

HIV/AIDS-Related Ethical Dilemma of Confidentiality

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The Centers for Disease Control and Prevention (2006) estimates over 1 million people are living with HIV/AIDS in the U.S. with 40,000 new infections reported yearly. Given the pervasiveness of HIV/AIDS, it has become almost inevitable that mental health professionals will come into contact with affected patients. As a result, mental health professionals often face ethical dilemmas specific to this population, such as the knowledge of one's HIV/AIDS status and unsafe sexual practices. This dilemma is raised when a clinician becomes privy to one's HIV-positive status, but the partner is not yet informed. Treatment poses complex legal issues as mental health professionals are faced with the uncertainty of reporting potential danger, while facing the ethical issue of confidentiality that is central to the field. In addition, an overview of the screening, progression, and treatment of HIV/AIDS is included.

Human Immunodeficiency Virus (HIV) was first identified in the United States in the 1980s and has since affected millions of people worldwide. In the United States, people of color seem to contract the disease in disproportionate rates. While several advances have been made that have aided in a better understanding of the disease, a cure has not yet been reached. Mental health professionals serve a crucial purpose in the treatment of those with HIV/AIDS, but at the same time, face certain ethical dilemmas in this context.

As such, this paper outlines the ethical dilemma of confidentiality when working with individuals with HIV/AIDS. Because of the gravity of HIV, mental health professionals seem to be in a predicament if, and when, they gain knowledge of their client's unsafe sexual behavior, as this could potentially put others in danger. A review of the literature suggests there is no clear solution to this dilemma, and often mental health professionals are subject to abiding by ambiguous or contradicting state laws and ethical codes. This paper highlights some of these laws and ethical codes to demonstrate the problem and discusses some of the related clinical implications.

What is HIV/AIDS?

HIV is an incurable disease that attacks one's immune system, thereby making it difficult to fight off infections. If the immune system becomes exceedingly compromised,

acquired immune deficiency syndrome (AIDS) can occur and an opportunistic infection can prove fatal. Not every individual who is diagnosed with HIV develops AIDS. However, research evidence supports that all persons who develop AIDS initially had HIV (Anderson & Rowe, 2006). AIDS occurs when a person's T cell count drops below 200 per cubic millimeter and when an opportunistic infection results (Kukoleck, 2008).

In order to become infected with HIV, one needs to be exposed to an infected other's bodily fluids, including blood, semen, vaginal fluid, and saliva. The most common ways for HIV to be spread among people is through risky behavior, including unprotected sex or sharing needles during intravenous drug use. Unprotected sex can include anal, oral, or vaginal intercourse. The Centers for Disease Control and Prevention (2008) reports that male-to-male sexual contact is the transmission category resulting in the highest number of AIDS cases in 2007 alone and through 2007 from the beginning of the epidemic. This is likely the reason HIV/AIDS has been stigmatized as a "gay person disease." However, the high-risk heterosexual contact transmission category elicited the second highest number of estimated AIDS cases in 2007 (Center for Disease Control and Prevention, 2008). Therefore, it is fair to say that HIV/AIDS is a disease that can affect anyone.

Upon contraction of HIV, the symptoms of HIV can initially be elusive. Soon after infection has occurred, one can experience flu-like symptoms and easily dismiss them as such. After this, much time can pass where the infected individual does not exhibit any symptoms but his or her body is rapidly producing antibodies to combat the virus that is quickly spreading throughout the body (Klimas, O'Brien Koneru, & Fletcher, 2008). In order to confirm that one has

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HIV, one must be tested for the presence of antibodies to HIV in the bloodstream. The caveat in this, however, is that antibodies can take awhile to develop. The CDC reports that detectable antibodies, on average, take two to eight weeks to develop from time of initial exposure. If one is tested for HIV shortly after exposure, they may not test positive for HIV antibodies because his or her body is still in the phase of creating those specific antibodies. This type of test would not be indicative of HIV in this situation, producing a false negative result. In most cases, HIV antibodies can be detected within three months of exposure. However, there have been rare cases noted where it took six months for HIV antibodies to be developed (CDC, 2009a). Also, it is important to note that when one is tested for HIV, multiple tests are done to ensure accuracy of the findings (Anderson & Rowe, 2006). If HIV is diagnosed, appropriate treatment is critical.

