Therapists' Handling of Secrets between Partners in Couple Therapy

Michael Alan Jansen
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THERAPISTS' HANDLING OF SECRETS BETWEEN PARTNERS IN COUPLE THERAPY

Michael Alan Jansen, Ph.D.

Western Michigan University, 2007

This study examines couple therapists' policies, procedures, and perspectives regarding secrets between partners in couple therapy. Handling secrets appropriately is necessary to avoid legal, ethical and therapeutic problems, especially when the secret involves contentious or potentially dangerous material such as infidelity, divorce, paternity, and HIV/AIDS infection.

One hundred sixty randomly selected Clinical Members of the AAMFT participated in a 38-question researcher-generated mail survey. Data provided descriptive statistics and allowed for between-groups comparisons to explore for differences between therapists with regard to experience and several specific practices related to handling secrets. The study also examined whether courses in HIV/AIDS confidentiality law and limits increased the likelihood of a therapist's adherence to state laws/statutes pertaining to such secrets.

Most respondents reported verbalizing a "professional judgment" approach to secrets. Respondents varied greatly in the reported frequency with which they see partners individually during couple therapy. Clinical experience and supervision were reported as being the most influential in the formation of therapists' secrets-related policies and practices. One quarter of the respondents indicated having had clients...
raise a concern about their mishandling of a secret. Therapists’ approach to handling
secrets did not appear to have an effect on the frequency of raised concerns.

An extra-relational affair, wanting a divorce, and Internet infidelity/chatting
were the three most frequently reported types of secrets. Most therapists reported
discomfort with keeping secrets between partners, especially when the secret pertained
to one partner’s positive HIV/AIDS-status. Couple therapists’ experience did not
appear to have a relationship with 1) the approach utilized in handling secrets, 2) the
frequency with which therapists see partners individually, 3) the provided level of
informed consent, or 4) the frequency with which written consent to share information
between partners is obtained.

Additionally, most respondents reported not informing their clients of
HIV/AIDS confidentiality limits or obtaining written consent to share confidential
information between partners. While most respondents reported considerable
awareness of HIV/AIDS confidentiality laws, this awareness was not demonstrated in
therapists’ responses to vignette questions assessing clinical practice. Training in
HIV/AIDS confidentiality laws appears to have an impact only on reported awareness,
and not on actual practice.
What is kept secret does not vanish,
neither within the family,
nor on the national level,
and we keep such secrets from ourselves
at our own peril.

- Evan Imber-Black (1993, p. 29)
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# TABLE OF CONTENTS

ACKNOWLEDGEMENTS ......................................................................................... ii  
LIST OF TABLES .................................................................................................... ix  
LIST OF FIGURES .................................................................................................. x  

CHAPTER

I.  INTRODUCTION ........................................................................................ 1  
    Statement of the Problem ................................................................. 1  
    The Problems Secrets Can Present ........................................... 2  
    The Working Alliance in Couple Therapy .................................... 3  
    Confidentiality in Couple Therapy ................................................ 4  
    Handling Secrets in Couple Therapy .............................................. 6  
    The Study of Secrets ........................................................................... 9  
    The Purpose of the Present Study ................................................... 10  

II. REVIEW OF RELATED LITERATURE ............................................. 13  
    Definition of Terms ........................................................................... 14  
    A Conceptual Overview of Secrets ................................................... 15  
    Separation and Divorce: Arguments for Handling Secrets Skillfully... 17  
    The Therapeutic Alliance in Couple Therapy .................................... 19  
    Approaches to Handling Secrets in Couple Therapy ....................... 23  
    The Approach of “No Revelation” .................................................... 24  
    The Approach of “Full Revelation” .................................................... 25
<table>
<thead>
<tr>
<th>CHAPTER</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Approach of Using “Professional Judgment”</td>
<td>28</td>
</tr>
<tr>
<td>Recommendations for Practices Related to Secrets</td>
<td>31</td>
</tr>
<tr>
<td>Ethical Guidelines Regarding Confidentiality and Secrets</td>
<td>32</td>
</tr>
<tr>
<td>Confidentiality Guidelines of Specific Professional Organizations.</td>
<td>33</td>
</tr>
<tr>
<td>Confidentiality, Ethical Codes and HIV/AIDS</td>
<td>37</td>
</tr>
<tr>
<td>HIV/AIDS State Confidentiality Laws and Statutes</td>
<td>41</td>
</tr>
<tr>
<td>The Tarasoff Cases</td>
<td>43</td>
</tr>
<tr>
<td>State Positions on HIV/AIDS Information and Confidentiality...</td>
<td>48</td>
</tr>
<tr>
<td>Past Research Related to Secrets</td>
<td>53</td>
</tr>
<tr>
<td>Studies Regarding General Secrets</td>
<td>53</td>
</tr>
<tr>
<td>Studies Related to Secrets Involving HIV/AIDS</td>
<td>59</td>
</tr>
<tr>
<td>Summary</td>
<td>63</td>
</tr>
<tr>
<td>III. METHODOLOGY AND DESIGN</td>
<td>64</td>
</tr>
<tr>
<td>Participants</td>
<td>64</td>
</tr>
<tr>
<td>Procedure</td>
<td>66</td>
</tr>
<tr>
<td>Instrument: Survey</td>
<td>69</td>
</tr>
<tr>
<td>Research Questions for the Present Study</td>
<td>71</td>
</tr>
<tr>
<td>Statistical Analyses</td>
<td>75</td>
</tr>
<tr>
<td>Summary</td>
<td>76</td>
</tr>
<tr>
<td>IV. RESULTS</td>
<td>78</td>
</tr>
<tr>
<td>Survey Response</td>
<td>78</td>
</tr>
</tbody>
</table>
Table of Contents-Continued

CHAPTER

Demographics ................................................................. 78

Therapist Practice .............................................................. 86

   RQ-1: Therapists’ Approaching to Handling Secrets .......... 86
   RQ-2: Therapists’ Practice of Seeing Partners Individually ..... 87
   RQ-3: Therapists’ Planning for Secrets ............................ 87
   RQ-4 & 5: Therapists’ Informed Consent Practices ............. 88
   RQ-6: Obtaining Written Consent to Share Confidential Information .......................................................... 89
   RQ-7 & 8: Therapists’ Adherence to Ethical Guidelines and State Laws/Statutes ............................................. 89
   RQ-9: Influences on Therapists’ Practices Related to Secrets... 91
   RQ-10: Therapists’ Rationales for Practices Related to Secrets.. 92
   RQ-11: Problems Related to the Mishandling of Secrets.. .... 93
   RQ-12: Therapists’ Awareness of HIV/AIDS Confidentiality Laws and Limits ................................................. 94
   RQ-13: Types of Secrets in Couple Therapy ...................... 95
   RQ-14 & 15: Therapists’ Perspectives on Secrets in Couple Therapy ................................................................. 97
       Vignette One: Affair and Paternity .............................. 100
       Vignette Two: HIV/AIDS Status ................................. 101
       Vignette Three: Past or Current Alcohol Abuse .......... 104
       Vignette Four: Intent to Divorce ................................. 105
   RQ-16: Therapists’ Experience and Approach to Handling Secrets ................................................................. 107
### Table of Contents-Continued

**CHAPTER**

- RQ-17: Therapists' Experience and Seeing Partners Individually. 107
- RQ-18: Therapists' Experience and Planning for Secrets. 108
- RQ-19 & 20: Therapists' Experience and Consent. 109
- RQ-21: Therapists' Adherence and HIV/AIDS Confidentiality Law Training. 110
- RQ-22: Therapists' Approach to Secrets and Complaints. 114

**V. DISCUSSION** 117

- Approaches to Handling Secrets. 118
- Individual Sessions in Couple Therapy. 122
- Planning for Secrets in Couple Therapy. 127
- Informing Couples about the Handling of Secrets. 129
- Obtaining Written Consent to Share Confidential Information. 132
- Influences on Therapists’ Practices Related to Secrets. 136
- Rationales for Practices Related to Secrets. 138
- The Mishandling of Secrets in Couple Therapy. 140
- Types of Secrets in Couple Therapy. 142
- Therapists’ Perspectives Regarding Secrets. 144
- Confidentiality, HIV/AIDS, Awareness and Training. 147
- Study Limitations. 154
- Implications for Further Research. 156
- General Conclusions. 158

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Table of Contents-Continued

APPENDICES

A. Research Study Survey............................................................... 161

B. Human Subject Institutional Review Board Approval, Western Michigan University......................................................... 171

BIBLIOGRAPHY......................................................................... 173
LIST OF TABLES

1. Statistical Comparison of Sample and Overall Population Demographics .......... 80
2. Survey Response Percentages for Four Practice Questions .................................. 89
3. Therapists' Reported Awareness of HIV/AIDS-Related Laws/Guidelines ............. 95
4. Reported and Assessed Percentages of Awareness of HIV/AIDS Laws/Statutes by Training ........................................................................................................... 112
5. Percentages of Reported Awareness, Assessed Awareness, and Reported-Assessed Awareness of HIV/AIDS Laws/Statutes by Training .......... 151
LIST OF FIGURES

1. Mean Ranks of Experiences Dictating Therapists' Secret-Related Practices 92
2. Mean Ranks of Therapists' Rationales Pertaining to Secret-Related Practices 93
3. Mean Ranks of Secrets Encountered by Couple Therapists 97
4. Mean Ranks of Secrets Encouraged for Disclosure by Therapists 99
5. Mean Ranks of Therapists' Reported Amount of Planning by Number of Couples Seen over Career 109
6. 95% Confidence Intervals for Assessed Awareness of HIV/AIDS State Laws/Statutes Stratified by Type of Training 113
7. 95% Confidence Intervals for Reported Awareness of HIV/AIDS State Laws/Statutes Stratified by Type of Training 115
8. Mean Percentage of Time Partners Seen Individually as a Function of Preferred Therapy Approach 124
9. 95% Confidence Intervals for the Differences between Reported and Assessed Awareness of HIV/AIDS State Laws/Statutes Stratified by Type of Training 152

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CHAPTER I

INTRODUCTION

Statement of the Problem

The field of couple therapy has grown significantly over the last few decades as the demands of the outside world have increased, stressing the importance of healthy intimate relationships (Glick, Berman, Clarkin & Rait, 2000; Johnson & Lebow, 2000). Almost 57 million people, or 19% of the entire U.S. population, were seen by marriage and family therapists in 2004 (Northey, 2004a). Couples have realized the benefits of strengthening their relationships and providing each other with a secure base from which to fend off the turmoil of the world, as intimate relationships have been found to contribute to both a partner's physical and mental health (Bowlby, 1988; Burman & Margolin, 1992; Dupre & Meadows, 2007; Kim & McKenry, 2002; Kiecolt-Glaser & Newton, 2001; Waite & Gallagher, 2000). Likewise, dissatisfaction with one's intimate relationship or the resulting anxiety and/or depression from being in an unhealthy relationship has become one of the most frequently presented problems in therapy (Christensen & Miller, 2001; Horowitz, 1979; Simmons & Doherty, 1995). The negative impact marital conflict has on children has also been duly noted (Cummings & Davies, 1994; Tresch Owen & Cox, 1997).

Steady progress in the field of couple therapy has produced many different theoretical approaches including behavioral, systemic, emotionally-focused, structural, strategic and integrative (Long & Young, 2007). The effectiveness of couple therapy has resulted in its increased use as a treatment of choice for numerous psychological ailments such as depression, substance abuse and
agoraphobia. In short, couple therapy is now viewed as a viable treatment for many problems that have traditionally been treated with individual therapy (Baucom, Shohan, Mueser, Daiuto & Stickle, 1998; Emanuels-Zuurveen & Emmelkamp, 1997; Gilliam & Cottone, 2005; Gollan, Friedman & Miller, 2002; Gurman & Kniskern, 1981; Jacobson, Holtzworth-Munroe & Schmaling, 1989; Johnson, 2002; Snyder & Whisman, 2003; Sprenkle, 2002; Stuart, Broderick & Gurman, 1980; Wohlman & Stricker, 1983).

It has been proposed that research pertaining to certain topics in the field of couple therapy have not been conducted sufficiently and in a timely manner given the field’s rapid growth (Imber-Black, 1993a; Miller, Scott & Searight, 1990; Wendorf & Wendorf, 1985). In fact, a few of these un-researched areas potentially pose major therapeutic dilemmas, resulting in ethical and legal ramifications for the unknowing therapist. Of specific relevance to this study, secrets between partners in couple therapy have the potential of creating considerable ethical, legal, moral and therapeutic dilemmas, making a therapist’s procedures, policies and perspectives related to them significant considerations.

The Problems Secrets Can Present

The consequences of a secret between partners are many and varied depending on the content of the secret, the context of the situation, and the therapist’s response to the secret (Johnson, 2002). Aside from the problems a secret may cause partners, such as feelings of betrayal or a loss of trust, there are essentially two other major problems secrets may present in the context of couple therapy. From a therapeutic standpoint, a secret may undermine the development of
the working alliance between the therapist and couple necessary for therapy to be helpful. Also, a therapist who does not handle a secret correctly may encounter ethical or legal problems related to breaking confidentiality. Each of these major problems will be discussed briefly here and more fully later.

The Working Alliance in Couple Therapy

One of the most crucial components to providing couples with a productive therapeutic experience, and the one that is placed at the greatest risk by secrets, is the building of a strong working alliance between the couple and the therapist. This alliance has emerged as one of the key components of therapeutic change in individual therapy (Greenberg & Pinsof, 1986; Horvath & Bedi, 2002), and it is suggested that such an alliance is also crucial to the success of couple therapy (Bourgeois, Sabourin & Wright, 1990; Friedlander, Escudero & Heatherington, 2006; Pinsof, 1995, Taibbi, 1996). Whether it is individual or couple therapy, unless clients are willing to engage in a collaborative therapeutic alliance, therapy has little chance of producing change. Rogers (1957) identified five attributes therapists must demonstrate to foster a collaborative therapeutic relationship: acceptance, genuineness, warmth, empathy and care. When there are two clients in therapy at odds with each other, being able to demonstrate these attributes to both partners simultaneously can be quite difficult. The problem encountered in couple therapy is that an intervention serving the best interest of one partner is frequently counterproductive to the other. In the May/June 1993 issue of the Family Therapy Networker, which was devoted entirely to the issue of secrets in family therapy, Richard Simon wrote that:
Probably no other subject so highlights the differences between a family and an individual orientation. The family therapist can't be content with discussing away problems in the rarefied atmosphere of the private consultation room. We are obliged to grasp the full systemic ripple effect of a secret beyond the one-to-one, therapist-client relationship. What this often means in practice is that the therapist becomes an immediate participant in some of the most painfully wrenching moments that families can experience—the confrontations triggered when people reveal their affairs to their spouses, when children first discover the truth about their parenthood, when lies that have been passed through the generations are finally exposed. At those moments, it becomes as clear as it ever will that this is not a profession for the faint-hearted (p. 2).

Family and couple therapy are not for those individuals who cannot deal with stressful situations on a daily basis. When working with couples, a therapist's ability to maintain fairness or balance in his or her relationship with both partners becomes one of many crucial attributes necessary to maintain the fragile relational equilibrium that exists in the counseling relationship and to build a strong working alliance (Weeks & Treat, 2001). Of the many hazards to be avoided in couple therapy, the inappropriate handling of the revelation of a secret represents one of the greatest.

Confidentiality in Couple Therapy

The inappropriate handling of a secret can also represent considerable ethical and legal consequences to a couple therapist who does not follow the confidentiality guidelines and state laws/statutes to which they must adhere (Hayman & Covert, 1986; Lindsay & Clark, 2000; Pope & Vetter, 1992). The mental health field is guided by the professional ethics of numerous organizations that establish standards of conduct and assist in the decision-making process regarding professional behavior. Historically, maintaining the confidences of clients has been one of the greatest ethical obligations within the field of mental health as a
means to both protect clients and facilitate treatment by allowing clients to speak freely without fear of social condemnation or retribution (Denkowski & Denkowski, 1982; Woody & Woody, 2001). The duty to maintain confidentiality is required within the code of ethics by virtually all professional organizations (American Association for Marriage and Family Therapy, 2001; American Association of Sexuality Educators, Counselors, and Therapists, 2004; American Counseling Association, 2005; American Mental Health Counselors Association, 2000; American Psychological Association, 2002; International Association of Marriage and Family Counselors, 2005; National Association of Social Workers, 2006). Similarly, federal and state laws and statutes generally support confidentiality within the mental health field, encouraging therapists to take sufficient steps to protect information shared within the context of a therapeutic relationship or face legal repercussions.

However, there are limits to the confidentiality provided to clients in therapy, and certain situations may necessitate the disclosure of information by a therapist. The most common circumstance requiring disclosure of confidential information is when it has been determined that a client represents a danger to self or others. In such instances, a mental health practitioner is obligated to take the proper steps to ensure the safety of those at risk. Such actions may involve the involuntary admittance of a suicidal client to a mental health facility, the filing of a report to Protective Services of suspected abuse and/or neglect of a child or elderly person, or the contacting of law enforcement to report a possible threat to a third party by a client. With the advent of HIV/AIDS, this “duty to warn/protect” has
become increasingly complex and complicated (Harding, Gray & Neal, 1993; Stewart & Reppucci, 1994). Obviously, therapists must be aware of the many nuances of both the requirements and limits of confidentiality that guide their practice relative to the handling of confidential information.

Handling Secrets in Couple Therapy

While not all couples present for counseling with secrets, a therapist never knows at the outset of therapy for which couple a secret might become an issue. Literature in the couple therapy field reveals that couple therapists can take one of three different approaches to dealing with secrets between partners in couple therapy (Karpel, 1980; Weeks, Odell & Methven, 2005; Weeks & Treat, 2001; Wilcoxon, Remley, Gladding & Huber, 2007). The first approach of "full revelation" insists that partners do not share any secrets with the therapist that they would not wish the therapist to share with the unknowing partner. This therapist informs their clients that any information that is shared individually, even in confidence, is open to revelation by the therapist to the unaware partner, and he or she may acquire a written release of information from each partner permitting them to share information with the other. The therapist may also work diligently to insure that they are not privy to a secret by reducing a client's opportunity to divulge one, perhaps by not seeing a partner individually or giving either partner even a brief window of opportunity to reveal a secret.

Therapists who are unwilling to keep a secret with one partner commonly operate on the premise that it is most imperative that he or she remain trustworthy and foster a strong therapeutic relationship with both partners. Such therapists
believe that a willingness to keep a secret with one partner undermines the ability of clients to be able to trust them. They also understand that collusion with one partner against the other by keeping a secret puts them in a precarious position and can ultimately undermine the therapeutic process. This process, known as triangulation, occurs when a third party (i.e. the therapist) is drawn in to form an alliance with one partner against the other (Brock & Barnard, 1999; Long & Young, 2007; Nichols & Schwartz, 2004). This occurrence typically results in less opportunity for problem resolution between partners because one of the partners feels outnumbered and becomes less trusting of the therapist and the other partner. The couple also misses out on a valuable opportunity to resolve a problem on their own and to develop the necessary skills to be able to do so in the future.

With the second approach of “no revelation,” therapists believe that they must keep the confidence of individual partners and, as a result, will not divulge information shared with them to an unknowing partner. These therapists sometimes feel that individual sessions are often required, especially with difficult couples, and that not providing confidentiality would reduce a client’s willingness to be open. The concern that relevant information may not be shared by either partner in the presence of the other is the biggest argument for seeing partners individually and therapists being willing to keep a secret (Imber-Black, 1993a; Karpel, 1980). Oftentimes, therapists feel that they cannot effectively help a couple unless they have all of the information relevant to a particular couple’s situation.

Therapists may also believe that clients’ rights of self-determination are not respected if a therapist takes the position of insisting that all information shared
with the therapist is privy to revelation. For the therapist to insist that a secret be
disclosed may be deemed as an imposition of a therapist’s personal values on the
couple.

In the third approach of “professional judgment” therapists reserve the right
to use their judgment regarding whether or not to maintain individual confidences.
These therapists typically base their decisions in accordance with their perception of
what will derive the greatest benefit for the couple. While Karpel (1980) has
termed this approach “accountability with discretion,” the term “professional
judgment” will be used in this paper. Further elaboration on this approach will be
made later in this paper.

The “professional judgment” approach appears to be somewhat riskier than
the other two already mentioned. Margolin (1982) notes that, while such an
approach leaves more options for therapists after a secret is revealed, it requires that
they carefully consider the therapeutic ramifications of their actions regarding
privileged information at all times. She also asserts that confusion on the part of the
therapist about how to deal with a particular secret can exacerbate the couple’s trust
issues with one another.

It has been argued that such an approach also allows a therapist to use a
process orientation, or to think interactionally, about a secret (Imber-Black, 1993a;
communication processes and an attempt to use it to manipulate or control one’s
partner is frequently a separate symptom of a deteriorating relationship from that of
the actual content of the secret itself (Imber-Black, 1993a; Karpel, 1980). Welter-
Enderlin (1993) has also suggested that a secret may represent an attempt by one partner to individuate from another, perhaps requiring a rebalancing of the relationship. In summary, the use of a secret by one partner against another may be a clinical issue in and of itself. By using an approach where decisions regarding the revelation of a secret are based on the best interest of the couple system, a therapist may be able to increase the likelihood of therapeutic progress by dealing with a secret in the most effective manner.

The Study of Secrets

In 1993, Imber-Black (1993a) edited Secrets in Families and Family Therapy, a book dedicated solely to the subject of secrets within family therapy. At that time, Imber-Black commented in the book’s preface on the paucity of attention given to secrets, commenting on the therapy field’s “seeming reluctance to engage the topic of family secrets.” While that book assuredly focused increased attention on the issue of secrets within family therapy and likely spawned awareness of and dialogue about secrets thereafter that otherwise would not have resulted, the limited literature and research within the last fifteen years since Imber-Black’s astute observation would suggest that little has changed.

It has also been argued that while much theoretical work has been done within the field of couple and family therapy, its practices have, to some degree, developed without an adequate empirical foundation (Friedlander et al., 2006; Gurman, 1983, 1990). The issue of how therapists should handle secrets between partners in couple therapy may be considered one example of the field’s reliance on theory and experiential conjecture rather than empirical research. With few
exceptions, the references regarding the handling of secrets by couple therapists to be discussed later in this paper have been based on experience and theory rather than empirically-based research. The one area of exception that has been empirically researched to some degree within the field of therapy is therapists' handling of confidential information related to the positive HIV/AIDS-status of a client (see Drecun, 2005; Johnson, 1995; Rein, 2000; Stewart, 1991; Terrell, 2001). The disease's lethality and the significant conundrums it can cause mental health practitioners are the likely reasons for such research, as well as the basis for some sense of relief that such research is being conducted.

The Purpose of the Present Study

The purpose of this study is based on the need for more stringent and thorough research in the area of therapists' handling of secrets between partners in couple therapy. Being an initial investigation for the most part, this study is exploratory in nature and quite large in scope, attempting to determine the aggregate practices of couple therapists with regard to secrets by the use of a researcher-constructed survey. This study examines couple therapists' policies, procedures, and perspectives regarding secrets between partners in couple therapy. It explores couple therapists' positions regarding keeping or revealing secrets between partners in couple therapy, how much planning they have done regarding the handling of secrets, the level of informed consent regarding secrets they provide their clients, and whether they obtain written consent from partners to reveal secrets. The study also examines the frequency with which couple therapists see couple therapy partners individually, the factors that have influenced their approach.
to handling secrets and the rationale behind their practices, and correlating results related to therapeutic success and the prevention of legal and ethical dilemmas. Additionally, the study investigates the frequency with which secrets are an issue in couple therapy and the types of secrets that are revealed, as well as examines the frequency with which therapists encounter difficulties in dealing with a secret. It further considers therapists' current perspectives and practice skills regarding such controversial secrets as infidelity, addiction, positive HIV/AIDS-status, and divorce.

Finally, the study attempts to discern the existence of a relationship between both the number of years of therapeutic experience and the number of couples a therapist has counseled and 1) the approach to secrets they use, 2) the amount of planning they have put into addressing secrets, 3) the frequency with which they see partners individually, 4) the level of informed consent they provide couples, and 5) the frequency with which they obtain written consent from partners in couple therapy. A relationship between state-mandated continuing education courses and therapists' adherence to both state laws/statutes and professional ethical codes as it pertains to HIV/AIDS confidentiality laws and limits is also explored, as well as therapists' approach to handling secrets and the frequency with which they encounter legal/ethical problems related to the disputed handling of a secret. The twenty-two specific research questions guiding this study can be found at the end of Chapter Three.

Beutler, Williams and Wakefield (1993) discovered that the research studies most desired by clinicians were those that focus on therapist and/or client behaviors
leading to therapeutic progress. Goldfried and Wolfe (1996) have argued additionally that in the field of couple therapy, consideration of what should be changed is important, but how change is promoted by the behaviors of both therapists and clients is imperative as well. The field of couple therapy now appears to be reaching the point where research can focus on specific therapist interventions and the effect of these interventions on outcome (Johnson, 1991, 2002). Recent process research into the nature of change is already producing promising results (see Butler & Wampler, 1999; Gordon, Baucom, & Snyder, 2000; Nichols & Fellenberg, 2000; Sprenkle, 2002; Worthington & Drinkard, 2000). As we continue to research and identify common interventions or approaches that work and do not work, we are not only better able to provide effective assistance to our clients, but the field of couple and family therapy gains credibility. By exploring the current, preferred policies, procedures and perspectives of therapists with regard to the handling of secrets between partners in couple therapy, this study takes an important first step toward identifying those things that may both increase the likelihood of therapeutic success for a couple, as well as decrease the likelihood of an unethical or illegal act on the part of the couple therapist. Summarily, understanding how therapists deal with the issues of secrets between partners in couple therapy and the moral, ethical, legal and therapeutic considerations that dictate these practices may result in improved practices.

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CHAPTER II

REVIEW OF RELATED LITERATURE

This chapter contains a review of the literature addressing the handling of secrets between partners in couple therapy. It includes: 1) the defining of terms related to secrets in couple therapy, 2) an elaboration of the concept of secrets, 3) a discussion of the reasons for therapists to handle secrets skillfully, 4) a discussion of the difficulty of establishing a therapeutic alliance in couple therapy and the necessary components for building and maintaining a strong working alliance, 5) a review of the problem of secrets and the approaches therapists can take to handling secrets and their respective advantages and disadvantages, 6) a review of the ethical guidelines relative to the issue of secrets between partners as set forth by the American Association for Marriage and Family Therapy (AAMFT) and several other professional associations, and 7) a review of the previous studies conducted in this area. This review also includes a discussion of the state laws/statutes that relate to confidentiality of information in therapy within the five states included in this study (i.e. California, Florida, Illinois, New York, and Texas). Particular focus is placed on the confidentiality laws and limits related to information about positive HIV/AIDS-status because of the disease’s lethality and the existence of specific laws and statutes around disclosure in many states, as well as the difficult position in which therapists are placed due to “duty to warn/protect” issues when they gain such knowledge about one partner and the other partner is unaware.
Definition of Terms

In this study, a number of terms will be used that are intended to convey specific meanings. They are listed below with their definitions.

Secret-holder: The person who knows and keeps a secret.

Unaware partner: The person who does not know the secret.

Secret: Information that is either withheld or differentially shared between or among people and directly affects the well-being of an individual or his or her relationship with a significant other or others (Karpel, 1980). In the context of an intimate relationship with a partner, secrets involve those cases in which one person keeps a secret from the other person. Whether particular information is a secret is determined by the relevance to the unaware partner, who is the only person who may rightfully determine whether withheld information is a secret to him or her.

Accountability with Discretion: A therapeutic stance toward secrets that, in practice, requires therapists to balance their need to know with their obligation to maintain trustworthiness in a way that works for the best interests of all family members. After one partner has disclosed a secret, it requires therapists to use their professional judgment and consider the relevance of the secret for the unaware partner by trying to see the situation from the viewpoint of the unaware partner as much as possible. It also calls for sensitivity and planning as to the timing, circumstances, and consequences of disclosure for both partners in an effort to minimize possibly destructive outcomes.

Multidirected Partiality: An approach in couple therapy defined by Boszormenyi-Nagy and Spark (1984) whereby a therapist takes sides with both
partners on occasion in order to promote fairness and equilibrium. This approach is particularly necessary when a power imbalance is preventing treatment progress.

A Conceptual Overview of Secrets

At the root of every secret is the meaning in which it engenders and the purpose that it serves. Secrets have been classified in a number of ways. Vangelisti (1994) has categorized secrets into three types according to content: taboo secrets, rule violations, and conventional secrets. Taboo secrets deal with topics that both family members and society condemn, such as incest or family violence. Rule violations pertain to the breaking of established family rules and may include cohabitation or pregnancy out of wedlock. Conventional family secrets, such as finances or illness, are those that are deemed unsuitable to converse about with non-intimate others (Vangelisti, 1994).

