be transferred to the mother. Mr. Mrozinski sued Dr. Pogue claiming that he received treatment from Dr. Pogue by virtue of participating in family therapy, and that his rights were violated. Dr. Pogue asked for summary judgment (immediate dismissal), asserting that the only patient was the 14 year old, and that he had no doctor-patient relationship with Mr. Mrozinski. Summary judgment was granted. Mrozinski filed an appeal. He countered that he had sought advice and assistance from Dr. Pogue and that he was assured the visits were confidential. The affidavit recommended that he "continue therapy," implying that he had received treatment from Dr. Pogue. The appellate court upheld the lower court's ruling, and the suit for wrongful disclosure was dismissed. Thus, in this case, the court ruled that a collateral family member had no rights to the confidentiality of statements which were made by them in the context of family therapy.

This case illustrates the myriad of dilemmas regarding who is the patient, who has the rights to what information, and how it is to be used. In Case #1, the mother sought legitimate treatment for her child but disclosed sensitive information to the therapist, not knowing that the father could have access to that information and use it against her. In Case #2, the father presented the child for “treatment” with questionable motives and without the mother’s knowledge. In this case, however, he felt that he, too, was the patient and had some rights to the confidentiality of his remarks to the therapist. Family therapy in such contexts is a virtual minefield.

Bennett et al. (2006) recommend that one not see a child in such a situation without the knowledge and permission of the other parent. These authors recommend that as with cases of family therapy with multiple family members, one would do well to have an informed consent agreement that is specific regarding requests for information about the child, requests for the child’s records, and what information in particular is to be regarded as part of the child’s file.

BEST PRACTICES

From the previous discussion, the following are offered as suggested guidelines for the clinician regarding the confidentiality rights of collateral family members in couples and family therapy.

Identify High Risk Cases From the Outset

This is a small subset of most family therapy cases, but many can be recognized at the outset. These are parents who are threatening to divorce, are in the midst of a divorce, or have divorced and are contemplating re-litigating. They are characterized by high levels of bitterness and rancor, allegations of abuse and betrayal, and vague threats to take legal action. They may have a past history of litigating against each other and/or filing complaints against other professionals—e.g., other therapists, attorneys, judges, guardians, and child custody evaluators.

In the above case studies, Case #1 had had a prior history of child custody litigation and could have been identified as a high risk case. The parents in Case #2 were in the midst of a divorce, and were the parents of a five year old child, and also could have been identified as a high risk case. Case #3 could not have been identified at the outset because it began as a routine individual psychotherapy case. Case #4 had had a history of past child custody litigation, but it had been resolved, and there was no current litigation pending. Thus the dispute over the child’s records might or might not have been anticipated.

Bennett et al. (2006) go so far as to recommend that one may ultimately develop a practice of refusing to take such cases. This may not only be

for the protection of the therapist who has a high risk of being sued in such cases or subject to a licensing board complaint, but may also be an acknowledgement of the reality that good treatment of the child cannot take place in such an incendiary atmosphere. Since all the case studies presented at the outset which focused on disputes over records and the rights of collaterals, the clinician who avoids these types of cases altogether will minimize the possibility of being involved in such a dispute.

Do a Careful and Thorough Informed Consent Process in High Risk Cases

Identifying high risk cases at the outset and having them sign informed consent agreements would be the ideal. The informed consent agreement should specify clearly who the patient is and who has access to the records. In couples and family therapy cases, the parties may be asked to sign agreements not to request copies of the record if the purpose is to use them in court proceedings, or not to subpoena the therapist to testify for one side in court. As stated before, it is rendered moot by state law and HIPAA.

If the therapist wishes to shield the spouse of the patient, or the child in treatment, or one of the parents who participated in the child's treatment from possible harm, the therapist might first defer to the informed consent agreement in the interest of coming to a mutually satisfying solution. If this fails, the next alternative is for the therapist to retain an attorney and file a motion to quash, or dismiss, the subpoena. In such cases a hearing would be scheduled and arguments would be made from both sides as to whether the therapist's objection to the subpoena (or the objection of one of the parties in the case) should be sustained (upheld) or over-ridden. The judge has the option to review the records *in camera* (in the privacy of the judge's chambers) before ruling on the issue. Another alternative, if subpoena-ed to testify in court, is to appear at the hearing with the requested records but to raise an objection to the judge regarding the release of the records. Providing a copy of the informed consent agreement to the judge may be very advantageous.

Most couples who seek marital therapy, as well as parents who seek family therapy with their child, do not realize that if the parties are involved in child custody litigation at a later date, they may have to surrender all rights to these psychotherapy records. It is common practice for child custody evaluators to demand that the parents surrender all rights to all previous psychotherapy records, including records of individual treatment (see: Ellis, 2010, for a fuller discussion). If they were made aware of this from the outset, they might be more careful with the disclosures that they make in individual, marital, and family therapy. Therefore, the clinician may want to go so far as to include a warning in the informed consent agreement that begins, "In the event of a divorce and the litigation that may ensue, and/or child custody litigation, you might have to waive your rights to confidentiality whether you

are the patient or a collateral family member participating in your spouse's or your child's treatment."

