Professional Psychology: Research and Practice
2009, Vol. 40, No. 6, 557–563


0735-7028/09/$12.00 DOI: 10.1037/a0017419

# Should a Psychotherapist Be Compelled To Release an Adolescent's Treatment Records to a Parent in a Contested Custody Case?

Elizabeth M. Ellis
Atlanta, Georgia

The issue of whether to release a minor's treatment records to a parent presents a complex ethical dilemma for clinicians. This is made more complex when the child is an adolescent and when the parents are involved in a custody dispute. The author presents a case summary followed by a review of the literature. A section on court rulings in similar cases is included. In general, courts have ruled in favor of maintaining the privilege for mature minors involved in custody proceedings. Health Insurance Portability and Accountability Act regulations pertaining to minors whose parents may not be acting in their best interests are also reviewed. Procedural recommendations by several experts in the field are offered that may serve to establish the child's rights to privacy at the outset of treatment and thus avert ethical conflicts. The author concludes with the case outcome and an advisory for the clinician.

*Keywords:* adolescents, child custody, children's rights, confidentiality, treatment records

## Case

A father sought treatment for a 14-year-old boy per court order that was issued at the end of a bitter, protracted child custody dispute in State X. The father gave the history that the child custody evaluator in that state had recommended that the father have custody of the child, after which the psychologist was physically assaulted by the mother in his office and was the subject of a licensing board complaint filed by the mother. Allegedly, the case was awaiting trial when the mother physically assaulted the boy. In an emergency hearing, the judge awarded the father custody of the boy, and he moved to State Y to live with his father. The superior court judge in State Y later domesticated the order, thus giving State Y jurisdiction. The mother continued to have joint legal custody, and the boy was ordered to have ongoing visitation with her.

On initiating treatment with the boy, the mother contacted the psychotherapist and demanded to be included by phone in the boy's psychotherapy sessions. The psychotherapist declined and instead scheduled an appointment by phone with the mother, which was set to occur after having two psychotherapy sessions with the boy. When contacted by phone, the mother declined the phone session and ordered the psychologist to stop treating her son. The psychologist complied.

Six months later, the mother's attorney demanded the records from the boy's treatment sessions. Under state law, in State Y, parents with joint legal custody have the right to access their children's medical records. The psychologist asked the father, who had primary physical custody of the boy, if he wished to release the boy's records to the mother. The father stated that he would prefer not to, if possible, and that he would ask his son, who was then 15. The father reported back that his son did not want his mother to see his records because he feared retaliation, both physical and emotional. The father stated further that the previous psychotherapist had, on the mother's demand, turned over the boy's records to the mother, who allegedly then used the notes to verbally berate and harass the son. The boy had expressed little confidence in the power of psychotherapists and the court to shield him. The father added that the mother had filed suit against the father in an attempt to regain custody of the boy, and that her request for the records appeared to be part of this suit.

Seeking to protect the boy, but also to provide information to the mother, the psychologist offered three compromises to the mother's attorney: (a) allow the boy to redact the record so as to shield those parts of the notes he did not want his mother to see, (b) provide a written summary of treatment to the mother, or (c) let a guardian ad litem appointed by the court review the case. The mother declined all three options. The psychologist wrote the superior court judge who domesticated the father's custody of the boy in State Y, asking for a ruling in the case. The judge declined to intervene as no petition had been filed on the boy's behalf. The mother then filed a complaint against the psychologist with the state licensing board.

## What Are an Adolescent's Rights to Confidentiality?

For those who practice in the area of child and family psychotherapy, this area is at times one in which ethics and the law are in conflict. The 2002 American Psychological Association (APA) Ethics Code, Section 3.04, Avoiding Harm, states, "Psychologists take reasonable steps to avoid harming their clients/patients, stu-

ELIZABETH M. ELLIS obtained her PhD from Emory University and has been in independent practice in the Atlanta area since 1980. Her areas of interest are in the treatment of adolescents and in child and family forensic evaluations. She is the author of *Raising a Responsible Child* (Birchlane, 1995) and *Divorce Wars* (APA, 2000) as well as numerous papers in the areas of psychotherapy and divorce conflict.

THANKS TO HERB ELLIS, attorney with the public defender's office of Columbia County, Florida, for assistance with legal research.

CORRESPONDENCE CONCERNING THIS ARTICLE should be addressed to Elizabeth M. Ellis, 2400 Pleasant Hill Road, Suite 165, Duluth, GA 30096. E-mail: Elizabethphd@bellsouth.net

dents, supervisees, research participants, organizational clients, and others with whom they work, and to minimize harm where it is foreseeable and unavoidable" (APA, 2002). Psychologists are also directed to maintain the confidentiality of patients' disclosures, as directed under Ethical Standard 4.01, Maintaining Confidentiality. In the case of minors, this privilege extends to the parents who act as representatives for their dependent children.