Taking a different approach, Berg-Cross (2000) has classified secrets into four primary categories: supportive, protective, manipulative, or avoidant. Of course, any one secret can serve more than one function at any given time, and the purpose of a secret can also change over time. Supportive secrets are those that function within a family to ensure a favorable image to the outside world. Such secrets typically promote increased cohesiveness within the family system (Vangelisti & Caughlin, 1997). Protective secrets are withheld from one family member or subsystem because others consider it in the best interest of that person or subsystem. These secrets may serve a maintenance function, protecting family members from stressors (Vangelisti & Caughlin). Manipulative secrets are withheld in order for the secret-holder to gain a personal advantage of some kind, while
avoidant secrets are kept in order to prevent having to deal with difficult, troublesome knowledge. Secrets between partners who present for couple therapy tend to be more manipulative or avoidant in nature, although the secret-holder frequently argues that he or she was maintaining a secret in order to protect the other partner.

Positive, beneficial secrets that unite families will not be the focus of this study. Instead, this study will focus on those secrets that are used to manipulate, gain power, or protect a guilty individual from reasonable consequences. Such secrets stand in the way of solving problems and allowing for normal development and growth. They may also erode trust, loyalty and happiness. These secrets often engender shame, and fear and anxiety regarding their disclosure typically exist (Imber-Black, 1993a). While it is difficult at times to determine what constitutes a “secret” because its definition can be influenced by context, time, culture and sociopolitical conditions, for the purposes of this study, the definition of a secret will be “any information being withheld or differentially shared that directly affects the well-being of an individual or his or her relationship with a significant other” (Karpel, 1980, p. 295). Because the harm caused by a secret to a particular individual can be subjective, the individual initially unaware of the secret, and not the secret-keeper, must be the one to decide whether withheld information meets this definition. In other words, whether something is a “secret” should be determined by the relevance of the information to the person who was not initially aware of the information and not the person keeping the information (Karpel). Typically, concealed information with a negative value commonly insinuates a
secret, while information that is morally neutral or socially acceptable would be considered an issue of privacy (Brown-Smith, 1998).

Imber-Black (1993b), one of the leading authors on secrets in the family therapy field has written:

Within the family, secrets define who is in and who is out, drawing some members into hidden alliances and leaving others out in the cold. When secret-keeping becomes a way of life, secrets and betrayals ricochet like pinballs from one family member to the next, triangulating each in turn... [Secrets] require at least avoidance, at worst outright lies that can become a habit, branching into seemingly innocuous areas until whole dimensions of life are off-limits to spontaneous talk. Secrets shape not only relationships, but inner lives... When a family with a secret walks into a therapy session the heaviness is palpable. The secret haunts the room like a ghost, looking over everyone's shoulder, a tense and hovering presence. Everyone waits for the other shoe to drop. When secrets are skillfully uncovered, the truth can make people free (p. 20).

Obviously, secrets can be very powerful. They are systemic and can create relational disequilibrium and power imbalances. They result in dyads, triangles, hidden alliances, and cut-offs. While some secrets can be positive and can bring family members together, many are toxic, or even dangerous, and erode relationships (Imber-Black, 1993a).

Separation and Divorce: Arguments for Handling Secrets Skillfully

Marital conflict, separation and divorce have become common phenomena in the United States. The latest studies place the divorce rate over 43% for first marriages, with the statistics being even higher for subsequent unions (National Center for Health Statistics, 2003). A large percentage of these separations and divorces are a result of the secret of an extra-relational affair (Amato & Rogers, 1997; Fine & Harvey, 2006). Research suggests that affairs are the second most damaging problem encountered by couples (behind physical abuse) and the third
most difficult to treat (behind loss of love feelings and alcoholism) (Whisman, Dixon & Johnson, 1997). Approximately a quarter of all couples seeking therapy present with the issue of extra-relational sex, and almost a third more disclose such information during the course of therapy (Fine & Harvey, 2006; Glass, 2002; Glass & Wright, 1997; Sprenkle & Weiss, 1978; Vangelisti & Gerstenberger, 2004). In fact, infidelity is the most frequently cited reason for seeking a divorce (Amato & Rogers).

While divorce and separation most assuredly may have some positive results, they are usually not without their negative ramifications as well. Divorce and separation have been found to detrimentally affect the health and well-being of all family members. Identified negative consequences for men include an increased rate of physical illness, suicide, homicide, violence and mortality from diseases, as well as an increased risk of psychopathology (Amato, 2000; Bloom, Asher & White, 1978; Haltzman, Holstein & Moss, 2007; Kposowa, 2003). Research suggests that women’s health can be equally negatively affected (Amato, 2000; Gottman & Levenson, 1992; Kposowa, 2003). Conversely, research suggests that marriage has an overall positive effect on health, especially for men (Kiecolt-Glaser & Newton, 2001).

Divorce and separation have also been implicated in a number of negative consequences for children. Studies suggest that children of divorce tend to exhibit increased symptomatology of depression, withdrawal and conducted-related problems including substance abuse, and decreased social skills and academic performance (Amato, 2000; Clark-Stewart & Brentano, 2006; Cummings & Davies,
1994; Doherty & Needle, 1991; Emery, 1982, 1988; Emery & O'Leary, 1982; Gottman & Katz, 1989; Hetherington, Cox & Cox, 1982; Huurre, Junkkari & Aro, 2006; Tresch Owen & Cox, 1997; Wallerstein, 1991, 2005; Wallerstein & Johnson, 1990; Wallerstein & Lewis, 2004). Summarily, evidence exists suggesting that divorce and separation often may have an overall negative impact on all family members, especially when parents maintain conflict and animosity over time. With the secret of infidelity being so prominent in couple therapy and resulting so frequently in divorce or separation, a couple therapist must be able to handle such a secret adeptly if he or she is going to provide the best services possible to help a couple save their relationship. Increasing our understanding of how to best help partners in couple therapy resolve their issues and improve their relationship is essential to strengthening couple relationships and to possibly reducing the potential negative effects of divorce or separation.

The Therapeutic Alliance in Couple Therapy

As previously discussed, the creation and maintenance of a strong therapeutic alliance is crucial to the success of all forms of psychosocial therapy, including couple therapy (Bourgeois, Sabourin & Wright, 1990; Estrada & Holmes, 1999; Friedlander et al., 2006; Taibbi, 1996). Horvath and Bedi (2002) have described the therapeutic relationship as:

[the] quality and strength of the collaborative relationship between client and therapist...[it] is inclusive of: the positive affective bonds between the client and therapist, such as mutual trust, liking, respect and caring...consensus about, and active commitment to, the goals of therapy and to the means by which these goals can be reached...a sense of partnership (p. 41).
A couple therapist’s bond must be strong with both partners in order to prevent a split alliance (Pinsof, 1995). Splits occur when one partner is positive about the therapist and the other has either neutral or negative feelings toward the therapist. To be effective in couple therapy, it may be necessary for a therapist to take sides with each partner at different times in order to promote fairness. This can be particularly true when a power imbalance is preventing treatment progress (Boszormenyi-Nagy & Spark, 1984; Hanna & Brown, 1999; Johnson & Greenberg, 1989; Kadis & McClendon, 1998). This approach has been termed “multidirected partiality” (Boszormenyi-Nagy & Spark), and its execution can be difficult. For an individual seeking therapy alone it is much simpler for the therapist to develop an alliance and validate and support that individual. Couples in therapy, on the other hand, often have quite conflicting views of their relationship, thus making validating and supporting each partner’s respective position more complicated. In addition, it is each partner’s prerogative as to what they reveal about the nature and extent of their relational issues, as well as when and how. Operating on partial information during much of the therapy process can make a therapist’s job quite complicated at times.

The essential working alliance in couple therapy is only strengthened as both partners’ feelings of trust in the therapist, and the process of treatment as a whole, increases. A therapist must pay attention to his or her interactions with both partners at all times because each partner takes stock not only of his or her own feelings and reactions to the therapist, but those of the partner (Pinsof & Catherall, 1986; Rait, 1998). Successful couple therapy depends on a therapist’s ability to
simultaneously meet the needs of both the individual and the system. Given that changes are always occurring in clients’ lives both within and outside of the couple, even the most secure therapeutic alliances can become strained. This makes it necessary for a therapist to constantly be mindful of, and evaluate, the therapeutic alliance that exists with both partners, and react accordingly as it shifts in strength, direction, and importance over time. Additionally, maintaining “multidirected partiality” in couple therapy is often made difficult by the fact that partners typically enter therapy with unequal amounts of interest and motivation for treatment, resulting in the need for therapists to “sell” therapy to unmotivated partners before therapy can progress (Patalano, 1997).

The process of maintaining relational balance within the context of couple therapy is perhaps most threatened when one partner attempts to get the therapist to side with her or him or expects that the therapist will collude with his or her partner (Nadelson, Bassuk, Hopps & Boutelle, 1977). The divulging of a secret to the therapist is one of the most effective methods in which a partner can solicit such collusion, putting the working alliance between the therapist and the other partner in jeopardy, and, hence, the entire therapeutic process. If a partner reveals a secret to a therapist and the therapist chooses to keep it from the unaware partner, the therapist essentially becomes an ally to that partner in an act of deception and betrayal (Johnson, 2002; Karpel, 1980). Should the unaware partner learn of this collaboration between the therapist and the other partner, he or she is likely to quickly lose trust in the therapist and terminate treatment. Kohut (1984) contends that breaches in a therapeutic relationship typically result from an “empathic
failure," or neglect on the part of a therapist to take a client's thoughts and feelings into account. Colluding with one partner to keep a secret from the other may be considered an example of such a failure by the victimized partner. To avoid being part of the deception, Brown (2001) contends that if one partner reveals a secret to the therapist and refuses to reveal it to his or her partner as well, the therapist should terminate counseling.

Additionally, should a therapist decide to keep a secret and even if he or she is effective in doing so, his or her hands oftentimes become tied in therapy because pertinent issues cannot be addressed without disclosure of the secret. An artificial sense of specialness in the colluded-with partner may also disrupt the therapist's ability to maintain balance in the therapeutic process (Brock & Barnard, 1999). Similarly, it is possible for the therapist to lose empathy for, or feel resentment toward the secret-holder, effectively destroying the "holding environment" crucial for clients to experience to freely express themselves and make therapeutic progress (Freeman, 1998). A therapist may even feel guilty for deceiving the unaware partner and consciously or unconsciously collude with that partner to make amends (Karpel, 1980).

A therapist also runs the risk of an unanticipated disclosure of the secret. In effect, the secret-holder has the power to expose the therapist's participation in the secret at any time, subsequently sabotaging the treatment entirely. Such a situation typically renders the therapist powerless (Karpel, 1980). Any of these situations is both undesirable and can prove to be both extremely anxiety-provoking for the
therapist and counterproductive to the building of a working alliance and, thus, a
couples’ therapeutic progress.

Approaches to Handling Secrets in Couple Therapy

The qualities of openness and partnership have been proven to be
instrumental components for the success of marital therapy (Hampson, Prince &
Beavers, 1999). Therapists must create an environment in which each partner feels
safe; facilitate effective communication between the partners, and help in resolving
couple problems (Estrada & Holmes, 1999). For this to occur, it is critical that a
therapist handle secrets effectively.

A review of the literature reveals much theoretical conjecture and advice
about how to deal with the issue of secrets between partners in couple therapy.
Authors in the couple and family therapy field have noted the frequently
contradicting advice regarding the best approach to handle secrets (e.g., no
revelation, full revelation, professional judgment) that has been given by therapists
who have written on the subject (Corey, Corey & Callanan, 2003; Patterson,
Williams, Grauf-Grounds & Chamow, 1999). It has been pointed out that these
views are guided by several, often competing, therapeutic considerations (Karpel,
1980; Margolin, 1982). As noted earlier, however, these presently promoted
practices have not been validated by empirically-based research. This issue will be
addressed in greater depth after present practices, with a specific focus on the three
primary approaches to handling secrets, have been examined in more detail.
The Approach of “No Revelation”

Some therapists treat each partner as though that person were an individual client. They are willing to hear secrets from one partner, usually in the context of an individual session or phone call, and keep the secret (Corey et al., 2003; Jacobson & Gurman, 1986; Margolin, 1982). Heitler (2001) argues that it is necessary to hold individual sessions with extremely conflictual couples, believing that such sessions allow partners more time to focus on personal symptoms as well as cater to individuals who are frequently shamed by their partner. She also maintains that individual sessions may be helpful when each partner’s symptoms effectively trigger the other’s, resulting in a vicious cycle that can escalate out of control. Other couple therapy approaches advocate the use of individual sessions as well, particularly in the early assessment phase of treatment.

Humphrey (1987) suggests that, even when dealing with perhaps the greatest of secrets between partners such as an active extra-relational affair, therapists who become privy to such knowledge must maintain confidentiality with all clients. He asserts that the therapist must maintain a position of ethical neutrality with regard to disclosure and that clients’ rights of self-determination must be respected. For the therapist to insist that the secret be disclosed is to impose his or her values on the couple.

Other like-minded therapists encourage conducting individual intake interviews to build rapport with each partner (Westfall, 1989), claiming that such sessions allow a therapist to recognize and value each partner as an individual. Individual sessions also permit disclosure of pertinent information that one client
may be reluctant to share in the presence of his or her partner. The concern that relevant information will not be shared by either partner in the front of the other is one of the biggest arguments for seeing partners individually (Karpel, 1980; Margolin, 1982).

The Approach of "Full Revelation"

Other therapists refuse to keep a secret with one partner, even if shared in the context of an individual session, either not wishing to enter into the triangulation that may result or because it contradicts their beliefs that psychological well-being and relational health can only be achieved in an environment of honesty. Several authors discourage the act of maintaining secrets, arguing that the sharing of secrets is necessary as an act of trust to restore power imbalances within a family (Bobes & Rothman, 2002; Imber-Black, 1993a; Johnson, 2002). Pittman (1993) contends that families or couples are frequently only freed from the bondage of a secret after it has been revealed, stating that, "What people don’t know can hurt them—and what they don’t reveal can hurt them even more" (p. 31) and that, "we cannot be loved, or trust the love we get accidentally, unless we take the risk of letting ourselves be known" (p. 36).

Therapists unwilling to keep secrets typically reduce the likelihood of becoming privy to a secret by only agreeing to see partners conjointly and making themselves unavailable when only one partner is present. They may also obtain prior consent from both partners at the beginning of therapy to reveal confidential material, as stipulated by virtually all professional organization ethical codes (Corey et al., 2003; Jacobson & Gurman, 1986; Margolin, 1982).
In response to Margolin’s (1982) concern that valuable information will often be withheld if such a stance is taken and only conjoint sessions are held, Wendorf and Wendorf (1985) argue that their experience reveals that most clients decide to divulge their secrets anyway, suggesting that little information is lost and that such a concern has no merit. They also believe that a “secret” is frequently known or suspected by the assumed unaware partner. Barker (1984) asserts that even if partners are seen separately, partners in couple therapy often do not reveal all pertinent information, including any secrets, anyway. As previously discussed, therapists also run the risk of their hands becoming tied and the colluded-with partner acquiring a disproportionate amount of the power within the therapeutic relationship should the decision be made to maintain a secret.

There are two other major arguments for not keeping a secret with one partner in couple therapy. First, there is the possibility that not revealing a secret would put one of the partners in harm’s way, as will be further elaborated upon during the discussion of counseling a partner who is positive for HIV/AIDS. The other argument is that therapists have an obligation to remain trustworthy and to foster a strong therapeutic relationship with both partners. The importance of the accomplishment of this task has also been previously discussed. Aside from the already mentioned opinions regarding dealing with secrets in this manner, some therapists contend that any possible advantages of individual sessions are not worth the suspicions that might arise in an absent partner or the conflicts of confidentiality and loyalty the therapist might experience (Framo, 1980; Karpel, 1980; Westfall, 1995). Brown and Brown (2002) go so far as to discourage therapists from seeking
intimate content in initial interviews until the nature of the couple’s relationship has been identified. Humphrey (1983) warns that even two or three sessions with a partner individually can magnify the absent partner’s resistance to therapy as well as increase his or her anxiety. Berg-Cross (2000) asserts that it is particularly important to reveal a secret in couple therapy when: 1) an individual partner’s well-being is at stake, 2) the emotional cost of the secret results in a psychological problem such as depression or anxiety, or 3) conversations between partners are strained and intimacy is lost.

With particular regard to extra-relational affairs, Pittman (1989) and Scharff (1978) advocate full revelation of secrets between partners as a prerequisite to offering sex and couple therapy, offering several arguments in favor of such an approach. First, they view an extra-relational affair as a sexual symptom of a deteriorating intimate relationship. In order to improve the relationship, the sexual component of the relationship must be addressed because it is connected to the internal processes of emotional growth. Scharff (1978) points out that the excuse often given by clients that the secret of an extra-relational affair is being kept to protect one’s partner is demeaning and self-serving, and should not be permitted. In reality, the secret is being kept in self-protection of the unfaithful partner. Some would argue that to allow a client to maintain the secret is to contribute to his or her delusions. Scharff (1978) also asserts that keeping a secret may also deny both partners the opportunity to share their doubts about their relationship; effectively reducing the likelihood of relational healing. The crisis resulting from the disclosing
of infidelity may produce a new foundation for the rebuilding of an intimate relationship.

Glass and Wright (1997) promote a different approach to dealing with the secret of an extra-relational relationship. They suggest that if a couple is receiving counseling to reconcile a marriage, a therapist should not keep such a secret. However, a therapist should maintain confidentiality if the couple is seeking separation counseling, being sure to make these walls of secrecy explicit at the start of therapy. Of course, a couple is able to renegotiate their intentions for therapy at any time. As an end note, Johnson (2002) argues that it may be wisest to keep an affair a secret if there is a potential for physical violence, as issues of safety and security should take precedence over honesty and forthrightness.

**The Approach of Using “Professional Judgment”**

Some therapists utilize a third approach to handling secrets between partners in couple therapy, that of reserving the right to use their “professional judgment” about whether or not to maintain individual confidences (Corey et al., 2003; Haley, 1976; Karpel, 1980; Wendorf & Wendorf, 1985). These therapists base their individual decisions in accordance with their perception of what will derive the greatest benefit for the couple. Karpel has termed this approach “accountability with discretion” and has identified three major considerations for determining whether secret information is shared. These considerations include the relevance of the material for the unaware partner, attempting to ascertain such relevance as much as possible from the perspective of the unaware partner, and being sensitive to the consequences of one’s decision for that partner as a therapist. Glick et al. (2000)
have suggested that, in general, a secret should be disclosed if it poses a danger to a
partner or shapes a coalition or alliance, thereby seriously affecting the connection
between the partners. Berg-Cross (2001) encourages therapists to make their
decision to reveal a secret based on “the extent to which the secret betrays the basic
trust on which the unknowing partner is predicating his or her feelings and actions”
(p. 436). The revelation of a secret is particularly promoted if 1) family members
are habitually fixated on the secret, 2) the secret is resulting in serious mental health
problems, 3) conversations within the family have lost their spontaneity for fear of
falling into “dangerous territory,” 4) intimate conversations with people outside the
family are avoided for fear of revealing the secret, 5) social and intellectual
developmental delays are resulting from the secret, or 6) one individual’s or group
of individuals’ well-being is chronically taking a back seat to others.

Additional relevant points regarding the revelation of a secret have been
made by other authors. It has been suggested that therapists can allow the couple to
discuss and decide how they would like the therapist to handle any secrets between
them. Johnson (2002) and Weeks (1989) point out that some secrets, such as those
embedded in the past and which would not help the couple improve their
relationship, are better left unrevealed. Depending on the perspective of the
therapist, such examples may include a twenty-year old affair, occasional illicit
drug use before a couple met, or a history of being abused as a child. It has also
been suggested that therapists refrain from revealing a secret before a couple has
committed themselves to treatment for fear that a sufficiently harmful secret may
drive an uncommitted couple away (Sholevar, 2003). Imber-Black (1993a) adds
that a therapist should always assess whether an attempt to open the secret in the past has been made and failed. It is possible that an attempt to reveal a secret has been made and that a partner was unable or unwilling to believe the secret was true. Such a situation would affect how a counselor would proceed to reveal the secret in the future.

If a therapist decides to use his or her discretion regarding the revelation of secrets, it is imperative that it be explicitly stated and agreed to at the start of therapy, as previously discussed. Margolin (1982) also notes that, while such an approach leaves more options for therapists after a secret is revealed, it requires that they carefully consider the therapeutic ramifications of their actions regarding privileged information at all times. She also proposes that confusion on the part of the therapist about how to deal with a particular secret can exacerbate the couple’s trust issues with one another. Of course, the chance also exists that a partner will not agree with a therapist’s decision to reveal a secret, leaving the therapist with very few options aside from terminating therapy.

As previously mentioned, a “professional judgment” approach also allows a therapist to use a process-orientation, or think interactionally, about a secret (Imber-Black, 1993a; Karpel, 1980; Welter-Enderlin, 1993; Wendorf & Wendorf, 1985). The presence of a secret, and perhaps its disclosure only to a therapist, may be a clinical issue in itself. By using this approach where decisions are based on the best interest of the system, a therapist is able to make the most appropriate decision to keep or reveal a secret, thereby preventing the couple from replicating a destructive
triangle in the therapeutic setting. If the decision to reveal a secret is made, a therapist will typically help a partner prepare for the revelation (Brown, 2001).

Recommendations for Practices Related to Secrets

Regardless of a therapist’s particular approach to handling secrets, several authors have made practice recommendations regarding the handling of secrets in couple therapy to avoid potential problems (Brendel & Nelson, 1999; Brock & Barnard, 1999; Corey, 1996; Imber-Black, 1993a; Karpel, 1980; Weeks et al., 2005; Wilcoxon et al., 2007). Weeks et al. emphasize that the discussion of confidentiality is one of the most important elements of informed consent. Corey (1996) emphasizes the importance of working from a clearly articulated theoretical orientation that serves as the therapist’s guide or framework for making consistent and competent decisions when confronted with challenges during the counseling process. The formulating of a policy for handling confidentiality and secrets is also encouraged, as well as making sure that this policy is clearly communicated to clients (Brendel & Nelson, Karpel, Weeks et al.). Couple therapists who neglect to clarify the limits of confidentiality before beginning therapy increase the likelihood for premature termination of the couple or an allegation of breach of confidentiality (Leslie, 2003). It is best if confidentiality limits are provided as part of a written professional disclosure statement that is signed by the clients (Brendel & Nelson). Weeks et al. also stress the importance of enforcing the rules of confidentiality and anticipating problems with confidentiality based on the presenting problem. Additionally, therapists should be familiar with the federal and state laws and statutes under which they operate and the ethical guidelines of their professional
organization as they pertain to confidentiality (Brendel & Nelson). It can also be helpful to turn to peers, either for consultation and/or supervision or as a source of additional counseling services for a family or couple.

Ethical Guidelines Regarding Confidentiality and Secrets

Couple therapists, regardless of professional licensure, are bound by the ethical standards of their profession. Ethics may best be defined as the process of making moral decisions about individuals and their societal interactions, while simultaneously protecting the rights and welfare of those same individuals (Kurpuis, Gibson, Lewis & Corbet, 1991). The issue of secrets and the ethical responsibility of confidentiality are inexorably entwined in the psychotherapy professions. Confidentiality is crucial to therapy and usually required, as it protects clients from the social stigma frequently associated with therapy, promotes vital client rights, and facilitates the therapeutic process by creating an environment conducive to client sharing (Denkowski & Denkowski, 1982; Woody & Woody, 2001).

Not surprisingly, issues related to confidentiality represent both the most frequently experienced and most difficult to solve types of ethical dilemmas therapists confront (Hayman & Covert, 1986; Lindsay & Clarkson, 2000; Pope & Vetter, 1992). The maintenance of confidentiality is especially tested when the welfare of society is at risk due to nondisclosure. The most obvious of these examples involve suspected abuse or neglect of children and the elderly, which require reporting to protective service agencies. However, the recent advent of HIV/AIDS has produced other instances in which a therapist may need to break
confidentiality, and, as will be discussed later, typically involves increased complexity, confusion and difficulty in making such a determination.

To resolve confidentiality issues, couple therapists need first to be able to differentiate the concepts of confidentiality, privacy and privileged communication. Confidentiality in the counseling profession may best be described as “the ethical duty to fulfill a contract or promise to clients that the information revealed during therapy will be protected from unauthorized disclosure” (Arthur & Swanson, 1993, p. 7). Privacy is defined as “being free from intrusion or disturbance in one’s private life or affairs (Merriam-Webster, 2004), while privileged communication is the legal term used for confidential material that is protected by law (Corey et al., 2003). Privileged communication is rarely absolute, and oftentimes, such as in cases of abuse and neglect, therapists are required by law to break therapist-client privilege and make a report to the proper authorities.

Confidentiality Guidelines of Specific Professional Organizations

Historically, versions of the American Psychological Association (APA) guidelines did not address ethical principles specifically related to confidentiality and couple and family therapy practices. Confidentiality guidelines espoused by the APA relevant to group therapy did not directly pertain to the issue of secrets between partners in couple’s therapy based on the increased level of knowledge and intimacy that exists between partners (Margolin, 1982; Miller, Scott & Searight, 1990). Recognizing that the APA’s ethical principles did not specifically address some pertinent family therapy issues, the American Association for Marriage and Family Therapy (AAMFT) and the International Association of Marriage and
Family Counselors (IAMFC), along with other professional marriage and family organizations, sought to clarify the guidelines for therapists regarding confidentiality and secrets between family members.

The AAMFT recognizes that couple therapists have “unique confidentiality concerns,” as more than one client constitutes the therapeutic relationship. Principle 2.2 of the AAMFT Code of Ethics asserts that a therapist must respect and guard the confidences of each individual client and may only disclose client information, even between family members, if mandated by law, if a duty to protect is required, if the therapist is a defendant in a suit arising from therapy, or if a waiver in writing is previously obtained (AAMFT Code of Ethics, 2001). In such instances, only the information stipulated by the terms of the waiver can be revealed.

The Ethical Code for the IAMFC (2005) reiterates the position of the AAMFT, stipulating that information shared by one family member with the counselor must be treated as confidential and not disclosed without the individual’s permission unless alternate arrangements have been agreed upon by all participants. However, relative to the AAMFT, the IAMFC appears to take a stronger stance concerning family (couple) secrets, stipulating in Section B, article 7 that:

…the marriage and family counselor should clearly identify the client of counseling, which may be the couple or family system. Couple and family counselors do not maintain family secrets, collude with some family members against others, or otherwise contribute to dysfunctional family system dynamics (p. 9).

The IAMFC Ethical Code further states that interference with the agreed upon goals of counseling by one individual’s unwillingness to share information with others
deemed relevant by the therapist may necessitate the termination of treatment with that counselor (IAMFC, 2005).

Principles within the ethical codes of both the AAMFT and the IAMFC dictate that therapists inform clients of the limits of confidentiality and acquire consent, preferably written, from a partner before sharing any information revealed to the therapist in confidence with the other partner. As pointed out by a number of authors (e.g., Brendel & Nelson, 1999; Brock & Barnard, 1992; Brown & Brown, 2002; Freeman, 1981; Hare-Mustin, 1980; Karpel, 1980; Weeks, 1989; Weeks & Treat, 2001), this requires therapists to take a pro-active approach to secrets, addressing how they will be handled at the beginning of therapy. It has been suggested that after carefully formulating one’s policy regarding confidentiality, particularly as it pertains to secrets, it should become part of the written professional disclosure statement given to clients before counseling starts (Brendel & Nelson, Young & Long, 1998). Having clients sign statements of understanding and agreement regarding how secrets will be dealt with creates a formal contract between therapists and clients, decreasing the likelihood that the revelation of a secret to the therapist will occur and thus hinder the counseling process (Brendel & Nelson). Further measures for dealing with secrets effectively include implementing specific strategies for handling secrets in the therapeutic process, using the services of other therapists as required, and participating in supervision.

With little deviation, the above ethical guidelines are also espoused now by the National Association of Social Workers (NASW), the American Psychological Association (APA), the American Counseling Association (ACA), the American
Mental Health Counselors Association (AMHCA), and the American Association of Sexuality Educators, Counselors, and Therapists (AASECT). Since 2002, the APA has stipulated in Standard 10.02 that psychologists providing couple and family therapy "take reasonable steps to clarify at the outset (1) which of the individuals are clients/patients and (2) the relationship the psychologist will have with each person...[including] the psychologist's role and the probable uses of the services provided or the information obtained (2002, p. 15).

Other guidelines from these organizations' ethical codes are worth noting because of their position or their clarity on therapists' handling of secrets. Principle 1.07f of the NASW Ethical Code encourages social workers to "seek agreement among the parties involved concerning each individual's right to confidentiality and obligation to preserve the confidentiality information shared by others" (p. 6) and to "inform participants in family, couples, and group counseling that social workers cannot guarantee that all participants will honor such agreements" (p. 6). Regarding confidentiality limits, Principle B.2.a. of the ACA Ethics Code (2005) states that, "The general requirement that counselors keep information confidential does not apply when disclosure is required to protect clients or identified others from serious and foreseeable harm or when legal requirements demand that confidential information must be revealed" (p. 7). The IAMFC takes a similar position in their ethical code. Finally, while all ethical codes of the aforementioned professional organizations capitulate to federal and state laws and statutes with regard to mandatory reporting of confidential information, which will be discussed in greater depth later within the context of HIV/AIDS confidentiality, perhaps the AMHCA
Code of Ethics stipulates it most comprehensively stating, “The mental health counselor complies with all state and federal statutes concerning mandated reporting of suicidality, homicidality, child abuse, incompetent person abuse and elder abuse” (p. 6).

