Review Article **IJPRR (2022) 5:66**

International Journal of Psychological Research and Reviews
(ISSN:2639-6041)

Privacy, Confidentiality, and Duty to Warn in Treating Persons Convicted of Sexual Offenses: A Narrative Review

Kelly Walk; Suchika Siotia

Fielding Graduate University

ABSTRACT

Various court systems often mandate treatment for individuals convicted of sexual offenses (ICSO). Legal parameters often limit how clinicians provide services, and information is shared to protect the community and the ICSO. Ethical challenges often present as clinicians serve ICSO, especially concerning privacy, confidentiality, and the duty to warn. Research shows that not all approaches to clinical treatment with ICSO are effective, especially when examining client treatment engagement and the therapeutic alliance. Issues of diversity and culture further complicate inherently complex and precarious situations involved in treatment with ICSO. This narrative review highlights the need for clinicians to stay well-informed, remain diligently transparent, and practice cultural sensitivity in approaches to therapy with ICSO.

Keywords: ICSO, privacy, duty to warn, confidentiality

***Correspondence to Author:**
Kelly Walk
Fielding Graduate University

How to cite this article:
Kelly Walk; Suchika Siotia.Privacy, Confidentiality, and Duty to Warn in Treating Persons Convicted of Sexual Offenses: A Narrative Review. International Journal of Psychological Research and Reviews, 2022, 5:66.

Individuals convicted of sexual offenses (ICSO) often undergo court-ordered mandated treatment to encourage rehabilitation and reduce the risk of recidivism. In recent years, federal and state statutes have bolstered laws regarding ICSO and augmented requirements for community-based supervision and court-ordered treatment (Walker, 2021). Current treatment approaches aim to prevent further societal harm by focusing on populations of individuals designated with a high risk of reoffending (Edwards & Hensley, 2001). Treatment for ICSO is offered both in individual and group settings. Valid participation requires individuals to examine and discuss intensely personal matters such as sexual arousal, self-examination, and victim empathy (Frost et al., 2019). In such treatment situations, ICSOs share past sexual behavior and habits and attempt to confront sexual knowledge, sexual interest, and cognitive distortion (Jung et al., 2020).

Self-disclosure on topics of this nature may cause extreme discomfort and shame, and individual response patterns may be influenced by a person's characteristics of self-directedness and openness (Frost et al., 2019). However, for ICSO, therapeutic disclosure is typically mandatory in treatment as it facilitates therapeutic rehabilitation (Jung et al., 2020). Clients will have improved odds of understanding themselves and developing efficacious strategies to avoid reoffending when they are open to disclosing past offenses, current attitudes, persistent urges, and fantasies. A study by Frost et al. (2019) involving clinician ratings of client progress illustrates this point. Results indicated that compared to clients who maintain a closed and other-directed disclosure management style (DMS), statistically significant improvements were found among individuals who presented openness and a self-directed DMS regarding their offenses. The authors presented these findings as support for encouraging those who have offended to use open and self-directed approaches to self-disclosure; however, they recognize that this effort requires expert facilitation skills to support the therapeutic process. Challenges are revealed as therapists consider the simultaneous competing needs of client rehabilitation, the therapeutic relationship, and legal requirements of privacy, confidentiality, and the duty to warn.

Legal Parameters

Considering and weighing all ethical, legal, and case-specific considerations can seem daunting. This task is especially challenging when one considers that the legal requirements of those who work with ICSO may frustrate the quality of the crucial element of therapeutic engagement. While acknowledging this complexity, Hansen and Goldberg (1999) highlight the importance of considering the legal factors and constraints in federal, state, and local statutes. They suggest a comprehensive understanding of current codes, laws, rules, and regulations, such as the duty to warn, privacy, and confidentiality in treatment.

The current societal precautionary approach includes several measures to protect the ICSO and the community in which such persons live. These measures include sex offender registration, residency restrictions (Walker, 2021), GPS tracking, community notifications, and sexual history disclosure interviews potentially accompanied by polygraph administration (Jung et al., 2020).

