Effects of Professional Affiliation on Group Therapists' Confidentiality Attitudes and Behaviors

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This study examines the influence of group therapists' professional characteristics on their attitudes and practices regarding confidentiality. Eighty-three highly experienced and well-trained group therapy providers representing the fields of psychiatry, psychology, and social work completed a survey questionnaire inquiring into their confidentiality practices. Although there is considerable consensus between medical and nonmedical practitioners on the issues addressed, there are also interesting differences and trends. Implications of the findings for clinical practice, ethics training, and confidentiality legislation are addressed.

In recent years, there has been increased attention paid to the impact of the therapist's ethical and legal obligations on the psychotherapeutic process.[1] While both the individual and group therapist must contend with the conflict between confidentiality rules requiring silence and legislation requiring reporting, the group therapist must also deal with the considerable uncertainty about the legal rights and responsibilities of individuals receiving care within the multiperson treatment context.[2–8]

If group therapy practitioners are to have an informed role in the development and shaping of confidentiality legislation, a line of relevant empirical research is needed. Specifically, areas of consensus and divergence between professions must be identified and addressed. This study constitutes an initial step toward this objective by expanding on a previous report of experienced group psychotherapists' confidentiality attitudes and practices.[6] Findings from the latter project indicated that therapists: (a) are very concerned about the risks for breaches of confidentiality in group treatments, (b) have experienced breaches of confidentiality in their own group work, (c) frequently instigate discussions of confidentiality with prospective group members, (d) rarely focus this

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discussion on the relatively high potential for breaches in the group context, (e) are rarely subpoenaed to testify in court about a group therapy patient but tend to restrict their record keeping out of concern with such an event, (f) seldom receive formal training concerned with confidentiality violations in group psychotherapy, and (g) primarily endorse legally mandated disclosures only in situations with potential physical harm either to the patient or others. Using the same data base,[6] the present report evaluates each of these results within the context of interprofessional consensus and divergence.

Method

Methodological details are presented at length elsewhere[6] and will be reported only briefly here.

Subjects One-hundred group therapy practitioners from a random sample of 300 members of the American Group Psychotherapy Association (AGPA) responded positively to a mail invitation to participate in this project. Fifteen psychiatrists, 32 psychologists, and 36 social workers were participants in the present study. Small numbers of professionals with other backgrounds (e.g., nurses, pastoral counselors, counselors) precluded their inclusion in the present research (Table 1).

Instrument Respondents completed a four-part, 15-page questionnaire that consisted primarily of questions about confidentiality attitudes and practices; questions were in checklist format with additional space provided for open-ended comments. The instrument was pretested on 15 experienced group therapists (mean of 12.4 years of therapy experience), and modifications were made to improve phrasing and comprehension of items.

Results

Concern with Confidentiality Respondents asserted that group psychotherapy poses a greater threat to breaches in confidentiality than individual psychotherapy (psychologists = 81%, psychiatrists = 87%, social workers = 83%). Psychologists and social workers attributed the difference to the sheer number of persons having access to the information; psychiatrists attributed it primarily to the interpersonal deficits of group therapy patients. Clinicians also indicated their concern about breaches of confidentiality along a 5-point scale. Differences were found in the degree of concern expressed by different professional disciplines, F (2, 80) = 4.24, p = .018. Specifically, social workers expressed greater concern about confidentiality violations (M = 3.55, SD = 1.25) than did psychologists (M = 2.78, SD = .91), t (66) = 2.89, p = .005. Psychiatrists' concerns (M = 3.13, SD = 1.06) did not differ significantly from either the psychologists or social workers.

Discussion of Confidentiality The professions did not differ in the proportions of prospective group members with whom they discussed the importance of maintaining confidentiality. However, there was a tendency for fewer psychiatrists to discuss confidentiality at the first session (73%) than either psychologists (81%) or social workers (91%). This

Table 1
Sample Demographics

	Psychology (n = 32)	Psychiatry (n = 15)	Social Work (n = 36)
Age			
M	48.28	52.33	49.11
SD	11.33	9.95	8.74
Years of group therapy experience			
M	15.85	18.60	16.39
SD	8.52	9.99	6.83
Gender	n (%)	n (%)	n (%)
Male	21 (66)	12 (80)	10 (28)
Female	11 (34)	3 (20)	26 (72)

trend was replicated in the reported discussion of confidentiality at important treatment junctures (e.g., periods of increased self-disclosure), with fewer psychiatrists (27%) than either psychologists (47%) or social workers (56%) reinforcing earlier confidentiality instructions.