Before ending the discussion on confidentiality, it should be noted that the AAMFT and other organizations continue to receive criticism for not providing clinicians with sufficient guidance regarding confidentiality with couples in a number of situations. It has been argued quite recently that the ethical codes in place today are too simplistic and deal in absolutes without considering the complexity that therapists commonly face in their work (Weeks et al., 2005). The frequent result is a therapist who is confused and wondering if he or she has violated an ethical code or is susceptible to legal action.

Confidentiality, Ethical Codes, and HIV/AIDS

While confidentiality issues can present dilemmas regardless of the content of the information, they become increasingly problematic when involving the controversial issue of HIV/AIDS. It is in such cases that therapists find themselves in the conundrum of whether to meet their concomitant ethical obligation to maintain client confidences or break confidences to satisfy their legal duty to potentially protect third parties from the dangers posed by their clients’ behaviors. Stewart and Reppucci (1994) note that HIV/AIDS “adds an entirely new dimension to the already confounded and complex debate about whether it is better to maintain confidentiality or protect a third party” (p. 118). Harding, Gray, and Neal (1993) add that, “The mental health professionals’ dilemma is acute. From a purely legal
standpoint, breach of confidentiality presents a high risk of liability because the
counselor has a clear duty to protect the client’s confidences. Failure to warn a third
party, however, also creates a high risk of liability” (p. 300). It is clear that the
positive HIV/AIDS-status of a therapy client that is unknown to a third party or
parties who are being put at-risk represents a unique and difficult confidentiality
issue for a therapist.

As one component of this study will be the assessment of how therapists
handle positive HIV/AIDS-status secrets as a possible representation of a “duty-to-
warn/protect” or “imminent danger” situation, it is pertinent to discuss the ethical
standards of professional organizations such as the AAMFT as well as state
laws/statutes related to confidentiality as they apply specifically to this subject. We
will start with a discussion of the ethical codes of professional organizations
influential in the field of couple therapy as they pertain to this issue.

As this review suggests, the positions taken by the various professional
associations that oversee the mental health field, while largely consistent with one
another, do vary to some degree. Of the aforementioned professional organizations,
only two specifically address the issue of breaking confidentiality to protect third
parties from infection of a disease by a counseling client. Perhaps the ACA Code of
Ethics is clearest in its stance regarding the handling of secret information involving
the possible transmission of a life-threatening disease from a client to a third party.
In Section B.2.b., entitled “Contagious, Life-Threatening Diseases, the ACA (2005)
states:

When clients disclose that they have a disease commonly known to be both
communicable and life-threatening, counselors may be justified in disclosing
information to identifiable third parties, if they are known to be at demonstrable and high risk of contracting the disease. Prior to making a disclosure, counselors confirm that there is such a diagnosis and assess the intent of clients to inform the third parties about their disease or to engage in any behaviors that may be harmful to an identifiable third party (p. 7).

Similarly, the AMHCA (another division of ACA) Code of Ethics recognizes that, “The protection of the public or another individual from a contagious condition known to be fatal also requires action that may include reporting the willful infection of another with the condition” (p. 6).

The ethical codes of the AAMFT, IAMFC, APA, NASW, and AASECT, while recognizing that situations may result in sound legal or ethical justification for disclosing information if someone is in imminent danger, remain silent on the specific possibility of such a situation arising from the irresponsible behavior from a communicable disease-infected client. The AAMFT Code of Ethics (2001), without a formal position on the specific topic of HIV/AIDS or other transmittable diseases, simply stipulates in Principle 2.2 that, “Marriage and family therapists do not disclose client confidences except by written authorization or waiver, or where mandated or permitted by law...In the context of couple...treatment, the therapist may not reveal any individual’s confidences to others in the client unit without the prior written permission of that individual” (p. 1). Essentially, the AAMFT position supports the maintenance of confidences, while simultaneously permitting disclosure in accordance with federal and state laws/statutes and with written permission. Thus, based on the respective laws of two states, a couple therapist in the state of New York would be within the ethical guidelines of the AAMFT to
report a patient’s HIV+ status to the local health department, while the same therapist in California would not.

The Ethical Code of the IAMFC (2005) also does not specifically address HIV/AIDS or other transmittable diseases. However, Principle B.3 addresses the issue of confidentiality in general stating, “Marriage and family counselors inform clients of exceptions to the general principle that information will be kept confidential or released only upon written client authorization. Disclosure or private information may be mandated by state law...Couple and family counselors may have sound legal or ethical justification for disclosing information if someone is in imminent danger” (p. 8). Again, the IAMFC Ethical Code capitulates to federal and state laws/statutes, neither mandating disclosure of confidential information based on a perceived “duty to warn/protect,” nor limiting a therapist’s ability to do so.

It is unknown whether the absence of ethical guidelines specific to the possible transmission of a communicable disease, purposeful or otherwise, from an infected client to an unaware third party is an intentional oversight on the part of these organizations or a deliberate attempt to avoid taking a position on such a controversial issue. One may ask when these professional organizations will address this issue directly and provide their members with specific guidelines pertaining to how such confidential information should be handled.

It is possible, however, that these organizations do not feel the need to specifically address the issue of whether or not the possible transmission of a communicable disease by a client to an unaware third party should result in a break of confidentiality. This is because, as previously alluded to, all professional
organizations stipulate that espoused ethical guidelines should capitulate to contradictory federal and state laws/statutes in all instances. Similar to the AAMFT and the IAMFC, the APA states in Standard 4.01 that psychologists protect confidential information while "recognizing that the extent and limits of confidentiality may be regulated by law or established by institutional rules or professional or scientific relationship" (p. 7). Likewise, the ACA advocates that, in situations where their ethical guidelines contradict state and federal laws/statutes, "...counselors may adhere to the requirements of law, regulations, or other governing legal authority" (p. 19). Such a capitulatory stance is necessary to insure that the professional organization is not liable for law-breaking practices by its therapists. Variance in laws/statutes across states also necessitates such a position (Cohen, 1997; Knapp & VandeCreek, 1990; Melton, 1988, Simone & Fulero, 2001).

HIV/AIDS State Confidentiality Laws and Statutes

To date, the federal government has been slow to create uniform standards of protection of health information such as positive HIV/AIDS-status. This is perhaps due to a desire by the federal government to allow states to experiment and improve upon current standards, as pre-emptive federal provisions may be at odds with much public health care legislation which has generally been within state authority, or simply because such reform has not been politically feasible (Gostin, Lazzarini & Flaherty, 1997). Unfortunately, as many authors have noted, state laws/statutes regarding confidentiality and privilege typically vary between physicians and mental health professionals such as marriage and family therapists,
psychologists, and social workers. Additionally, therapists’ “duty to warn/protect” vary from state to state, as well as even between mental health professionals within states (Burris, 1993; Cohen, 1997; Denkowski & Denkowski, 1982; Erickson, 1993; Harding, Gray & Neal, 1993; Knapp & VandeCreek, 1990; Lamb, Clark, Drumheller, Frizzell & Surrey, 1989; Lynch, 1993; Mappes, Robb & Engels, 1985; Melton, 1988; Millstein, 2000; Schlossberger & Hecker, 1996; Simone & Fulero, 2001; Stanard & Hazler, 1995). To give one example, New York State law differs from most other states in that it allows any type of mental health professional with knowledge of a person’s positive HIV/AIDS-status to disclose such information to a federal, state or local health official without client consent (New York State HIV/AIDS Confidentiality Law 2782.1.g, p. 35). The specific laws and statutes of each of the states included in this study will be elaborated on fully later in the chapter.

While all states have HIV/AIDS-related laws/statutes, some address the collection and protection of such information directly, while others do so indirectly. Thirty-nine states have either HIV/AIDS-specific privacy statutes or general privacy provisions that expressly mention HIV/AIDS, while the remaining states protect its confidentiality under other statutes or provisions (Gostin et al., 1997). Similarly, forty-five states have either criminal or civil penalties for unauthorized disclosure of HIV/AIDS-related information. Thirty-three states have criminal penalties, thirty-three have civil penalties, and twenty-one provide for both civil and criminal penalties (Gostin et al.). The typical penalty for impermissible disclosure
of public health data related to positive HIV/AIDS-status is a fine between $500 and $10,000, and imprisonment from three to twelve months.

The three primary reasons for the selection of the five states to be sampled in this study included the desire to have each geographical region of the nation represented, as well as to sample in states with both a high number of marriage and family therapists for sampling purposes and high HIV/AIDS populations to increase the likelihood of surveying therapists with experience in working with this population. Additionally, the states of California, Florida, Illinois, New York, and Texas were also chosen, in part, because of their varying state laws/statutes related to the maintenance of confidential information pertaining to positive HIV/AIDS-status. The discussion will begin with an examination of the laws/statutes in the state of California as its case law has perhaps had the greatest impact on the nation, as a whole, with regard to the debate over maintaining client confidentiality or breaking confidentiality to protect society.

*The Tarasoff Cases*

At the heart of the debate over maintaining client confidentiality or breaking it to protect third parties is the foundational California case, *Tarasoff v. Regents of the University of California et al.* in 1976. This case has become the benchmark case for all "duty to warn/protect" statutes for mental health workers nationwide. In brief, the case involved the killing of a young woman by a former patient of the University of California Counseling Center. The patient, Prosenjit Poddar, had verbalized to his therapist his wish to kill the woman for rejecting his advances. After consultation with two colleagues, his psychologist contacted the campus
police both orally and in writing that Poddar represented a danger and should be committed for emergency 72-hour psychiatric detention and observation. The campus police followed-up with an interrogation of Poddar, who denied any such desire to kill the future victim, as well as talked with others familiar with him. They concluded that commitment was not necessary and warned Poddar to stay away from the young woman. Her family and she, however, were not notified of the possible danger. Poddar terminated therapy shortly after the police interrogation. Approximately two months after Poddar terminated therapy, he followed through on his threat. The victim’s parents sued, alleging negligence by the university and, primarily, the treating psychologist (Winslade & Ross, 1983). The case was heard four separate times—twice before the California Supreme Court.

In Tarasoff I, the Supreme Court found the defendants liable for negligence based on the theory of a failure to warn, stating that “public policy favoring protection of the confidential character of patient-psychotherapist relationships must yield in instances in which disclosure is essential to avert danger to others; the protective privilege ends where the public peril begins” (1974, p. 556). After the initial Tarasoff decision, several professional groups, including the American Psychiatric Association, filed an amicus brief contending that it compromised the confidentiality necessary to conduct psychotherapy and required therapists to determine their patients’ propensity for violence without legitimate criteria. A new opinion, Tarasoff II, was thus rendered eighteen months later, with the decision being upheld with modification. This time the court ruled that when a therapist determines, or should have determined, that a patient presents a serious danger of
violence to another, the therapist “bears a duty to exercise reasonable care to protect the foreseeable victim of that danger” (1976, p. 345).

The Tarasoff decisions, and subsequent cases in which the decisions have been applied, identify several requirements necessary to warrant the breaking of confidentiality for third-party protection by a therapist. First, a fiduciary relationship must exist between the therapist and the client. Obviously, such a relationship is created when a patient begins to see a therapist. Similarly, such a relationship does not exist between a patient and any mental health workers not working with that individual. Second, an assessment of the dangerousness of the patient must cross a sufficient threshold as to warrant breaking confidentiality. Dangerousness lies on a continuum of infinite degrees of risk and is influenced at any given moment by psychological and social factors. For better or worse, determining if individuals have a potential to cause harm to others has fallen on mental health professionals (Pollack, Gross & Weinberger, 1982). However, the difficulty of accurately predicting someone’s future potential for violence against others has been demonstrated by a large body of psychological research (see Beigler, 1984; Ewing, 1991; Miller, Doren, VanRybroek & Maier, 1988; Monahan, 1981). Fortunately, the Tarasoff II court recognized therapists’ difficulty in predicting a patient’s future violence and required non-negligent behavior rather than a perfect performance from mental health professionals, stating that the court, “[does] not require that the therapist, in making that determination, render a perfect performance; the therapist need only exercise that reasonable degree of skill, knowledge, and care ordinarily possessed and exercised by members of that
professional specialty under similar circumstances (*Tarasoff II*, p. 335).

Foreseeability of danger in the form of a client's violence against a third party has three accepted criteria: (1) a history of violence, (2) threats against a specific person, and (3) an apparent motive (Beck, 1990; Matflerd, 1992).

Additionally, in situations involving HIV/AIDS clients, it has been determined that the degree of dangerousness of such individuals depends on at least three general factors: (1) the medical diagnosis, (2) the client's engagement in high-risk behaviors, and (3) the use of "safer sex" techniques to reduce the likelihood of HIV transmission (Lamb, Clark, Drumheller, Frizzell & Surrey, 1989). Obviously, therapists must be current regarding medical information pertaining to HIV/AIDS, including such things as transmission risks and deterrence (Koocher & Keith-Spiegel, 1998).

The third *Tarasoff II* standard warranting a "duty to protect" is that of an existing identifiable victim. The California Supreme Court ruled that therapists are not required to interrogate a patient or conduct an independent investigation to determine a potential victim's identity, yet placed considerable burden on therapists by stating that, "there may also be cases in which a moment's reflection will reveal the victim's identity" (*Tarasoff II*, p. 335). To complicate the meeting of this third requirement considerably, since the *Tarasoff II* ruling, subsequent rulings in other states have been contradictory (see Lamb et al., 1989 and Simone & Fulero, 2005 for a thorough review). With regard to HIV/AIDS individuals, determining an identifiable victim is made difficult for therapists by the characteristics of HIV

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including being able to remain dormant for years and being able to be passed from women to their children at birth.

The ruling of *Tarasoff II* and the three standards necessary to warrant a “duty to protect” have had a significant impact on the landscape of psychosocial therapy with regard to confidentiality, both in California and many other states across the nation. To date, twenty-three states have passed laws regarding the “duty to warn/protect” (Anderson & Barret, 2001). *Tarasoff II* has not been the final word, however. Notably, the state of Maryland has rejected *Tarasoff* in both statute and court action, maintaining that confidentiality may not be breached by therapists even when the lives of others are at risk (Mappes, Robb & Engels, 1985). This makes it possible for a therapist in Maryland to be found guilty of a breach of confidentiality if they attempt to warn probable victims of a life-threatening danger from their clients.

Great debate has also raged over the last three decades regarding whether the three *Tarasoff* standards are, or can be, met in HIV/AIDS situations; as well as whether mental health providers are capable of determining the attainment of such standards in all cases. Recognizing that past behavior is the best predictor of future behavior, Applebaum (1985) recommends that therapists routinely ask patients about whether they have ever seriously injured someone else, or ever think about harming someone else to assist in determining the likelihood of future dangerous behavior. However, therapists are still often left with the very difficult task of determining possible first-time offenses. As would be expected, they often err on
the side of caution by concluding that a patient is dangerous when, in fact, he or she is not.

Since the Tarasoff decisions, many other legal cases have been brought against mental health professionals and facilities in suits regarding breach of duty to protect (see Lamb et al., 1989 and Simone & Fulero, 2005 for a thorough review). Most states, including California, have felt the need to clarify confidentiality laws/statutes as they pertain specifically to positive HIV/AIDS-status. This has, in large part, been due to therapists’ difficulty in determining whether the behaviors of an HIV/AIDS client represent a “duty to warn/protect” situation (see Cohen, 1997; Erickson, 1993; Fulero, 1988; Hughes & Friedman, 1994; Knapp & VandeCreek, 1990; Lynch, 1993; Melton, 1988; Millstein, 2000; Stanard & Hazler, 1995; Totten, Lamb & Reeder, 1990). However, as some professionals have contended, state statutes/laws are frequently poorly written with both confusing and ambiguous language, and individual states’ case law related to the duty to protect exhibit significant variability (Beck, 1987; Simone & Fulero, 2005). It has become clear that a mental health provider’s knowledge of the various ethical dilemmas surrounding HIV/AIDS is essential in order practice ethically, legally and therapeutically.

State Positions on HIV+/AIDS Information and Confidentiality

Based on the strong and clear decisions in the Tarasoff cases, one might assume that the state of California would lean heavily toward the protection of the public at the cost of breaking confidentiality in all cases. In reality, although California has made it mandatory for physicians to report to the public health
department when a patient tests positive for HIV in order to receive federal funding for related programs, mental health providers such as psychologists and marriage and family therapists have no such responsibility to report. This exemplifies the common trend across the nation of different HIV/AIDS confidentiality standards for physicians and non-physicians. In California, section 121025 of the Health and Safety Code stipulates that, "public health records relating to human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS)...shall be confidential and shall not be disclosed, except as otherwise provided by law for public health purposes or pursuant to a written authorization by the person who is the subject of the record or by his or her guardian or conservator" (CHSC, 2006, p. 93). As previously mentioned, the major exception to this law pertains to physicians reporting to local health departments for the purposes of partner notification in order to insure federal funding of HIV/AIDS-related programs. It should be noted, however, that physicians may also disclose positive HIV-test results to persons who are reasonably assumed to be the spouses, or sexual or needle-sharing partners of their patients.

Similarly, section 5328 of the California Welfare and Institutions Code stipulates that marriage and family therapists divulging confidential HIV/AIDS information to others without patient consent is taking charge of a patient’s care beyond the lawful scope of practice for that discipline (California Welfare and Institutions Code, p. 38). The same statute would apply to all other non-physician mental health providers. In summary, the laws and statutes of the state of California effectively limit all mental health providers, including marriage and family
therapists, from reporting, without the client’s consent, a client’s positive HIV/AIDS-status, either to third parties or organizations such as the local health department. Of course, the local health department should already be aware of said client’s condition based on a physician’s earlier reporting.

The state of Florida has similar stringent laws/statutes regarding the disclosure of HIV/AIDS-status. While physicians are required to report positive HIV-test results to local health departments, the Florida Omnibus AIDS Act stipulates that such results are classified as “superconfidential,” meaning the information is only made available to healthcare personnel on a need-to-know basis. This precludes even physicians from informing the spouses of HIV/AIDS patients of their partner’s status, and certainly bars any such disclosure by a mental health practitioner. Such a disclosure to the local health department, even for the purposes of partner notification, would also be breaking the law.

The AIDS Confidentiality Act of the state of Illinois also varies little from the laws and statutes of California and Florida. Again, mental health practitioners are legally barred from revealing the positive HIV/AIDS-status of any of their patients, even to the local health department. The state of Illinois differs from California and Florida, however, in that it permits physicians to notify the spouses of patients receiving positive HIV-test results, although physicians must first attempt to convince patients to disclose the information themselves. To complicate matters, however, Illinois has created a privileged communication act permitting therapists to break confidentiality in order to save human lives without placing themselves in legal jeopardy, despite the fact that no definite “duty to warn/protect”
like that of *Tarasoff* in California has been established (Mappes, Robb & Engels, 1985). This suggests that therapists could reveal the positive HIV/AIDS-status of a client to his or her unaware partner without repercussions.

The state of New York differs from the aforementioned states with regard to HIV/AIDS confidentiality laws and limits for mental health workers such as marriage and family therapists, psychologists, and social workers. While New York state has ruled that no person, including a mental health provider, who obtains confidential HIV/AIDS-related information in the course of providing social services may disclose said information to a third party without consent, such information may be disclosed to federal, state, county or local health officers "when such disclosure is mandated by federal or state law," primarily for the purpose of alerting third parties to their exposure to HIV (New York State Bar Association, 1989, p. 35). Similar to other states, New York promotes such reporting to insure receipt of federal funding. By applying its provisions to any holder of HIV/AIDS-related information, including persons such as mental health workers, New York law effectively allows the reporting of a patient's positive HIV/AIDS-status to the local health department. It should be noted, however, that this reporting is only permissible, and not yet mandatory or prescriptive. This may, in large part, be due to the strong position the APA has taken with legislatures of not imposing a legal duty on psychologists to protect third parties from HIV/AIDS patients (Hughes & Friedman, 1994). As an aside, to date, a court case testing the relief of responsibility from such a legal duty for non-physician mental health providers has not occurred. However, one could assume that in this litigious era, it will only be a matter of time
before a mental health provider is sued for negligence for not informing a third party who becomes infected with HIV of a client’s HIV/AIDS status in a situation where there is a question of whether the three Tarasoff standards have been met.

After a number of statute amendments and court cases in the 1990’s involving HIV/AIDS, the state of Texas has still another position on the disclosure of positive HIV/AIDS-status. Originally, Texas law permitted, but did not require, physicians to disclose positive HIV-test results to spouses of their HIV-infected patients (Furrow, Johnson, Jost & Schwartz, 1991). This law, rule 81.103(7) of the Texas Health and Safety Code, was later amended, however, to allow the release of positive HIV/AIDS-status to a spouse of the infected person by any person possessing such knowledge, apparently including all types of mental health providers (Hughes & Friedman, 1994). The release of this information may only be made to a spouse, however, and does not include sexual, or needle-sharing, partners of any other form. Like most other states, Texas has a partner notification program that is carried out by the local health department, suggesting that mental health providers such as marriage and family therapists could also contact them for the purpose of spousal notification. Maintaining consistency, however, a therapist could not contact the health department for the purposes of notifying someone other than a spouse without the patient’s permission. Again, the reporting of an individual’s positive HIV/AIDS-status to his or her spouse is only permissible, not prescriptive, for mental health providers in Texas.

As many authors argue, mental health professionals may need to breach confidentiality and warn identified parties in cases where an HIV/AIDS client is
putting the lives of others in danger (Cohen, 1990; Erickson, 1990; Hook & Cleveland, 1999; Pryzwansky and Wendt, 1999). The inherent difficulty in making such a decision, however, has been demonstrated. Therapists must first consider the federal and state laws and statutes that govern their practices. They must also consider the ethical guidelines of the professional organization with which they are affiliated. Finally, and perhaps most problematically, they must be able to assess whether their particular situation indicates a need to breach confidentiality to protect a third party and, if so, exactly how to proceed taking the well-being of all involved into consideration.

Past Research Related to Secrets

As previously mentioned, secrets and therapists’ handling of them has received little research attention to date. Only a handful of studies have been conducted in this area, and most of them have focused strictly on secrets involving HIV/AIDS. This section will elaborate on the studies that have been done thus far.

Studies Regarding General Secrets

In the late 1980’s, Brock and Coufal (1989) conducted the first nationwide survey of practice behaviors related to the practice ethics of marriage and family therapists. They randomly surveyed 1,000 AAMFT Clinical Members, asking subjects to report on 104 clinical behaviors related to ethical practice. The return rate was high (54%), suggesting that the findings of the study were likely generalizable to the AAMFT membership. While not all of the questions that were asked related to the handling of confidential information, i.e. secrets, within the context of couple therapy, some of the questions did, with some surprising results

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(Brock & Coufal, 1989, 1994; Vesper & Brock, 1991). First, regarding confidential information in general, only 29% of therapists reported never inadvertently disclosing confidential information, with 64% reporting that they rarely do, and 7% reporting that they sometimes do. Second, results suggested that 62% of therapists were willing to keep one spouse’s secrets from the other sometimes, often or always. If the secret had to do with an affair, therapists rarely or never revealed the affair to the other spouse 96% of the time. Unfortunately, the study did not assess whether the therapist would encourage disclosure, or even insist upon it. This brings into question whether therapists were actually willing to share in secrets, or if they were simply adhering to their professional organization’s ethical principles related to confidentiality, but also encouraging the secret-holder to disclose the secret to his or her partner. Related specifically to informing one partner of his or her partner’s positive HIV/AIDS-status, the study found that 44% would never tell the partner, while the remainder of the reporting therapists were largely evenly divided between rarely (14%), sometimes (14%), often (9%) or always (18%) telling. Again, there was no further investigation into other ways the therapist might handle the situation such as attempting to encourage the knowing partner to disclose the information him or herself, or contacting the local health department, or how these results correlated to the adherence of ethical guidelines and state laws/statutes related to the handling of such information.

Drecun (2005) researched the policies, procedures and perspectives of mental health practitioners with regard to secrets using a researcher-generated survey. Specifically, the researcher explored the percentage of therapists who
implemented a verbal or written “no secrets” policy in their practice. She also explored preferred procedures related to secrets and therapists’ perspectives pertaining to disclosure of certain types of secrets. However, the study had several methodological weaknesses that may have impacted the validity and generalizability of the reported findings and conclusions. First, the sampling procedure was not random including subjects of opportunity. The volunteer sample was recruited from several, unspecified, professional conferences and continuing education classes in California targeting mental health professionals. Respondents included marriage and family therapists, social workers and psychologists; with over half of the respondents being psychologists and fewer than a third being marital and family therapists. The number of overall attendees at these conferences is unknown. Second, the respondents were few in number and appeared to be both young and relatively inexperienced. Seventy-nine respondents completed the survey. Over one-third of those respondents were under the age of 36 and almost a quarter reported that they were not seeing clients at the time. Additionally, half of the respondents indicated that they had seen fewer than 200 clients in individual therapy and almost two-thirds reported having seen fewer than 50 clients in couple therapy. The following results of the Drecun (2005) study should be regarded with caution given these limitations.

In Drecun’s (2005) study, 53% of respondents reported utilizing a verbal “no secrets” agreement and 42% reported no verbalization of such a policy. Only 14% reported using a written “no secrets” agreement, with 79% reporting putting no such policy in writing. However, the structure of the survey questionnaire did not
allow for therapists to report using other policies regarding secrets, such as “full revelation” or “professional judgment,” or whether these other approaches to handling secrets were verbalized or provided in writing to clients. Thus, it is not possible to determine from the data if the respondents were using other approaches to handling secrets, or if they were using other practices besides verbalizing their “no secrets” policy or putting it in writing.

Other findings of the study indicate that 6% of the respondents reported *always* seeing partners individually in couple therapy, 34% reported *sometimes*, 27% reported *rarely*, and 23% reported *never*. Overall, 14% of respondents reported being *very comfortable* or *comfortable* maintaining a secret between partners in couple therapy, 23% of respondents reported feelings of indifference, and the vast majority (56%) reported feeling *slightly uncomfortable* or *very uncomfortable* keeping a secret.

Drecun (2005) also asked respondents to share their perspectives regarding encouraging or discouraging clients to reveal particular types of secrets to an unaware person in marriage and family therapy. Five scenarios (out of a total of nine) related to couple therapy and the present study. In the first scenario dealing with the secret of a current affair, 84% of the respondents indicated that they would encourage disclosure, while 11% would discourage disclosure. All but one respondent (99%) indicated that they would encourage a couple therapy client to disclose their positive HIV-status to a partner. Eighty-five percent of respondents encouraged disclosure and 11% discouraged it in a situation where a woman revealed to the therapist that her husband was not the biological father of a child of
whom he assumed to be the father. In a scenario involving the loss of a job, 98% of
respondents indicated encouraging a husband to reveal such a secret to his wife.
Finally, in the last scenario 96% reported encouraging a wife to disclose to her
husband that she was at the bar drinking when he thought that she was working
overtime.

While Drecun's (2005) study provides some information regarding the
perspectives of therapists related to specific types of secrets, once again, some of
the data may be confounded and opportunities to gain further insight are lost due to
the ambiguity of the survey questions and the limited information collected. Beyond
the exploration of whether a therapist would encourage or discourage disclosure of
a particular secret to an unaware partner, there is no further investigation in any of
the cases of how the therapist would proceed beyond that point. Would the therapist
reveal the secret to the unaware partner him or herself if the secret-holder was
unwilling? Would the therapist terminate counseling if the secret-holder was
unwilling to disclose the secret? Additionally, in the case of the positive HIV-status
client, there is considerable ambiguity related to the exact relationship between the
two partners (spouse, life-mate, live-in partner), as well as their sexual practices
(protected or unprotected sex).

Finally, Drecun (2005) explored therapists' practices regarding disclosure of
secrets as they relate to ethical standards and legal statutes in California. Eighty-
four percent of respondents indicated that they would maintain a secret if the secret-
holder did not disclose a secret to an unaware partner. With 5% of the respondents
reporting uncertainty, 11% of the respondents reported that they would reveal the
secret without the secret-holder's written permission, notwithstanding that such behavior would contradict most ethical standards and legal mandates. Relatedly, 51% of respondents indicated that they would be more likely to disclose a secret if ethical principles and legal laws/statutes made it acceptable. Other data indicated that 65% of respondents did not agree with California law prohibiting therapists from disclosing a client's positive HIV-status to an identifiable unaware partner having unprotected sex with that client; nor did the majority of therapists (62%) believe that California law protected them in situations where ethical principles and state law did not clearly pertain to their particular situation.