HIV is now treated with medications known as highly active antiretroviral treatment (HAART). HAART medications are actually combinations of different classes of antiretroviral medications which act on the virus at various stages of its life cycle (Klimas et al., 2008). These combinations of medications have markedly slowed the progression of HIV to AIDS for many. Up until this, the average time span for HIV to develop into AIDS was seven to ten years (Anderson & Rowe, 2006). HAART medications have increased life expectancy and overall quality of life for those infected with HIV/AIDS (Liu et al., 2006).

In spite of this, people of color, specifically African Americans, have a disproportionately higher incidence rate of contracting HIV and AIDS (Klimas et al., 2008). Some of this appears to be due to educational level and socioeconomic status, and hence, a lack of resources. A 2004 study by Ebrahim and colleagues, found that these disparities may be due to a significantly lower level of knowledge about HIV among African Americans and Latinos than Whites, even though these ethnic groups were tested for HIV at a significantly higher rate. Moreover, people of color have been shown to develop AIDS as a result of HIV at a significantly higher rate than Whites, even when matched for education and SES (Anderson & Rowe, 2006).

Ultimately, HIV and AIDS can have major impacts on one's interpersonal and intrapersonal relationships; therefore one's sociological and psychological well-being can be affected. HIV infection is highly correlated with depression. Because of this, an interdisciplinary approach to treating someone with HIV is paramount. Mental health professionals can play a major role in the functioning and well-being of those infected with HIV/AIDS.

Who is affected by HIV/AIDS?

According to the CDC (2006), 49% of those living with HIV are African Americans, 30% Caucasians, 18% Hispanics, 1% Asian/Pacific Islander, and <1% American Indian/Alaska Native (see Table 1). More specifically, males

account for 73% of those living with HIV whereas women account for 26% (CDC, 2006). The CDC (2008) recently reported the estimated new HIV/AIDS infections by transmission category in 2006. Fifty-three percent of new HIV infections were transmitted by male-to-male sexual contact; 31% from high-risk heterosexual contact; 12% from injection drug use (IDU); and 4% from male-to-male sexual contact and IDU. The CDC (2008) also broke down estimated new infections by age in 2006: 34% ages 13-29; 31% ages 30-39; 25% ages 40-49; and 10% ages 50 and over.

Table 1
HIV/AIDS in the United States (2006)

Gender		Race/Ethnicity		Age	
Male	73%	African Americans	49%	<13	<1%
Female	26%	Caucasian	30%	13-24	15%
		Hispanic/Latinos	18%	25-34	26%
		Asian/Pacific Islander	1%	35-44	32%
		American Indian/Alaska Native	<1%	45-54	20%
				55-64	6%
			≥ 65	2%	

Note. Data obtained from: Center for Disease Control and Prevention (2006).

Retrieved from: <http://www.cdc.gov/hiv/resources/factsheets/us.htm>

According to the American Psychological Association's (APA) Standard 2.01, Boundaries of Competence, mental health professionals have an ethical obligation to ensure that they are competent in the area in which they provide services. This includes and is not limited to culture, ethnicity, gender, and sexual orientation (APA Ethics Code, 2002). Since research indicates that African Americans and gay and bisexual men of all races continue to be most severely affected by HIV/AIDS, it is important for mental health professionals to be aware of the cultural, familial, and community norms and values pertinent to their patients (CDC, 2006). One example of how this can be accomplished is by attending seminars or conferences regarding cultural diversity.

A 2002 study by Low-Beer and colleagues examined prevalence rates of HIV/AIDS in relation to sexual orientation, socioeconomic status, and education among a large sample of men from the west end of Vancouver, Canada. The study surveyed a total of 1,176 men; 300 men identified as being either gay or bisexual. About 16% of those men, who identified as gay or bisexual, reported being positive for HIV. The results of the study indicated that, in general, gay or bisexual men who were HIV-negative had more education, higher rates of full-time employment, and

higher incomes than the HIV-positive participants. The data collected from this study is presented in Table 2 (Low-Beer et al., 2002).

