Preserving Hope in the Duty to Protect: Counselling Clients with HIV or AIDS

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ABSTRACT

Psychologists may struggle with what to do when counselling recalcitrant HIV-positive clients who refuse to disclose to third parties at risk. This paper revisits the legal and ethical quagmire that pits "dangerous patient exception" against client confidentiality rights. With the notion that hope leads to more ethical behaviour, this paper further elucidates the significance of maintaining client hope in the face of a legal "duty to protect." A 'duty to maintain hope,' which may ultimately minimize the spread of HIV in society by inviting client's social responsibility, is proposed. A four-level guide is offered to assist Canadian psychologists in this endeavour. Future research directions are suggested.

RÉSUMÉ

Les psychologues se demandent parfois quoi faire quand ils conseillent des clients récalcitrants séropositifs pour le VIH qui refusent de divulguer leur situation à de tierces personnes à risque. Cet article examine de nouveau le bourbier déontologique et juridique qui met en opposition « l'exception du patient dangereux » et les droits du client à la confidentialité. L'auteure avance la notion que l'espoir contribue à un meilleur comportement éthique et explique l'importance du maintien de l'espoir chez le client face à « l'obligation légale de protection d'autrui ». Elle propose « l'obligation de maintien de l'espoir », ce qui pourrait finalement minimiser la propagation du VIH dans la société en encourageant la responsabilité sociale chez le client. Dans le but d'aider les psychologues canadien(ne)s à adopter ce principe, elle propose un guide à quatre niveaux et suggère des orientations de recherche future.

In a decade and a half the alarm of the Acquired Immune Deficiency Syndrome (AIDS) epidemic in Canada has not ceased nor grown fainter. Infection rates remain high with 46,651 individuals diagnosed as living with the Human Immune Deficiency Virus (HIV), the virus known to cause AIDS (CDC, 2000). In the province of British Columbia, 10,084 persons have tested positive for HIV comprising the highest proportion (21.6%) of the total number of HIV cases in Canada from 1985 to 2000. Although there are various anti-retroviral drug cocktails being used in the treatment of the HIV, the mystery of this virus remains, as well as its terminal nature, its societal stigma, and its increasing prevalence.

Counsellors almost inevitably will encounter persons living with HIV or AIDS in their psychotherapy practice. As such, a new challenge such as working with clients who refuse to disclose their HIV status to persons at risk confronts counsellors with the onerous decision of whether or not to breach confidence.

Counselling clients with HIV or AIDS can introduce an ethical, legal, and moral quandary. On one hand, possibly the most perplexing issue in AIDS-related literature analyses the tug of war between a counsellor's duty to protect third parties and thwart the spread of HIV in society versus client confidentiality rights (Harding, Gray, & Neal, 1993). On the other hand, we are aware that hope is an essential component of living with critical illness and taking future-oriented healthy actions. The critical question arises: How can a psychologist maintain his or her professional duty in a way that does not violate the hope of the client? A four-level guide is presented in this paper to assist in this endeavour. This guide represents an ethic of preserving hope and breaching confidence as a last measure.

What is Hope?

Although a consensus definition of hope[1] does not exist, there is agreement that it is a universal need for humans. A burgeoning of research and resultant literature has underscored the significance of hope in the face of human adversity. In health psychology literature, hope has been proposed as an intrinsic element of life that assists patients to emotionally endure crisis (Miller, 1989), especially major disability or catastrophic illnesses (Mader, 1988). Herth (1990) suggested that the presence of hope is vital for persons who are terminally ill, regardless of their physical limitations or proximity to death. In fact, depletion of hope has been linked to compromised psychological health and thwarted response to therapy and recovery (Bruhn, 1984; Cousins, 1989).

For persons living with HIV/AIDS, which is not only life-threatening, but is also transmittable and stigmatizing, finding a cure or preventing loss of life are most obvious pursuits of hope. However, hope also exists in situations where a cure is not foreseeable (Edey, Jevne, & Westra, 1999). Striking evidence has identified hope as an essential factor enabling a sustained quality existence and has illustrated the impact that the quality of relationship with significant others can have on the hope of persons living with HIV (Giacquinta (nee Stewart) 1989; Keen, 1994; Wong-Wylie & Jevne, 1997). Hope also positively influences healthy choices and behaviours (Cousins, 1989; Dufault & Martocchio, 1985) and leads to expanded functioning (Farren, Herth, & Popovich, 1992). Moreover, hope encourages individuals to plan futuristically and assertively (Snyder, 1995), adopt action-oriented decision-making processes, and elicit help (Jevne, 1993). In short, hopeful people tend to get the assistance required to make healthier and more responsible choices for the future. This is a critical consideration when counselling HIV positive clientele who are faced with the decision to disclose HIV and protect others at risk.