The comprehensiveness of therapist discussion about confidentiality with prospective group members was assessed by asking respondents which of seven alternate topics they addressed during the screening process (see Table 2). For all three professions, the discussion of confidentiality most frequently included: (a) a definition of confidentiality, (b) an emphasis on the importance of total confidentiality, (c) permission to discuss only one's own therapy issues out of group, and (d) a discussion of the harmful effects that confidentiality violations will have on group process (e.g., decrease in trust).

Further, all clinicians, regardless of professional background, tended to avoid directly discussing confidentiality limitations or consequences to group members who violate the confidentiality norm.

Confidentiality Infractions Confrontation with confidentiality violations was assessed by asking respondents to indicate their experience with a list of seven infractions. No differences were observed between the experiences of different professional disciplines. Many respondents (47% of psychiatrists and psy-

Table 2
Proportion of Therapists Discussing Each Confidentiality Topic

Topic	Psychology (%)	Psychiatry (%)	Social Work (%)
Total confidentiality	66	73	78
Definition of confidentiality	78	87	86
One's own therapy issues	59	67	80
Consequences to violator	34	27	33
Limitation of confidentiality	37	27	28
Post-termination limits	34	47	58
Consequences to group	59	40	61

chologists; 33% of social workers) reported experiencing an incident in which a group member had inappropriately identified another participant to others outside the group. A sizable minority (20% of psychiatrists; 16% of psychologists; 22% of social workers) also reported group members gossiping about sexual indiscretions of co-members. Violations pertaining to illegal activities, marital and family issues, and employment occurred relatively infrequently for therapists, regardless of profession.

Court-ordered violations of confidentiality were very infrequent. Clinicians reported that none of their patients had ever been subpoenaed to testify in court about a co-member. Further, only five percent of all therapist-respondents (1 psychologist, 1 psychiatrist, and 2 social workers) reported being subpoenaed to testify about a group therapy patient. Although the occurrence of these incidents is quite low, a majority of respondents from all professions (73%) reported that they kept less detailed notes out of concern about being court ordered to testify. Further, there was a slight trend toward greater reduction in record keeping by psychiatrists (80%) compared with either psychologists (68%) or social workers (73%).

Ethics and Confidentiality The three professions showed a trend toward differences in the proportion of respondents that had completed either an ethics course or seminar, χ^2 (2, n = 83) = 5.54, $p = .06$, with 53 percent of psychologists, 37 percent of social workers, and 27 percent of psychiatrists having received relevant training. All respondents with formal training in ethics stated that while general issues about confidentiality were discussed in their classes, only 23 percent of psychologists, 29 percent of social workers, and zero percent of psychiatrists reported that their courses had addressed the special issues of confidentiality in group treatments.

Mandatory Reporting Therapists exhibited considerable agreement regarding the types of patient disclosures that should and should not be protected by legislation (see Table 3). A composite index, derived by summing over endorsed incidents, indicated that respondents favored legislated disclosure in a number of the situation ($M = 5.19$, SD = 2.27). A trend was also noted toward a greater interest in legislative controls by social workers ($M = 5.89$, SD = 2.56) compared with psychiatrists ($M = 4.40$, SD = 2.29), t (49) = 1.95, $p = .06$. Psychologists ($M = 5.06$, SD = 2.29) tend to favor less legislation than social workers and more legislation than psychiatrists.

Clinicians from all three professions agreed that a therapist should be compelled to disclose information concerning threatened physical harm to identified others, inappropriate sexual behavior with physical harm, and child abuse. Furthermore, clinicians from all three disciplines were not in favor of legislated disclosure of information pertaining to inappropriate sexual behavior without physical harm, or past involvement in any criminal activities. Finally, a notable minority of clinicians from all three professions favored the legislated disclo-

Table 3
Proportion of Each Profession Recommending Mandatory Reporting For Specific Patient Disclosures

Patient Disclosure	Psychology (%)	Psychiatry (%)	Social Work (%)
Threatened physical harm			
To self	75	53	81
To identified other(s)	91	87	89
To nonidentified other(s)	28	20	36
Child abuse	94	87	94
Criminal activities			
Plans to engage in any	22	20	28
Plans to engage in felony	53	33	61
Disclosure of any past crimes	3	0	8
Disclosure of past felony	12	0	25
Inappropriate sexual behavior			
Without physical harm	6	0	14
With physical harm (rape)	72	67	83
Sexually promiscuous HIV+	50	73	69

sure of information regarding planned involvement in any criminal activity, threatened physical harm to nonidentified others, and prior involvement in a felony. Although statistically significant differences were not obtained, social workers tended to be more in favor of legislated disclosure on almost all issues compared with psychologists, who tended to favor legislation more than psychiatrists.