Psychologists are expected to maintain standards of privacy and confidentiality in protecting their clients (American Psychological Association [APA], 2017). Attempts to encourage full disclosure by ICSO and to ensure community awareness of their presence demand that clinicians skillfully navigate legal requirements for privacy, confidentiality, and the duty to warn. Because privacy and confidentiality are critical components for effective therapeutic engagement, this effort in treating ICSO is critically important. Though self-disclosure is essential for effective treatment, clients will not fully disclose if they feel their

privacy is threatened or suspect their therapist may not ensure confidentiality.

Several regulations set strict limits to safeguard information in individuals' medical records (Centers for Disease Control and Prevention, 1996). However, psychotherapy notes have special considerations that prevent others from accessing these records except for scenarios including mandatory reporting of abuse and duty to warn responsibility. However, circumstances may arise in which keeping others safe and healthy requires disclosing information without a client's authorization. For example, several Washington state laws address this circumstance, including a legal code on a “Need-to-know basis” for unauthorized disclosures (Disclosure without patient’s authorization, 2017).

An example of such a qualifying circumstance is when a clinician learns that their client offended another individual, and this act is unknown to the authorities. Though the client is currently in treatment for sexual offending, this act has not yet been reported to the authorities and must be addressed. The clinician is ethically responsible for making the report but should limit disclosed information to that which directly pertains to the recently revealed offense. This effort may satisfy the need for community safety while preserving client confidentiality.

Relatedly, according to Washington state legislation, the duty to warn requirement requires psychology professionals to take reasonable precautions to communicate to law enforcement actual threats of physical violence to reasonably identifiable victims (Exemptions from liability, 2020). During disclosure in therapy, if the psychologist identifies a credible threat of sexual violence by their client to another individual, they are legally required to take steps to prevent such harm. Clinicians should remain aware that this type of necessary disclosure, however necessary, may harm the alliance and slow further progress in the therapeutic relationship.

Ethical Parameters

The APA provides a Code of Ethics to guide providers in the ethically competent delivery of services (American Psychological Association [APA], 2017). Enforceable ethical standards include details on how providers must use precautions to protect confidential information and proactively communicate with clients regarding such confidentiality's practical and reasonable limits. These ethical standards also speak to minimizing intrusions on client privacy, especially when information disclosures not authorized by the client are deemed necessary and lawful. While the standards are helpful for providers, determining how to apply ethical parameters around privacy, confidentiality, and duty to warn in treating ICSO is a complex and nuanced issue.

Providers offering treatment to ICSOs must often report qualifying disclosures to authorities (Walker, 2021). Unfortunately, such mandated disclosure risks threatening and damaging the therapeutic alliance between clinician and client. Research has demonstrated that therapeutic alliance quality is essential to efficacious treatment for ICSO (Youssef, 2017). Due to the mandated, coercive nature of legal system-directed treatment orders, therapeutic alliances between clinicians and ICSOs may naturally be threatened from the beginning of the relationship. Threats to the therapeutic alliance are problematic as research has shown that the client's perception of the clinician (Levenson et al., 2009) and the bond that exists (especially with female clinicians) is correlated with treatment engagement and risk of recidivism (Blasko & Jeglic, 2014).

Ethical treatment of ICSO involves understanding system factors that may contribute to clinician decisions in preparing treatment approaches and utilizing targeted psychological theories in client sessions (Youssef, 2017). Knowing the population characteristics (generally hostile, more resistant, less motivated), clinicians can tailor their engagement methods and therapeutic approach

to address boundaries and concerns for the therapeutic alliance and dyad work (Youssef, 2017). Understanding that treatment providers must minimize harm to all while assisting their client's rehabilitation, ethical codes exist for clinicians engaged in work with ICSO, which require community protection to be prioritized over client confidentiality (Association for the Treatment of Sexual Abusers [ATSA], 2017). As providers are transparent with ICSO they are treating, they can work towards a transparent understanding of the benefit to the well-being of the client and society by following such standards.