ETHICAL ISSUES

The Canadian Code of Ethics for Psychologists uphold two obligations that abruptly clash in the context of HIV/AIDS: (a) maintaining confidentiality

(Principle I.40) derived from the ethical principle of Respect for the Dignity of Persons and (b) the duty to warn (Principle II.36) which is derived from Offsetting Harm within the principle of Responsible Caring (Canadian Code of Ethics for Psychologists, 2000). While the Canadian Counselling Association Code of Ethics (1999) does not directly address HIV/AIDS, a more general discussion can be found. Article B3 suggests that counsellors use "reasonable care" to warn third parties about foreseeable danger. Even so, in the face of this directive, Drodge (2000) cautioned that the "most dangerous action might be to act in such a manner [to breach confidence] that would result in termination of the relationship" (p. 103).

The American Psychological Association (APA) and the Canadian Psychological Association (CPA) do not currently state specific guidelines regarding duty to protect in cases of HIV. The closest mention is in the current APA Ethical Standards 5.05, which invites counsellors to maintain confidentiality unless the disclosure is "mandated by law or where permitted by law for valid purpose such as . . . to protect the patient or client or others from harm" (APA, 1992, p. 1606). An APA policy on legislation also exists which proposes that counsellors not be required to warn but if they choose to, they are protected against civil litigations (1991). Canadian counsellors thus are best informed by the American guidelines. Ultimately, the decision rests with each counsellor to ascertain risk and the unique factors in each case.

Based on the moral principle of autonomy, a strong defense has been asserted against an automatic breach of confidence. It is well argued that consenting, able-minded adults have a right to make decisions about their body (Harding et al., 1993; Standard & Hazler, 1995). Harding et al. emphasized that in light of general awareness of the AIDS epidemic people are informed and should be refraining from high-risk behaviours. This not only asserts the autonomous rights of clients but also those of third parties. These arguments are strong assertions against an ethical, legal, and moral obligation to immediately breach to third parties. Driscoll (1992) also warned that counsellor's breach of a client's HIV status is in violation of an ethic of caring and trust known as "ethics of covenant" (pp. 704). This covenant emphasizes basic relational dynamics of trust and maintaining fidelity. Driscoll's attention to this covenant is the closest to acknowledging the importance of preserving client hope in the HIV counselling literature.

LEGAL ISSUES

A paucity of AIDS-related Canadian publications exists in contrast to the abundance of theoretical and practice oriented publications in the United States debating HIV/AIDS legal and ethical perspectives in counselling. American scholars in psychiatry, psychology, medicine, law, and ethics have entered into this complex debate and have noted the potential applicability of a legal "duty to protect."

The famous *Tarasoff v. Regents of the University of California* (1976) was the landmark case that suggested counsellors have a duty to protect third parties

from foreseeable harm and has been scrupulously applied to test for "dangerous patient exception" in HIV cases. *Tarasoff* sparked considerable debate amongst courts, legal scholars, medical ethicists, and mental health professionals concerning the extent to which confidentiality within psychotherapeutic relationships should yield the duty to protect third parties outside of the therapy relationship (Beck, 1990). Controversy as to whether the parallel can be made revolves around the difficulty in assessing "imminent danger" of HIV. Harding, Gray, and Neal (1993) alleged that in the *Tarasoff* case, Poddar made a "specific and active" intent to kill Ms. Tarasoff whereas clients with HIV are "passive" and without intent. Similarly, Driscoll (1992) compared the linear relationship (action incurs consequence) between the physical assault and death of Ms. Tarasoff to the non-linear relationship (action does not always incur consequence) between sexual and/or needle-sharing activity and HIV transmission. In reality, the application of *Tarasoff* 'dangerousness' to HIV cases has been found to be variable (Chenneville, 2000).

There have been no HIV-related legal cases involving counsellors in Canada. Litigation involving counsellors are typically concerns around negligence, which is governed by tort principles rather than criminal law (Birch, 1992). Negligence presupposes a legal duty of care owed to a third person (Schopp & Quattrocchi, 1985). Canadian civil law suits involving psychiatrists have proven that there are no absolutes in these matters (see Pittman Estate v. Bain, 1994; Wenden v. Trikha, 1991). As such, counsellors have not surprisingly become wary of the ethical and legal demands placed on them (Drodge, 2000).

