

## Breaking Confidence: When Silence Kills

*This article presents the dilemma faced by mental health practitioners whose maintenance of strict confidentiality may result in harm or injury to the client or to others. As a crisis worker, I spent over a decade working with high-risk clients in community mental centers in rural New England and in a major metropolitan area in Virginia. Having gained some distance from my work, I increasingly question the power and authority granted me as a "professional." I am increasingly concerned about illusions of self-determination and true mutuality between client and practitioner and the role that helping professionals play in social control. Narrative accounts exemplifying legal precedents and ethical conflicts are presented using my own professional experiences with mental health and medical involuntary hospitalizations.*

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Social workers should protect the confidentiality of all information obtained in the course of professional service, except for compelling professional reasons. The general expectation that social workers will keep information confidential does not apply when disclosure is necessary to prevent serious, foreseeable, and imminent harm to a client or other identifiable person or when laws or regulations require disclosure without a client's consent (NASW Code of Ethics, 1996, section 1.07).

As helping professionals, we are taught that mutuality, respect for human dignity, and self-determination are the cornerstones of positive helping relationships with our clients. Practitioners and clients are seen as collaborators, mutual relationships whose purpose is to empower clients towards improving their particular life circumstances and to increase control over their lives. These are important ideals and certainly pivotal to developing trusting relationships between any two people.

There are times, however, when as helpers we are re-

quired to take control, move swiftly and assertively, and act on behalf of society. We have the power to take away from our clients the fundamental right of freedom. Early on in my career, I held the naive belief that helping relationships were truly mutual and egalitarian. It could be that I was not yet ready to accept the mantle of social control agent that society was putting on my shoulders. Or perhaps I simply did not want to acknowledge the power that I had over others by my position.

It was not until I had to strip clients of their basic right of freedom by making the decision to hospitalize them against their will that I came to understand the social control and trustee responsibilities inherent in helping relationships. I found it necessary to expand my repertoire of interventions to include temporary detention orders (TDOs) and involuntary commitment, to re-define "client" to include society, with a duty to protect potential victims from violence. I came to recognize the community protection and social control functions

served by my profession. There are times when I have a legal and ethical responsibility, even an obligation, to act with authority and break the confidentiality implicit in helping relationships. And this often must be done without the permission or knowledge of my client.

This article explores confidentiality, self-determination, and issues of power and control and situations in which practitioners are required to assert control, break confidence, and go against the value of client self-determination. The role of the practitioner in hospitalizing clients against their will and its impact on the helping relationship is discussed with criteria for involuntary commitment exemplified by case study. The Tarasoff ruling and its implications for the duty of helping professionals to warn potential victims is examined.

### Breaking Confidence: Helper as Guardian

I remember well the first time that I found it necessary to act against the wishes of a client and act in what I deemed to be his or her best interest. I was a clinician with a community support program in Virginia where I was a clinical supervisor for a continuum of care service residential treatment programs for adults with severe and persisting mental illness. I was responsible for providing case management services and residential support. Bill would be my first "client" contact. I noted in his chart that he was diagnosed with paranoid schizophrenia.

Fresh out of graduate school, I was nervous at our first meeting.

Bill was my age, mid-twenties, and at the time was dressed in khakis, a button-down shirt, and deck shoes. A successful student at a local community college, Bill prided himself in his appearance and maintained an active social life, including recent involvement with a female classmate. He was six-foot-two with blue eyes and well-groomed, shoulder-length blond hair. We seemed to have much in common, and Bill and I bonded quickly as I helped him learn the daily living skills society had deemed necessary for independent living.

Six months later, after losing track of Bill for a couple of weeks, several phone calls to his apartment went unanswered. I decided to stop by for an unannounced visit. As I drove up to his building, I noted that the curtains of his unit were drawn even though it was mid-afternoon and the sun was behind the building. Initially Bill did not invite me in, purposefully blocking my entry with his six foot frame. It was only after I reminded him with gentle insistence that the apartment he occupied was actually rented by the community mental health center residential services that he opened the door enough for me to enter.

I remember clearly the stench of stale cigarette smoke, the drawn curtains, and the darkness of the apartment that drew in upon me as Bill allowed

me in. He was alone, and the two bedroom apartment, normally immaculate, was a wreck. Clothes were strewn about the cluttered living room. Dirty plates, bowls, and glasses were on the sofa end tables, the coffee table, and the kitchen counter—many had been used as ashtrays. The kitchen was filthy, with dishes filling the sink and a white plastic trash bag overflowing. Although the autumn air outside was cool, the temperature in the apartment was stifling. Bill was dressed in shorts and a t-shirt.