Diversity Considerations

As the literature on this topic is examined, rare mention is made of issues like client culture or diversity in legal, ethical, and duty to warn considerations during treatment for ICSO. However, one significant diversity issue is the current trend to focus policy and legislation disproportionately on older ICSOs with repeat offense histories. At least one study challenges the suitability of this approach, as findings suggest the risk of ICSO is not as linear, high, and stable as was once supposed (Lussier et al., 2010). In addition to issues of age discrimination in ethical treatment and policy of older ICSOs with repeat offenses, one could reasonably suppose that therapists who are culturally insensitive or incompetent may jeopardize the treatment quality they offer ICSO clients. Sexual offending is an emotion-laden topic that clinicians may not be able to accept or understand personally, so they should seek other characteristics and commonalities on which they can begin to build a therapeutic alliance. If therapists see great differences between themselves and the clients they treat, their personal biases may frustrate client engagement. A clinician's lack of understanding of their client's unique experience (e.g., cultural, ethnic, racial, and gender factors) may impede a profitable therapeutic alliance and ethical handling of client trust and expectations.

Recommendations for Future Practice

Treatment for ICSO is routinely beset by challenges of both a legal and ethical nature. Concerns of privacy, confidentiality, and duty to warn can make work with ICSO particularly fraught with complex dilemmas that clinicians must be able to navigate skillfully. Findings from several studies also detail essential insights, such as polygraph use and providing tailored treatment approaches for treatment engagement. Regarding the ethical use of polygraphs, research findings regarding test accuracy are mixed, at best. However, some studies show that clients disclose significantly more information when polygraphs are used in interviews for post-conviction testing (Jung et al., 2020). While this information may be helpful for disclosure purposes, clients who undergo such experiences may feel coerced and increasingly resistant in future dialogue, which may negatively affect the therapeutic alliance. The question remains, is this technique worth the potential harm to the therapeutic alliance, especially when the accuracy of findings is not wholly reliable? Continuing such a practice may lack empirical justification.

Another point of interest in practice is the bond between a therapist and client: this is of great importance for efficacy in treatment. Research points to a critical need for clinician proficiency as client treatment engagement, and the therapeutic alliance may be negatively impacted by unskillful clinician practice. Providers can enhance treatment practices and therapeutic interactions by ensuring the clinician understands each client's unique cultural identities and values. Maintaining constant consideration and remaining aware of how cultural influences may inform client receptivity to various treatment modalities can further the therapeutic alliance and improve client engagement. This point is illustrated in recent research by Blasko and Jeglic (2016). Study authors found that clients' sexual recidivism was negatively correlated with perceived therapist bonds, particularly for female therapists, which

finding supports the importance of developing and preserving the therapeutic alliance. Perhaps most informative amongst the plethora of research on this topic were Levenson et al. (2009) findings that treatment engagement was the most significant predictor of the client's perception of treatment. Ensuring a tailored approach with each ICSO may bolster the therapeutic alliance and treatment engagement leading to optimal rehabilitation outcomes.

Sexual abuse is an emotionally charged issue that leads to lawmakers hastily enacting legislation that appears functionally strong but, under examination, shows a lack of efficacious outcomes (Edwards & Hensley, 2001). With the several complexities at issue, what should be done to ensure the legal and ethical treatment of ICSO? Ethical treatment of ICSO requires focused effort in overcoming obstacles to developing and sustaining a therapeutic alliance. Understanding correctional institution policies and legal constraints regarding confidentiality and privacy boundaries is the first step for all clinicians (Youssef, 2017). Awareness of these boundaries and honestly sharing them with the client is fundamental to cultivating a therapeutic alliance. Therapists should be transparent from the beginning of the therapy experience, ensuring clients know the exact limits of confidentiality and the competing yet compelling need for clients to disclose as fully as possible.