THERAPEUTIC ISSUES

Ethical and legal perspectives provide some focus to reflect on this controversial issue; however, one must also gauge the consequential impact on client hope. Driscoll (1992) advocated that therapy be used to help foster clients' own social responsibility. The therapeutic alliance is a strong basis from which clients can be supported to behave responsibly (Drodge, 2000). Client insight and behaviour change are less likely with an immediate breach in confidence; and counsellors could not be guaranteed third parties would act responsibly with the information. An immediate breach of confidence can sever the alliance, diminish hope, and decrease the likelihood of he client seeking future counselling support. Thus, any opportunity to collaboratively work towards self-disclosure to partners is thwarted (Schlossberger & Hecker, 1996; Chenneville, 2000). Counsellors lacking experience and knowledge counselling clients with HIV have been found to be less thoughtful of the therapeutic alliance and more likely to immediately breach confidence (Simone & Fulero, 2001).

In contrast, counsellors who respond with sensitivity to clients have a greater chance to benefit society in the long run by motivating clients' social responsibility and ethical behaviour. In maintaining the therapeutic alliance and focusing on hope, counsellors can assist clients through the natural psychological responses to HIV/AIDS (denial, anger, shame, depression, anxiety, etc.) and psy-

chological obstacles (inability to negotiate safer sex, disempowerment, low self-esteem, etc.) that influence clients' ability to act responsibly (Standard & Hazler, 1995). Driscoll (1992) concurred that a client's external behaviour "may mirror an internal process of struggle or conflict" and that "such a dynamic process will not near resolution, let alone recognition, by a therapeutic breach of confidence" (p. 705).

A FOUR-LEVEL GUIDE IN PRESERVING HOPE AND PROMOTING CLIENTS' SOCIAL RESPONSIBILITY

Various guiding frameworks have been proposed to assist psychologists through this ethical quandary (Harding et al., 1993; McGuire et al., 1995; Knapp & VanderCreek, 1990). These models range in their suggested immediacy of warning third parties and the sensitivity with which confidential information is shared. The four-level framework proposed in this paper synthesizes previous models and guides psychologists through the process of this dilemma with an emphasis on client hope. Furthermore, these guidelines are theoretically derived from Truscott, Evans, and Mansell's (1995) conceptualization of counsellors' decision making with dangerous clients and most emulate the models of Harding et al. (1993), McGuire et al. (1995), and Chenneville (2000) who advocate confidentiality as the hallmark of therapeutic alliances.

It has been suggested that hopeful individuals are better equipped to make healthier life choices (Cousins, 1989; Dufault & Martocchio, 1985). Hope also impacts social responsibility (Dufault & Martocchio, 1985) while hopelessness has been linked to a more "sociologically oriented destructiveness and violence" (Farren, Herth, & Popovich, 1992, p. 39). Indeed, preserving client hope is critical to influencing clients' ethical behaviour and promoting social responsibility. The four level-guide presented herein maintains a consciousness to hope and is unique in "drawing hope out, nurturing it, making it visible, [and] bringing it into the light where clients and counsellors can see it and put it to some useful purpose" (Edey, Jevne, & Westra, 1999, p. 7).

The CPA's proposed seven steps in ethical decision making (2000) is an excellent problem resolution process to be considered in conjunction with this four-level guide. For instance an analysis of alternative courses of action (Step 3) on client hope and hope of those involved would be emphasized. This assessment would clarify that the central question is not whether to breach confidentiality; rather it becomes how to protect third parties without obliterating the therapeutic relationship (Chenneville, 2000) and destroying hope.

Level I: Proactiveness in general counselling protocol. This level delineates four important aspects involved in protecting the privacy and engendering the hope and welfare of clients. They are: (a) sharing clearly written informed consent which outlines all limits of confidentiality and the agency's stance on warning third parties of HIV risk (Harding et al., 1993; Lamb et al., 1989); (b) counsellors educating themselves of the significance of HIV viral load and CD4 counts,

treatments, modes of transmission, and risk-prevention strategies (Harding et al., 1993; Lamb et al., 1989; McGuire et al., 1995); (c) documenting therapeutic goals, decisions, and progress accurately and rigorously (Harding et al., 1993; Lamb et al., 1989), and (d) being aware of one's hope and being intentional about preserving hope for clients. Assuming a solid therapeutic alliance, counsellors are encouraged to directly bring hope into conversation by saying such things as "people often find it helpful to focus on hope. Would it be all right to be intentional about hope in our conversations?" A statement such as this paves the way to explore, expand, and engender client hope.