Psychologists are also obligated to protect the well-being of those in their charge who may be legally unable to control their rights to confidentiality, such as children, the mentally disabled, and the infirm. Standard 3.10, Informed Consent, states, "For persons who are legally incapable of giving informed consent, psychologists nevertheless (1) provide an appropriate explanation, (2) seek the individual's assent, (3) consider such persons' preferences and best interests, and (4) obtain appropriate permission from a legally authorized person. . . ."

Although adolescents' rights must be considered, who owns the rights to their records? Under Georgia law, as well as many other states, parents with joint legal custody are entitled to a copy of their children's "medical records." Remar and Hubert (1996) have written that "the Medical Consent Law does not address the provision of psychotherapeutic care to minors by psychologists and other nonphysician MHP's [mental health professionals]" (p. 256). They argue that a contract exists between the parent and the psychologist given that the child can't enter into such a contract independently. Therefore, the psychologist must honor that contract and assume the privilege extends to the parents.

Adolescents in Georgia, and in most states, do have exceptions to the rule of parental consent, such as when they request treatment in a hospital for drug abuse or at a clinic for HIV. As to issues of confidentiality and the release of records to the parent, the law is not clear. Remar and Hubert (1996) write, "Although there are no Georgia cases dealing with the issue" (p. 257), one would have to assume that if the parents consented to treatment, then they are entitled to a copy of the minor's records.

In the above case, the law giving the parents the rights to the adolescent patient's records and the psychologist's ethical duty to do no harm to the patient and to provide privacy were in conflict. The 2002 APA Ethics Code provides guidance in such situations. Standard 1.02 states, "If psychologists' ethical responsibilities conflict with law, regulations, or other governing legal authority, psychologists make known their commitment to the Ethics Code and take steps to resolve the conflict." Did the psychologist above follow the correct course in attempting to seek a compromise?

## Review of the Early Literature

Writing in 1984, Belter and Grisso used the term *the child's rights movement* to describe a wave of legislation that had occurred, reflecting the changing attitudes of the populace toward protecting the rights of children. This movement increasingly emphasized the rights of minors toward "self-determination." Mental health care professionals, in particular, had begun to grant minors more rights in regard to consent to treatment, participation in treatment planning, confidentiality, and access to records. One of the early texts to come out of this movement was Melton, Koocher, and Saks's book, *Children's Competency to Consent*, published in 1983. In it, Weithorn (1983) wrote, "It is suggested that professionals working with children involve their clients . . . in decisions regarding their own welfare to the major extent possible, given the minor's own desire for involvement, the minor's capacity for meaningful participation, and the legal standards regarding consent requirements" (p. 240). She suggested the rationales for such involvement were many. It is consistent with our own legal and ethical principles that respect the human right to self-determination. It contributes to adaptive and healthy psychosocial functioning in children. It may increase their motivation and commitment to treatment. And last, it may facilitate collaborative problem solving between the child, psychotherapist, and parents.

Seeking a scientific basis for granting minors more rights to self-determination, Grisso and Vierling (1978) reviewed the literature on the cognitive development of adolescents and concluded that "there is little evidence that minors of age 15 and above as a group are any less competent to provide consent than adults" (p. 423). In a follow-up study, Belter and Grisso (1984) attempted to apply this principle with a study in which they surveyed groups of young people who were 9 years old, 15 years old, and 21 years old. The researchers presented them a list of "patient's rights" that is normally given to adults. After reading a psychotherapy analogue, they were asked to answer questions regarding whether the person in the vignette had confidentiality rights, whether a violation of those rights had occurred, and whether and how they would assert themselves to protect those rights. They concluded that 15-year-olds, but not 9-year-olds, performed as well on these variables as did the 21-year-old subjects.

Perhaps the standard paper in this field is that written by Gustafson and McNamara (1987), "Confidentiality With Minor Clients: Issues and Guidelines." These authors first review the issue of consent to treatment. They noted that in many states, minors are given the right to seek treatment confidentially if the nature of the treatment is such that the minor may not seek treatment if parental consent is required. This would include such services as counseling for sexual abuse or drug abuse or medical care for pregnancy, sexually transmitted diseases, or contraception. Gustafson and McNamara go on to cite seven other studies that support the position that adolescents develop an evolving sense of the value of confidentiality, and that they respond to treatment more effectively when they have a voice in treatment planning, and decision making.