From the beginning of the therapeutic relationship, providers of ICSO are wise to explain that though such ethical and legal difficulties are likely to arise, needful client disclosure will hasten the end goal of treatment: rehabilitation and integration into the community. Clinicians can model such openness by reiterating what the data shows and how future possibilities hinge on treatment engagement and compliance. Providers can share that clients can expect superior rehabilitative results when they work to improve their transparency in disclosure management. This approach may further empower ICSO to disclose treatment-related thoughts and behaviors to accelerate therapeutic recovery. Clinicians that remain knowledgeable of legal constraints, maintain transparency with clients, and utilize a culturally sensitive treatment approach throughout the therapeutic relationship can more deftly and successfully traverse these legal and ethical dilemmas during treatment for ICSO. Therapists should also clearly state the premier priority of protecting the community, which ultimately includes the ICSO, as ICSO are members of their larger communities.

References

[1]. American Psychological Association. (2017). Ethical principles of psychologists and code of conduct (2002, amended effective June 1, 2010, and January 1, 2017). https://www.apa.org/ethics/code/

[2]. Association for the Treatment of Sexual Abusers. (2017). Ethical standards and principles for

[3]. the management of sexual abusers. https://www.atsa.com/atsa-code-ethics

[4]. Blasko, B. L., & Jeglic, E. L. (2016). Sexual offenders' perceptions of the Client–Therapist relationship: The role of risk. *Sexual Abuse, 28*(4), 271–290. https://doi.org/10.1177/1079063214529802

[5]. Centers for Disease Control and Prevention. (1996). *Health Insurance Portability and Accountability Act of 1996* Pub. L. No. 104-191.

[6]. Disclosure without patient's authorization-Need-to-know basis, RCW 70.02.050 (2017). https://app.leg.wa.gov/RCW/default.aspx?cite=70.02.050

[7]. Edwards, W., & Hensley, C. (2001). Contextualizing sex offender management legislation and policy: Evaluating the problem of latent consequences in community notification laws. *International Journal of Offender Therapy and Comparative Criminology, 45*(1), 83–101. https://doi.org/10.1177/0306624X01451006

[8]. Exemptions from liability, RCW 71.05.120 (2020). https://app.leg.wa.gov/rcw/default.aspx?cite=71.05.120

[9]. Frost, A., Grace, R. C., & McLean, A. P. (2019). Therapeutic engagement and treatment progress: Developing and testing an in-treatment measure of client engagement among sex offenders in a group program. *Sexual*

Abuse, 31(8), 952–971. https://doi.org/10.1177/1079063218791178

[10]. Hansen, N. D., & Goldberg, S. G. (1999). Navigating the nuances: A matrix of considerations for ethical-legal dilemmas. *Professional Psychology: Research and Practice, 30*, 495-503.

[11]. Jung, S. H., Jin, M. J., Lee, J., Kim, H., Ji, H., Kim, K., Hyun, M., & Hong, H. (2020). Improving the quality of sexual history disclosure on sex offenders: Emphasis on a polygraph examination. *PloS One, 15*(9). https://doi.org/10.1371/journal.pone.0239046

[12]. Levenson, J. S., Macgowan, M. J., Morin, J. W., & Cotter, L. P. (2009). Perceptions of sex offenders about treatment: Satisfaction and engagement in group therapy. *Sexual Abuse, 21*(1), 35–56. https://doi.org/10.1177/1079063208326072

[13]. Lussier, P., Tzoumakis, S., Cale, J., & Amirault, J. (2010). Criminal trajectories of adult sex offenders and the age effect: Examining the dynamic aspect of offending in adulthood. *International Criminal Justice Review, 20*(2), 147-168. https://doi.org/10.1177/1057567710368360

[14]. Walker, A. M. (2021). A delicate dance: Ethical and systemic issues in providing community-based sex offender treatment. *Sexual Abuse, 33*(7), 769–792. https://doi.org/10.1177/1079063220965946

[15]. Youssef, C. (2017). The importance of the therapeutic alliance when working with men who have committed a sexual offense. *Journal of Criminal Psychology, 7*(3), 206–220. https://doi.org/10.1108/JCP-09-2016-0027