He was barefoot. I was struck by body odor as I walked by him and noted with concern his long dirty fingernails and greasy hair. It seemed apparent that he had not showered in several days.

In my inexperience, I was confused by his attitude toward me and felt betrayed by the overt hostility that seemed directed at me. I realize now that Bill was actively psychotic. His delusional thoughts were apparent—he was God and needed to rid the world of evil and the influence of the devil. Experiencing command hallucinations, he told me that God was speaking to him and told him that his roommate, Randy, was a follower of Satan and needed to die. He said God wanted him to kill Randy upon his return. When I expressed my concern for him, Bill's friendly demeanor shifted quickly, and I became the devil, and I was the cause of what was evil in the world. And the evil needed to be exorcized from the



world. The strength of his conviction and the genuineness of his belief was profound. There was no question in my mind at the time that my safety, as well as that of his roommate, was in immediate danger.

Making a swift exit, I struggled with the first of what would become scores of TDOs over the next ten years. I remember well my sense that somehow I had failed Bill and that I should have noticed warning signs that he had been decompensating. I attended the commitment hearing at the local hospital. His sister and his mother both appeared and thanked me profusely for my intervention. Bill was nearly catatonic when I saw him and was continuing to refuse his medication.

I submitted my mental health evaluation to the magistrate who issued a temporary detention order for Bill, thus allowing for him to be detained for 48 hours in a psychiatric facility and undergo a psychiatric evaluation. I had police watching the apartment until the temporary detention order could be issued, so Randy was never in any real danger. But what if Randy had returned? And what if Bill had acted upon his perception of me as the devil? Bill would spend the next six months in the state mental hospital before re-initiating psychotropic medication. Stabilized, he would later return to and complete his degree at the community college.

My concern about Bill aside, what I struggled with the most in this situation was the

recognition that society had granted me permission to work with the legal system in taking away Bill's right to self-determination. This flew in the face of everything I had been taught in graduate school and seemed to be contrary to the values relating to client self-determination inherent in social work and other helping professions. To this day I struggle with this contradiction while often wondering what might have happened to Bill had I not acted.

A colleague of mine, new to the profession, was not so lucky. Six months after I transferred Betty to case management for services, she told her case manager, my colleague, that she had ceased taking her medication and that she was hearing voices telling her to kill her mother because she was evil. The case manager forestalled taking action, did not communicate to Betty's mother the threat against her, and did not take action to immediately protect the potential victim against violence. That night Betty went into her mother's bedroom and brutally killed her with a pair of scissors.

After the death of Betty's mother, I felt a tremendous unease over the lack of training I had received in this area. My graduate program had focused on normative developmental theories, personality and psychopathology theories, and skills and interventions associated with various clinical models of treatment. Limits to confidentiality were not emphasized, and the possibility of my adopting a guardian role and a

social control function simply was not in the curriculum.

### Tarasoff: Duty to Protect

My concern led me to research more fully the limits of confidentiality. I knew, given the nature of my work, that I would be confronting this issue all too often. At the time of my intervention with Bill, I had not heard of Tatiana Tarasoff or Prosenjit Poddar and did not know that there was legal precedence that suggested I had a duty to protect Randy from the threat that had been made against him, or that my colleague had a duty to protect Betty's mother from her daughter.

#### Tarasoff v. Regents of the University of California

In 1966, Tatiana Tarasoff met Prosenjit Poddar, an Indian by nationality, while they were graduate students at the University of California at Berkeley. They dated briefly, and although she told him that she was not interested in a serious relationship, he became obsessed with her. Unable to win her affections, Poddar became withdrawn and depressed and began to neglect his studies.