In addition to the descriptive data above gathered in the Drecun (2005) study, between-groups analyses suggested that younger therapists were more likely to encourage disclosure of an affair and issues related to paternity relative to older therapists. Similarly, more experienced therapists were more likely to see partners individually during couple therapy and to feel more comfortable keeping a secret from an unaware partner relative to less experienced therapists. Perhaps the most interesting between-groups differences related to professional licensure. Marriage and family therapists and social workers reported utilizing a verbal "no secrets" agreement more frequently than psychologists (74% and 75%, respectively versus 55%). Marriage and family therapists were also less likely to disclose a secret to an unaware partner even if ethical principles and state statutes supported it relative to social workers and psychologists (33% versus 86% and 60%, respectively).
Studies Related to Secrets Involving HIV/AIDS

With the introduction of HIV/AIDS in the early 1980’s, the world was forever changed. The number of people who have died of AIDS and who are presently HIV-infected is staggering. At the end of 2005, in the United States alone it was estimated that AIDS had killed over one million people. A half million people were living with AIDS and another quarter million were HIV-infected (CDC, 2005). That same year, the prevalence rate in the United States was estimated at 176.2 per 100,000 (CDC). In other areas, especially on the continent of Africa, HIV/AIDS has been even more prevalent, reaching pandemic proportions.

With the increased prevalence of HIV/AIDS has come the greater likelihood that mental health professionals will encounter clients or family members of clients who are HIV-seropositive. Anticipating both the increased prevalence of working with this population as well as the ethical problems related to confidentiality and a “duty-to-warn/protect” likely to face therapists, a number of researchers have conducted studies related to the management of HIV/AIDS-status information.

Some of the first studies conducted in this area were done in the early 1990’s. Totten et al. (1990) used hypothetical vignettes to examine the factors that affected a mental health provider’s decision regarding informing a third party of a danger represented to them by an HIV+/AIDS individual. Their results suggested that the perceived degree of dangerousness of the infected individual was the primary factor used to determine if an identifiable victim should be warned. The study also suggested that persons who participated in prostitution or homosexuality were viewed as more dangerous by therapists, and that therapists who had never
worked with an infected client before were more likely to break confidentiality than those who had. In a similar study, Schwartzbaum, Wheat and Norton (1990) surveyed physicians to explore their decision-making process related to the maintenance or breaking of confidentiality regarding a possible threat presented by an HIV-infected person. Unlike the Totten et al. study, their study suggested that the race and gender of the mental health provider played a significant role in deciding to report, with Caucasian females the most likely to report; while the characteristics of the client did not.

Additional studies by Stewart (1991) and Stewart and Reppucci (1994) examined urban mental health providers' views of the dangerousness of HIV/AIDS clients compared to uninfected clients. The findings of these studies indicated that HIV/AIDS clients were perceived as potentially more dangerous than a client with homicidal ideations, although clinicians were more likely to intervene in cases that involved traditional threats of homicide. Terrell (2001) conducted a similar study of rural practitioners in Missouri with essentially the same results. Finally, Pais, Piercy and Miller (1998) examined the effects of both therapist and client variables on therapists' willingness to break confidentiality when HIV+ clients disclosed high-risk sexual behavior to them. Client variables included age, gender, race, sexual orientation and HIV-status; while therapist variables included age, gender, experience, religious affiliation and practice setting. The results of this national survey of 309 marriage and family therapists suggested that respondents were more likely to break confidence when their clients were male, young, gay or African-American. Therapists who were more likely to disclose were typically older,
female, Catholic, very religious, practiced in urban settings and had less experience working with gay/lesbian populations.

One of the more imperative issues related to a therapist’s decision to maintain confidentiality or break it in order to protect third parties from harm in HIV/AIDS-related situations is whether professional ethical guidelines and state laws/statutes are followed. Two studies suggest that therapists do not do a good job in this area. Johnson (1995) surveyed both physicians and licensed professional counselors in the state of Texas. Results indicated that, while respondents identified ethical guidelines and state laws/statutes as the two most important resources to utilize when making such a decision, therapists were not knowledgeable about Texas’ laws and statutes and inappropriately breached confidentiality in instances when they should have maintained it. Specifically, both therapists and physicians were more likely to inform an endangered third party in instances where the infected client continued to engage in unprotected sex with the unaware partner rather than maintain confidentiality or notify law enforcement or medical personnel. The decision to maintain confidentiality was more frequently made if HIV+ clients reported engaging in “safer sex” with an unaware partner, however. Additionally, nearly a quarter of the therapists reported hesitating to treat HIV+ individuals because of perceived unclear ethical guidelines and state laws/statutes.

A similar, yet more thorough, study by Rein (2000) randomly surveyed 800 subjects who were both APA members and licensed clinical psychologists. The study had a 43% return rate. Results indicated that only 50% of total respondents followed the prescribed ethical guidelines of the APA regarding the maintenance or
breaking of confidentiality related to an HIV/AIDS situation. Respondents were even less likely to adhere to their respective state’s laws/statutes in such cases. For instance, only 34% of the respondents from the state of Florida reported operating within that state’s laws and statutes. A full 44% of the total respondents indicated being uncertain regarding the correct legal action involving issues of notification with HIV+/AIDS individuals.

Rein’s (2000) study yielded a number of other findings relevant to the present study. It suggested that 50% of all respondents discussed confidentiality limitations with clients during the initial interview and as-needed thereafter. Of the remaining half, 15% only discussed the limits during the initial interview, 25% informed clients on an “as-needed” basis, and 5% reported not discussing confidentiality issues with clients. Similarly, 39% of the respondents reported providing confidentiality limits to clients in writing as part of a “Consent to Treatment” form; while 36% indicated documenting discussions in clients’ charts when confidentiality issues arose during treatment and 21% reported utilizing no paperwork related to confidentiality issues.

Additionally, in cases where the therapist had to break confidentiality, 69% of the respondents reported that they believed breaking confidentiality had little or no negative impact on the effectiveness of the work with the client. Twenty-one percent felt that such disclosures had somewhat of a negative impact, and 10% believed their work with a client was greatly affected when they broke confidentiality. Forty-eight percent of all respondents reported needing to disclose client information to others against their own clinical judgment; typically to a third-
party insurer (33%), the law (33%), the courts, (26%), or a supervisor (2%).

Regarding resolving confidentiality issues, 65% reported seeking consultation from various multiple sources. It should be pointed out that the state of Florida has mandatory training for physicians and mental health practitioners in HIV/AIDS confidentiality laws and limits.

Summary

A review of the literature reveals the frequency with which secrets occur in couple therapy and the hazards they can represent. It also suggests the complexity of handling secrets appropriately given the sensitive and possibly dangerous nature of some types of secrets and the confusing and often ambiguous ethical standards and legal mandates to which couple therapists must adhere. These factors make the present study an important inquiry. The next chapter will elaborate on the design of the study.
CHAPTER III

METHODOLOGY AND DESIGN

The purpose of this study was to investigate the policies, procedures and perspectives of couple therapists regarding secrets between partners in couple therapy and the types and frequency of secrets commonly experienced in the practice of couple therapy. Clinical Members of the AAMFT from the five states of California, Florida, Illinois, New York and Texas were randomly recruited to participate in a self-administered, paper and pencil mail survey. The survey consisted of 38 demographic and practice-related questions relating to the handling of secrets between partners in couple therapy. Approximately 15 to 20 minutes was needed to complete the survey. The survey also contained information outlining the research procedure guaranteeing the participant’s anonymity and stated that a returned survey indicated a subject’s willingness to participate in the study and for their data to be used for such purposes by the researcher. The survey and research procedures employed in this study are described in detail below.

Participants

The sample for this study consisted of couple therapists who met the following criteria:

1) Subjects practiced in one of the five chosen survey states of California, Florida, Illinois, New York, Texas.

2) Subjects had experience counseling at least 25 couples.

3) Subjects were Clinical Members of the AAMFT.
The study states were chosen for sampling to meet a number of research criteria that were discussed in Chapter Two. First and foremost, selecting clinicians from these states allowed for representation from all regions of the United States, which in turn, increased the ability to generalize the findings. Moreover, the use of these states allowed for possible between-states comparisons suggesting regional differences in the handling of secrets. Second, because one of the key components of the study relates to the handling of a positive HIV/AIDS-status secret by one partner, it was desirable to survey therapists from states with generally higher populations of such individuals, thus increasing the likelihood that sampled therapists had experience counseling couples dealing with this issue. Based on current statistics, over 53% of all Americans living with AIDS reside in one of these five states (Center for Disease Control and Prevention, 2005). Similarly, it was desired to sample from states with a large number of couple therapists in order facilitate the randomization process and allow for the surveying of sufficient subjects in each state. The selected states have between 291 AAMFT Clinical Members (Illinois), and 1,765 (California). Lastly, it was desired to include states in the study that had both varying confidentiality laws and statutes related to HIV/AIDS, as well as varying continuing education requirements to maintain licensure to, again, determine any between-groups differences in therapist practice as a result of these state variations.

Therapists having counseled fewer than 25 couples were removed from the pool to insure at least a minimal amount of experience counseling couples. While perhaps appearing arbitrary, this number was chosen after consultation with a
number of individuals with considerable experience as both practitioners and leaders in the field of marital and family therapy. Given the population from which the sample was drawn, it was determined to be unlikely that many respondents would fall into this category. Clinical Members of the AAMFT were chosen for surveying because the AAMFT is the primary professional organization serving marital and family therapists in the United States. Additionally, Clinical Members of the AAMFT have completed the requirements designated by the national organization as having competency to conduct couple and family therapy.

Procedure

The researcher purchased a randomized list of Clinical Members of the AAMFT for the five test states. From that list, a random group was selected to comprise the final surveying pool by numbering each of the members and using a random list of numbers. Surveys were then mailed to the identified study population. In order to determine the number of participants necessary to maximize the probability of demonstrating a statistically significant difference between the various groups compared to one another on a number of variables, an a priori power analysis was conducted (Cohen, 1988; Howell, 2002). As there was no way to estimate the required parameters in this study due to a lack of prior research and no standardization of the assessment tool (the researcher-generated survey), Cohen's (1988) proposed set of conventions was used. Adopting a value of $d$ of 0.35 (between a small and medium effect size) and establishing the value of alpha at .05, it was determined that the number of participants needed to provide power equaling .90 for the between-groups comparison with the most stringent parameters.
was 172. Accounting for the typical return rate of 20-35% for questionnaires mailed to mental health professionals focusing on the topic of secrets (Drecun, 2005; Rein, 2000; Terrell, 2001), the total number of subjects randomly selected and solicited for participation was 750, or 150 from each state. However, after the initial mailing produced a lower than expected return rate, another 50 subjects were randomly selected from each state, bringing the total to 1,000.

To insure participant anonymity, surveys were coded in the bottom right corner of the front page prior to being mailed. Upon return, the code was removed from the survey. The surveys were compiled randomly, and the code was used to remove that individual from the master list of subjects. All individual responses and compiled test data were stored in a locked file during data analysis and interpretation. Research results were e-mailed to study participants upon request after the completion of the study. The original results will be kept in a locked file for five years. To facilitate participation, all survey participants were able to choose from three different charities provided by the researcher to which the researcher donated $1 for each completed survey. The charities included the AAMFT Educational Research Foundation, the Foundation for AIDS Research, and Advocates to End Domestic Violence and were chosen because of being related to the study.

The survey informed potential subjects that the purpose of the research was to study the policies, procedures and perspectives of couple therapists as they relate to secrets between partners in couple therapy. The researcher provided potential subjects the option to participate or not in the study as long as they had counseled at
least 25 couples, otherwise they were directed to state so and exclude themselves from the study. If subjects chose to participate, they completed a 38-question survey taking approximately 15 to 20 minutes. A self-addressed, postage paid envelope was provided to return the materials to the researcher. Each survey was stamped with approval for one year by the Western Michigan University Human Subjects Institutional Review Board (HSIRB) for one year.

All subjects were informed of their rights of participation, as outlined by the Western Michigan University HSIRB. Subjects were also informed that participation was voluntary and that minimal distress was expected from their participation. There was no reason to believe that any direct harm would be inflicted from participation in this study. It is possible, but unlikely, that some questions did have the possibility of resulting in mild discomfort if it encouraged subjects to recall negative past experiences or reminded them of some unsatisfactory past or present action on their part. Subjects were provided with the contact numbers of the researchers and the Western Michigan University HSIRB if they had any questions or concerns in this regard. Subjects were also informed that a returned survey indicated consent of participation. They were asked not to sign the survey in order to maintain participant anonymity. Survey data remained confidential and anonymous during the duration of the study. All documents related to the study were secured in a locked file at the primary investigator’s office. As previously mentioned, to encourage participation, subjects were given the opportunity to choose one of three provided charities to which the researcher would donate $1 in their stead.
Instrument: Survey

The instrumentation used for this research was the survey created by the researcher. The survey can be found in Appendix A. The process of creating the survey involved identifying the practices related to handling secrets between partners in couple therapy to be studied, reviewing the literature related to these practices, creating the initial survey, and piloting the survey for content and time. The survey was edited over twenty times based on the feedback of numerous professional educators and practitioners in the field of marital and family therapy, as well as of a professional editor.

Demographic information including age, gender, ethnic background, degree attainment, licensure type, primary professional identity, preferred couple therapy approach, state of licensure, professional organization membership, and level of experience were collected to satisfactorily describe the study participants. Some of this information was also collected for analytical purposes to test the research questions that are listed later in this chapter.

The survey questions related to couple therapist practice were largely generated by the researcher based on the review of the literature in the area of handling secrets between partners in couple therapy, although some questions were modified from those asked in previous studies. The literature reveals three possible approaches to handling secrets (no revelation, full revelation, professional judgment), so item 28 was researcher-generated to determine individual therapist practice in this regard. To determine the influences on and rationale for such a practice, items 29 and 30 were also created by the researcher. Items 31, 32, and 33
were also researcher-generated. Items 31 and 32 explore the frequency with which couple therapists have experienced problems related to how they handled a secret, while item 33 investigates the frequency with which particular secrets are encountered.

Other researcher-generated items include items 16, 20, 26 and 34 and vignette items 35, 37 and 38. Item 16 explores the amount of reported planning that couple therapists put into their personal approach to handling secrets, while item 20 asks subjects to identify any formal training they have had related to handling secrets involving the positive HIV/AIDS-status of a partner in couple therapy. Item 26 explores the frequency with which couple therapists obtain written consent from both partners prior to therapy to share confidential information with the other partner. Item 34 explores the likelihood with which therapists encourage a partner to reveal several different types of secrets to an unaware partner. Vignette items 35, 37 and 38 assess how a couple therapist would handle the respective secrets of infidelity and paternity, addiction, and separation, respectively, with regard to possible partner notification.

Other items of the survey are adapted from previous studies. Items 15, 17, 21, 22, 23, 24, and 25 are adapted from Drecun’s (2005) survey of marriage and family therapists’ procedures, policies and perspectives regarding family secrets. Item 15 examines the percentage of couple cases in which couple therapists see partners individually some time during the course of therapy. This is relevant because the likelihood of being made privy to a secret increases with an increase in this percentage. Item 17 asks couple therapists to identify their comfortableness
with maintaining secrets between partners. Items 21 and 22 explore the likelihood with which couple therapists are willing to divulge a secret, despite both the ethical standards of the professional organization which governs their practice and the laws and statutes of their respective state. Items 23 and 24 explore these practices if the confidentiality limits established by these two governing bodies were made less stringent. Item 25 explores the level of informed consent provided to the couple by the therapist prior to therapy.

Items 18, 19 and 27 and vignette item 36 are all adapted from Rein’s (2000) work assessing how psychologists respond to dilemmas of possible “duty-to-warn/protect” with regard to HIV/AIDS clients. Items 18 and 19 assess the degree to which couple therapists are aware of their state’s laws and statutes and the ethical guidelines of the primary professional organization to which they adhere as it pertains to confidential information about positive HIV/AIDS-status. Similarly, vignette item 35 assesses how a couple therapist would handle the revelation of such a secret with regard to possible partner or local health department notification.

Research Questions for the Present Study

The present review of the literature reveals that there is a paucity of research based on feedback from a large, random sample examining the present policies, practices and perspectives of couple therapists regarding issues related to secrets. Drecun (2005) examined mental health professionals’ policies, perspectives and procedures regarding family secrets using a self-report measure, however the study was severely limited by the number of participants, the sampling method used by the researcher, and the respondents’ lack of therapy experience. Totten et al. (1990),

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Schwartzbaum et al. (1990), Stewart (1991), Pais et al. (1998), and Rein (2000) conducted more rigorous studies of secrets, however these researchers focused exclusively on clinicians' handling of HIV/AIDS-related information. The present study differs from these studies in that it focuses on secrets in general (not just related to HIV/AIDS), only explores secrets between partners in couple therapy (instead of between all types of family members), and attempts to assess the policies, procedures, and perspectives of a larger sample of couple therapists than in previous studies. There are twenty-two research questions pertaining specifically to the handling of secrets between partners in couple therapy guiding this study. The research questions (RQs) are:

RQ-1: What percentage of couple therapists use each of the following three possible approaches (no revelation, full revelation, and accountability with discretion/professional judgment) in managing secrets between partners in couple therapy?

RQ-2: How frequently do couple therapists see partners individually during the course of couple therapy?

RQ-3: How much planning do couple therapists report regarding managing secrets between partners in couple therapy?

RQ-4: What percentage of couple therapists verbally inform a couple about how revealed secrets will be handled? Similarly, what percent of couple therapists inform couples as part of a written professional disclosure statement?

RQ-5: What percentage of couple therapists informs their clients of the limits of confidentiality with regard to positive HIV/AIDS-status?
RQ-6: What percentage of couple therapists obtains written consent from each partner as a means to share secret information with the other should the need arise?

RQ-7: What percentage of couple therapists, based on current ethical guidelines and state laws/statutes, are willing to disclose a secret revealed by one partner to the other without permission if it is their clinical judgment that the secret should be disclosed?

RQ-8: Would couple therapists be more likely to disclose secrets between partners if confidentiality limits were less stringent?

RQ-9: Which factors, including therapeutic practice, consultation, education and supervision, are reported to have the greatest influence on couple therapists’ approach to manage secrets?

RQ-10: Of the ethical, legal, moral and therapeutic considerations that go into determining how a couple therapist will handle secrets, which of these do they deem most important and least important?

RQ-11: What percentage of couple therapists report experiencing couples expressing a concern or making a complaint about how a secret was mishandled by them and/or encountering ethical/legal trouble related to the mishandling of a secret?

RQ-12: To what degree do therapists report being aware of the laws/statutes of the states in which they operate, as well as the ethical code(s) to which they adhere, as they pertain to confidentiality limits and therapist revelation of positive HIV/AIDS-status?
RQ-13: What types of secrets between partners do couple therapists encounter most, and least, frequently?

RQ-14: How comfortable do therapists report feeling about maintaining secrets between partners in couple therapy?

RQ-15: Does the type of secret influence therapists' perspectives about whether it should be disclosed or not to an unaware partner? If so, for which types of secrets are therapists more likely to encourage disclosure and for which types are they less likely to encourage disclosure?

RQ-16: Do couple therapists who implement the approaches of “no revelation,” “full revelation” and “professional judgment” differ from each other significantly with regard to both the total number of years of providing couple therapy and the total number of couples counseled over their careers?

RQ-17: Does a statistically significant difference exist with regard to the frequency with which couple therapists see partners individually during the course of therapy based on the total number of years of providing couple therapy and the total number of couples counseled over their careers?

RQ-18: Does the reported amount of planning regarding how secrets will be handled differ between therapists with regard to both the total number of years of providing couple therapy and the total number of couples counseled over their careers?

RQ-19: Does the reported level of informed consent regarding how therapists will handle secrets between partners in couple therapy differ between therapists
with regard to both the total number of years of providing couple therapy and the total number of couples counseled over their careers?

RQ-20: Does the reported frequency with which therapists obtain written consent from both partners to allow them to share confidential information with the other partner differ between therapists with regard to both the total number of years of providing couple therapy and the total number of couples counseled over their careers?

RQ-21: Do state-mandated continuing education courses in confidentiality law and limits that relate to positive HIV/AIDS-status increase the likelihood of a therapist’s adherence to both state laws/statutes and professional ethical codes?

RQ-22: Do therapists who use a particular approach of handling secrets (no revelation, full revelation, and professional judgment) differ in the amount of legal/ethical problems they encounter related to the disputed handling of a secret?

Statistical Analyses

This study utilized a variety of methods for data analyses. All of the statistics were calculated with the use of Statistical Analysis Software, or SAS. Basic statistics, such as percentages, means, and medians were used to both describe the participants demographically as well as their practices and perspectives related to handling secrets in couple therapy. Confidence intervals (95%) were used to determine whether the study sample was representative of the overall study population by the sample population and, in some cases, to determine whether statistically significant variance existed between groups. For this same purpose,
analyses of variance (ANOVAs) and Pearson chi-square tests were also used. After preliminary tests indicated a significant difference between comparison groups, the Bonferroni-Welch approach to multiple comparisons was used. In a number of instances, the pair-wise multiple comparisons were of mean ranks. Finally, in order to determine whether or not a relationship existed between therapists' experience and seeing partners individually during couple therapy, a Pearson's test of correlation was used. The specific method of analysis used for each research question is also provided with the results in the next chapter.

Summary

In this study, couple therapists affiliated with the AAMFT from five states were mailed surveys asking them to inform the researchers about their policies, procedures and perspectives related to handling secrets between partners in couple therapy. Descriptive data was collected to determine percentages related to how often a secret becomes a part of couple therapy, the individual approach therapists take in dealing with secrets, and the types of secrets encountered. The study also explored the level of informed consent provided by couple therapists, and the frequency both with which therapists required written consent prior to therapy and with which they encountered ethical/legal problems related to the inappropriate handling of secrets. Participants were asked to share their procedures and perspectives related to the handling of secrets in general, as well as to particular secrets such as infidelity, divorce/separation, addiction, and HIV/AIDS-status. Between-groups analyses (ANOVAs and chi-square tests) were conducted to identify any statistically significant differences between couple therapists with
regard to years of counseling experience and the number of couples counseled over their careers on a number of these measures.
CHAPTER IV

RESULTS

The purpose of this study was to examine the policies, procedures and perspectives of therapists related to secrets between partners in couple therapy. This chapter presents the results to the twenty-two research questions investigated in this study.

Survey Response

After the initial 750 surveys were distributed, it was apparent that the return rate would be lower than anticipated so another 50 subjects were randomly selected from each state and another 250 surveys were mailed. Of the 1,000 distributed surveys, eight were returned as undeliverable, resulting in an overall distribution rate of 99.2%. Two hundred and four surveys were returned by respondents for an overall return rate of 20.6%. The response rate distribution by state was 33 of 198 (16.7%) for California, 48 of 199 (24.1%) for Florida, 46 of 199 (23.1%) for Illinois, 38 of 198 (19.2%) for New York, and 39 of 198 (19.7%) for Texas. Of the 204 returned surveys, 5 were returned by respondents indicating that they were retired and 39 by respondents who had not yet conducted couple therapy with at least 25 couples. Subtraction of these unusable surveys from the total returned surveys resulted in 160 usable surveys for data analyses.

Demographics

Demographic questions were asked in the survey to determine the characteristics of the survey participants and to allow for comparisons of the sample population to the entire AAMFT Clinical Member population from which the
sample was drawn. Sample population demographics were compared to those of the population proportions with the use of the articles by Northey (2004a, 2004b) in *Family Therapy Magazine* that compiled the results of various research projects from 1986 to 2004 to establish the best estimate of the present demographic make-up of the AAMFT membership. To establish the representativeness of the sample population by the population proportions, confidence intervals (95%) were used to verify that the sample population was similar to the population proportions on key parameters which characterize the population. Table 1 summarizes the demographic data of the study respondents, as well as their representativeness of the sample population.
Table 1

Statistical Comparison of Sample and Overall Population Demographics

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Population</th>
<th>Sample Estimate</th>
<th>95% Confidence Interval</th>
<th>Conclusion</th>
</tr>
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<tbody>
<tr>
<td>Age (% per Category)</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>&lt;=46</td>
<td>24.51</td>
<td>24.69</td>
<td>(18.05, 31.33)</td>
<td>Match (S, 5%)</td>
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<tr>
<td>47-54</td>
<td>28.8</td>
<td>18.52</td>
<td>(12.54, 24.50)</td>
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<td>55-59</td>
<td>22</td>
<td>17.90</td>
<td>(12.00, 23.80)</td>
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<td>&gt;=60</td>
<td>24.9</td>
<td>38.89</td>
<td>(31.38, 46.40)</td>
<td>Does Not Match</td>
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<tr>
<td>Gender (%)</td>
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<tr>
<td>Female</td>
<td>61</td>
<td>64.20</td>
<td>(56.82, 71.58)</td>
<td>Match (S, 5%)</td>
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<td>Male</td>
<td>39</td>
<td>35.80</td>
<td>(28.42, 43.84)</td>
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<td>Ethnicity (%)</td>
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<tr>
<td>Asian</td>
<td>1.4</td>
<td>1.23</td>
<td>(0, 2.93)</td>
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<td>Hispanic</td>
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<td>White</td>
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<td>91.36</td>
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<tr>
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<td>76.10</td>
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<td>Social Worker</td>
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<td>Counselor</td>
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<td>-</td>
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<tr>
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<td>-</td>
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<td>-</td>
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</tbody>
</table>
The mean age of this study's participants was 54.4, closely resembling the mean age of 54 of AAMFT Clinical Members determined by Northey (2004b). Breaking the age into groups, 11.1% of respondents in this study indicated being "less than 37" years old, 13.6% reported being "37 to 46", 18.5% reported ages from "47 to 54," 17.9% reported ages from "55 to 59," and 38.9% reported being "over 59." The age breakdown of AAMFT Clinical Members compiled by Northey (2004b) indicated at that time that 24.4% were under age 47, 28.8% were from 47 to 54 years old, 22.0% were between the ages of 55 and 59, and 24.9% were over 59 (Northey, 2004). Comparing the age breakdown of the overall AAMFT Clinical Member population to the sample population indicates that that population falls within the expected limits of the sample population at the 95% confidence interval (CI) for both the "under 47" and the "55 to 59" age groups (18.05%<24.5%<31.3% and 12.5%<22.0%<24.5%, respectively). The age group of "47 to 54" is slightly underrepresented in the sample population at 18.5%, which results in a 95% CI of 12.5% to 24.5%, with the overall population purportedly represented by this age group at 28.8%; while the age group of "over 59" is overrepresented in the sample population at 38.9% (95% CI of 31.4% and 46.4%), with the overall population being represented by this age group at 24.9%. There are a number of possible explanations for the apparent increased representation of "over 59" in the sample population data compared to the overall population data collected from 1986 to 2004, with the simplest being that the data used for the overall AAMFT population is three to eleven years old and that AAMFT members have aged, resulting in a larger percentage of the overall population being in the "over 59" today. It is also
possible that more subjects in the "over 59" category responded to the survey because people may reduce workloads in their 60's, leaving more time to fill out the survey compared to their younger counterparts. Differences between age groups with regard to a sense of social or professional responsibility may also have produced the greater response rate of therapists in the "over 59" category. Regardless, the determined discrepancies with regard to age between the sample population and the overall population are small and do not appear to introduce significant doubt about the representativeness of the overall AAMFT Clinical Member population by the sample population.

With regard to gender, 64.2% of the survey respondents were women and 35.8% were men. The overall population percentages of these two indices are approximately 61% and 39%, respectively, meaning that both fell within the 95% CI of 56.8% to 71.6% and 28.4% to 43.8%, respectively (Northey, 2004b). In this study, a vast majority of the respondents were White (91.4%), with Asians, Blacks, and Hispanics/Latinos representing 1.2%, 0.6%, and 3.7%, respectively. The category of "Others," mostly Native Americans, represented 3.1% of the sample population. The work by Northey (2004b) suggested that Whites made up 91% of the AAMFT (within 95% CI of 87.0% and 95.7%), Asians constituted 1.4% of the population (within 95% CI of 0% and 2.9%), Blacks made up 3% of the AAMFT (just outside of 95% CI of 0% and 1.8%), Hispanics/Latinos constituted 2.1% of the AAMFT (within 95% CI of 0.8 and 6.6%) and "Others" made up 2.2% of the AAMFT (within 95% CI of 0.4% and 5.8%). These figures indicate that the Black constituency of the AAMFT was slightly underrepresented in the sample population.
(by approximately five surveys) relative to the most recent 2004 data of the overall AAMFT population. It is speculated that this may be the case because of a lower percentage of Black therapists in the survey states relative to those states not surveyed.

With regard to primary professional identity, 75% of AAMFT Clinical Members identify themselves as marital and family therapists (Northev, 2004b), while 76.1% of the respondents in this study identified themselves as such (within the 95% CI of 69.5% and 82.7%). Data collected by Northev (2004b) also found that 4.6% of AAMFT Clinical Members identified themselves as psychologists, 4.2% as social workers, 5.8% as counselors, 5.4% as clergy, 0.2% as psychiatrists, and 5.7% as “others.” In this study, 5.0% of the respondents identified themselves as psychologists (within the 95% CI of 1.7% and 8.4%), 5.0% as social workers (within 95% CI of 1.7% and 8.4%), 7.6% as counselors (within 95% CI of 3.5% and 11.6%), 1.3% as psychiatrists (within 95% CI of 0% and 3.0%). Clergy were part of “other” in the present study, and therefore cannot be compared to the 2004 data.