Level II: Maintaining client confidentiality and hope intentionality. In the event of a client's disclosure of engaging in HIV risky behaviour(s) with unsuspecting partners, psychologists are encouraged to not immediately breach confidence. The primary goal is to work collaboratively towards client behaviour change and self-disclosure to partners at risk. It is also prudent for counsellors to review CPA Guidelines for Non-Discriminatory Practice (2001) as a reminder of non-judgemental approaches and the sensitivity required in working with diverse populations. At this point, it is wise to develop a contract about not engaging in further HIV risky behaviour and provide support to third parties if a self-disclosure is made. Counsellors are encouraged to employ strategies of hope-focused counselling (See Edey et al., 1999) and appeal to client's social responsibility to disclose and protect third parties at risk. This might include the expression of hope through a creative process like art and proposing questions such as "What helps you to stand more in a place of hope in a situation of disclosure?," "If a disclosure turned out to be a story of hope, what would be the title?" and "How could a disclosure lead to a hopeful outcome for the both of us?"

Level III: Assessing the risk. In the process of assessing client progress toward self-disclosure, counsellors need to consider a client's potential for victimization, stigmatization (Molina & Basinait-Smith, 1998; North & Rothenberg, 1993), and further losses while monitoring the following challenges to maintaining confidentiality: (a) if there is purposeful deception and/or a verbal intent to infect another; (b) if a psychiatric disorder inhibiting responsible behaviour of the client or partner is evident (Searight & Pound, 1992); (c) if the partner is not consenting to the risky behaviour; and (d) if the client is engaging in extremely high-risk behaviours (e.g. unprotected anal intercourse) (McGuire et al., 1995). These factors bring the situation into crisis and counsellors may feel the need to ensure the protection of third parties immediately. Consultation with colleagues, knowledge of current provincial laws and professional ethics policies (Lamb et al., 1989; McGuire et al., 1995), and consistently monitoring personal attitudes and biases are imperative in such situations.

If third party notification is assessed as vital: (a) seek consent and assistance of the client to disclose HIV in your presence. You may want to suggest that the partner become part of the therapy, thereby obviating any breach of confidentiality problem (Fulero, 1988); (b) offer your professional support to third party; (c) make every effort to maintain a therapeutic relationship with the client; (d)

release only necessary information to third parties; and (e) consider contacting local health authorities with the client to employ the partner notification program to inform casual partners of HIV risk.

Level IV: Breaching without consent. If all attempts to collaboratively inform partners at risk are unsuccessful, counsellors need to re-evaluate the situation. The client should be informed and debriefed of the decision to notify third parties at risk for HIV. Counsellors should not inform third parties unless trained in partner notification. Only relevant information should be disclosed to local health authorities to contact third parties. Verify with authorities that partners have been appropriately notified and contact the client to inform him or her. If requested, provide support to those concerned and document the process with painstaking accuracy. As much as possible, be transparent, honest, respectful, and descriptive with the client in nurturance of hope and the possibility of maintaining the therapeutic relationship.

SUMMARY AND CONCLUSIONS

This paper delineates poignant legal, ethical, and therapeutic issues and advocates for preserving hope in counselling clients with HIV. Legally, most scholars in light of the precariousness in assessing degree of dangerousness in HIV third party risk, concluded a *Tarasoff* "duty to protect" as incongruous. Furthermore, with great substantiation in the literature, it is proposed that counsellors have a better chance to protect society in the long run by maintaining confidentiality and exploring with clients the issues that impede their self-disclosure and protection of others (Chenneville, 2000). An automatic breach of a client's HIV status is viewed as diminishing client hope and compromising the necessary relationship from which this valuable insight can be garnered.

Further clarification of the roles and obligations of counsellors is required as dialogue concerning this multifaceted and controversial issue continues. Additional qualitative and quantitative research on the nature of counsellors' breach of confidence and the impact on hope of all concerned (counsellor, client, third party) would further guide us. Moreover, the development of succinct federal and/or provincial HIV/AIDS directives and policies is needed to assist counsellors on this matter. There is no simplistic response in this complicated dilemma. Guiding this writer's ethic is respecting client autonomy, maintaining confidentiality, and above all being conscious of hope. It is reasonable to assert that a duty to client hope can help to create more opportunity to have a standard of care that meets both the legal duty to protect as well as the ethical obligations to maintain confidentiality.

Note

[1] There is a distinct difference between ***hope for***, where hope is syntactically used as a verb and semantically used to infer a desire for a specific outcome, and ***hope*** as a noun denoting an essence to life that is vital in the face of human adversity. For the purposes of this paper, hope refers to the latter.

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