Considerable disagreement was apparent in the endorsement of legislated disclosures of a sexually promiscuous HIV+ patient, threatened physical harm to the self, and plans to engage in a felony. A majority of social workers favored the legislated disclosure of all of these behaviors. A majority of psychologist favored the legislated disclosure of self-injurious threats but were divided with regard to a legislated disclosure of criminal plans and HIV infection. A notable minority of psychiatrists favored disclosure of criminal plans, with no clear consensus on the issue of self-harm threats, and a majority in favor of the legislated disclosure of a sexually promiscuous HIV+ patient.

Discussion

This study examines the influence of professional background on group psychotherapists' beliefs and practices concerning confidentiality. Due to the small sample size, caution must be exercised in making attribution of divergence in confidentiality attitudes and practices exclusively to professional backgrounds. That is, "uncontrolled factors not directly related to the therapists' professions may shape their views on confidentiality more than the professional affiliation *per se*" (anonymous reviewer). Consequently, until these findings are replicated by more rigorous investigations, we need to consider them tentatively.

Our data indicate that social workers report the most concern about breaches

of confidentiality. This finding may reflect training issues. Social work, more than the other two professions, emphasizes a systems approach to group interventions. That is, the social worker may be more attuned to the likelihood that group members might share information learned in group with significant others in their social context (e.g., family members, friends) than are other professionals.

Possibly due to their greater concerns with confidentiality and desire to reassure patients that confidentiality is extremely important, a larger percentage of social workers discuss the importance of confidentiality beyond the initial screening of prospective members and the first session. Psychiatrists tend to give confidentiality instructions during the initial screening of prospective patients, but after that point are less likely to do so than psychologists and social workers. It might be that the psychiatrist-group therapist's medical background is associated with a more influential stature. That is, the psychiatrist-therapist may assume that once they communicate "the rules," group members will comply with them. Another hypothesis is that psychiatrist-group therapists may simply not be as intensively exposed to group dynamics and contextual factors in their training as their professional counterparts. Pinney[7] reports that less than 50% of psychiatric residency programs offering group therapy training have a group dynamic focus. Unfortunately, we do not have comparable data from psychology or social work training programs.

Regardless of profession, all respondents who had an ethics course in their training report that confidentiality in multiperson treatments was infrequently addressed. Clearly, this is an omission in the education of mental health providers that needs to be remedied.

Topics discussed in confidentiality instructions are also consistent across professions with efforts at defining confidentiality and discussing its importance for group process taking precedence. Much less attention was given to issues such as the importance of confidentiality rules still being in effect after group termination, consequences for violation of the confidentiality bond, and limited confidentiality. Clinicians may be hesitant to discuss negative consequences for confidentiality because it may lead to a confusion of roles (punitive vs. care-giving). The issue of limited confidentiality can be very threatening to group therapists because of its perceived negative impact on group process.[6, 8] However, in not informing patients of exceptions to confidentiality, they are acting unethically and placing themselves at legal risk if a patient experiences injury because of any unauthorized disclosure.[6]

A greater percentage of social workers favor legislation requiring group therapists to report patient disclosures of antisocial behavior. This may also reflect social workers' community orientation; that is, they think about the negative effect of such patient behavior on the latter's social field. Psychiatrists feel the least need for legislating what should and

should not be reported to third parties. They may already be experiencing too much legal involvement in the practice of medicine to embrace further legislation. This interpretation is further supported by the trend toward more restrictive record keeping of psychiatrists out of concerns about being subpoenaed.

It is hoped these tentative findings and discussion will help shape hypotheses to be used by future researchers in their designing of research in the area of confidentiality with clinical groups. From an educational perspective, the findings indicate that insufficient attention has been paid to confidentiality issues in group psychotherapy training across disciplines. Although considerable interprofessional consensus is apparent with respect to many of the issues addressed, disagreements were also apparent. The development of mutually acceptable professional standards and legislated controls will have to address both the agreement and dissention expressed by the different professions that play a role in the provision of group therapy services.

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