Respondents were also asked to provide their one preferred couple therapy approach. To this forced-choice question, most therapists reported using an eclectic or cognitive-behavioral approach (both 18.1%), followed by: systemic-structural (16.8%), brief/solution-focused (11.6%), emotion-focused (8.4%), insight-awareness/psychodynamic (7.1%), Imago (4.5%), experiential-existential (3.2%), narrative (3.2%), integrative behavioral (2.6%), strategic (1.9%), pragmatic-experiential (1.3%). Behavioral, Christian, collaborative language systems, feminist,
and internal family systems approaches were all reported by 0.7% of the respondent population.

In this study, 56.8% of the respondents indicated having a master's degree (M.A., M.S. or M.Ed.), while 43.2% indicated having a doctoral degree (Ph.D., Psy.D., Ed.D. or D.Min.). The Northey (2004b) data indicated that 65.9% of AAMFT Clinical Members had master’s degrees (slightly above 95% CI of 48.7% and 63.9%) and 34.1% had doctoral degrees (slightly below 95% CI of 35.6% and 50.8%). This suggests a slightly greater representation of respondents with doctoral degrees in the sample population of this study relative to the best approximations of the overall AAMFT population. The researcher speculates that this may be the case because those therapists with doctoral degrees better understand the challenges of completing a dissertation study and may be more willing to participate relative to master’s level therapists with no dissertation research experience. Again, differences between groups with regard to a sense of professional responsibility may also exist.

With regard to licensure, all respondents indicated licensure of some form, with 90.7% of the respondents reporting licensure as a marital and family therapist. Northey’s (2004b) work indicated that 84.8% of AAMFT Clinical Members reported being licensed as an MFT (within 95% CI of 85.5% and 94.7%). The percentage of respondents in this study reporting licensure as a professional counselor was 22.8%, followed by: social worker (9.9%), psychologist (4.3%), and psychiatrist (1.2%). These percentages add up to over 100% because 27.7% of respondents indicated dual licensure and 0.6% reported having three licenses.
Respondents were also asked to list their professional organization membership. Despite the fact that all respondents should have reported being an AAMFT member as that was the survey population, only 98.8% did so. The percentage of respondents reporting membership in the APA was 13.8%, followed in decreasing order by: ACA (12.6%), NASW (7.5%), AASECT (5.0%), AMHCA (3.8%), AMA (1.9%), and ApA (1.3%).

Northey (2004b) determined that AAMFT Clinical Members have an average of 20 years of experience in behavioral health and 17 years in marriage and family therapy. The years of experience in both of these categories reported by the respondents in this study were 21.7 and 19.5, respectively. Additionally, the respondents in this study reported seeing an average of 640 clients over their careers, and an average of 45.8 in the last year. Respondents were also asked about their professional experience treating HIV/AIDS clients to determine how the spread of the illness has affected the service rate of this population by couple therapists. The percentage of study participants indicating that they had yet to treat a known HIV/AIDS client was 30.9%, and 45.7% reported having counseled between one and ten such clients. The remainder of the respondents reported having counseled between 11 and 50 HIV/AIDS clients (10.5%), 51-100 such clients (3.7%), and over 100 (9.3%).

Respondents were asked to rank order, from most influential to least influential, any and all professional organization ethical codes guiding their professional practice. A considerable majority of respondents (78.4%) reported that the AAMFT was the most influential professional organization guiding their
practice per the ethical code. The percentage of respondents ranking the AAMFT as the second most influential organization in this regard was 15.4%. Additionally, 7.6% of the respondents ranked the APA as the most influential professional organization guiding their practice, followed by: the NASW (4.3%), the ACA (2.5%), the AASECT (1.2%), the AMHCA (1.2%), and the AMA (0.6%). No respondents rank-ordered the APA as the most influential organization guiding their practice.

Therapist Practice

To gain a better understanding of the clinical practices of couple therapists in 2007, respondents were asked to answer questions about specific practices related to conducting couple therapy. This section discusses the answers to the twenty-two research questions of this study in the order they were articulated previously. All of the statistics were calculated with the use of Statistical Analysis Software, or SAS.

RQ-1: Therapists’ Approach to Handling Secrets

Of primary interest in this study was the approach therapists take in handling secrets between partners in couple therapy. The first research question examined which of the three possible approaches to handling secrets (full revelation, no revelation, or using professional judgment on a case-by-case basis), a considerable majority (57.3%) of the respondents reported taking a “professional judgment” approach to secrets. The remainder of the responding therapists were approximately equally divided (22.3% and 20.4%, respectively) between requiring “full revelation” of all secrets shared in couple therapy and promoting a policy of
"no revelation" of secrets. Discussion of any relationship in the approach used to individual therapists’ years of experience or the number of couples counseled will be addressed later.

*RQ-2: Therapists’ Practice of Seeing Partners Individually*

To answer the second research question, therapists were also asked what percentage of the time they see partners individually some time during the course of couple therapy. Study respondents indicated the following frequencies of cases in which they see an individual within the context of couple therapy: 3.1% reported never seeing an individual partner during couple therapy; 30.9% reported seeing an individual partner in less than a quarter of the cases, 28.4% indicated seeing an individual partner in between a quarter and three-quarters of all cases, and 37.7% reported seeing an individual partner in over three-quarters of all of their cases, with 14.8% reporting that they see an individual partner in the context of couple therapy in all cases.

*RQ-3: Therapists’ Planning for Secrets*

The third research question examined couple therapists’ self-reported level of planning related to managing secrets between partners in couple therapy. Forty-nine percent of respondents indicated *extensive* planning in this regard; 42.9% reported *some* planning; and 8.1% reported *little* planning. No respondents indicated *no planning* regarding how they would handle being informed of a secret in couple therapy by one partner.
RQ-4 & 5: Therapists’ Informed Consent Practices

Professional practice related to informing couples before therapy of one’s approach to handling secrets was also assessed as part of research question four. Respondents were given five choices from which to choose related to their present practice in this regard: a) not addressing how a secret revealed in couple therapy will be handled at all, b) addressing how a secret will be handled after a revelation makes it an issue, c) verbalizing one’s position on how a secret will be handled, d) stating one’s position in writing, and e) providing one’s position both verbally and in writing. A majority of respondents (52.5%) indicated that they only verbalize their position on how they handle secrets. The percentage of respondents reporting that they state their position both verbally and in writing was 24.4%, followed by: addressing a secret only after one has been revealed and it becomes an issue (13.1%), not addressing how a secret would be handled at all (8.1%), and only providing one’s position in writing (1.9%).

In a related research question (five), participants were asked to identify the frequency with which they inform their clients of the limits of confidentiality with regard to a partner’s HIV/AIDS-status. Refer to Table 2 for a summary. The greatest percentage of respondents (57.2%) reported never informing their clients of such limitations. The percentage of respondents indicating that they sometimes inform their clients in this regard was 18.9%, while 4.4% reported that they frequently do so. The second most frequent response to this question (19.5%) was that couple therapists always inform their clients of the confidentiality limits related to HIV/AIDS status.
Table 2

Survey Response Percentages for Four Practice Questions

<table>
<thead>
<tr>
<th>Responses</th>
<th>RQ-5: Do you address confidentiality limits as they apply to HIV-status?</th>
<th>RQ-6: Do you obtain written consent detailing how confidential information between partners will be handled prior to therapy?</th>
<th>RQ-7a: Would you disclose a secret to an unaware partner based on the ethical standards of the professional organization with which identify?</th>
<th>RQ-7b: Would you disclose a secret to an unaware partner based on the legal laws/statutes of the state in which you practice?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Always</td>
<td>19.5%</td>
<td>13.8%</td>
<td>6.9%</td>
<td>8.2%</td>
</tr>
<tr>
<td>Frequently</td>
<td>4.4%</td>
<td>5.0%</td>
<td>6.3%</td>
<td>6.9%</td>
</tr>
<tr>
<td>Sometimes</td>
<td>18.9%</td>
<td>11.3%</td>
<td>22.0%</td>
<td>22.6%</td>
</tr>
<tr>
<td>Never</td>
<td>57.2%</td>
<td>70.0%</td>
<td>64.8%</td>
<td>62.3%</td>
</tr>
</tbody>
</table>

**RQ-6: Obtaining Written Consent to Share Confidential Information**

The sixth research question explored the frequency with which therapists obtain written consent in order to be able to share confidential information revealed by one partner with the second partner. Again, Table 2 can be referred to for a summary. The vast majority of therapists (70.0%) reported that they never use such a practice. Eleven and a quarter percent of the survey respondents indicated that they sometimes obtain written consent of this form, while 5.0% of the respondents indicated that they frequently do. Only 13.8% of the sample population reported always implementing such a practice.

**RQ-7 & 8: Therapists’ Adherence to Ethical Guidelines and State Laws/Statutes**

This research study also explored the frequency with which therapists self-reported adhering to the ethical guidelines of the primary professional organization with which they identified as well as the legal statutes/laws of the state in which they practice in situations that did not qualify under a “duty to warn/protect” (RQ-
7). Without exception, all professional organizations and federal and state systems stipulate that client confidentiality may not be broken in cases that do not meet the criteria of a “duty to warn/protect” without written client consent. Therapists were asked whether they would disclose a secret that did not qualify under a “duty to warn/protect” to an unaware partner in couple therapy based on current ethical guidelines and state laws/statutes if it was in their clinical judgment that it should be shared. Table 2 summarizes the data. The percentage of respondents indicating that they would never disclose a secret in such a situation was 64.8%. The percentage of respondents indicating that they would never disclose a secret based on legal statutes/laws was slightly lower at 62.3%. In contradiction to ethical guidelines and state laws/statutes, 22.0% of respondents indicated that they would sometimes disclose a secret based on ethical guidelines, while 22.6% responded the same based on legal considerations. The percentage of respondents indicating that they would frequently disclose a secret, despite ethical guidelines or legal standards, was 6.3% and 6.9%, respectively. The percentage of respondents reporting that they would always disclose a secret in such a situation, regardless of ethical guidelines and state laws/statutes, was 6.9% and 8.2%, respectively.

This study also examined therapists’ propensities to disclose a secret to an unaware partner in couple therapy based on their clinical judgment if confidentiality limits were less stringent both within professional organization ethical guidelines and state laws/statutes (RQ-8). The percentage of therapists in this study reporting that they would still never disclose a secret in such a situation despite more freedom from ethical guidelines or state laws/statutes is 45.3% and 42.1%, respectively.
Using confidence intervals, this represents a statistically significant 19.5% and 20.2% drop, respectively, from the previous question in these response categories and indicates that, within this study, a significant percentage of therapists would use the relaxed confidentiality limits to reveal a secret if it was their clinical judgment that it should be revealed (0% outside of 8.9% and 30.1%, 0% outside of 9.5% and 30.8%, respectively). The percentage of respondents who indicated one of the other three responses based on both less stringent ethical guidelines and state laws/statutes are as follows: sometimes (35.2% and 39.6%, respectively), frequently (10.7% and 9.4%, respectively), and always (8.8% and 8.8%, respectively).

**RQ-9: Influences on Therapists’ Practices Related to Secrets**

The ninth research question explored the influence of particular experiences on a therapist’s approach to handling secrets between partners in couple therapy. Respondents were asked to rank-order (from 1 to 7) the influence of university courses, internship/practicum training, seminars/conferences, journal articles, therapeutic practice, supervision, and consultation on the development of their particular practices related to managing secrets. To determine any statistically significant difference between these influences, the individual rankings of each of these influences was pooled and a mean was calculated for each experience. These means were then compared using an analysis of variance (ANOVA), yielding a significant F-value of 36.81 with a p-value of <0.0001. Refer to Figure 1 for a summary of the data. Use of the Bonferroni-Welch approach to pair-wise comparisons of the mean ranks based on respondents’ reports indicates that “therapeutic practice” is a statistically significant leading influence in the
development of secrets-related practices with a mean of 2.57. "Supervision" is the statistically significant second most influential experience in this regard ($\mu=3.65$). Reading journal articles represent a statistically significant least influential experience in the formation of secrets-related practices ($\mu=6.28$); while the means of the remaining experiences falling between these three experiences are too close to produce a rank-order that is statistically discernible.

**Figure 1**

Mean Ranks of Experiences Dictating Therapists’ Secret-Related Practices

<table>
<thead>
<tr>
<th>Influence</th>
<th>Mean ($\mu$)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapy</td>
<td>2.57</td>
</tr>
<tr>
<td>Supervision</td>
<td>3.65</td>
</tr>
<tr>
<td>Intern</td>
<td>4.50</td>
</tr>
<tr>
<td>In-Service</td>
<td>4.74</td>
</tr>
<tr>
<td>College</td>
<td>4.81</td>
</tr>
<tr>
<td>Consultation</td>
<td>5.10</td>
</tr>
<tr>
<td>Journals</td>
<td>6.28</td>
</tr>
</tbody>
</table>

Figure 1: Multiple comparisons of mean ranks of influential experiences with regard to therapists' approach to managing secrets between couples. μ’s sharing a common line do not demonstrate statistically significant differences whereas those not sharing a common line differ significantly.

**RQ-10: Therapists’ Rationales for Practices Related to Secrets**

Further exploration into why therapists handle secrets as they do also involved asking therapists to provide a rationale for their approach and practices related to handling secrets in couple therapy (RQ-10). Therapists rank-ordered from most important (1) to least important (4) the four major categories of considerations involved in all practice decisions of therapists, namely ethical, legal, moral and therapeutic. A summary of the data can be found in Figure 2. A statistical analysis similar to the one used in the previous research question involving the use of an
ANOVA and pairwise comparisons using Bonferroni-Welch’s approach yielded an F-value of 45.66 a p-value of <0.0001, indicating that ethical considerations are clearly ranked the most important in the formation of approaches and practices related to handling secrets in couple therapy with a mean of 1.96. A statistically significant difference in means also establishes that moral considerations are ranked the least important (u=3.25). The means of therapeutic and legal considerations (2.25 and 2.44, respectively) were too close to discern a statistically significant difference.

Figure 2

Mean Ranks of Therapist’s Rationales Pertaining to Secret-Related Practices

<table>
<thead>
<tr>
<th>Rationale</th>
<th>Ethical Mean (u)</th>
<th>Therapeutic Mean</th>
<th>Legal Mean</th>
<th>Moral Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethical</td>
<td>1.96</td>
<td>2.25</td>
<td>2.44</td>
<td>3.25</td>
</tr>
</tbody>
</table>

Figure 2: Multiple comparisons of mean ranks of rationales determining therapists’ approach to handling secrets between couples. μ’s sharing a common underline do not demonstrate statistically significant differences whereas those not sharing a common line differ significantly.

RQ-11: Problems Related to the Mishandling of Secrets

In research question eleven, this study also examined the frequency with which couple therapists experience problems related to the mishandling of secrets such as complaints by couples to them or someone else, or encountering ethical and/or legal trouble. In this study, 71.6% of the respondents indicated that they have never had an instance in which a couple raised a concern about how they handled a secret to them or anyone else, while 28.4% indicated that they have experienced such a situation at least one time in their career.
Of the 28.4% of the respondents indicating that a couple has raised a concern with them, just over one-third of them reported that they have encountered only one complaint (representing 9.4% of the entire sample population). Almost one-half of these respondents reported between two and five complaints during the course of their careers (12.6% of the entire sample population); while about 10% reported between six and ten such instances, and another 10% indicated over ten such complaints in their careers. In other words, the percentage of couple therapists of the entire sample population reporting six or more complaints during the course of their entire careers was 5.0%.

Regarding encountering ethical and/or legal problems related to the mishandling of a secret in couple therapy, none of the 160 respondents reported ever having to appear in court or being found guilty of improprieties in a court of law, having to appear before a licensing board or having action taken against them by a board, or having membership within a professional organization terminated for the mishandling of a secret in couple therapy.

RQ-12: Therapists’ Awareness of HIV/AIDS Confidentiality Laws and Limits

The twelfth research question investigated the degree to which therapists report being aware of the ethical codes to which they adhere and their state’s laws/statutes regarding confidentiality limits on HIV/AIDS status information. Therapists were asked to indicate their awareness of the principles and laws governing their practices in this regard using a Likert scale from not aware to extremely aware. Table 3 summarizes the data. Over a third of respondents (37.9%) reported being mostly aware of their state’s laws/statutes pertaining to the
confidentiality of such information, while 33.5% of the respondents indicated being extremely aware. The percentage of the respondents indicating that they were not aware of the laws/statutes regulating their sharing of HIV/AIDS information was 14.9%, and 13.7% reported being somewhat aware. Respondents appeared to be less aware of the ethical principles of their professional organization guiding their practices in this regard, with 28.4% of the respondents reported being extremely aware and 32.1% being mostly aware. The percentage of the respondents indicating that they were somewhat aware of the ethical guidelines related to confidentiality of HIV/AIDS information was 23.5%, while 16.1% reported being not aware at all. Of the five states surveyed, California and Florida have mandatory training in the form of continuing education in confidentiality laws and limits of HIV/AIDS information, while Illinois, New York and Texas do not.

Table 3

Therapists' Reported Awareness of HIV/AIDS-Related Laws and Guidelines

<table>
<thead>
<tr>
<th></th>
<th>State Laws Related to HIV/AIDS-status, Clients &amp; Disclosure</th>
<th>Ethical Standards Regarding HIV/AIDS-status, Clients &amp; Disclosure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extremely Aware</td>
<td>33.5%</td>
<td>28.4%</td>
</tr>
<tr>
<td>Mostly Aware</td>
<td>37.9%</td>
<td>32.1%</td>
</tr>
<tr>
<td>Somewhat Aware</td>
<td>13.7%</td>
<td>23.5%</td>
</tr>
<tr>
<td>Not Aware</td>
<td>14.9%</td>
<td>16.1%</td>
</tr>
</tbody>
</table>

RQ-13: Types of Secrets in Couple Therapy

To gain insight into secrets in the context of couple therapy, this study also explored the types of secrets couple therapists report encountering and the frequency with which different secrets occur (RQ-13). Therapists were asked to rank several types of secrets by how frequently they had encountered them. The list
of secrets included extra-relational affairs, Internet affairs/chatting, wanting a
divorce, money problems/gambling, history of abuse as a victim, history of abuse as
the abuser, sexually transmitted diseases, illness (mental/physical), history of legal
problems, child paternity, drug/alcohol use/abuse, pornography use/abuse, sexual
orientation, and sexual paraphilia practices. The ranks given to each secret by each
respondent were added together and a mean for each type of secret was calculated.
Figure 3 summarizes the results. An ANOVA and a test of multiple comparisons of
the mean ranks using a Welch approach determined, with statistical significance (F-
value of 116.93 p-value of <0.0001), that the most frequently encountered secret by
couple therapists is the "extra-relational affair," with a mean of 2.36. The next most
encountered secret was "wanting a divorce," followed by the secret of an "Internet
affair/chatting." The means of these two secrets (3.44 and 6.58, respectively) both
had a statistically significant difference from the means of the other secrets.
Statistical analyses indicated that the means of the remainder of the secrets were not
significantly different from each other, although the order of them will be provided
for interest’s sake. After the three secrets already mentioned, the secrets reported by
the respondents in decreasing frequency were: history of abuse as a victim,
pornography use/abuse, money problems/gambling, drug/alcohol use/abuse, sexual
orientation, illness (mental/physical), history of legal problems, sexually transmitted
diseases, history of abuse as the abuser, child paternity, and sexual paraphilia
practices.
Figure 3

Mean Ranks of Secrets Encountered by Couple Therapists

<table>
<thead>
<tr>
<th>Type of Secret</th>
<th>Mean ($\mu$)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Affair</td>
<td>2.36</td>
</tr>
<tr>
<td>Divorce</td>
<td>3.44</td>
</tr>
<tr>
<td>Internet</td>
<td>6.58</td>
</tr>
<tr>
<td>Abuse (Victim)</td>
<td>8.60</td>
</tr>
<tr>
<td>Pornography</td>
<td>8.68</td>
</tr>
<tr>
<td>Money</td>
<td>8.79</td>
</tr>
<tr>
<td>Drugs/Alcohol</td>
<td>8.99</td>
</tr>
<tr>
<td>Sexual Orientation</td>
<td>12.25</td>
</tr>
<tr>
<td>Illness</td>
<td>12.38</td>
</tr>
<tr>
<td>STDs</td>
<td>12.79</td>
</tr>
<tr>
<td>Legal</td>
<td>12.86</td>
</tr>
<tr>
<td>Paternity</td>
<td>12.90</td>
</tr>
<tr>
<td>Abuse (Abuser)</td>
<td>12.92</td>
</tr>
<tr>
<td>Paraphilia</td>
<td>13.27</td>
</tr>
</tbody>
</table>

Figure 3: Multiple comparisons of mean ranks of types of secrets encountered most often when working with couples. $\mu$'s sharing a common line do not demonstrate statistically significant differences whereas those not sharing a common line differ significantly.

RQ-14 & 15: Therapists’ Perspectives on Secrets in Couple Therapy

Research question fourteen examined therapists’ level of comfort in maintaining secrets between partners in couple therapy. The percentage of the respondents reporting feeling very uncomfortable about keeping a secret from one partner in couple therapy was 29.2%, while another 38.5% reported that practicing in such a way makes them feel uncomfortable. The percentages of respondents reporting feeling comfortable and very comfortable with maintaining secrets was 18.0% and 8.1%, respectively. Only 6.2% of the respondents reported feeling indifferent with the practice.
Another area of interest related to secrets between partners in couple therapy in this study was whether or not the type of secret influenced therapists’
tives regarding whether a secret revealed to them by one partner should be
disclosed to the unaware partner. For research question fifteen, therapists’
perspectives were assessed in two manners. First, therapists were asked to indicate
the likelihood with which they would encourage a partner to reveal each type of the
previously discussed secrets using a Likert scale ranging from 1 for not at all to 5
for definitely. Second, therapists were given case vignettes that included the issues
of an extra-relational affair, child paternity, HIV/AIDS status, alcohol addiction,
and wanting a separation. For the first form of assessment, a chi-square test of
independence was performed, yielding a highly significant p-value of <0.0001 and
indicating that the type of secret and the degree of encouragement for disclosure
were dependent. An ANOVA using the Welch approach for multiple comparisons
yielded an F-value of 10.85 and a p-value of <0.0001, indicating that therapists
were statistically significantly more likely to encourage disclosure of a secret
related to a sexually transmitted disease, with a mean of 4.66. Differences in the
remainder of the means were not statistically significant from one another, although
the order of the means of the remaining types of secrets from most encouraged to
reveal to least encouraged to reveal are still included here and in Figure 4: sexual
orientation (4.43), drug/alcohol use/abuse (4.35), money problems/gambling (4.33),
wanting a divorce (4.29), sexual paraphilia practices (4.14), illness
(mental/physical) (4.10), pornography use/abuse (4.09), history of abuse as the
abuser (4.09), child paternity (4.06), history of legal problems (3.89), history of
abuse as a victim (3.86), Internet affair/chatting (3.85), and extra-relational affair (3.82). It should be noted that therapists fell heavily on the side of encouraging disclosure of all secrets as all of the means were well above “3,” with “3” representing *somewhat likely* to encourage disclosure, “4” representing *very likely* to encourage disclosure, and “5” representing *definitely likely* to encourage disclosure. It is also interesting to note that two of the three most frequently reported secrets by therapists (the extra-relational affair and Internet infidelity/chatting) ranked as the last two types of secrets of which therapists were most likely to encourage disclosure.

**Figure 4**

Mean Ranks of Secrets Encouraged for Disclosure by Therapists

<table>
<thead>
<tr>
<th>Type of Secret</th>
<th>Mean ((u))</th>
</tr>
</thead>
<tbody>
<tr>
<td>Affair</td>
<td>3.82</td>
</tr>
<tr>
<td>Internet</td>
<td>3.85</td>
</tr>
<tr>
<td>Abuse (Victim)</td>
<td>3.86</td>
</tr>
<tr>
<td>Legal</td>
<td>3.89</td>
</tr>
<tr>
<td>Paternity</td>
<td>4.06</td>
</tr>
<tr>
<td>Abuse (Abuser)</td>
<td>4.09</td>
</tr>
<tr>
<td>Pornography</td>
<td>4.09</td>
</tr>
<tr>
<td>Illness</td>
<td>4.10</td>
</tr>
<tr>
<td>Paraphilia</td>
<td>4.14</td>
</tr>
<tr>
<td>Divorce</td>
<td>4.29</td>
</tr>
<tr>
<td>Money</td>
<td>4.33</td>
</tr>
<tr>
<td>Drugs/Alcohol</td>
<td>4.35</td>
</tr>
<tr>
<td>Sexual Orientation</td>
<td>4.43</td>
</tr>
<tr>
<td>STDs</td>
<td>4.66</td>
</tr>
</tbody>
</table>

Figure 4: Multiple comparisons of mean ranks of types of secrets encountered most likely to receive encouragement for disclosure. μ's sharing a common line do not demonstrate statistically significant differences whereas those not sharing a common line differ significantly.
The second form of assessment of the influence of secret type on couple therapists' prerogatives related to encouragement of disclosure was in the form of four vignettes, as previously mentioned. Results from the individual vignettes will be discussed first, followed by a comparison.

**Vignette One: Affair and Paternity**

The first vignette explored therapists' perspectives related to a situation in which a wife had an affair with one of her husband's co-workers, became pregnant, and was unsure of the child's paternity. The first question related to this vignette asked therapists if they would encourage or discourage disclosure of the affair and pregnancy by the woman if she was willing to end the affair. The percentage of the respondents stating that they would strongly encourage disclosure was 53.3%, 39.6% reported that they would encourage disclosure, and 5.2% and 2.0% reported that they would discourage and strongly discourage disclosure, respectively. Respondents were even more likely to encourage disclosure if the woman was unwilling to end the affair, resulting in the following percentages: strongly encourage (60.4%), encourage (36.4%), discourage (2.6%), and strongly discourage (0.7%). The results collected from this question support the considerable tendency of therapists to encourage disclosure of extra-relational affairs and child paternity issues identified in the results from the previous question. Drecun (2005) got an analogous result in a similar question in that study, with 83.5% of the respondents indicating encouraging disclosure.

In the same vignette, therapists were then asked how likely they would be to break confidentiality limits and reveal the secret to the unaware partner themselves
if the woman was unwilling to reveal the secret herself. A considerable majority (55.6%) of the respondents indicated that the likelihood of them revealing the secret was not at all, with another 27.5% reporting not likely. The percentage of the respondents indicating that it was somewhat likely that they would reveal the secret was 11.9%, with 3.8% reporting very likely and 1.3% indicating definitely. Despite the obvious break in confidentiality represented by the therapist disclosing such a secret to the unaware husband against the wife’s wishes in this situation, one out of six therapists would reveal the secret.

Pertaining to this vignette, therapists were then asked how likely they would refer the wife to another therapist for individual therapy. The greatest percentage of therapists (34.2%) reported that they would definitely refer, followed in decreasing order of percentages by: very likely (31.7%), somewhat likely (19.3%), not likely (8.7%), and not at all (6.2%).

Vignette Two: HIV/AIDS Status

The second vignette in this study describes a situation in which a partner in couple therapy discloses to the therapist being HIV+ without the partner’s knowledge. Drecun (2005) had a similar question in her study and discovered that a vast majority of respondents (98.7%) would encourage the infected partner to disclose the secret to the unaware partner. In this study’s vignette, beyond revealing a positive HIV-status, the infected partner also reveals that the couple is having unprotected sex. Because differentiations between spouses and non-spouses have been made by state law in these situations, therapists were first asked to share their perspectives regarding the disclosure of such a secret to a spouse. Similar to the
Drecun (2005) study, 96.3% of the respondents strongly encouraged disclosure of the secret by the secret-holding partner to the unaware partner. Another 3.1% of the respondents encouraged disclosure, with only one respondent in the study (0.6%) indicating discouraging revelation of the secret. Interestingly, the results were identical when therapists were asked about disclosure to an intimate non-spouse, indicating that therapists do not make a differentiation between spouses and non-spouses in such circumstances.

Therapists were again asked in this vignette how likely they would disclose the secret to an unaware partner (i.e., either a spouse or non-spouse) if the secret-holder refused to do so. In the case of a spouse, the greatest percentage of respondents (27.2%) reported that they would very likely disclose the infected partner's positive HIV-status to the unaware partner. In decreasing order of percentages, the remainder of the respondents reported: not at all (26.5%), definitely (19.9%), not likely (13.3%), and somewhat likely (13.3%). Respondents answered slightly differently for situations involving a non-spouse, resulting in the following percentages (in decreasing order): not at all (27.0%), very likely (25.7%), definitely (18.9%), not likely (16.2%), and somewhat likely (12.2%). These results reveal obvious disagreement, and perhaps confusion, among therapists about how to handle such a situation.

Because some states allow therapists to report the HIV+ status of a client to the local health department if an unknowing partner may be endangered, therapists were also asked if they would contact the local health department in such a situation, again involving either a spouse or an intimate non-spouse. In the case of
an unknowing spouse, 30.1% of the respondents reported that they would *definitely* contact the local health department to protect a spouse. The percentage of the respondents indicating that they were *very likely* to do so was 24.0%, followed by: *somewhat likely* (15.1%), *not likely* (16.4%), and *not at all* (14.4%). Respondents answered similarly in such situations involving a non-spouse, with the following results: *definitely* (29.5%), *very likely* (24.0%), *somewhat likely* (13.7%), *not likely* (17.2%), and *not at all* (15.8%).