A second issue is that of confidentiality of children's records. Gustafson and McNamara (1987) first cite several authors who take the position that minors are entitled to the same confidentiality rights as adults. They also cite the American Psychiatric Association's (1979) Task Force on Confidentiality of Children's and Adolescents' Clinical Records, and cite its position paper "Model Law of Confidentiality." In that paper, the American Psychiatric Association recommended the age at which minors may give consent to release confidential information be 12 or over. In an earlier study, McGuire (1974) surveyed community mental health centers and found that the majority of the mental health professionals on staff supported the position that minors should be provided the same confidentiality rights as adults.

On the other side of the debate, Gustafson and McNamara (1987) cite several authors who support giving minors limited confidentiality. For example, Thompson (1983) reasoned that "the psychotherapist should decide how the client's guardian is apt to use the disclosed information before deciding whether or not to release it" (p. 99). Some authors propose resolving this issue on a

case-by-case basis. Some suggest giving the minor some form of limited informed consent at the outset of treatment. For example, the psychotherapist might explain that the adolescent's privacy is waived if he or she is perceived to be engaging in behavior that is a danger to him/herself or others.

On the basis of their review of 26 studies, Gustafson and McNamara (1987) recommended the following as practice guidelines: "The degree of confidentiality afforded a minor client should be based on consideration of several factors. First, the psychotherapist should consider the age of the client.. . . The psychotherapist should consider the needs and desire of the child, the concerns of the parents, the particular presenting problem, and relevant state statutes in deciding what degree of confidentiality is appropriate with preadolescent children" (p. 194).

Gustafson and McNamara (1987) make a strong case for maintaining some level of confidentiality for adolescents. They note that adolescents who are not guaranteed some level of confidentiality may not enter psychotherapy or may not disclose important concerns. Thus, it benefits society, in that adolescents who need treatment will seek it and participate in it. Involving adolescents in treatment planning and giving them informed consent may also foster a stronger therapeutic alliance. The authors go so far as to assert that providing adolescents with the privilege provides them with an important social learning experience and gives them a sense of being active, responsible participants in their own treatment.

Gustafson and McNamara (1987) outline an idealized approach to treating adolescents. They suggest that the psychotherapist first determine what level of confidentiality is needed on the basis of the child's presenting problems, age, maturity, and so forth, then hold a pretreatment family meeting to explain his/her rationale for this decision. The psychotherapist should then prepare a written professional services agreement that provides details of the limits and conditions on confidentiality. From there, the parents should be involved in the adolescent's treatment in various ways, with the implication that family sessions be held periodically. They note that in some cases the adolescent's relationship with a parent may have deteriorated to such a point that family work is not feasible. In those cases, the psychotherapist may want to first focus on building a therapeutic relationship and communication skills before including the parent. They suggest that parents be allowed to initiate family sessions when they feel a need to, but they insist that the psychotherapist continue to maintain confidentiality of the psychotherapist–adolescent sessions.

In concluding their seminal paper, Gustafson and McNamara (1987) note that it is very important for the clinician "to be familiar with any relevant statutes in his or her state of residence and adopt policies consistent with these statutes" (p. 195). They add that the law is "unclear" and "inconsistent" on this issue. Many statutes make no mention of the particular case in which the adolescent wants to assert the privilege and the parent wants the child's treatment records.

## Brief Review of Recent Case Law

There exists case law on the subject of minors' rights to confidentiality versus their parents' requests for their mental health records. In an early landmark case (*Kremens v. Bartley*, 1977), five plaintiffs between the ages of 15 and 18 filed a petition to overturn a Pennsylvania statute governing the voluntary admission of juveniles to state mental health facilities. The district court held that their rights were violated when they were admitted to a psychiatric hospital by their parents. The provision was repealed. Under the 1976 act, a person age 14 or over may voluntarily admit himself to treatment or withdraw from treatment and is essentially treated as an adult. This ruling was upheld by the U.S. Supreme Court.

In the matter of *Attorney ad litem for D.K. v. The parents of D.K* (2001), the petitioner daughter requested that an order of the circuit court for her medical and mental health records be quashed on the grounds that the information was privileged. In this matter, the parents were in litigation over the custody of D.K., a mature minor. The daughter was in treatment for alleged abuse by her father. Both parents sought copies of her mental health records given that the issues were relevant to the custody of D.K. The appellate court concluded that the daughter had a statutory privilege in the confidentiality of her communications with her psychotherapists. The appellate court also concluded that her privilege could not be waived by her parents. The petition was granted, and the order authorizing release of the records was quashed.