Minimize Individual Meetings With Collateral Family Members

Many family therapists are aware of the possibilities of ethical dilemmas that may occur when the therapist meets with one member of a couple or family in treatment (Margolis, 2008). Material may be disclosed in confidence that the family member wishes not to be shared with the other family members. This person, who is not the patient, then requests that this material be regarded as "confidential." Many couples therapists are prepared for this and either refuse to see one partner alone or explain at the outset that there is no privilege that extends to the notes of that session. The clinician who is treating a couple who have young children and who are moving toward divorce may want to be especially cautious about seeing the non-patient partner alone.

In cases where a child is the patient, Bennett et al. (2006) recommend that the clinician always have the consent of both parents at the outset. It would be wise also to meet with both parents jointly when a feedback session is needed. However, refusing to meet with one parent may be difficult to enforce, especially where the parents are separated or divorced and are not speaking to each other. One parent may be only marginally involved in the child's life. Even when both parents intend to be present at the session, one parent may have a busy work schedule and can't be in attendance at the parent meeting.

In Case #1, Psychologist X could have requested to see the divorced parents together to provide feedback on the child's treatment. If the parents had been seen together, it is unlikely that the mother would have disclosed sensitive information about herself. Similarly, in Case #2, Psychologist B may have requested to see the parents together to provide history at the outset of treatment and at the feedback session. It is likely that the father would not have complied, given that his motive for seeking treatment for the child was to gather information to use against the mother in his petition for primary custody. This strategy would, on the other hand, have averted the dispute over the records.

If One Sees a Family Member Individually, Give a Cautionary Warning

In Case #1, identified as a high risk case, Psychologist X who was treating the 13 year old girl might have given the mother a cautionary warning, i.e., "I will be taking notes of our session today. Keep in mind that you and the father both have access to your child's treatment record. Both of you can at any time request copies of these notes and I am obligated under state law

to provide them to you or the other parent with joint legal custody. Once I release these notes to the parents, I have no control over how they may be used. You or the other parent may provide copies of them to family members, teachers, attorneys, or officers of the court. There have been occasions when psychotherapy notes of a child's treatment have been used against a parent in a child custody proceeding." When this author has used such a warning, the parents have been surprised at first that their remarks were not protected, then thankful that they were notified ahead of time. In Case #2 and Case #4, the psychologist could have notified the parent at the outset that their remarks were not protected. It would have been advisable to document such notification in the record as well. This might have prevented conflicts that arose over the records at a later time.

Some psychotherapists may want to use caution in whether to accept personal materials from the parents to include in the child's records. Sensitive material such as journals, diaries, emails, letters, greeting cards, photographs, may be viewed in the session and given back to the parent (or husband/wife). In Case #4, Psychologist Y was given a large three ring binder with over one hundred pages of material. It was briefly reviewed and given back to the father. Thus, when the mother requested it four years later, it was not in the psychologist's possession, and the issue of releasing it was moot.

The psychotherapist would have to use his/her judgment as to whether to write down personal disclosures by the spouse of the patient or the parent or other family member—disclosures which may be used against them at a later time. Certainly disclosures from the person's distant past or which have no bearing on the patient's treatment do not need to be written down.

Seek Ways to Shield the Privacy of Meetings With Collateral Family Members Who Are Seen Individually

Gerald Koocher (2008) and Eric Harris (1997) recommend that notes of meetings with collateral family members, particularly the parents, be kept in a separate file. Thus, if one parent requests the "child's records," only the notes in the child's chart are surrendered, not the notes of separate meetings with a parent. Both are recognized experts in the area of psychologist ethics and have conducted seminars on risk management for the APA. APA ethics expert, Jeff Younggren (2009) was asked about this practice. He stated that keeping the notes of the meetings with the parents in a separate file was unethical and improper. All the notes and documents must be kept in one file. Thus, it appears that three of the top experts in the country may disagree on this issue.

Another option is to advise the family that when the therapist needs to meet individually with one parent (in order to obtain history, or be given an update on progress in treatment), it is best to open a second chart and account in the parent's name. The psychotherapist might code the service as

a “consultation” since no treatment is rendered. It would not be covered by the health insurance plan, but the parent would control access to the notes in their own file.

As stated in the opening remarks, the area of confidentiality rights of collaterals in family therapy is very complex. Clinical goals, medical billing procedures, professional ethics, and the law may clash when requests are made for records. The practice suggestions made here are not agreed upon by a majority of clinicians and are bound to be controversial. Hopefully, they will open up a dialogue which will ultimately result in clearer standards in the future.

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