It was also desirable to ascertain whether infected partners reporting that they only engaged in "safer sex" with their unknowing partners influenced the perspectives of therapists regarding their urge to inform an unaware partner when the HIV+ client refused to do so. In such a situation involving a spouse, the percentage of respondents reporting each answer is as follows: *definitely* (12.6%), *very likely* (20.5%), *somewhat likely* (14.6%), *not likely* (22.5%), and *not at all* (29.8%). Respondents answered similarly in cases involving an intimate non-spouse, with the following percentages: *definitely* (12.0%), *very likely* (20.7%), *somewhat likely* (14.0%), *not likely* (24.0%), and *not at all* (29.3%). Therapists were also asked whether they would contact the local health department when a client indicated only "safer sex" with an unaware partner, with the following results: *definitely* (21.2%), *very likely* (20.5%), *somewhat likely* (13.3%), *not likely* (24.5%), and *not at all* (20.5%). Due to the wealth of information captured in this one vignette and the need to elaborate on it fully, these results will not be discussed now but rather in the next chapter. Suffice it to say at the present time that
respondents reported very mixed, and perhaps confused, thoughts regarding the handling of a secret related to positive HIV/AIDS-status.

**Vignette Three: Past or Current Alcohol Abuse**

There were two objectives of the third vignette. First, it explored therapists’ perspectives regarding the secret of alcohol use/abuse. Second, it examined whether therapists have different perspectives regarding secrets based on whether the secrets are part of the present, or the past. The third vignette describes a situation in which one partner in couple therapy shares a *past* alcohol addiction with the therapist that is unknown to his or her partner. Therapists were asked whether they would encourage or discourage disclosure of the secret. The majority of respondents (57.3%) indicated that they would *encourage* disclosure, while 38.9% of the respondents reporting that they would *strongly encourage* disclosure. These results were followed by *discourage* (2.6%) and *strongly discourage* (1.3%). Again, therapists were asked how likely they would tell the secret of a past alcohol addiction to the unaware partner if the secret-holding partner refused to share it. A considerable percentage (58.2%) indicated *not at all*, followed by: *not likely* (37.3%), *somewhat likely* (3.3%), and *very likely* (1.3%). No respondents reported that they would *definitely* disclose the secret.

Therapists were then asked how they would respond to the situation if the partner reported *current* drinking problems. Under these circumstances, respondents indicated that they would be much more likely to *strongly encourage* (68.6%) disclosure compared to the alcohol problem being part of the partner’s past. The percentage of the respondents indicating that they would *encourage* disclosure was
30.8%, with only one respondent (0.7%) *strongly discouraging* disclosure.

Inquiring about whether the therapist would reveal a current drinking problem to an unaware partner without the secret-holding partner’s permission revealed that 44.2% would disclose the secret *not at all*, followed by: *not likely* (34.4%), *somewhat likely* (12.7%), *very likely* (7.6%), and *definitely* (1.3%). The results indicate that therapists felt much more favorably about encouraging the secret-holding partner to disclose the *current* secret of addiction compared to the same secret in the *past*. Similarly, therapists were much more willing to disclose the secret of alcohol addiction themselves if the secret was about a *current* addiction instead a *past* one.

*Vignette Four: Intent to Divorce*

The last vignette explores therapists’ perspectives related to one partner in couple therapy secretly wanting a divorce while the other hopes to save the relationship. Therapists were presented with a vignette in which, during individual intake interviews, one partner expresses a desire to save the relationship and the other states that the relationship is unsalvageable. Therapists were first asked whether they would even see the couple together for therapy. A considerable percentage of the respondents (48.8%) indicated that they would *very likely* see the couple. Twenty-one percent stated that they would *definitely* counsel the couple, followed in decreasing order by: *somewhat likely* (16.9%), *not likely* (12.5%), and *not at all* (1.3%). If a therapist agreed to see the couple, they were then asked how likely they would be to encourage disclosure of the one partner’s desire for a divorce to the unaware partner. The percentages of responses were: *definitely*
(41.2%), very likely (37.8%), somewhat likely (12.2%), not likely (5.4%), and not at all (3.4%). The likelihood that the therapist would reveal the secret to the unknowing partner if the secret-holding partner would not resulted in the following percentages: definitely (1.4%), very likely (4.1%), somewhat likely (11.0%), not likely (34.9%), and not at all (48.6%).

Therapists who responded that they were not likely to counsel the couple themselves under the given circumstances were asked how likely it was that they would refer the couple to another therapist for conjoint therapy. Of the respondents who answered this question, 12.5% reported that they would definitely refer the couple to another therapist, followed by responses of: very likely (23.9%), somewhat likely (20.5%), not likely (30.1%), and not at all (12.5%). All of the respondents were asked whether they would also refer each partner to individual therapy. To this question, the percentage of each response was: definitely (14.3%), very likely (31.8%), somewhat likely (34.4%), not likely (16.9%), and not at all (2.6%). Summarizing the results of this vignette, most of the respondents reported that they would see the couple, encourage the secret-holding partner to reveal the desire to end the relationship to the unaware partner, and not reveal the secret themselves if the secret-holder would not. Those therapists who were not likely to see the couple themselves were torn about referring the couple to another therapist for conjoint therapy, although most therapists would refer the individual partners for their own therapy.
Relationships between Therapists’ Experience and Practices Related to Secrets

Another major objective of this study was to attempt to determine whether years of counseling experience or the number of couples counseled was somehow related to particular practices, policies or procedures pertaining to secrets between partners in couple therapy.

RQ-16: Therapists’ Experience and Approach to Handling Secrets

The sixteenth research question asked if couple therapists who implement the approaches of “no revelation,” “full revelation,” and “professional judgment” differed from each other significantly with regard to either the total number of years of providing couple therapy or the total number of couples counseled during their careers. A one-way ANOVA was performed on the count of couples counseled and years of experience doing couple therapy using the approach as the factor. Both of the ANOVAs were insignificant, with an F-value of 1.91 and a corresponding p-value of 0.1523 determined using couples counseled and an F-value of 0.12 with a p-value of 0.8856 using years of experience. Thus, neither years of experience in couple therapy nor the number of couples counseled affected the approach to secrets that is used.

RQ-17: Therapists’ Experience and Seeing Partners Individually

A similar question to the last one was asked regarding the frequency with which couple therapists see partners individually during the course of therapy (RQ-17). The researcher hypothesized that as therapists gain experience and see more couples, they would feel more comfortable seeing partners in couple therapy individually. Conversely, those therapists with less experience and fewer couples
seen would be more likely to want to keep couple therapy simple and avoid being made privy to a secret by only seeing partners conjointly. To test this research question, a Pearson correlation between percentage of clients seen individually and both years of couple therapy experience and number of couples seen was determined. It was determined that there was no statistical evidence in support of a correlation between frequency with which therapists see partners individually and either of the demographic variables, with p-values between percentage of clients seen and both years of couple therapy experience and number of couples counseled of 0.7645 and 0.3368, respectively.

RQ-18: Therapists' Experience and Planning for Secrets

Research question eighteen asked if the reported amount of planning regarding how secrets would be handled differed between therapists on the variables of years of experience and number of couples counseled. A one-way ANOVA was performed using number of couples counseled as the response. Results indicated that significant differences exist among the means of amount of planning (F-value of 3.50 with a p-value of 0.0331). Homogeneity of variance did not exist as verified by the insignificant F-value of 2.93 with a corresponding p-value of 0.0573. A Welch approach to multiple comparisons was used in light of the heterogeneity of variance, indicating that therapists who plan extensively for the revelation of secrets in couple therapy have seen far more couples than those who plan little or some of the time. Results are summarized in Figure 5 below. The same statistical approach was used with years of experience as the response, with statistically insignificant results (F-value of 2.37 and a p-value of 0.0964).
Figure 5

Mean Ranks of Therapists’ Reported Amount of Planning by Number of Couples Seen over Career

<table>
<thead>
<tr>
<th>Amount of Planning</th>
<th>Little</th>
<th>Some</th>
<th>Extensive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean (μ)</td>
<td>145.0</td>
<td>374.56</td>
<td>815.41</td>
</tr>
</tbody>
</table>

Figure 5: Multiple comparisons of mean reported amount of planning performed in regard to the handling of secrets between partners using number of couples counseled as response. μ's sharing a common underline do not demonstrate statistically significant differences whereas those not sharing a common line differ significantly.

RQ-19 & 20: Therapists’ Experience and Consent

Research question nineteen explored whether the reported level of informed consent regarding how therapists handle secrets between partners in couple therapy differed between therapists with regard to both years of experience in couple therapy and to the number of couples counseled over their careers. The same ANOVA procedure used in previous analyses was run, with statistically insignificant results (F-value of 0.18 with a p-value of 0.9461, and F-value of 0.41 with a p-value of 0.7976, respectively). Similarly, research question twenty examined the reported frequency with which therapists obtain written consent from both partners to allow them to share confidential information with the other partner. ANOVA results were insignificant for this test as well, with an F-value of 0.09 with a p-value of 0.9656, and an F-value of 1.49 with a p-value of 0.2208, respectively. Thus, neither years of experience or number of couples seen seemed to influence therapists’ practices regarding obtaining consent about revealing secrets.
Some therapists in this study work in states (i.e., California and Florida) requiring continuing education courses in confidentiality law as it relates to HIV/AIDS information while others do not. The twenty-first research question explored whether state-mandated continuing education courses in confidentiality law as it relates to positive HIV/AIDS-status increase the likelihood of a therapist’s adherence to state laws/statutes. Answers to the second vignette, which was previously discussed, in which a partner with HIV/AIDS in couple therapy was unwilling to reveal his status to an unaware partner was used for this analysis.

Because laws/statutes vary among states, the vignette assessed therapists’ actions in such a situation with the unaware partner as both a spouse and an intimate non-spouse. Based on state laws/statutes, therapists from the states of California, Florida, Illinois and New York are prohibited from revealing such information, making a response of 1 for not at all the only correct response. Couple therapists in Texas are allowed, but not required, to inform a spouse of their partner’s positive HIV/AIDS status in such a situation (making any response acceptable), but not allowed to inform an intimate non-spouse (again, only making a not at all response correct).

Because therapists in New York State are allowed to notify their local health department of a client’s positive HIV/AIDS-status for follow-up partner notification purposes in such a situation, respondents were also asked if they would make such a contact. Any answer to this question was acceptable for New York therapists as notification is permissive but not prescriptive, while only not at all responses were
correct for therapists in California, Florida and Illinois as they are prohibited from divulging such information to the local health department without the client's permission. In accordance with previously mentioned state law, therapists in Texas are permitted (but not required) to inform the local health department of the situation if the partner is a spouse but not if he or she is a non-spouse. Therefore, any response to the question of informing the local health department of the client's positive HIV/AIDS-status is correct in the case of a spouse, but only a not at all response is correct for a case involving an intimate non-spouse.

For statistical analyses of this research question, the respondents were divided into the four groups of no training, voluntary training, mandatory training, and both mandatory and voluntary training based upon their reported training experiences. The cumulative percentages of correct answers demonstrating adherence to state laws/statutes were then calculated for each group for comparative purposes. The assessed percentages of adherence to state laws/statutes for each group, as displayed in Table 4, was: both mandatory and voluntary training (41.2%), mandatory training (40.5%), voluntary training (50.0%), and no training (30.2%). While the assessed adherence rate for the no training group is lower than the other three groups, especially compared to that of the voluntary training group, the use of 95% CIs indicate no statistically significant differences between the means for any of the training groups. Refer to Figure 6 for a visual representation of this data.

After running the statistical analyses above, it was decided that the reported awareness of state laws/statutes of each of the four groups based on training
Table 4

Reported and Assessed Percentages of Aware of HIV/AIDS Law/Statutes by Training

<table>
<thead>
<tr>
<th></th>
<th>Reported</th>
<th></th>
<th>Assessed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Count</td>
<td>%</td>
<td>SE</td>
</tr>
<tr>
<td>Both Mandatory &amp; Voluntary Training</td>
<td>15</td>
<td>88.24%</td>
<td>7.81%</td>
</tr>
<tr>
<td>Mandatory Training</td>
<td>37</td>
<td>88.10%</td>
<td>5.00%</td>
</tr>
<tr>
<td>Voluntary Training</td>
<td>46</td>
<td>92.00%</td>
<td>3.84%</td>
</tr>
<tr>
<td>No Training</td>
<td>15</td>
<td>28.30%</td>
<td>6.19%</td>
</tr>
</tbody>
</table>
Figure 6: Each horizontal line represents a 95% confidence interval for the assessed awareness by training type. A comparison of confidence intervals to determine statistically significant differences is achieved by attempting to draw a vertical line that crosses all confidence intervals (horizontal lines). Applying this methodology to Figure 6 indicates no statistically significant differences in assessed awareness among the four groups of respondents based on reported training type.
experience would be calculated. Table 4 indicates the reported percentage of therapists reporting being either extremely aware or mostly aware of their state’s laws/statutes related to their ability/duty to disclose to a third party the positive HIV/AIDS-status of a partner in couple therapy. A visual representation of this data is provided as well in Figure 7. Statistical analyses provided the following results of percentages of therapists reporting being mostly or extremely aware by reported training experience: both mandatory and voluntary training (88.2%), mandatory training (88.1%), voluntary training (92.0%), and no training (28.3%). A comparison of these percentages indicates that those therapists with any form of training reported considerably greater awareness of their state laws/statutes relative to those therapists with no such training.

RQ-22: Therapists’ Approach to Secrets and Complaints

The last research question (twenty-two) examined whether therapists using a particular approach of handling secrets (no revelation, full revelation, or professional judgment) differed from each other in the reported number of times they (or a supervisor, etc.) encountered complaints from clients regarding the disputed handling of a secret. A one-way ANOVA was performed using the number of concerns as the response. The results indicated that approach to disclosure does not have a significant effect upon the number of concerns voiced. This was verified by an F-value of 1.22 with a p-value of 0.2987.

This study uncovered a wealth of information regarding the procedures, policies, and perspectives of couple therapists related to secrets between partners in
Figure 7: Each horizontal line represents a 95% confidence interval for the reported awareness by training type. A comparison of confidence intervals to determine statistically significant differences is achieved by attempting to draw a vertical line that crosses all confidence intervals (horizontal lines). Applying this methodology to Figure 7 indicates no statistically significant differences in assessed awareness among those respondents reporting any form of training, while the reported awareness of respondents reporting no training is statistically less than the reported awareness of respondents with training.
couple therapy. The next chapter will explore the possible conclusions and clinical implications that can be drawn from this study for the field of couple therapy.
CHAPTER V
DISCUSSION

Secrets between partners in couple therapy are prevalent. Approximately half of all couples who seek counseling do so to deal with the secret of an extra-relational affair (Fine & Harvey, 2006; Glass, 2002; Glass & Wright, 1997; Sprenkle & Weiss, 1978; Vangelisti & Gerstenberger, 2004). Secrets also have the power to destroy a couple’s relationship, and can represent a considerable problem for couple therapists therapeutically, ethically and legally. Proper and effective handling by a therapist of any form of secret between partners in couple therapy is essential in order to provide couples with both the best therapy services possible and the greatest likelihood of benefiting from therapy. It is also imperative for a therapist to be in compliance with ethical and legal codes of conduct.

As already discussed, few research studies have been conducted to-date on secrets between partners in couple therapy and the handling of those secrets by therapists. Only a few researchers (i.e. Brock & Coufal, 1989, 1994; Drecun, 2005) have examined the issue of secrets in therapy in a general sense. Only studies related to HIV and AIDS, with their dire consequences and the complex issues they present for therapists, have produced any significant results into how secrets are handled in therapy (e.g., Johnson, 1995; Pais, Piercy & Miller, 1998; Rein, 2000; Stewart, 1991; Stewart & Reppucci, 1994; Terrell, 2001; Totten et al., 1990). While the importance of HIV/AIDS-related research cannot be understated, research regarding how therapists handle any type of secret, not just one type, should be considered just as important given the frequency with which they occur in couple
and family therapy cases and the considerable damage they can cause. This study attempted to better understand the effects secrets have on the couple therapy process, the policies and procedures used by today’s couple therapists, and their perspectives on specific types of secrets as well as secrets as a whole. For organization’s sake, a discussion of the results of the study will be done by topic, largely following the order in which the research questions and the results were presented in the previous chapters.

Approaches to Handling Secrets

One of the most important decisions therapists make pertaining to secrets between partners in couple therapy is the approach they take regarding what will happen with the secret after it has been revealed to the therapist. Each of the three main approaches of “full revelation,” “no revelation,” and “professional judgment” have their advantages and disadvantages, as previously discussed in Chapters One and Two. It is up to each therapist to decide, based on education, supervision and experience, which of the approaches he or she will utilize.

Not surprisingly, this study discovered that over half of all therapists take a case-by-case “professional judgment” approach to secrets. It was speculated by the researcher prior to the study that this would be the case, given that such an approach affords the therapist the greatest flexibility and maneuverability in the therapy process after a secret has been revealed. The point was made earlier that this approach also allows the therapist to maintain a process-orientation, examining the secret for its effect on the relationship as a secret instead of simply focusing on the content of the secret. This approach, however, does have its limitations. While such
an approach provides the therapist with more freedom and power to respond to the secret's disclosure, this is accompanied by a greater responsibility on the part of the therapist to make the “correct” decision about the possible disclosure of the secret to the unaware partner (Karpel, 1980; Margolin, 1982).

Statistical analyses in this study suggest no relationship between a particular approach to handling secrets and the likelihood of encountering complaints or ethical/legal problems about the mishandling of a secret. In other words, therapists using a “professional judgment” approach do not appear to be more susceptible to the expressed concerns of couples or ethical/legal problems about mishandling a secret anymore than those therapists using “no revelation” or “full revelation” policies. Interestingly, the arguments made by Karpel (1980) and Margolin (1982) that a “professional judgment” approach is inherently riskier than the other two approaches, the results of this study seem to suggest that those therapists using such an approach are no more at risk than those using the other approaches.

An error in judgment using any of the three approaches is more likely than not to have detrimental repercussions. However, it appears that the use of a “professional judgment” approach would require greater confidence in one’s abilities as a therapist compared to the other two approaches. For this reason, one might assume that therapists would have a greater likelihood of using a “professional judgment” approach to secrets with increased experience, assuming, of course, that with more experience comes increased competency and confidence in one’s abilities.
However, the results of this study also suggest that this is not the case. Statistical analyses did not identify a greater propensity for those therapists reporting the use of a “professional judgment” approach to secrets to also report a lengthier career or a greater number of couples counseled relative to those therapists reporting the use of the other two approaches. So if experience in the way of career length or the number of couples counseled has little, if any, bearing on the approach a particular therapist adopts regarding how they will handle secrets between partners in couple therapy, what does?

In an attempt to answer this question, a post hoc analysis seeking a possible relationship between therapists’ preferred therapy approach and the approach they use to handle secrets was conducted. These results should be considered with caution due to the small representation (sample size) of some of the preferred therapy approaches. Additionally, and, perhaps, the greatest confounding factor is that respondents were only allowed to report one preferred therapy approach while they may use multiple approaches. A chi-square test between these two variables produced a chi-square of 26.03 and a corresponding p-value of 0.3518. This insignificant p-value suggests that these two variables are not dependent and that other factors are influencing therapists’ chosen method of handling secrets between partners in couple therapy. Future studies may wish to explore this issue with greater attention to establishing preferred modes of treatment and with greater sample sizes to yield more adequate statistical power.

Because experience neither guarantees confidence nor is a prerequisite for it, perhaps confidence in one’s ability, regardless of age and experience, still comes
into play when a therapist decides how they will handle the disclosure of a secret. A "professional judgment" approach to handling secrets offers the therapist greater influence compared to the use of the other two approaches ("no" and "full revelation") as the therapist is making the decision regarding secret disclosure on a case-by-case basis instead of a rigid "policy" making the decision. Perhaps therapists who believe that "the more influence they have, the better their services are" are more apt to use such an approach. Some therapists may simply choose the "professional judgment" approach because they feel that it offers their clients the best possible service and the greatest likelihood of therapeutic success. It may also be that therapists appreciate the nuances inherent in each particular case and are reluctant to establish and maintain a "full" or "no revelation" policy regarding secrets.

Perhaps a therapist's philosophical orientation on the continuum of support for individual rights versus the greater good of the group also comes into play. It is possible that those therapists who would put the "group before the individual" would gravitate toward "full revelation." Many therapists work from the perspective that in couples therapy, the "client" is the couple, and not the individual partners. Meanwhile, those therapists who fight for the privacy and sanctity of the individual might be more likely espouse a "no revelation" approach. As previously mentioned, therapists may also opt for a "no revelation" approach if they believe that partners will not be forthcoming with relevant information. Education, training and experience are also likely to influence the decision-making process when a therapist contemplates his or her approach to the revelation of a secret in couple therapy. In
summary, the results of this study suggest that something other than preferred therapy approach or experience, or the lack thereof, determine the approach an individual therapist adopts to handle secrets between partners in couple therapy.

Individual Sessions in Couple Therapy

The likelihood of a secret’s disclosure in couple therapy is greatly increased when the therapist sees one or both of the partners individually during the therapeutic process. Drecun (2005) examined this same component of couple therapy practice. In that study, respondents’ tendency to see partners in couple therapy individually were as follows: always (6.3%), sometimes (34.2%), rarely (26.6%), never (22.8%) and unknown (10.1%). In this study, almost an equal percentage of respondents indicated that they were just as likely not to see an individual partner in the course of couple therapy as the percentage of therapists who indicated that they would. A comparison of the results of the present study to that of Drecun (2005) indicate that respondents reported a greater likelihood of seeing partners individually in this study (37.7% reported seeing an individual in over three-quarters of their cases), bringing the findings of the Drecun study into question. As previously mentioned, the differences in results between that study and this one may be attributable to sampling methods.

The results of this study indicate that therapeutic practice with regard to seeing partners individually in couple therapy is quite varied. In an attempt to understand this variance, this study sought statistical evidence suggesting a correlation between the frequency with which couple therapists see partners individually during couple therapy and the number of years of therapy experience,
as well as the total number of couples counseled. The statistical analysis did not indicate any such correlation, implying that practice differences in this regard involve characteristics besides those related to experience.

As an additional post hoc analysis, an ANOVA was conducted to identify a possible relationship between therapists' preferred therapy approach and the frequency with which they see partners individually during couple therapy. Again, these results should be regarded as tentative. First, the small representation (sample size) of some of the preferred therapy approaches makes the statistical results questionable. As previously mentioned, however, perhaps the greatest confounding factor is that therapists were only permitted to report one preferred therapy approach and, while they may use that approach most of the time in most cases, they may also use other approaches.

The initial analysis produced an F-value of 2.52 and a significant p-value of 0.0049. Follow-up analysis using a Least Squares Means approach produced the mean percentage of the time partners are seen individually as a function of each preferred therapy approach displayed in Figure 8. The data suggests that those therapists reporting the use of Integrative Behavioral Couple Therapy and the Imago Relationship Therapy were statistically significantly less likely to see partners individually relative to therapists using other approaches. The respective means in percentage of time partners were seen individually during couple therapy was 24.50% and 25.86% for these two approaches. Figure 8 contains the order of the remaining preferred therapy approaches and their respective means. The category of “Others” contained two therapists indicating the use of Pragmatic-

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Figure 8

Mean Percentage of Time Partners Seen Individually as a Function of Preferred Therapy Approach

<table>
<thead>
<tr>
<th>Preferred Therapy Approach</th>
<th>Mean Percentage (μ)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integrative Behavioral</td>
<td>24.50</td>
</tr>
<tr>
<td>Imago</td>
<td>25.86</td>
</tr>
<tr>
<td>Emotionally-Focused</td>
<td>39.23</td>
</tr>
<tr>
<td>Systemic-Structural</td>
<td>39.62</td>
</tr>
<tr>
<td>Brief/Solution-Focused</td>
<td>45.00</td>
</tr>
<tr>
<td>Strategic</td>
<td>46.67</td>
</tr>
<tr>
<td>Experiential-Existential</td>
<td>53.00</td>
</tr>
<tr>
<td>Cognitive-Behavioral</td>
<td>60.61</td>
</tr>
<tr>
<td>Narrative</td>
<td>64.00</td>
</tr>
<tr>
<td>Others</td>
<td>69.17</td>
</tr>
<tr>
<td>Eclectic</td>
<td>69.50</td>
</tr>
<tr>
<td>Insight-Awareness</td>
<td>72.27</td>
</tr>
<tr>
<td>Behavioral</td>
<td>95.00</td>
</tr>
</tbody>
</table>

Figure 8: Multiple comparisons of mean reported percentage of cases in which partners are seen individually during couple therapy using preferred therapy approach as the response. μ’s sharing a common line do not demonstrate statistically significant differences whereas those not sharing a common line differ significantly.

Integrative Behavioral Couple Therapy (IBCT) is an empirically supported treatment for couple problems developed by Andrew Christensen and the late Neil Jacobson in the 1990’s. It focuses both on the negative behaviors of each partner and the other partner’s emotional reactivity to those behaviors (Jacobson & Christensen, 1998). The fact that those respondents reporting the use of IBCT also reported the lowest frequency of seeing partners individually in couple therapy is confusing because the treatment program, as developed by the originators, calls for
an individual session with each partner during an initial evaluation period (Jacobson & Christensen). This may suggest a misunderstanding on the part of the respondents about what the term "integrative behavioral" meant on the survey or a departure from original IBCT program practices by the responding therapists. Again, the low number of respondents representing this therapy approach introduces the possibility of error into the results, emphasizing the fact that this data should be interpreted with caution.

Imago Relationship Therapy (IRT) is a short-term structured relationship program developed by Harville Hendrix in late 1980's and furthered by the work of Wade Luquet in the 1990's (Hendrix, 1988; Luquet, 1996). Luquet’s version of IRT entails six sessions focusing on developing a couple’s ability to communicate, as well as increasing each partner’s understanding of the purpose of their relationship and ability to both empathize with his or her partner and create a caring environment for his or her partner. As designed, the therapy approach does not include individual partner sessions, reinforcing the lower reported frequency of seeing partners individually by respondents using this approach. However, one may also question why respondents using this approach indicated seeing partners individually, on average, a quarter of the time. Again, these results may be explained by respondents’ departure from intended program practices or statistical error.

Related to preferred therapy approach, one difference between those therapists who are more likely to see partners individually compared to those who are not may lie in each groups’ respective intake practices. Some therapists make a
practice of meeting with each partner in couple therapy individually during intake, while others do not. However, while intake practices may explain the approximately 15% of all respondents in this study who report always seeing individual partners during couple therapy, that leaves 85% of the respondents who see individual partners in only a portion of their cases.

The inconclusive results of the inquiry into therapists’ practices in this regard, unfortunately, generate more questions than they provide answers. Is the variance in practice regarding seeing individual partners during couple therapy a result of therapist characteristics? Because couple therapy is frequently complicated by seeing partners individually, perhaps, again, the difference is a result of therapists’ varying feelings of confidence or competency. Seeing partners individually requires increased attention to the therapeutic alliance with both partners, as this is more easily threatened by individual sessions. While some therapists might argue that individual alliances with partners in couple therapy can be strengthened by seeing them alone, and correctly so, other therapists would argue that it comes at the price of the relationship with the other partner due to jealousy or suspicion. It also requires greater organizational skills and mindfulness on the part of the therapist to keep accurate records of relevant information. Therapists who do not feel confident in their abilities to take on these additional responsibilities may be more prone to only seeing partners conjointly.

The differences in reported therapeutic practice regarding seeing partners individually during couple therapy may also have to do with the characteristics of therapists’ cases. Heitler (2001) has asserted that it is necessary to hold individual
sessions with extremely conflictual couples, thus allowing partners more time to focus on personal symptoms as well as to serve individuals who are frequently shamed by their partner. She also believes that individual sessions may be helpful when each partner’s symptoms trigger the other’s, resulting in a vicious cycle that escalates out of control. Perhaps the cases of those respondents reporting seeing individual partners during couple therapy a greater percentage of the time are qualitatively different from the cases of those therapists who see partners individually infrequently. Most therapists, however, do not see couples for just one particular problem, but see couples for a variety of reasons, making it unlikely that there are actual significant differences in therapists’ cases that would result in the substantial practice differences this study has identified in this regard. More research examining the influences of particular therapy approaches on seeing partners individually or when therapists deem it necessary or beneficial to see partners individually during couple therapy would be helpful. This would best be accomplished by surveying therapists regarding their reasons for seeing partners individually and under what circumstances.

Planning for Secrets in Couple Therapy

Planning is a crucial component to functioning competently and effectively as a therapist. In this study, therapists were asked to share how much planning they do in preparation for the revelation of a secret by one partner in couple therapy. This planning could involve such things as deciding the approach one will take to handle secrets, how and when one will inform the couple of this approach, and whether one is going to obtain written consent from each partner to share
confidential information with the other partner, as well as how and when this might be done. Fifty percent of the respondents in this study reported that they do extensive planning for the revelation of a secret in couple therapy. It is likely that these therapists are well-prepared when a secret becomes an issue in couple therapy. The percentage of the respondents indicating that they do some planning was 42.4%. These therapists, as well, are likely to be prepared in most circumstances. The percentage of the respondents indicating that they do little planning in preparation for the disclosure of a secret to them in couple therapy was 7.6%. Given the many problems that can result from the inappropriate handling of a secret in couple therapy that have been previously discussed, it would appear that these therapists are placing themselves and their clients in jeopardy by not planning sufficiently.