Under the Florida Mental Health Act, also known as the Baker Act, a parent is entitled to copies of the child's clinical health records (Fla. St. ch. 394.4615(2) (a), 2000). A parent can request and receive information limited to a summary of the child's treatment plan as well as the minor's current mental and physical condition. Although parents are entitled to hospital records of the children, these do not include psychiatric care records. Thus, the statute favors maintaining the confidentiality of a minor's psychiatric records in some cases. Where the parents are involved in litigation themselves over custody of the child, they may not assert or waive the privilege on their child's behalf.

In its ruling in the case of D.K., the court noted that neither parent is acting in the child's behalf when each has his or her own interests at stake. The court referred to a Maryland case, *Nagle v. Hooks* (1983). In this case, the court was asked to rule on who had the authority to waive the statutory psychiatrist–patient privilege of the child in a child custody proceeding. In conjunction with the father's petition to modify custody, he sought to have the child's psychiatrist testify. The mother, who had primary custody, refused to waive the psychotherapist–patient privilege for the child. The intermediate appellate court affirmed the trial court's order that only the parent with custody had the authority to waive the privilege. However, the Maryland Supreme Court granted *certiorari* (review of the case) and quashed the order. The court wrote, "Although arguably the parent who, pursuant to court order, has custody of a child could qualify as a guardian under the statute, it is patent that such custodial parent has a conflict of interest in acting on behalf of the child in asserting or waiving the privilege of nondisclosure. We believe it is inappropriate in a continuing child custody 'battle' for the custodial parent to control the assertion or waiver of the privilege of nondisclosure. In resolving custody disputes, we are governed by what is in the best interest of the particular child and most conducive to his welfare. . . ."

The Florida court also cited a similar ruling in Missouri (*Wilfong v. Schaeperkoetter*, 1996). In that case, the court agreed that when parents are involved in litigation themselves in which the child's mental state may be relevant, such as in a custody battle, the parents are not the proper persons to assert or waive the privilege. The court reasoned that a parent would have the right to

claim the privilege when it would be in the best interests of the minor to do so. However, "where the privilege is claimed on behalf of the parent rather than that of the child, or where the welfare and interest of the minor will not be protected, a parent should not be permitted to either claim the privilege . . . or, for that matter, to waive it."

In another landmark case, *Abrams v. Jones* (2000), the court again upheld the rights of minors in these contested custody cases. K.J., an 11-year-old, was the subject of ongoing custody litigation between her parents. The mother sought psychotherapy for her daughter with Abrams. In subsequent treatment sessions, the child requested that her remarks be kept confidential, and Abrams reassured her that he would release only a treatment summary to her parents. Her father, Jones, met with Abrams and requested her entire record. Abrams responded that it was not in the child's best interests to release the records and offered to turn the child's records, as well as her treatment, over to another psychologist to make the decision about the release of the records. Jones declined. Jones then filed suit against Abrams to compel the release of the records. The mother filed suit against Abrams to block the release of records. The trial court held that Jones had a right to the child's records. Abrams appealed. The mother filed a briefing in the court of appeals in support of Abrams. The appellate court upheld the trial court's decision. On review, the Texas Supreme Court overturned the trial court's position. It ruled that a professional could deny a parent access to part of a child's records if they could show (a) the parent was not acting on behalf of the child, and (b) the release would be harmful to the child. Abrams was able to successfully persuade the court that releasing K.J.'s records to her father would be harmful to her.

The Supreme Court of Iowa recently made a similar ruling in the case of *Harder v. Anderson, Arnold, Dickey, Jensen, Gullickson, and Sanger, LLP, and Jane Pini* (2009). In this matter, the mother, Susan Harder, entered her three children into treatment with social worker Jane Pini in 2003, following her divorce. In August 2005, the court modified the decree and gave primary custody to the father, Kirk Harder. Around that time, a criminal action was filed against Susan Harder, charging her with assault against the middle daughter, who was then 11 years old. The court imposed a no-contact order, although Harder continued to have joint legal custody. In October 2007, Susan Harder requested, through her attorney, copies of all of the records concerning the counseling services Pini provided to her three children. Pini declined on the basis that the two older children, who were then 14 and older, had a reasonable expectation that their records were confidential. She argued also that her professional code of ethics required that she release only the minimum amount of information necessary. Pini offered to have a phone conference with Susan Harder, but she declined.

The district court denied Susan Harder's application for a mandatory injunction. She appealed to the Iowa Supreme Court. She argued that she was entitled to copies of her children's treatment records under Iowa law, which granted parents with joint custody access to their children's medical records. The court opined that, although Iowa law granted a parent "access" to their children's records, it did not give either parent an absolute right to those records. It further determined that when joint legal custodians have a disagreement concerning a course of treatment affecting their child, the court must step in and decide the dispute by considering what is in the best interest of the child. On the basis of the facts of the case and Pini's rationale, the court upheld the district court's ruling and declined the request for the children's psychotherapy records.