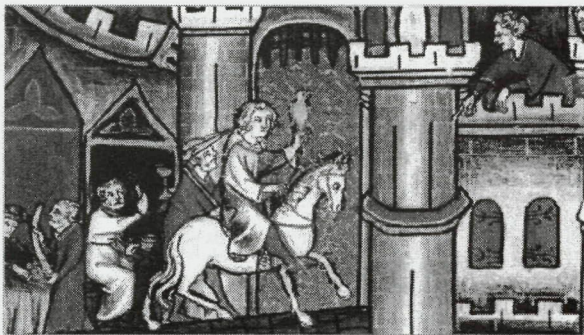
In the summer of 1969, Poddar entered into weekly outpatient psychotherapy with a psychologist at the Cowell Memorial Hospital of the University of California. During his session on August 18, Poddar expressed fantasies of harming or even killing Tarasoff. The

therapist also learned from a friend of the client that Poddar planned to purchase a gun. Concerned about Poddar's potential for violence, the practitioner contacted the campus police to arrange for involuntary hospitalization, citing the fact that his potential lethality fit California's civil commitment criteria. Due to a lack of understanding of the then novel civil commitment statute, Poddar was not hospitalized, and he subsequently dropped out of treatment. No further action was taken to detain Poddar, and at no time was any member of the Tarasoff family warned of the threats against Tatiana's life.

In October 1969, Poddar went to Tarasoff's home. She was alone. When she refused to speak to him and began screaming for him to leave, Poddar shot her with a pellet gun. As she fled from the house, he followed and stabbed her to death with a butcher knife. The Tarasoff family sued the University of California, alleging that the police had been negligent in not detaining Poddar and that mental health practitioners had been negligent in not warning Tarasoff of Poddar's threats and in not detaining him. The defendants argued that there was no legal duty to protect or to warn (*Tarasoff v. Regents of the University of California*, 1973). On appeal, the California Supreme Court in 1974 held that the practitioner had a duty to warn. "When a

doctor or a psychotherapist, in the exercise of his professional skill and knowledge, determines, or should determine, that a warning is essential to avert danger arising from the medical or psychological condition of his patient, he incurs a legal obligation to give that warning" (*Tarasoff v. Regents of the University of California*, 1974).

The fundamental issue in this case was the question of whether reasonable care was used in providing for the safety of Ms. Tarasoff. Although existing codes of ethics provide general directions for social workers and counselors in situations where there may be imminent danger to the client or to others, it was this case that set legal precedence in the state of California for the duty-to-warn principle. The decision radically changed existing law by creating a legal duty to protect the



foreseeable victim of the patient's dangerousness where no duty had previously existed in the law. Generally, under common law, a person is under no duty to control the conduct of another or to warn those endangered by that conduct. The Tarasoff court found the relationship between a therapist and

a patient to be a "special relationship," which constitutes an exception to the common law. The case clearly reflects a value that in some situations societal rights for safety override individual rights to privacy. Although similar laws do not exist in most states, many professional associations have adopted duty-to-warn principles in their ethical guidelines. The duty to warn has become an integral component of many therapists' application of confidentiality in the client-therapist relationship.

There was a great deal of concern among members of professional organizations that requiring practitioners to warn potential victims would lead to frequent and often unnecessary breaches of the client's right to confidentiality. Further, professionals worried about the chilling effect that might occur in telling patients at the outset of treatment that certain things that the patient may say could trigger a warning to third parties (Beck, 1985).

These concerns led to the California Supreme Court rehearing the Tarasoff case in 1976 and the issuing of a second opinion. This opinion modified the duty to warn as defined in the first Tarasoff opinion, making it in effect a duty to protect. The court held that "When a therapist determines or pursuant to the standard 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" (*Tarasoff v. Regents of*

the University of California, 1976, p. 346).

Over the next several years I had many occasions to apply the Tarasoff ruling to my practice. As a crisis worker, my primary responsibility was to carry a caseload of high-risk clients and to conduct hospital assessments for the area police, jail, and school personnel. I applied Tarasoff very judiciously and prided myself on never "losing a client" over seven years of crisis-oriented work at the Center.

Since that first experience with Bill, advocating for taking away an individual's civil right to freedom, I have conducted mental health evaluations that have led to the involuntary hospitalizations of scores of men, women, and children. The faces of these people remain etched in my mind. Sometimes in the dark of long nights when sleep arrives late, I lie awake wondering how Bill has fared. I feel relieved that while my actions sometimes resulted in the perception of a break of trust between my clients and me, and their temporary loss of freedom, they also saved innumerable lives.

### **Breaking Confidence: Danger to Self**

**I**t did not take long for me to learn that there are other occasions when my job required that I break confidence with a client. Paul was a 42-year-old white, male, police officer referred to me by his supervisor, who became concerned that

Paul had shared that he was feeling depressed and that his marriage was in distress. Paul was instructed to get counseling, and we worked together for several weeks, developing a trusting relationship. After our eighth session, Paul told me that his wife had decided to leave him. He shared with me for the first time that for the past several months, he frequently would pull to the side of a back road during his night patrol and sit with his gun, loaded and cocked, in his mouth. We talked at length. He told me that his uncle was a police officer and had killed himself when Paul was a child. He refused to contract with me not to harm himself and, whereas he certainly had the means to carry out his threat, we eventually agreed that Paul needed to take time off from his police duties and to check into the hospital for his own safety. He agreed to admit himself to the hospital when it became clear that the only other option was an involuntary commitment for observation.