This study also examined whether the amount of planning reported by therapists correlated in some way with therapists’ reported years of experience and the reported number of couples they had seen. Statistical analyses indicated that, while there was no relationship between reported years of experience and reported amount of planning, there was a statistically significant difference in those who reported certain levels of planning and the number of couples seen. This study’s results suggest there is a direct correlation between the number of couples a therapist has seen and the amount of planning he or she does. Therapists who reported having seen significantly more couples also reported considerably more planning, while those who had seen fewer clients reported little planning. This appears to suggest that, with increased experience via the greater number of couples
counseled, therapists learn the importance of being prepared and plan more
diligently for the revelation of a secret. Therapists with less experience would be
wise to take heed the lessons of their more experienced counterparts.

Informing Couples about the Handling of Secrets

One of the most important aspects of conducting therapy is providing
prospective clients with informed consent regarding how the therapy process works,
the likely benefits from therapy, the possible costs of therapy, and, perhaps most
importantly, the confidentiality limits that exist in the therapist-client relationship. It
is essential for the protection of the therapist and the client that both parties
understand and agree to the conditions of the therapeutic relationship, including its
goals and objectives, and its limitations. Therapists should provide this information
as part of a professional disclosure statement to all clients prior to the start of
therapy, and some states may require this. This study examined the level with which
therapists inform clients about how secrets disclosed in couple therapy will be
handled, with disconcerting results. While four-fifths of the study respondents
reported that they provide clients with this information either in writing, verbally, or
in both manners, one-fifth of the respondents indicated that they never discuss the
matter or only do so after a secret has become an issue. Given the great frequency
with which secrets emerge in couple therapy and the significant damage they can
cause, it is alarming to consider that one out of every five therapists does not inform
clients about how secrets will be handled in therapy should they arise.

Of further interest regarding this matter is that an ANOVA was used to
determine whether a relationship between respondents’ reported level of informing
clients regarding how they would handle secrets in couple therapy was related to both years of experience and the number of couples counseled. Statistical analyses determined that a relationship did not exist, meaning that a lack of experience did not necessarily mean that therapists would do a poorer job of providing such information, and more experience did not guarantee that therapists would do a better job in this regard. This implies that other factors besides the number of couples counseled, such as education, training or supervision, are influencing therapists’ practices of informing clients on this matter.

In this study, therapists were also asked to report the frequency with which they inform their clients of the laws and limits of confidentiality related to positive HIV/AIDS-status. Results indicated that over half of all respondents stated that they never address such confidentiality limits, while almost one-fifth of the respondents reported that they sometimes do, and about a quarter indicated that they frequently or always do. One might assume that couple therapists do not address this issue because they never counsel clients with HIV/AIDS. However, subjects were also questioned about the approximate number of such clients with whom they have worked. About one-third of the respondents indicated that they had never counseled an individual with HIV/AIDS, and the other two-thirds indicated that they had. While most respondents who reported counseling clients with HIV/AIDS reported that they had counseled fewer than ten such clients in their careers, about one-eighth of all respondents indicated that they had worked with over fifty. So while over half of all respondents reported never making couples aware of confidentiality laws and limits related to positive HIV/AIDS-status, only one-third of all
respondents indicated never working with such clients, meaning that a quarter of all respondents have had occasion to work with a client with HIV/AIDS without making them aware of HIV/AIDS confidentiality laws and limits. This fact, once again, is a cause for concern. While one might expect that therapists who do not work with clients with HIV/AIDS would not inform them of confidentiality laws and limits pertaining to the disease, one would certainly hope that those therapists who have worked with such individuals and are aware of the probability of such an occasion arising again would include it as part of their informed consent process. The argument could also be made that a therapist never knows when the first client with HIV/AIDS will seek services from him or her, necessitating that all therapists be aware of state laws/statutes and ethical guidelines in this area and have a procedure for informing clients of HIV/AIDS confidentiality laws and limits.

After this initial statistical analysis, it was decided that a possible relationship between therapists’ training experiences and how likely they were to address HIV/AIDS confidentiality laws and limits with their clients would be explored. With the use of an ANOVA, followed by the Welch approach, an F-value of 3.47 with a significant p-value of 0.0177 was determined between the means, indicating a statistically significant difference in the likelihood of informing couples of HIV/AIDS confidentiality laws and limits between those therapists reporting either mandatory ($\mu=2.00$) or voluntary training ($\mu=2.16$) and those reporting no training ($\mu=1.45$). A statistically significant difference did not exist between those reporting no training and those reporting both mandatory and voluntary training ($\mu=1.88$). These results suggest that mandatory or voluntary training increase the
likelihood that therapists will address HIV/AIDS confidentiality laws and limits with clients relative to their counterparts with no training, while those therapists with both forms of training revealed a tendency to do so, but the results were inconclusive.

Obtaining Written Consent to Share Confidential Information

Another interesting research question explored the frequency with which therapists obtain written consent from each partner in couple therapy to share secrets revealed to them with the unaware partner should the need arise. Almost three-quarters of all respondents indicated that they never use such a practice, with a tenth of all respondents indicating that they sometimes do and a fifth reporting that they frequently or always do. The results suggest that such a practice is not commonplace or a part of standard operating procedure in couple therapy practice. It is possible, or even likely, that therapists do not feel the need to obtain such consent if they have informed their clients of their approach to handling secrets. However, as previously mentioned, over one-fifth of all therapists do not address the issue of secrets or how they will be handled at all before beginning therapy with a couple. It could be assumed that these same therapists do not go through the trouble of obtaining written consent to share secrets between partners, meaning that it is likely that one-fifth of all therapists do virtually nothing to protect themselves or their clients from the possible fallout of a secret between partners in couple therapy. Additional statistical analyses in this area indicated that, once again, no significant relationship exists between the frequency with which written consent is obtained and the therapists' experience based on the number of years counseling.
couples or the total number of couples counseled. In other words, less experienced therapists are just as likely to obtain written consent from couples prior to therapy as more experienced therapists, and more experience is not an assurance that this practice will be used. Again, it appears that other factors besides experience are influencing therapists' practices in this regard.

Other data collected in this study related to this topic suggested even greater concern regarding the present practices of some couple therapists. Therapists were asked, based on the ethical standards and state laws/statutes under which they operate, if they would ever disclose a secret not qualifying under a "duty to warn/protect" to an unaware partner in couple therapy without the secret-holding partner's permission if it was their clinical judgment that the secret should be revealed. While approximately two-thirds of all respondents reported that they would never disclose a secret under such circumstances, over one-fifth of the respondents indicated that they sometimes do, and one out of seven therapists reported that they frequently or always do. Drecun (2005) asked a similar question in her study, with 11.4% of respondents indicating that they would disclose a secret based on their clinical judgment if the aware partner refused, 83.5% indicating that they would not, and 5.1% stating uncertainty. A comparison of the two studies suggests a greater likelihood by this study's respondents to not adhere to ethical guidelines and legal laws/statutes by disclosing a secret in cases when the knowing partner is unwilling to disclose the secret and the therapist feels it should be revealed. It should be noted, however, that the response options in the two survey studies varied. The survey question in the Drecun (2005) study required a yes or no
response, while the present study offered the options of never, sometimes, frequently, or always. Respondents who answered never or sometimes in the present study accounted for approximately 87% of the sample population; very similar to the percentage of therapists who responded no (83.5%) to the same question in the previous study.

These data indicate that while two-thirds of all therapists never obtain written consent from each partner to share secret information between partners revealed in couple therapy, one-third of all respondents make a practice of revealing such information. If it can be assumed that the one-third of all therapists reporting that they disclose secrets are the same one-third reporting that they obtain written consent to do so (which would be the best of circumstances), it still leaves a third of all respondents who are disclosing confidential information to an unaware partner in couple therapy without permission despite ethical guidelines and state laws/statutes prohibiting such action.

As would be expected, additional data on this topic indicates that therapists would be even more likely to disclose confidential information under such circumstances if the ethical guidelines and state laws/statutes to which they adhere were less stringent. This is indicated by the statistically significant difference between the proportions of therapists who reported that they would never disclose a secret under the present ethical guidelines and state laws/statutes, and less stringent ones (approximately 65% and 45%, respectively). The greater propensity to disclose a secret based on clinical judgment given less stringent confidentiality limits was also identified in the Drecun (2005) study in which the percentage of
respondents willing to disclose a secret in such instances increased to 50.6%, representing a percent increase of almost 40% relative to therapist practice based on more stringent, actual confidentiality limits. Of course, less stringent ethical guidelines and state laws/statutes would make it more acceptable to disclose confidential information in the form of a secret between partners in couple therapy.

Based on the data of this study, it appears at this time that a considerable percentage of couple therapists may not be taking confidentiality laws and guidelines into consideration sufficiently. This point is supported by other research indicating that the breaking of confidentiality is among the most common improprieties carried out by therapists, frequently resulting in the loss of licensure (Hayman & Covert, 1986; Lindsay & Clarkson, 2000; Pope & Vetter, 1992). As previously mentioned, it may also be that couple therapists view the couple or relationship as the “client,” and thus do not feel as bound on matters of confidentiality as they would with disclosing information from an individual client, or even information from the couple to those outside the therapy. However, such a perspective does not exempt couple therapists from confidentiality laws and limits laid forth by professional ethical codes or state laws/statutes. Focusing on a solution to this problem, a good question to ask at this time would be, “Where should couple therapists be learning the appropriate management of confidential information such as secrets between partners in couple therapy?” While this study may not be able to answer this question fully, it may be able to shed some light on this matter.
Influences on Therapists’ Practices Related to Secrets

This study explored the influence of specific types of educational and training experiences on respondents’ therapeutic management of secrets between partners in couple therapy. Therapists reported that their own experience counseling couples had the greatest influence on their practices related to handling secrets. This was followed by supervision received during their counseling training and careers, as a differentiation was not made between the two on the survey. Statistical analyses via the use of an ANOVA indicated that a statistically significant difference existed between these two influences and all other influences, emphasizing their considerable importance in forming secret-related practices of couple therapists. Reading journal articles represented a statistically significant distant seventh influence, suggesting that they have very little influence with couple therapists in the formation of their practices in this regard. While the statistical differences between the remainder of the influences were not significant enough to provide a guarantee of proper order, therapists reported that, after therapeutic practice and supervision and before journal articles, the most important influences on their therapeutic management of secrets were (in decreasing, but not statistically significant, order): 3) internship/practicum training, 4) in-services/seminars/conferences, 5) university courses, and 6) consultation.

A number of possible implications can be drawn from this data. First, the reliance of couple therapists on their own clinical experience in the formation of their practices related to handling secrets may suggest a number of things. Because therapists are learning from their own experiences and experience is never gained...
“all at once,” the development of procedures and policies for the therapeutic management of secrets may, for most therapists, be a process that occurs over time. It may also suggest that the development of therapists’ procedures and policies regarding the management of secrets is more of a reactionary process, rather than a pro-active process in which a therapist prepares for them before they are encountered. Perhaps, in large part, therapists develop their practices in this regard in response to cases in which they encounter a dilemma or problem related to secrets. If this is the case, it suggests that therapists may be flirting with danger as it only takes one instance of inappropriate behavior to mar one’s entire career, or for that matter, end it.

Second, this study suggests that experiences outside of the educational arena are just as, if not more, influential than those within the school walls. Clinical experience and supervision were statistically more influential than university courses in developing couple therapists’ policies and procedures for management of secrets; while training experiences and in-services were just as influential as university courses. Two possible explanations for this come readily to mind. First, the issue of secrets and their management may not be addressed sufficiently within the curriculums of marriage and family therapy, psychology, social work, or other counseling programs. If this is the case, it would behoove the directors of these university programs to make sure the therapeutic management of secrets is added to the curriculum when the topic of confidentiality is discussed, perhaps within an ethics or marriage and family therapy course. Second, it is possible that, despite the therapeutic management of secrets between partners being discussed at the
university level, respondents did not rank it as a major influence because at that point they did not yet consider themselves therapists. However, once they entered the counseling field as therapists and experienced an actual need for, or application of, an approach to handling secrets, they were sufficiently influenced by clinical experience or supervision to develop one.

The fact that journal articles represent the least influential experience in the development of an approach to handling secrets between partners in couple therapy is also notable. It appears to suggest an uncommon practice on the part of therapists to research matters related to handling secrets possibly due to time and accessibility constraints. The lack of research in this area noted in Chapter Two might also explain this, as there simply has not been much literature published on this topic.

Rationales for Practices Related to Secrets

Another objective of this study was to determine therapists' rationale for their practices related to secrets between partners in couple therapy. Therapists were asked to rank-order the four “umbrella” categories under which rationales generally fall (ethical, legal, moral and therapeutic) from the one they deemed most important to the one they deemed least important. To clarify these four rationales, an ethical rationale would be one based on a professional organization’s ethical guidelines to which a therapist adheres, such as those of the AAMFT, APA, or NASW. A legal rationale would be based on the federal and state laws and statutes under which a therapist operates. A moral rationale would be one based on the “inner compass” of a therapist, perhaps, but not necessarily, derived from a “higher power.” A therapeutic rationale would be one based on a therapist’s expectation of how their
particular approach to handling secrets would likely affect the therapeutic process. While the first three types of rationales are self-explanatory, the last may not be. Examples of therapeutic rationales for handling secrets in a particular manner may include how the therapist’s approach affects the creation of a working alliance with the couple, whether the therapist believes he or she will be able to collect all the pertinent information necessary for a couple’s therapeutic success, or whether a therapist believes revelation of a secret is necessary for a couple to rebuild a relationship. Described succinctly, an ethical rationale is derived from one’s peers and professional organization, a legal rationale is derived from the government, a moral rationale comes from within or from a “higher power,” and a therapeutic rationale is derived from a consideration of the therapy process itself.

Another way of looking at these rationales is by examining the consequences one may experience by engaging in practices that are inconsistent with one or more of the aforementioned rationales. The breaking of an ethical code may result in being reprimanded by or expelled from a professional organization consisting of one’s peers. The breaking of a legality, or law, may result in a fine, revocation of licensure to practice, or even incarceration. The breaking of a moral code may lead to feelings of personal regret or disdain, or feelings of guilt or shame for one’s actions before a “higher power.” The breaking of a therapeutic rationale may result in failure, either in the eyes of the therapist or the couple, of the therapy process.

The results of this study suggest that therapists consider a profession organization’s ethical guidelines as the most important rationale for how they
address secrets in couple therapy. A statistically significant difference in mean ranks indicated that a moral rationale was reported as the least important form of rationale, with a therapeutic rationale and a legal rationale being ranked second and third most important, respectively (although statistical analyses could not verify a statistically significant difference between the means of these two rationales). This data may come as a surprise to some. While one might expect, and hope, to see that therapists report ethical guidelines as playing a key role in the regulating of their practices, given the significantly greater ramifications of breaking the law, one might expect a rationale based on legal grounds to have a greater influence, especially in comparison to a therapeutic rationale. The possible negative consequences of procedures or policies based on a therapeutic rationale that are not unethical or illegal, while undesirable, are still considerably less severe than those resulting from a breach in professional ethics or breaking the law.

The Mishandling of Secrets in Couple Therapy

One of the objectives of this study was to gain a better idea of how frequently couple therapists encounter problems related to their mishandling of secrets between partners in therapy. Previously discussed results suggest that approximately a third of all respondents in this study are not handling secrets correctly based on ethical and/or legal guidelines by conducting such practices as not informing clients sufficiently of policies or procedures prior to therapy or sharing confidential information without permission. This study examined the frequency with which couple therapists experience problems related to the mishandling of secrets such as complaints by couples to them or someone else, or
encountering ethical and/or legal trouble. Noteworthy is that none of the respondents in this study reported experiencing any ethical or legal trouble related to the mishandling of secrets. However, this fact may be related to the sampling method used in this study, which only included Clinical Members of the AAMFT, effectively eliminating from the study any therapists who have lost their licenses or AAMFT membership due to unethical or illegal behavior in this regard. It is also possible that surveyed therapists who have experienced ethical and legal problems did not respond to the study. A study of licensure revocation and professional organization membership termination would provide a better idea of the couple therapists who have acted unethically or illegally in this regard to the point of expulsion from the profession.

Regarding a couple voicing a concern or complaint about how their therapist handled a secret, 71.7% of the respondents in this study indicated that they have never had such an experience, while 28.3% indicated that they have experienced such a situation at least one time in their career. Interestingly, this 28.3% is close to the approximately one-third of all therapists in this study reporting questionable behavior regarding the handling of secrets at other times in the survey.

Of this 28.3%, just over one-third of these respondents reported that they have encountered only one complaint (representing 9.6% of the entire sample population). Almost one-half of these respondents reported between two and five complaints (12.1% of the entire sample population); while about 10% of the respondents reported between six and ten such instances and an additional 10% indicated over ten such complaints in their careers. In other words, one-fifth of all
respondents reported two or more instances in which a couple complained about how they handled a secret in couple therapy, with one out of twenty therapists indicating six or more such complaints.

If clinical practice does have the greatest influence on therapists' policies and procedures regarding the handling of secrets between partners in couple therapy, as other results of this study would indicate, one would hope that a couple therapist would develop and implement them after one incident in which an unhappy couple expressed a concern to avoid a similar situation in the future. It appears that some therapists, albeit a small minority, are not implementing appropriate policies and procedures to deal with secrets between partners in couple therapy effectively.

Types of Secrets in Couple Therapy

While there are innumerable types of secrets intimate partners can keep from each other, there are a handful of secrets that occur frequently in relationships. These secrets bring couples to therapy and frequently end their relationships. To get a better understanding of the types of secrets couple therapists encounter and the frequency with which they occur, respondents were asked to rank-order by frequency the common secrets of an affair, divorce, pornography use, drug and alcohol abuse, physical and sexual abuse, illnesses and diseases, sexual practices, sexual orientation, and paternity they experience between partners. Statistical analyses indicated that three types of secrets are encountered more frequently than all others, the secrets of an extra-relational affair, wanting a divorce, and Internet infidelity/chatting.
That the secret of an extra-relational affair would be at the top of the list of secrets encountered by couple therapists is of no surprise. Repeated research over the last few decades has established the great frequency with which such a secret occurs (Fine & Harvey, 2006; Glass, 2002; Glass & Wright, 1997; Sprenkle & Weiss, 1978; Vangelisti & Gerstenberger, 2004). It also likely comes as no surprise that a partner’s desire for a divorce would also be at the top of the list. Couple therapists are quite familiar with the fact that a considerable percentage of couples do not seek out their services for “marriage” therapy, but rather for “divorce” therapy. However, the fact that the secret of Internet infidelity/chatting would rank as the third most frequent type of secret encountered by couple therapists might come as a surprise to most, although not all, couple therapists.

Despite the fact that Internet infidelity/chatting is a rather recent phenomena, being only a decade or two old, this research supports the findings of other recent studies indicating the growing problem of people using the Internet for sexual gratification outside of a committed relationship (see Cooper, 2002; Cooper, McLoughlin & Campbell, 2000; Maheu & Subotnik, 2001; and Whitty, 2005 for a thorough review). While many types of problems related to the Internet have been identified, including such things as simple overuse, pornography use, gambling, and harassment, research indicates that a considerable portion of these problems (21%) encountered by mental health professionals involve acts of infidelity (Mitchell, Becker-Blease & Finkelhor, 2005). Additional research by Schneider (2000) suggests that up to a quarter of all separations and divorces today are a result of
compulsive cybersex. Another two-thirds of the respondents in that study reported that they lost interest in sex with their partner after engaging in cybersex.

While the necessary skills of practitioners concerning Internet-related problems are still evolving, Mitchell et al. (2005) offer therapists a number of suggestions for clinical practice. First, they encourage therapists to ask pointed questions about Internet use during intake interviews. They also stress the need for therapists to understand the dynamics of problematic Internet-related behavior and how to assess them. This includes: 1) acknowledging and addressing the role clients may be playing in their Internet-related problem, 2) being aware of how these problems may be interacting with more conventional mental health issues, 3) confronting the values and normative issues posed by evolving technology, and 4) having an awareness of how age relates to problematic Internet-related behaviors. These authors also encourage the further education of mental health practitioners and the public alike about problematic Internet-related behaviors, as well as more research in this area. The results of this study support evidence of a growing threat to intimate relationships. It would behoove couple therapists to educate themselves about the secret of Internet infidelity/chatting and develop policies and procedures for handling them effectively should the need arise.

Therapists' Perspectives Regarding Secrets

A major component of this study was to develop a better understanding of therapists' perspectives regarding secrets, including how comfortable therapists reported feeling about maintaining secrets between partners in couple therapy and how the type of secret affected therapists' feelings about disclosure of the secret to
the unaware partner. As might be expected, a majority of the respondents in this study (68%) indicated feeling *uncomfortable* or *very uncomfortable* maintaining a secret between partners. About 6% of the respondents indicated feelings of indifference, and 27% reported being *comfortable* or *very comfortable* with the practice. Drecun’s (2005) study explored this dynamic of couple therapy as well. That study revealed that 45.6% of the respondents were *very uncomfortable* keeping secrets between partners, with another 10.1% reporting being *slightly uncomfortable* with the practice. The percentage of the respondents indicating feeling *neither comfortable nor uncomfortable* maintaining a secret was 22.8%. Only 13.9% of the respondents reported feeling *comfortable* or *very comfortable* keeping secrets between partners in couple therapy.

While therapists were not questioned about their thoughts and perspectives affecting their feelings, we can assume that where therapists fall on the various arguments for and against disclosing secrets previously set forth in this paper come to bear on their comfort level with maintaining secrets. It is likely that those therapists expressing feelings of discomfort over maintaining secrets believe that they need to be revealed for a couple to rebuild trust and move forward in their relationship. These therapists also likely have misgivings about being triangulated by the holding of a secret with one of the partners. Therapists who are comfortable with maintaining secrets probably take a more individualistic approach to couple therapy, and may value full disclosure in order to have a complete picture of what is going on for both partners.
Interestingly, while a considerable percentage of therapists reported feeling comfortable with maintaining a secret between partners in couple therapy, other results from this study suggest that, for the most part, the respondents lean heavily toward the side of encouraging the disclosure of secrets between partners. Respondents reported the likelihood of encouraging disclosure of a specific form of secret on a Likert scale from 1, representing not at all, to 5, indicating definitely encouraging disclosure. The means of all the forms of secrets ranged from a high of 4.65 to a low of 3.81, indicating that even for the disclosure of the secret least likely to be encouraged, respondents still reported being nearly very likely to encourage its revelation. As mentioned in the previous chapter, strong encouragement for the disclosure of a secret was particularly true of those related to a positive HIV/AIDS status (μ=4.65), based on the statistically significant difference in the analyses of this form of secret from all others. It is very likely that therapists were most adamant about the revelation of such a secret due to its potential lethality. Ironically, two of the three most frequently reported secrets by therapists, extrarelational affairs and Internet infidelity/chatting, ranked as the secrets of which therapists were least likely to encourage disclosure. While there seems to be no intuitive reason for why this is the case, perhaps couple therapists become desensitized to these forms of secrets due to the frequency with which they deal with them and, as the secrets lose their novelty and power, therapists are less inclined to feel the need to encourage their revelation relative to other forms of secrets. It might also be that therapists do not find it necessary to reveal short-term or one-time extra-relational sexual encounters in the distant past. Further research
exploring the reasons why couple therapists would be more likely to encourage the revelation of one form of secret over another would help to clarify this conundrum.

Confidentiality, HIV/AIDS, Awareness and Training

The percentage of therapists in this study reporting past counseling work with HIV/AIDS clients (69.5%) is higher than that indicated in the Rein (2000) study of 62.4%, possibly suggesting the increased likelihood of working with this population as the population itself grows. However, it should be remembered that the five study states were partially chosen because of their greater populations of HIV/AIDS individuals in order to increase the likelihood of sampling therapists with experience counseling such clients. Thus, the results of this study may be biased by a sample population that has both more experience counseling HIV/AIDS clients, as well as, perhaps, more knowledge relative to the overall AAMFT Clinical Member population. Regardless, with over two-thirds of all participants indicating counseling experience with at least one client with HIV/AIDS, it appears that couple therapists should prepare themselves for working with such clients. The data would suggest that it may only be a matter of time for those without such experience.

Because HIV/AIDS has become so widespread and it presents considerable challenges to therapists with regard to confidentiality and its limits, a number of research questions in this study focused on secrets related to HIV/AIDS between partners in couple therapy. This study examined both therapists’ reported feelings of self-awareness, as well as their actual awareness, regarding state laws and
statutes related to HIV/AIDS confidentiality laws and limits. It also explored possible relationships between these two things and training.

Respondents in this study reported feeling quite aware of their state’s HIV/AIDS confidentiality laws and limits and how those laws and limits affected their ability to reveal the secret of one partner’s positive HIV/AIDS-status to an unaware partner. Over 70% of respondents reported feeling *mostly aware* or *extremely aware* of their state’s laws/statutes related to their ability/duty to disclose to a third party the positive HIV/AIDS-status of a partner in couple therapy. Approximately 14% of the respondents reported feeling *somewhat aware*, with the same percentage reporting feeling *not aware*. As previously discussed, the percentage of therapists reporting being *mostly or extremely aware* was greatest in those individuals reporting some form of training in HIV/AIDS confidentiality law and limits, and considerably less for those with no such training.

Therapists reported less confidence in their awareness of the ethical guidelines to which they adhere related to their ability/duty to disclose to a third party the positive HIV/AIDS-status of a partner in couple therapy. Only 60% of the respondents felt *mostly aware* or *extremely aware*, with 23% reporting feeling *somewhat aware*, and another 16% reporting feeling *not aware*. The fact that respondents reported a greater feeling of awareness of their state’s laws/statutes over the professional ethical code(s) to which they adhere is an interesting one in light of the fact that respondents also endorsed ethical rationales as being more important than legal rationales in the handling of confidential information in the form of secrets. It appears that therapists are more inclined to rely on their state’s
laws/statutes, rather than ethical guidelines, when handling confidential information in the form of positive HIV/AIDS-status, as they should. The point was made previously that all professional organization ethical codes defer to federal and state laws/statutes in the case of a discrepancy between the two. It should also be reiterated here that the AAMFT code of ethics does not specifically address disclosure issues related to HIV/AIDS-status.

Despite the fact that approximately 90% of the respondents with some form of training in HIV/AIDS confidentiality laws and limits indicated being mostly aware to extremely aware of their state’s laws/statutes and their professional organization’s ethical code regarding HIV/AIDS confidentiality laws and limits, statistical analyses indicated that only 41% of the respondents responded correctly to the vignette question in which a partner with HIV/AIDS in couple therapy was unwilling to reveal his status to an unaware partner and therapists were asked if they would do so. Only 25% of the respondents answered this question correctly in the case of an intimate non-spouse. In the question asking therapists if they would contact the local health department under such circumstances, 46% of the respondents answered correctly in the case of a spouse, while only 29% answered correctly in the case of a non-spouse.

A substantial component of this study was that, while it examined therapists’ reported feelings of awareness regarding HIV/AIDS confidentiality laws and limits, it also assessed their actual awareness with the use of specific case vignettes. Both reported and assessed awareness were reported in the previous
chapter. However, at that time, no comparisons between these two forms of awareness were made. This will be done now.

Table 5 reviews the data reported in Table 4 regarding the reported and assessed awareness of respondents of their state laws/statutes related to their ability/duty to disclose to a third party the positive HIV/AIDS-status of a partner in couple therapy. An overview indicates that about 90% of therapists with any form of training in HIV/AIDS confidentiality law and limits report feeling mostly or extremely aware in this regard, while only 28% of therapists with no training report feeling this level of awareness. The table also portrays the assessed awareness again, which is 32% for those respondents with no training, about 40% for those with mandatory training or both mandatory and voluntary training, and 50% for those with voluntary training. What Table 5 portrays that Table 4 does not, however, is a comparison of reported and assessed awareness by group based on training experience. A visual representation of this data is also provided in Figure 9.