## Review of the Recent Literature

Since the Gustafson and McNamara (1987) article was published, the issue of privacy rights and minors has been repeatedly addressed most thoroughly by the APA, through the *Monitor on Psychology* "Ethics Rounds," through the Internet newsletter *APAPractice.org*, and through texts it has issued on risk management. The regular column "Ethics Rounds" began in March 2002, during the final development of the 2002 Ethics Code, and has continued every other month since that time. Stephen Behnke, along with coauthor Elizabeth Warner, began this series with the article "Confidentiality in the Treatment of Adolescents." Behnke revisited this topic in December 2005 and February 2007.

In their 2002 article, the authors respond to the reader/clinician's question about confidentiality with minors with the answer that the clinician should look at the question from three perspectives: that of law, of clinical practice, and of ethics. Legally, the law is black and white. A minor cannot consent to treatment; a parent or guardian consents on the minor's behalf. The laws in most states grant exceptions for certain kinds of treatment or for emancipated minors, but the exceptions prove the rule that minors are not sufficiently mature to make treatment decisions. That said, what is advisable from a clinical practice standpoint is another matter. Clinically, an adolescent is growing in autonomy and independence and wants some level of privacy. Good treatment will foster the conditions that allow this to flourish.

Ethics is the third prong of the argument. Does the 2002 Ethics Code provide answers? The authors review the same ethical standards that were cited in the opening paragraphs of this article (although the numbers are incongruent; the APA Ethics Code was not formally adopted until August 2002). They recommend that the psychotherapist first make clear at the outset of treatment what relationship the psychotherapist will have to both the adolescent and the parent and discuss what information will be shared with whom and under what conditions. As the adolescent matures, greater respect for autonomy and privacy should be granted the adolescent.

Behnke and Warner (2002) argue that the psychotherapist cannot make a blanket guarantee to keep clinical information from a parent. A parent who has joint or sole legal custody may, under state law, exercise that right and obtain that information, no matter how counterproductive it is to treatment. Behnke and Warner continue with the assertion that the psychotherapist should use clinical judgment when considering whether to release information to the parent. At times, the psychologist is mandated to provide disclosure to the parent, if there is a serious threat of harm to self or others, for example. Reports of neglect or abuse also fall under mandatory reporting laws. Disclosures of risky behavior or poor judgment that do not rise to the level of reportable by state law require the use of clinical judgment and a good rapport with both the adolescent and the parent.

Finally, they conclude with the most difficult situation, which is one in which disclosure of information to the parent may result in harm to the child or adolescent. They offer the opinion that a refusal to disclose in this situation, even in the face of a parent's

request, may be "legally supportable" (Behnke & Warner, 2002, para. 16). In this case, they suggest that the psychotherapist seek legal counsel and consultation from colleagues.

In subsequent columns, Behnke continues to make the case that some issues with adolescents and confidentiality cannot be solved by the simple recitation of rules. Behnke (2007) further develops the idea that the clinical, ethical, and legal perspectives are like overlapping circles in a Venn diagram. Where there is clear overlap, it is fairly easy to make decisions. It is where they don't overlap that the clinician has difficulty. He offers the suggestion that the clinical perspective should be the starting point of the decision process, and the legal issues should flow from there. What is clinically best for the adolescent? To break confidentiality or not? To release the record to the parent or not? From there, he suggests that the clinician then factor in the relevant laws in the state, the informed consent agreement, and the APA Ethics Code, although he does not say in what order. An example of when the overlap between the three is small, and thus most difficult to resolve, is the case where it is clinically contraindicated to turn over the treatment records although the parent has a legal right to the records. In this case, he advises appealing to the court for a ruling on the matter, "That is, we seek more overlap by attempting to shift the legal landscape" (Behnke, 2007, para. 7).

In June 2005, the Legal and Regulatory Affairs Staff of APA drafted the document "A Matter of Law: Privacy Rights of Minor Patients" and disseminated it to members through the *APAPractice.org* monthly bulletin. The authors begin by noting that the area of minors' rights to confidentiality is a particularly complex area of ethics, and that there are unique issues related to the privacy rights of minors. They recommend that practitioners familiarize themselves with state law. If the request for the adolescent's records triggers the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, then the practitioner should know how HIPAA interacts with state law. Although this is ideal, in reality only a handful of legal experts in any state would be able to articulate an answer to that question.