Paul did not appear at the hospital and after a great deal of angst, I met with the magistrate and a TDO was issued, to be served by his own police department. He was located by fellow officers in his patrol car with a gun in his lap. After some tense negotiation, Paul was escorted to the hospital. He progressed well and later returned to the police force in an administrative capacity. I learned a great deal from Paul. He knew that I would have to break confidence when he told me of his suicide plans, and his

decision to tell me could only have been a cry for help. Yet he could not make the decision to go to the hospital himself and needed for me to make the decision for him. My failure to initially hospitalize him could have led to his death, and I learned a poignant lesson. As much as I wanted to respect individual self-determination and wanted to believe Paul in his promise to go to the hospital, I should have heeded my professionally informed gut feeling and hospitalized him even though he promised me that he would leave my office and drive straight to the hospital. There are times when trust and confidences must be broken for the safety of my client and times that I must make decisions that go against the explicit wishes of a client. I was fortunate that my failure to fulfill my social control role ended happily in this case.

I was not quite as fortunate with Nathan, 42, a white male living in his parent's home. Nathan's presenting problem was depression. He was a city employee and worked as a security guard in the city morgue. Working evening shifts, he was often alone and quite isolated, though it was reported that he preferred not to be around people. Nathan reported having no friends. A survivor of repeated sexual abuse by his father, Nathan reported having frequent flashbacks and nightmares. Over the several years that we worked together, Nathan frequently reported varying symptoms of depression and suicidal ideation but always agreed that he would

speak with me first before harming himself. After a particularly difficult several weeks for Nathan and a report of increasing suicidal thoughts, I received a phone call one morning from the trauma center of the local hospital. Nathan had been admitted with a self-inflicted gunshot wound to the head. While the bullet had gone through the brain and remained lodged in his skull at the back of his head and he did lose the hearing in one ear, Nathan was otherwise miraculously unaffected. He told me later that he had been falling asleep with a gun to his head for months and that he truly did not intend to kill himself that night but must have twitched. I wonder, often, if I should have hospitalized him sooner, particularly given his high risk profile—single, white, middle aged, isolated, traumatized.

His life turned around radically after the incident, and the close brush with death appeared to have had a powerful impact on him. It affected me in a profound way as well. I often wonder if I might have hospitalized him sooner. I believed him when he contracted not to harm himself and erred on the side of caution and advocating for self-determination. After agonizing for many months about what I could have done differently, I eventually came to the conclusion that it is impossible to predict all violent acts and that if someone truly wants to hurt him or herself, there is only so much that I as a helping professional can do about it.

A colleague's client did not fare so well. Hinting of sui-

cide for weeks, he secured his chainsaw to the floor, started it, and plunged his face into its gnawing blade, spraying blood, bone, and brain on the white walls and ceiling. I often imagine the horror and responsibility I would feel had I been the clinician in this case, or if Nathan had succeeded in his suicide attempt. It is an awesome responsibility that we have as helping professionals, and while I am not generally in favor of excessive social control, it is impossible for me not to acknowledge that I have saved a great many lives because society, through its laws, gave me the decision-making authority, and, yes, the power to determine for others what is in their best interest.

As an assistant professor of social work, I feel an ethical responsibility to impress upon students the necessity to understand the limits to confidentiality and to learn from my experiences as a crisis clinician. We need to understand that while we cannot take responsibility for the actions of others, the wrong decision on our part may prove fatal for our clients and for others. Although I realize that I cannot prepare students for every potential experience they may encounter, I am hopeful that by revealing to them the uncertainty that I feel in making decisions as a helping professional, they will develop an awareness of the limits of confidentiality and the apparent contradiction between ideal values taught in graduate

school and the practical and legal necessities of the "real world."

While I promote self-determination as a value central to working in the helping professions, there are occasions when holding onto this value too tightly may come into conflict with what may ultimately be in the best interest of the client. On more than one occasion, someone that I recommended be involuntary committed to the psychiatric hospital for evaluation has returned later and thanked me for making the decision that saved his or her life.