Table 5 indicates that, for those therapists reporting any HIV/AIDS confidentiality training, there is a statistically significant difference between reported awareness of HIV/AIDS confidentiality laws and limits and assessed awareness. This is revealed by the fact that 0% does not lie within the 95% CIs of reported minus assessed awareness for these groups (0% outside of 19.10% to 75.02%, 29.84% to 65.4%, and 26.23% to 57.77% for both mandatory and voluntary training, mandatory training, and voluntary training, respectively). In other words, these therapists report that they are aware of HIV/AIDS confidentiality laws and limits, however, this knowledge is not demonstrated in the application of
Table 5

Percentages of Reported Awareness, Assessed Awareness, and Reported-Assessed Awareness of HIV/AIDS Laws/Statutes by Training

<table>
<thead>
<tr>
<th></th>
<th>Reported</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Count</td>
<td>%</td>
<td>Count</td>
<td>%</td>
<td>Estimate</td>
<td>Standard Error</td>
</tr>
<tr>
<td>Both Mandatory &amp; Voluntary Training</td>
<td>15</td>
<td>88.24%</td>
<td>7</td>
<td>41.18%</td>
<td>-5.47%</td>
<td>14.27%</td>
</tr>
<tr>
<td>Mandatory Training</td>
<td>37</td>
<td>88.10%</td>
<td>17</td>
<td>40.48%</td>
<td>47.62%</td>
<td>9.07%</td>
</tr>
<tr>
<td>Voluntary Training</td>
<td>46</td>
<td>92.00%</td>
<td>25</td>
<td>50.00%</td>
<td>42.00%</td>
<td>8.04%</td>
</tr>
<tr>
<td>No Training</td>
<td>17</td>
<td>28.30%</td>
<td>17</td>
<td>32.08%</td>
<td>-2.00%</td>
<td>8.91%</td>
</tr>
</tbody>
</table>
Figure 9

95% Confidence Intervals for the Differences between Reported and Assessed Awareness of HIV/AIDS State Laws/Statutes Stratified by Type of Training

Figure 9: Each horizontal line represents a 95% confidence interval for the difference between reported and assessed awareness by training type. A comparison of confidence intervals to determine statistically significant differences is achieved by attempting to draw a vertical line that crosses all confidence intervals (horizontal lines). Applying this methodology to Figure 8 indicates no statistically significant differences in assessed awareness among those respondents reporting any form of training, while the reported awareness of respondents reporting no training is statistically less than those with training. Also, the figure indicates that respondents with any form of training reported more awareness than was assessed (the confidence intervals of these groups do not contain 0%). There was no statistically significant difference between reported and assessed awareness for those respondents with no training (the confidence interval includes 0%).
such knowledge in the case vignette. Whether this is because respondents exaggerated their knowledge or they choose to disregard this knowledge in their actual practice is unknown.

Statistical analyses of the therapists with no training in HIV/AIDS confidentiality laws and limits indicated that this group reported both a low level of awareness as well as demonstrated a low level of assessed awareness. With this group, the reported and assessed awareness were within statistical parameters (0% within reported-assessed awareness CI of -19.46% and 15.46%) to suggest that respondents with no training had a more realistic self-assessment of their knowledge in this area. It should be remembered that this group had only a 28% assessed awareness rate, while the other groups, while not much better, had 40%-50% rates.

The data on the relationship between training in HIV/AIDS confidentiality laws and limits and the reported and assessed awareness of respondents by training experience suggest an important point. Those therapists reporting awareness of confidentiality laws and limits due to HIV/AIDS training but who are not demonstrating it appear to be placing themselves at risk. If these therapists perceive their self-knowledge incorrectly, they may believe that they are practicing ethically and legally, when, in fact, they are not. It is also possible that these therapists know how to act ethically and legally, but are choosing not to do so. Either case can be a dangerous situation. The percentage of HIV+/AIDS clients seen by respondents according to training experience was calculated, revealing that almost 90% of all such clients are seen by therapists who report some form of training. This suggests
that the vast majority of counseling of clients with HIV/AIDS occurs under the above circumstances. One implication of this finding is that HIV/AIDS confidentiality training courses, if they are not already doing so, may want to incorporate an assessment component to program to insure that participants can apply their new knowledge.

Study Limitations

Like all studies, this one is not without its limitations. A good return rate and a large sample size increase the likelihood that those who choose to participate are representative of the entire population, in this case therapists practicing couple therapy. One limitation of this study is its relatively low return rate compared to those of other survey studies done in the area of secrets in couple therapy. The low return rate makes it necessary to interpret the statistical results with caution, particularly of the post hoc analyses. It is speculated that the return rate was affected by the length of the survey. A power analysis established a goal sample size of 172 analyzable surveys. Based on the return rates of other studies, it was speculated that 750 surveys would need to be disbursed. After the initial 750 surveys were distributed, it was apparent that the return rate would be lower than anticipated so another 50 subjects were randomly selected from each state and another 250 surveys were mailed. At the end of the study, the overall response rate was 20.6%. Of the 204 returned surveys, 44 were returned by respondents indicating that they were retired or had not yet conducted couple therapy with at least 25 couples. Subtraction of these unusable surveys from the total returned surveys resulted in 160 usable surveys for data analyses, about 7% fewer than was
hoped. While the sample size is only slightly smaller than desired, all results should be interpreted with some caution.

Another major limitation of this study is that it is based on voluntary participation. While the sample used in this study was chosen randomly from an already random sample of Clinical Members of the AAMFT, participants were self-selected in returning a completed survey. Thus, the sample population may differ demographically from the entire population, although statistical analyses conducted in this regard suggest otherwise. It is also possible that therapists who volunteered to participate in the survey provided results that are quantitatively different from those who declined to participate. Additionally, the study only used AAMFT Clinical Members from five states, with no representation from other professional organizations or other states. As previously mentioned, based on the greater HIV+/AIDS populations in the study states, the results of this study may be biased by therapists with more experience working with such clients.

Couple therapists who have had their membership terminated by the AAMFT for unethical behavior, and perhaps who have also lost their licensure, were also excluded from this study due to the sampling procedure used. This could result in the reporting of fewer legal and ethical problems related to secrets. Based on these considerations, how well the results generalize to couple therapists in the United States and their policies, procedures and perspectives as a whole is unknown.

This study is also limited by the fact that the survey is a self-report, asking participants to recall past events and make approximations. The possibilities of
participants not correctly recalling information or altering responses, perhaps for the purpose of putting themselves in a more favorable light, also introduced error to the study. It should also be kept in mind that the survey itself has unproven reliability and validity. Participants’ responses may not reflect their actual practices due to mistaken translation or interpretation of the survey questions.

The potential for error from these limitations cannot be ignored. Regardless of these limitations, however, this study remains important. It provides insight into therapists’ policies, procedures and practices related to secrets between partners in couple therapy, as well as the experiences that form them and the rationales that support them. This study also sheds light on therapists’ perspectives regarding specific secrets and how these perspectives impact clinical practice. Additionally, it increases our understanding of therapists’ knowledge of state laws/statutes and ethical guidelines related to secrets, and the effects of training on this knowledge. Finally, this study provided information on the types of secrets encountered in couple therapy and the frequency with which they occur.

Implications for Further Research

While this study has added to the body of knowledge about therapists’ policies, procedures and perspectives regarding secrets between partners in couple therapy, further research is needed. This study has raised a number of questions for future inquiries. First, while this study identified the percentage of therapists using a “no revelation,” “full revelation,” and “professional judgment” approach to secrets between partners in couple therapy, future research might examine why individual therapists endorse a particular approach. Such research may be most effective using
a qualitative design as it would allow therapists to expound upon their individual reasons for the approach they use. Second, therapists' reported frequency of seeing partners individually in couple therapy was extremely varied. Future research exploring when and why couple therapists see partners individually may help explain this observation. Third, this study suggests that training in HIV/AIDS confidentiality laws and limits affects therapists' perceived awareness but not their assessed awareness related to disclosure of this form of confidential information. Future research might explore the reasons for this phenomenon, as well as identify a solution that would lower the percentage of therapists engaging in unethical and/or illegal practices.

Fourth, it appears that this study's results pertaining to the frequency with which therapists experience ethical or legal repercussions for mishandling a secret were tainted by the study design. By limiting the possible participants to AAMFT Clinical Members, any couple therapists who have had their membership terminated, and likely their license revoked, were effectively excluded from the study. Future research may wish to study this population of couple therapists to both determine the types of inappropriate behavior resulting in their license revocation and/or membership termination, as well as the respective frequencies of these misdeeds. Such a study, albeit difficult to undertake, would provide a better idea of the frequency with which the mishandling of a secret results in these two consequences.

Finally, given the importance of the therapeutic alliance, the possible effects of therapists' use of each of the three approaches to handling secrets or other
policies and practices related to handling secrets might have on the development of the therapeutic alliance might also be explored. Results of such a study would likely be helpful in assisting couple therapists in identifying and implementing policies and procedures that would promote the therapeutic alliance and, thus, increase the likelihood of therapeutic success.

General Conclusions

The results of this dissertation study provide insight into therapists' policies, procedures and perspectives regarding secrets between partners in couple therapy. Results suggest that most therapists plan considerably for dealing with secrets, implement a "professional judgment" approach, and inform clients verbally of this approach. Approximately only a quarter of respondents indicated ever having a couple make a complaint or raise a concern about the mishandling of a secret, although one out of twenty respondents indicated such an occurrence at least six times in their careers. Therapists' approach to handling secrets did not appear to have an effect on the frequency of complaints or concerns.

In the formation of policies and practices related to handling secrets between partners in couple therapy, most therapists report their own clinical experience and supervision as being the most influential. They also report that their rationale for how they handle secrets is supported by ethical considerations more than therapeutic, legal or moral considerations.

Study respondents indicated that the types of secrets most frequently encountered were the extra-relational affair, wanting a divorce, and Internet infidelity/chatting. A considerable majority of couple therapists are uncomfortable
with the practice of keeping secrets between partners. This is especially true when
the secret pertains to the positive HIV/AIDS-status of one of the partners.
Therapists appear to vary greatly in the frequency with which they see individual
partners in couple therapy, a practice that makes them more susceptible to being
“brought in” on a secret.

The experience of a couple therapist considered either by years of
experience or the number of couples counseled does not appear to have a
relationship to: 1) the approach utilized in handling secrets, 2) the frequency with
which they see partners individually during couple therapy, 3) the level of informed
consent provided to couples, or 4) the frequency with which written consent to
share information between partners is obtained. Study results did indicate a
propensity for greater planning regarding how to handle secrets between partners in
couple therapy for those therapists who have seen more couples.

Most therapists do not inform their clients of HIV/AIDS confidentiality
limits or obtain written consent from each partner to share confidential information
with the other partner. A majority of couple therapists report adhering to their
professional organization’s ethical guidelines and to their state’s laws and statutes
by maintaining confidentiality while handling secrets, and would be more likely to
break confidentiality if such limits were less stringent. In the case of confidentiality
laws and limits pertaining specifically to positive HIV/AIDS-status, most
respondents reported feeling mostly or extremely aware, although this awareness
was not demonstrated in the study’s vignettes assessing clinical practice. Training
in HIV/AIDS confidentiality laws and limits only appeared to have an effect on the
reported awareness of the respondents, but not on actual therapist practice. This suggests that couple therapists should not only educate themselves about ethical and legal policies and practices related to handling confidential HIV/AIDS secrets, or any secret for that matter, but implement them as well. To maintain the profession's prestige and respect, couple therapists must continue to strive for, and exhibit, professional standards and guidelines above reproach.
Appendix A

Research Study Survey
Therapists’ Handling of Secrets between Partners in Couple Therapy

Dear Couple Therapist,

Secrecy between partners in couple therapy can pose a considerable challenge to a therapist who may be forced to handle the revelation of information by one partner that is unknown to the other. A therapist can manage this potentially tenuous situation in any number of ways. I am conducting a nationwide survey of couple therapists to investigate how the revelation of secrets between partners is handled. It is my hope that this survey will better inform those practicing and receiving training in couple therapy, thereby improving our counseling services. You are invited to help in this research project being conducted as part of a Ph.D. dissertation.

This study is approved for one year by the Western Michigan University Human Subjects Institutional Review Board as of 8/02/2007 as indicated by the stamped date and signature of the board chair in the upper right corner. Do not participate in this study if the stamped date is older than one year. This project is neither endorsed nor supported by any state or national association. Individual anonymity of respondents will be maintained by the researchers via the use of a coding system, so please do not put your name anywhere on the survey. Survey data will be kept in a locked cabinet for up to five years, after which time it will be shredded. Please answer the following questions about your practice related to secrets to the best of your ability. The 38-question survey has been created for ease of completion and should take 15 to 20 minutes to complete. While participation has limited risks and is not likely to cause any discomfort, should you have any questions or need additional information, please contact the student investigator, Michael A. Jansen, M.A., Western Michigan University, 2617 Willa Dr., Saint Joseph, MI 49085, (231) 578-9523, michael.jansen@wmich.edu, or the primary investigator, Alan Hovestadt, Ed.D., Western Michigan University, Department of Counselor Education and Counseling Psychology, 3102 Sangren Hall, Kalamazoo, MI 49008, (269) 387-5100, alan.hovestadt@wmich.edu. You may also contact the Western Michigan University Human Subjects Institutional Review Board Chair at (269) 387-8293 or the Vice President for Research at (269) 387-8298 if questions or problems arise during the course of the study.

Your participation is voluntary and you may refuse to participate or withdraw at any time, or refuse to answer any question without prejudice, penalty, or risk of any loss. Returning the survey indicates your consent for use of the answers you supply. The results of this study may be published in professional and/or scientific journals, as well as used for educational purposes or for professional presentations. Individual subjects, however, will not be identified. To encourage participation, the researcher will donate $1 for each returned survey to the one charity of your choice from the three indicated at the end of the survey. Study results will be sent via e-mail to participants upon request. Please place a check mark next to the statement below and return the survey uncompleted if you have not conducted couple therapy with at least 25 couples.

I have not conducted therapy with at least 25 couples. Please exclude me from the study.
DEMOGRAPHIC INFORMATION (Please fill in the blank/circle best answer(s).)

1. Age: __________  
2. Gender: a) Female  b) Male

3. Ethnic Background: a) Asian  b) Black  c) Hispanic/Latino(a)  d) White  
   e) Other (please specify) ______________

   f) M.S.W.

5. Licensure Type (Please circle all that apply.):
   a) Marital/Family Therapist  
   b) Social Worker  
   c) Psychologist  
   d) Psychiatrist  
   e) Professional Counselor  
   f) Other (please specify) ______________

6. Primary Professional Identity (Please circle just one.):
   a) Marital/Family Therapist  
   b) Social Worker  
   c) Psychologist  
   d) Psychiatrist  
   e) Professional Counselor  
   f) Other (please specify) ______________

7. Professional Organization Membership (Please circle all that apply.):
   a) AAMFT  
   b) NASW  
   c) AASECT  
   d) ACA  
   e) AMA  
   f) AMHCA  
   g) ApA (American Psychiatric Association)  
   h) APA (American Psychological Association)  
   i) Other(s) (please specify) ______________

8. Preferred Couple Treatment/Therapy Approach (Please circle just one.)
   a) Behavioral  
   b) Brief/Solution-Focused Therapy  
   c) Cognitive-Behavioral  
   d) Emotionally-Focused Therapy  
   e) Experiential-Existential  
   f) Imago  
   g) Insight-Awareness/Psychodynamic  
   h) Systemic-Structural  
   i) Strategic  
   j) Integrative Behavioral Couple Therapy  
   k) Narrative  
   l) Other (please specify) ______________

9. Please rank order, from most influential to least influential, any/all professional
organization ethical codes that guide your professional practice. Assign the code you adhere to
the most with the number 1, the second most with the number 2, and so on. Assign a 0 to all
ethical codes to which you do not specifically adhere. (It may be easiest to first go through the
list and assign 0’s to those codes that do not guide your practice, and then rank-order those
remaining.)

   a) ______ AAMFT  
   b) ______ NASW  
   c) ______ AASECT  
   d) ______ ACA  
   e) ______ AMA  
   f) ______ AMHCA  
   g) ______ ApA (American Psychiatric Association)  
   h) ______ APA (American Psychological Association)  
   i) ______ Other  
   j) ______ Other
10. Total years providing any form of counseling/therapy:__________

11. Total years providing couple counseling/therapy:__________

12. Approximate number of couples counseled over career:__________

13. Approximate number of couples counseled the past 12 months:__________

14. Approximate number of HIV-positive clients counseled__________

COUNSELING PRACTICE RELATED TO SECRETS (Please fill in the blank/circle best answer(s). Do not make any other comments on the survey.)

For the purposes of this study, a “secret” is defined as “any information being withheld that directly affects the well-being of an individual or his or her relationship with a significant other.”

15. In approximately what percentage of your couple cases do you see partners individually some time during the course of therapy? ________% 

16. With respect to conducting couple therapy, how much planning have you done regarding how you would handle being informed of a secret by one of the partners?

   a) None   b) Little   c) Some   d) Extensive

17. In general, how comfortable do you feel maintaining secrets between partners when engaging in couple's therapy?

   a) Very comfortable  b) Comfortable  c) Indifferent  d) Uncomfortable  e) Very uncomfortable

18. To what degree are you aware of your state’s laws/statutes related to your ability/duty to disclose to a third party the positive HIV-status of a partner in couple therapy?

   a) Not aware  b) Somewhat aware  c) Mostly aware  d) Extremely aware

19. To what degree are you aware of the ethical guidelines of the primary professional organization with which you identify related to your ability/duty to disclose to a third party the positive HIV-status of a partner in couple therapy?

   a) Not aware  b) Somewhat aware  c) Mostly aware  d) Extremely aware

20. Indicate the type of formal training or continuing education (if any), you have had related to your ability/duty to disclose to a third party the positive HIV-status of a partner in couple therapy?

   a) Mandatory training  b) Voluntary training  c) No training

21. Based on the ethical standards of the professional organization with which you primarily identify, would you disclose a secret (that did not qualify under a “duty to warn/protect”) to an unaware partner in couple therapy if it was your clinical judgment that it should be shared?

   a) Never  b) Sometimes  c) Frequently  d) Always
22. Based on your state’s legal statutes/laws, would you disclose a secret (that did not qualify under a “duty to warn/protect”) to an unaware partner in couple therapy if it was your clinical judgment that it should be shared?

   a) Never   b) Sometimes   c) Frequently   d) Always

23. If there were no confidentiality limits within the ethical standards of the professional organization with which you primarily identify, would you disclose a secret (that did not qualify under a “duty to warn/protect”) to an unaware partner in couple therapy if, in your clinical judgment, it was in the best interest of the couple?

   a) Never   b) Sometimes   c) Frequently   d) Always

24. If there were no confidentiality limits within your state’s legal statutes/laws, would you disclose a secret (that did not qualify under a “duty to warn/protect”) to an unaware partner in couple therapy if, in your clinical judgment, it was in the best interest of the couple?

   a) Never   b) Sometimes   c) Frequently   d) Always

25. At the onset of therapy, therapists may or may not inform a couple regarding how they would handle the revelation of a secret being kept from one partner by the other. Please circle the ONE option below that best applies to your present practice?

   a) I do not address how I will handle a secret revealed in couple therapy.
   b) I address how I will handle a secret after the revelation of one makes it an issue.
   c) I only verbalize my position on how I will handle a secret.
   d) I only state my position on how I will handle a secret in writing (perhaps as part of a professional disclosure statement).
   e) I state my position both verbally and in writing on how I will handle a secret.

26. Before therapy begins, do you obtain written consent from both partners to allow you to share confidential information, such as revealed secrets, with the other partner?

   a) Never   b) Sometimes   c) Frequently   d) Always

27. Do you address confidentiality limits as they apply to positive HIV-status with a couple prior to therapy?

   a) Never   b) Sometimes   c) Frequently   d) Always

28. Therapists sometimes have to deal with being informed of a secret that exists between partners and can essentially take one of three approaches in dealing with secrets. Which ONE of the following approaches do you typically use?

   a) NO REVELATION- I am willing to hear secrets from one partner and keep the secret with that partner from the unaware partner.
   b) FULL REVELATION- I refuse to keep a secret with one partner and require full revelation of all secrets to an unaware partner within a timely fashion.
   c) PROFESSIONAL JUDGMENT- I use my professional judgment, on a case-by-case basis, about whether a secret revealed to me should be shared with an unaware partner.
29. Please identify the following experiences that have influenced your therapeutic management of secrets between partners in couple therapy by rank ordering those that apply. Place a 1 next to the influence that was greatest, followed by a 2, and so on. Only rank-order those influences that apply, placing a 0 next to those items that have had no influence on your decision. (It may be easiest to first go through the list and assign 0’s to those experiences that have had no influence, and then rank-order those remaining.)

University/College Courses
_____ Internship/Practicum Training
_____ In-Service/Seminar/Conference
_____ Journal Articles (excluding required course readings)
_____ Therapeutic Practice
_____ Supervision
_____ Consultation
_____ Other: __________________________

30. A therapist's rationale for dealing with secrets between partners in couple therapy in a particular fashion is based on ethical, legal, moral and therapeutic considerations. Please rank-order these four considerations as they guide your practice, placing a 1 next to the consideration you deem most important and ending by assigning a 4 to the consideration you deem least important.

_____ Ethical
_____ Legal
_____ Moral
_____ Therapeutic

31. Please indicate the number of times one of your couple therapy clients has raised a concern (made a complaint) to the following person or group related to how you handled a secret?

a) _____ You
b) _____ Supervisor
c) _____ Licensing Board
d) _____ Professional Organization/Society
e) _____ Health Maintenance Organization
f) _____ Legal System

32. Related to the disputed handling of a secret between partners in couple therapy, please indicate the number of times you have:

a) _____ Had to appear in court to defend your actions
b) _____ Had a judge/jury deem you guilty of improprieties
c) _____ Had to appear before a licensing board to defend your actions
d) _____ Had action taken against you (probation, suspension, etc.) by a licensing board
e) _____ Had membership from a professional organization terminated

33. Please rank-order the secrets below that you may have encountered according to how frequently such a secret has arisen in your couples work. Assign the most frequent secret with the number 1, the second most frequent secret the number 2, and so on. Please designate any form of secret you have not encountered with a 0. (It may be easiest to first go through the list, assigning 0’s to those secrets you have not encountered, and then rank-order those remaining.)
34. Please indicate the likelihood with which you would encourage a partner to reveal each type of secret below to his or her partner by using the provided Likert scale.

(1=Not at all, 2=Not likely, 3=Somewhat likely, 4=Very likely, 5=Definitely)

<table>
<thead>
<tr>
<th>Secret</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
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</thead>
<tbody>
<tr>
<td>Extra-relational affair (physical)</td>
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<tr>
<td>Internet affair/chatting</td>
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<td>Wanting a divorce</td>
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<td>Money problems/gambling</td>
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<td>History of abuse (as victim)</td>
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<td>History of abuse (as abuser)</td>
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<tr>
<td>Sexually transmitted diseases (e.g. HIV/AIDS, herpes, etc.)</td>
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<tr>
<td>Illness (mental, physical, etc.)</td>
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<td>History of legal problems</td>
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<td>Child paternity</td>
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<td>Drug/Alcohol use/abuse</td>
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<td>Pornography use/abuse</td>
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<td>Sexual orientation</td>
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<tr>
<td>Sexual paraphilia practices (e.g. exhibitionism, cross-dressing, etc.)</td>
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<tr>
<td>Other ________________</td>
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</table>

35. Vignette One: You have been seeing a husband and wife for relational difficulties for a month with the feeling that one, or both, of the partners is hiding something. One day, you receive a phone call from the wife. She is very distraught and informs you that she has been having unprotected sex with one of her husband’s co-workers for about a year and that she just found out that she is pregnant. She is unsure of whether her husband or his co-worker is the father. She relates that she does not know what to do and wants your help.
A) Will you encourage or discourage the woman to disclose the affair and the pregnancy to her husband...
if the woman is willing to end the affair?
   a) Strongly encourage  b) Encourage  c) Discourage  d) Strongly discourge
if the woman is unwilling to end the affair?
   a) Strongly encourage  b) Encourage  c) Discourage  d) Strongly discourge

B) If the woman is unwilling to disclose the information to her husband, and it is your clinical judgment that it should be disclosed, how likely would you disclose it to him?
a) Not at all  b) Not likely  c) Somewhat likely  d) Very likely  e) Definitely

C) How likely would you refer the wife to another therapist for individual therapy?
a) Not at all  b) Not likely  c) Somewhat likely  d) Very likely  e) Definitely

36. Vignette Two: You are seeing a couple for relational difficulties. During an individual session with one partner, the partner discloses being HIV-positive and that the second partner, with whom the partner is having unprotected sex, is unaware of this secret.

A) Will you encourage or discourage the partner from disclosing this information to the unaware partner if it is...
   a spouse?
   a) Strongly encourage  b) Encourage  c) Discourage  d) Strongly discourage
   an intimate non-spouse?
   a) Strongly encourage  b) Encourage  c) Discourage  d) Strongly discourage

(If discouraging in both cases, skip to question 36C, otherwise proceed to question 36B.)

B) If you encourage disclosure and the partner is unwilling to reveal the secret, how likely would you tell...
   a spouse?
   a) Not at all  b) Not likely  c) Somewhat likely  d) Very likely  e) Definitely
   an intimate non-spouse?
   a) Not at all  b) Not likely  c) Somewhat likely  d) Very likely  e) Definitely

C) If the partner is unwilling to tell the secret, and you decide not to disclose it yourself, how likely would you still inform the appropriate contact at your local health department...
   to protect a spouse?
   a) Not at all  b) Not likely  c) Somewhat likely  d) Very likely  e) Definitely
to protect an intimate non-spouse?

a) Not at all  b) Not likely  c) Somewhat likely  d) Very likely  e) Definitely

D) If the scenario is different in that the client reports only engaging in “safer sex” with the partner, how likely would you tell...

the partner if it is a spouse?

a) Not at all  b) Not likely  c) Somewhat likely  d) Very likely  e) Definitely

the partner if it is an intimate non-spouse?

a) Not at all  b) Not likely  c) Somewhat likely  d) Very likely  e) Definitely

the local health department?

a) Not at all  b) Not likely  c) Somewhat likely  d) Very likely  e) Definitely

37. Vignette Three: You are seeing a couple for relational difficulties. During an individual session with one partner, she states that she had an alcohol addiction before the couple met.

A) Will you encourage or discourage the woman to disclose the addiction to an unaware partner?

   a) Strongly encourage  b) Encourage  c) Discourage  d) Strongly discourage

(If encouraging, proceed to question 37B, otherwise skip to question 37C.)

B) If the woman is unwilling to tell her partner, how likely would you tell the partner yourself?

   a) Not at all  b) Not likely  c) Somewhat likely  d) Very likely  e) Definitely

C) If the woman later discloses current drinking concerns to you, will you encourage or discourage disclosure to the woman’s partner?

   a) Strongly encourage  b) Encourage  c) Discourage  d) Strongly discourage

(If encouraging, proceed to question 37D, otherwise skip to question 38.)

D) If the woman is unwilling to tell her partner of the present addiction, how likely would you tell the partner yourself?

   a) Not at all  b) Not likely  c) Somewhat likely  d) Very likely  e) Definitely

38. Vignette Four: A couple presents for therapy to address relational difficulties and during the intake interview, while talking to each partner individually, one partner expresses a desire to save the relationship and the other tells you that it is unsalvageable.
A) How likely would you agree to see the couple together for therapy?

a) Not at all  b) Not likely  c) Somewhat likely  d) Very likely  e) Definitely

(If you might agree to see the couple, proceed to question 38B, otherwise skip to question 38D.)

B) How likely would you encourage the one partner to disclose the desire to separate from the other partner?

a) Not at all  b) Not likely  c) Somewhat likely  d) Very likely  e) Definitely

(If possibly encouraging, proceed to question 38C, otherwise skip to question 38E.)

C) If the one partner is unwilling to tell the other partner of the desire to end the relationship, how likely would you tell the partner yourself?

a) Not at all  b) Not likely  c) Somewhat likely  d) Very likely  e) Definitely

(Skip to question 38E.)

D) If you do not agree to see the couple, how likely would you refer them to another therapist for conjoint couple therapy?

a) Not at all  b) Not likely  c) Somewhat likely  d) Very likely  e) Definitely

E) Regardless of whether you see, or refer, them as a couple, how likely would you refer each partner to other therapists for individual therapy?

a) Not at all  b) Not likely  c) Somewhat likely  d) Very likely  e) Definitely

That is the end of the survey. Thank you for your participation. If you would like to receive the findings of this study after its completion, please e-mail the researcher indicating so at michael.jansen@wmich.edu within four weeks. Please indicate the charity below to which you would like a $1 donation to be made.

_____ AAMFT Educational Research Foundation
_____ The Foundation for AIDS Research
_____ Advocates to End Domestic Violence

Thank you,
Michael A. Jansen, M.A.                        Alan Hovestadt, Ed.D.
Western Michigan University                   Western Michigan University
Counseling Psychology Doctoral Student        Professor of Counseling Psychology &
Family Therapy Education                      Family Therapy Education

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Appendix B

Human Subject Institutional Review Board Approval

Western Michigan University
Date: August 2, 2007

To: Alan Hovestadt, Principal Investigator
    Michael Jansen, Student Investigator for dissertation

From: Amy Naugle, Ph.D, Chair

Re: HSIRB Project Number: 07-07-18

This letter will serve as confirmation that your research project entitled “Therapists’ Handling of Secrets between Partners in Couple Therapy” has been approved under the exempt category of review by the Human Subjects Institutional Review Board. The conditions and duration of this approval are specified in the Policies of Western Michigan University. You may now begin to implement the research as described in the application.

Please note that you may only conduct this research exactly in the form it was approved. You must seek specific board approval for any changes in this project. You must also seek reapproval if the project extends beyond the termination date noted below. In addition if there are any unanticipated adverse reactions or unanticipated events associated with the conduct of this research, you should immediately suspend the project and contact the Chair of the HSIRB for consultation.

The Board wishes you success in the pursuit of your research goals.

Approval Termination: August 2, 2008
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review. *Journal of Marital and Family Therapy*, 26, 23-38.


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