The authors begin by noting that state law varies on this issue. In some states, a minor in his or her early teens can object to the release of records to a parent. In other states, the parent may be allowed to have copies of the adolescent's records but with certain exclusions. One exclusion is when the court denies the parent access. A second exclusion is when the treating psychologist has determined that releasing the records would be detrimental to the minor's well-being.

The authors advise that a written agreement between the child, the parents, and the psychotherapist may be used to set guidelines on how information about the minor is released to the parent. Some parents may be persuaded that treatment will be more effective if the child is allowed some privacy, as long as the psychotherapist pledges to notify the parent if the child is in danger. They caution, however, that these agreements are not legally binding, and that parents may be able to revoke them at any time. For example, if the parents are involved in a custody dispute, one parent may seek the records for the purpose of using them against the spouse. APA still advises that psychologists use written agreements because they clarify the psychotherapist's position on this subject and give the psychotherapist some leverage in the event of a conflict later on.

APA again emphasizes extreme caution when working with children and adolescents whose parents are divorced. Determining who has the right to consent to treatment, to end treatment, and to have the records may be a complex task. Some states have laws that spell out the rights of custodial or noncustodial parents to the records of minors. A good rule of thumb is to review the parents' divorce decree and the most recent modification of that decree, if there is one. The psychotherapist should look for a section on the rights of the parents to seek treatment for the child and obtain copies of the child's medical records. In reality, however, there often is vague language or no language on this issue in temporary or final divorce decrees.

## HIPAA Regulations

Over the past 7 years, this issue has become even more complex with the advent of HIPAA. Although the language of the HIPAA Privacy Rule may be complex, the general goal of the Privacy Rule is to strengthen patients' rights to privacy and give them more control over their medical records. The HIPAA regulations were published in the *Federal Register* in 2002 and are available on the Internet. Under Section 3, Parents as Personal Representatives of Unemancipated Minors (2002), the record states that the purpose of the December 2000 Privacy Rule is "to assure that parents have appropriate access to health information about their children." It also states that under the Privacy Rule, parents will have new rights to "access and control health information about their minor children." The section goes on to explain the limited exceptions to the rule, such as the right of a minor to be tested privately for and receive treatment for HIV.

The Privacy Rule states that there are three situations in which the parent is not the "personal representative" with respect to the health information about his or her child. These are (a) "when State or other law does not require the consent of a parent or other person before a minor can obtain a particular health care service, and the minor consents to the health care service" (e.g., HIV counseling, pregnancy testing), (b) "when a court determines or other law authorizes someone other than the parent to make treatment decisions for a minor" (i.e., such as psychotherapy for an adolescent in the foster care system), and (c) "when a parent agrees to a confidential relationship between the minor and the physician." Even in these cases where the parent is not the personal representative, the Privacy Rule defers to state law. If state law is silent or unclear on the issue of parental access to the child's records, the psychologist (or other licensed health care professional) has discretion to provide or deny a parent access to the minor's records "in the exercise of professional judgment."

These rules aside, the situation shifts if there is a history of abuse, neglect, or endangerment. The Privacy Rule states that when the health care provider believes that any individual, including a child or adolescent, has been or may be subjected to domestic violence, abuse, or neglect by the personal representative, or that treating that parent as a personal representative could endanger the child, the health care provider can choose not to treat the parent as a personal representative for the child if, in their professional judgment, doing so would not be in the child's best interests (see U.S. Department of Health and Human Services, 2003, 2006).

## Minors' Rights to Confidentiality in High-Conflict Cases

In its recent text *Assessing and Managing Risk in Psychological Practice* (Bennett et al., 2006), the APA amplified its proviso of

caution when working with children and adolescents who are in the midst of contentious divorce proceedings. Bennett et al. (2006) note that practice with this population carries a high risk of board complaints by angry and dissatisfied parents. In these situations, one cannot take it on face value that the parents who schedule an appointment with a psychotherapist are actually presenting the child for treatment. One parent may request treatment without the consent or even notification of the other. The parent may wish to use treatment to gather information about the other parent to use in a child custody proceeding. One parent may be intending to subpoena the child's psychotherapist to court and ask him/her to make a custody recommendation. He or she may be seeking treatment for their child in order to rehabilitate their image in the eyes of the court. Some have been court ordered to seek treatment with and for their children—treatment that they would not have chosen voluntarily and that they resent.