#### Threat Towards Property

The Tarasoff ruling has been extended by many professionals to include threat to property. Only once have I found it necessary to break confidentiality for this reason. Mark, a 28-year-old white male, was a client of mine at the day-treatment program. It was Christmas and his parents, needing respite, had left to spend a week in Florida. Mark had ceased taking his medication for symptoms of schizophrenia and quickly de-compensated. I received a phone call from Mark's sister saying that Mark had called from an unknown loca-

tion and told her that he was going to burn down the fire station. I felt that I needed to call the police and the fire station immediately to warn them of the potential danger to the fire station as well as to the men inside. Mark was located a few



hours later, and after an evaluation, I recommended to the magistrate that a TDO be issued so that he could be evaluated at an area hospital. He was admitted, resumed his medication regimen, and stabilized quickly.

#### Medical Temporary Detention Order

On several occasions I have found it necessary to have clients involuntarily committed, though they may not be suicidal or homicidal or threatening harm to property but, due to mental illness, for the danger presented to themselves through their inability to care for themselves.

Lisa, for example, was an elderly black woman living alone in a trailer in the rural South. Due to severe arthritis, she had not been able to walk for two years. During those two years, her son had supplied her food which he would leave near her bed. To use the bathroom necessitated her crawling down the hall, so she was not always successful in making the trip down, and the room was rank with the smell of urine and feces. She had not bathed in two years. She had no insurance and was quite adamant about her desire to remain in her home. A mental health evaluation found Lisa to be mentally competent and not in danger. However, when the medical evaluation was conducted, Lisa was involuntarily hospitalized on a medical TDO, only one of two that I saw issued in nearly a decade at the county mental health center. For Lisa to qualify, a medically

trained professional needed to evaluate her and determine that she was within 24 hours of death. Committed to the hospital, Lisa was cleaned up and fed well for a week, and then she died in her sleep. Her family felt much better, and I had fulfilled my function of forcing care upon those whom society determines are in need. While her family was happy that she died in the hospital, I nevertheless am left with an uneasy sense of having been manipulated by a system that, through its laws and behaviors, acts as though it knows better than the individual. I am, at times, uncomfortable with the power that I have as a "professional" over identified clients and patients and the control that I have over their lives



and the decisions they make. That is not to say that I would have advocated leaving Lisa to die alone in a trailer in her feces, but it does give me pause as to where lines are drawn and by whom.

On other occasions I was forced to examine my own beliefs around euthanasia and the right that individuals have to take their own lives. Keith was a young man who had decided to commit suicide by starvation. He was a young man and had recently tested positive for HIV.

He had spent several weeks on a mattress in his garage and refused to consume anything other than water. He denied being suicidal, but based on his refusal to eat and the apparent shutting down of his major organs, a medical TDO was used to get him the help that society apparently deemed necessary for his physical survival.

I thought of Keith frequently as I watched my father dying of cancer. He and I had several discussions on suicide and had gone so far as to contact the Hemlock Society to determine the most effective and least painful way to end his life. A medication cocktail combined with something as basic as a loose plastic bag over the head to decrease oxygen intake would produce a gradual falling asleep sensation and lead to death. A minister for 40 years, my father had a great deal of experience on the topic, and he talked rationally and with great clarity about planning his death. Having witnessed hundreds of deaths in his career, he wanted to end his own life with a measure of dignity when his health deteriorated to the point that the pain was severe and irreversible and that he felt that it was no longer worth living. Certainly in cases such as that of my father, I am in complete support of the right to self-determination, and had he asked, I would have assisted him in his decision to end his life with dignity, perhaps at the expense of my professional career and even my freedom.

But where do I draw the line and who decides what is

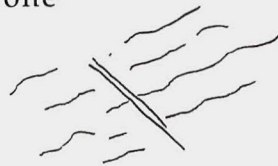
considered suicide/murder and what is euthanasia? What are the limits to self-determination? What right does society have in substituting societal determination and control for self-determination and control? And where do I draw the line between professional and legal responsibilities and personal beliefs and values? And how do I reconcile differences between my beliefs regarding euthanasia and assisted suicide, and my professional and legal responsibilities toward clients?

### Lines in the Sand

Ethicists are struggling with these issues and with the implications that emerge when we begin to extrapolate. Who decides where we draw the line? The examples drawn from my own experiences may seem clear to me, though others may have elected other options and still have made appropriate decisions (who defines appropriate?). Certainly there are scenarios where the decision to break confidence is decidedly unclear, where the practitioner must struggle with questions of social justice, social control, self-determination, and even the question "When does life begin?" The responses to these questions may not always be as clear as we would like. While ethical guidelines may be clear about duty of the professional to protect, the waters are often quite muddy.