Bennett et al. (2006) emphasize from the outset that consent of both parents is a starting point, provided they have joint legal custody. Even if the consent of only one parent is legally sufficient, treatment may be ineffectual without the consent of the other. It may also evoke the resentment of the parent who was not consulted. If possible, a court order compelling both parents to participate cooperatively is even better. They advise that the psychotherapist have a contract clarifying that the child or adolescent is there for treatment and not for a court-related purpose. The contract should spell this out by stating that the psychotherapist will not speak to attorneys, will not testify in a child custody proceeding, will not write a letter recommending that a parent have custody, and so forth. In some cases, the child custody evaluator or the guardian may request an interview with the child's psychotherapist or request that the psychotherapist submit a treatment summary. The authors advise that the contract spell out the charge for these ancillary services as a way to cut down on these requests. And finally, the contract should lay out some terms in regard to what sort of information will remain confidential and what will be disclosed to the parents. They note that the HIPAA Privacy Rule allows parents to enter into "agreements of confidentiality," which constitute a limited waiver of their rights to the child's records in order to facilitate treatment. This may be allowable, however, only in those states that grant minors the right to consent to treatment independently.

Gerald Koocher, who has been in the forefront of writing about the ethical minefield of working with minors and their families, revisits this issue is his latest articles (Koocher, 2003, 2008). Like other writers in this field, he notes that psychotherapy with minors, but particularly adolescents, is much more challenging than working with adults because they often come to treatment at the epicenter of a group of people and institutions that may have competing goals. These may include not only the adolescent him/herself, who may or may not want treatment, and his parents, but divorced parents who have opposite and conflicting agendas, teachers and school officials, case workers with state agencies, the admitting psychiatrist at an inpatient facility, and the juvenile court judge and probation officer. Koocher (2003) advocates for the careful balancing of the needs and goals of all involved. "Because minor children are by definition the least in control and hence the most vulnerable, the psychotherapist must keep their best interests paramount" (p. 1252). Because adolescents are under the care of their parents, the parents' best interests as a whole must be balanced with those of the adolescent. Koocher (2003) advises that the psychotherapist working with adolescents familiarize themselves well with the knowledge base on adolescence and case law in their jurisdiction on the rights of minors. He also recommends that the psychotherapist spend some time at the outset of treatment developing common treatment goals with the adolescent and both parents, reviewing the limits of confidentiality, and outlining the ways in which the parents will be updated on and involved in the adolescent's treatment.

In his 2008 article, Koocher revisits many of the same issues above but also addresses some of the special problems of working with children whose parents are divorced or contemplating divorce and are in conflict. As other experts have, he cautions that the psychotherapist should seek the consent of both parents to treat the child, whether legally required to or not. Like others, he recommends that the psychotherapist have the parents sign an agreement that they will not call the psychotherapist as a witness in any legal proceeding or seek to introduce the child's psychotherapy records as evidence in a custody dispute. He reasons that such actions compromise the therapeutic process by eroding trust and rapport with all the parties involved. One must keep in mind, again, however, that this agreement can be breached if the psychotherapist is subpoenaed to testify or court ordered to turn over the records. The parent may insist this is their legal right to have access to those records—and, by extension, to use them to their advantage in a legal proceeding. If this occurs, Koocher recommends that the psychotherapist consider asking the judge to appoint a guardian ad litem to oversee the child's privacy or exercise the child's privilege.

Koocher (2008) also recommends that the psychotherapist separate the child's treatment records, keeping the notes of interviews with parents apart from those of the child. In that way, if the child's records are requested by a parent, only the notes of the child's sessions would be turned over to the parent. This practice would prevent one parent from obtaining the notes of a conference with the other parent to use those private disclosures against the other parent in a custody proceeding. Whether this is a defensible solution is debatable. If records are subpoenaed in a court action, most subpoenas specify that the psychologist turn over *all* records regarding the child's treatment. Instead, the psychologist might want to open a separate chart for each parent and keep the records of meetings with those parents in those separate charts, billing the meetings with the parents as "consultation." In closing, Koocher offers a sample consent form that one should consider using when working with children and adolescents.

## Case Outcome

The psychologist in the above case was sanctioned by the licensing board for withholding the records from the mother in violation of state law. The psychologist was ordered to turn the records over to a psychologist in the mother's state who would then review them and make the decision as to their disposition.

The case outcome further illustrates the complexity of the ethical dilemma posed by cases involving the treatment of a minor in a contested custody matter. In this case, although the psychologist considered what was clinically and ethically appropriate and the APA's Ethics Code and was in compliance with HIPAA regulations, the licensing board determined that the psychologist had

violated the mother's rights under state law. Thus, a psychotherapist may want to also consider, in addition to the three circles of the Venn diagram proposed by Behnke, two additional circles—an anticipation of how the licensing board operates in the psychotherapist's state as well as one's own self-interest—before "falling on one's own sword" in the name of protecting the child's privilege and safety. The psychologist might have averted the complaint by meeting with both parents prior to seeing the adolescent to assess their goals in treatment. Anticipating conflict and having a written contract in place may ultimately be the best strategy.

## References


Abrams v. Jones, Supreme Court of Texas, 35 S.W. 3d 620 (2000).

American Psychiatric Association. (1979). Task force on confidentiality of children's and adolescents' clinical records. *American Journal of Psychiatry, 136,* 138–144.

American Psychological Association. (2002). *Ethical principles of psychologists and codes of conduct.* Washington, DC: Author. Retrieved from http://www.apa.org/ethics/code2002.html

American Psychological Association. (2005, June 21). A matter of law: Privacy rights of minor patients. Retrieved from http://www.apapractice.org/apo/insider/practice/pracmanage/legalminor

Attorney ad litem for D. K. vs. The parents of D. K., Court of Appeals of Florida, 4th District (780 So. 2d 30, 2001).

Bartley v. Kremens, 402 F Supp 1039 DCPa 1975.

Bartley v. Kremens, 402 F Supp 1039 (E.D. Pa 1975).

Behnke, S. (2005). Letter from a reader regarding a minor client and confidentiality. *Monitor on Psychology, 36*(11). Retrieved from http://www.apa.org/monitor/dec05/ethics.html

Behnke, S. (2007). Adolescents and confidentiality: Letter from a reader. *Monitor on Psychology, 38*(2). Retrieved from http://www.apa.org/monitor/feb07/adolescents.html

Behnke, S., & Warner, E. (2002). Confidentiality in the treatment of adolescents. *Monitor on Psychology, 33*(3). Retrieved from http://www.apa.org/monitor/mar02/confidentiality.html

Belter, R., & Grisso, T. (1984). Children's recognition of rights violations in counseling. *Professional Psychology: Research and Practice, 15,* 899–910.

Bennett, B., Bricklin, P., Harris, E., Knapp, S., VandeCreek, L., & Younggren, J. (2006). *Assessing and managing risk in psychological practice: An individualized approach.* Washington, DC: American Psychological Association.

Grisso, T., & Vierling, L. (1978). Minors consent to treatment: A developmental perspective. *Professional Psychology: Research and Practice, 9,* 412–427.

Gustafson, K., & McNamara, R. (1987). Confidentiality with minor clients; Issues and guidelines for psychotherapists. *Professional Psychology: Research and Practice, 18,* 503–508.

Harder v. Anderson, Arnold, Dickey, Jensen, Gullickson, and Sanger, LLP, and Jane Pini (IA, 08–0475, April 17, 2009). Retrieved from http://www.iowacourts.gov/Supreme_Court/Recent_Opinions/20090417/08–0475

Koocher, G. (2003). Ethical issues in psychotherapy with adolescents. *Journal of Clinical Psychology, 59,* 1247–1256.

Koocher, G. (2008). Ethical challenges in mental health services to children and families. *Journal of Clinical Psychology, 64,* 601–612.

Kremens v. Bartley, 431 U.S. 119 (1977).

McGuire, J. (1974). Confidentiality and the child in psychotherapy. *Professional Psychology, 5,* 374–379.

Melton, G., Koocher, G., & Saks, M. (1983). *Children's competence to consent.* New York: Plenum Press.

Nagle v. Hooks, 296 Md., 123 460 A 2d. 49 (1983).

Parents as personal representatives of unemancipated minors. (2002, August 14). *Federal Register, 67*(157), 53199–53203.

Remar, R., & Hubert, R. (1996). *Law and mental health professionals/Georgia.* Washington, DC: American Psychological Association.

Thompson, A. (1983). *Ethical concerns in psychotherapy and their legal ramifications.* New York: University Press of America.

U.S. Department of Health and Human Services. (2003). *Personal representatives.* (45 CFR 164.502(g)). Retrieved from http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/personalreps.html

U.S. Department of Health and Human Services. (2006). *Does the HIPAA Privacy Rule allow parents the right to see their children's medical records?* Retrieved from http://www.hhs.gov/ocr/privacy/hipaa/faq/personal/227.html

Weithorn, L. (1983). Involving children in decisions affecting their own welfare. Guidelines for professionals. In G. B. Melton, G. P. Koocher, & M. J. Saks (Eds.), *Children's competence to consent* (pp. 235–260). New York: Plenum Press.

Wilfong v. Schaeperkoetter, 933 S. W. 2d 407, 409 Mo. (1996).


Received March 24, 2009
Revision received August 3, 2009
Accepted August 11, 2009 ■