What responsibility does a society have, for example, to protect a batterer from an

abused woman who says, "Next time he lays a hand on me, I'm going to kill him," and she has the means to carry out the threat? If the husband is warned, the woman is likely to be in for a severe beating, or perhaps will herself be killed. To her it may feel as though it has come down to a choice of kill or be killed, particularly in a legal system that historically has done little to instill faith in battered women that they will be protected against batterers. By warning the batterer of the threat against him, am I not putting my client at risk? Is this social justice? And who decides? From where does my power over clients and others derive? As someone



who has seen the effects of battering on family members, I can imagine the rage and the internal justification of killing in self-defense and can imagine feeling very conflicted about warning a battering man that his battered partner has threatened him. Is it my right to decide who lives and who dies by my reporting or not reporting threatening behavior? I know whom I would prefer to see live in the battering relationship.

What about the person who tests positive for HIV and informs you that he or she is going to continue having sex with HIV negative partners? Numerous articles dealing with

issues of confidentiality and HIV-infected clients can be found in the literature (e.g., Gostin & Curran, 1987; Silva, Leong & Weinstock, 1989; Rosmarin, 1989). The American Medical Association AIDS policy states that if an HIV positive person is endangering a third party, the practitioner should 1) attempt to persuade the infected client to cease the endangering behavior, 2) if this persuasion fails, notify the authorities, and 3) if the authorities take no action, warn the endangered third party (Rosmarin, 1989). It would appear that social values favor protecting others at the risk of restricting the limits of confidentiality between practitioner and client. In *Kathleen K. v. Robert B.* (1980), the court found that it is one's civic duty to protect third parties against the transmission of herpes. What is the function of social workers as agents of social control? When do we become tools of repression rather than sources of help?

What about the pregnant client who is an active poly-drug abuser and whose use may lead to Fetal Alcohol Syndrome and other developmental difficulties? With the increase in public awareness regarding this issue, it is perhaps inevitable that society will develop laws to protect the lives of unborn children, holding their rights above the rights of the mothers. There is a notable paucity in the literature on this issue. Is it inconceivable that future practitioners will be required to report other drug-abusing women to Child Protec-



tive Services for child abuse toward the unborn child? Who determines at what point the fetus is a human being with individual rights? And where does the woman's right to make decisions about her body enter into the discussion?

Why do I feel so much more comfortable breaking confidentiality in some scenarios than in others? Is it not a slippery slope that we are starting down? While the values that I adhere to may make me more comfortable with my social control function in some situations rather than others, the reverse may be the case with another practitioner coming from a different ideological perspective.

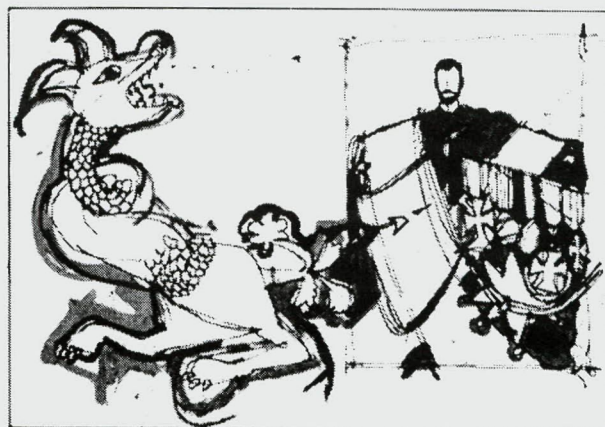
I end this article with more questions than answers. The experiences that I have presented are very real to me and have had a profound impact on my views of myself as helper as well as social control agent. I hope that the questions, while supportive, challenge the limits of the duty of professionals to protect their clients and others. While I am appreciative of the case law and ethical guidelines that allow me to protect potential innocent victims and to protect clients from their own self-injurious acts, I wonder about the increasing expectation that as a helper I am expected to act in the role of social control agent, about the increasing limits to self-determination, and about my potential role in thwarting social justice.

Though it has been several years since I last found it necessary to break the confidence of a client, I continue to

struggle with these issues. While there is plenty of case law and ethical guidelines to help guide us in practice, there is also a great deal of room left for interpretation. As I head into the next millennium, I suspect that the waters will become muddier still. □

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