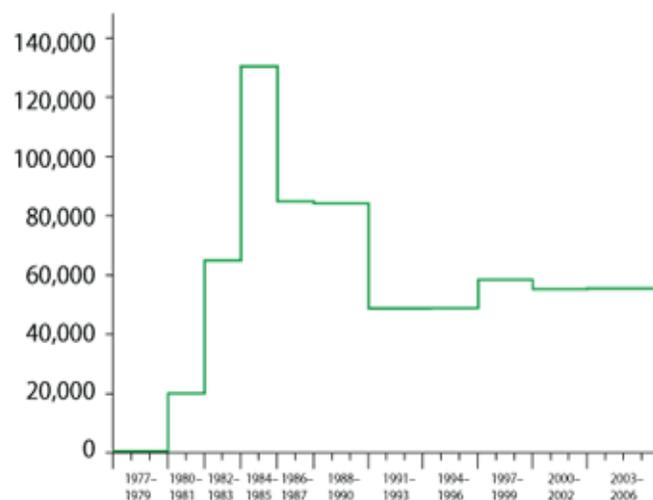
Table 2
Comparison of Sociodemographic Characteristics between Gay and Bisexual HIV-positive (n = 47) and HIV-negative men (n = 237) in Vancouver’s West End

Characteristics	HIV-positive [n (%)]	HIV-negative [n (%)]
Age		
Median	38	37
Education		
≥ 12 years	44 (94)	228 (97)
< 12 years	3 (6)	8 (3)
Full-time Employment		
Yes	19 (40)	187 (79)
No	28 (60)	50 (21)
Income		
> 20,000	31 (66)	198 (85)
< 20,000	16 (34)	36 (15)

The CDC (2009b) reported a study that showed a 15% increase in HIV/AIDS diagnoses from 2004-2007 in 34 states. These 34 states all have long-term HIV/AIDS reporting. The CDC suggests four possible reasons for this increase: (1) the increase may be the result of changes in state reporting regulations. Some states have now included reporting all viral loads and CD4s during laboratory tests. (2) More people are getting tested for HIV/AIDS due to increased emphasis on the benefits of early testing. The CDC reports that the testing rates are higher for pregnant women, people who engage in behaviors that are known HIV risks, young people (ages 18-34), and African Americans. (3) There may be instability in the data. (4) There may be an actual increase in HIV/AIDS infections. The CDC has identified specific subgroups that have shown the greatest increase in HIV/AIDS diagnosis. There has been a 26% increase in HIV/AIDS diagnoses among men who have sex with men (MSM). The Centers for Disease Control and Prevention states that “although it is difficult to determine whether the increase in diagnoses represents a true increase in incidence, a recent CDC analysis indicated that HIV incidence among gay and bisexual men has been increasing since the early 1990s” (CDC, 2009). Along with increases among all racial/ethnic groups, there has been a 9% increase seen among high-risk male heterosexuals, and a 14% increase among females. Increases in HIV/AIDS diagnoses were seen in 28 out of the 34 states included in this study.

Although increases were seen the most in the southern states, estimates per region were not included (CDC, 2009b).

A recent CDC (2008) report used an extended back-calculation model to show the estimated number of new HIV infections. Figure 1 is taken directly from the August 2008 CDC report “Estimates of New HIV Infections in the United States.” As can be observed from the figure, the estimated number of new HIV infections have drastically decreased since the mid-to-late 1980s, but have slowly risen from the early 1990s and have since began to level off.



Note: Estimates are for 2-year intervals during 1980–1987, 3-year intervals during 1977–1979 and 1988–2002, and a 4-year interval for 2003–2006.

Figure 1. Estimated number of new HIV infections, extended back-calculation model, 1977–2006

Ethical and Legal Issues

The Ethical Principles of Psychologists and Code of Conduct (APA Ethics Code, 2002) serve as the mental health professionals’ reference for professional standard of care. The HIV/AIDS-related ethical dilemma of confidentiality involve ethical Principle A: Beneficence and Nonmaleficence, and APA Standard 4.01: Maintaining Confidentiality.

Principle A: Beneficence and Nonmaleficence

The ethical principle of beneficence refers to being kind and doing good for others. Furthermore, the principle involves “respecting the dignity and worth of the individual” (Hughes & Friedman, 1994, p.2). Under this principle, mental health care professionals are required to provide compassion for their patients infected with HIV/AIDS (Hughes & Friedman, 1994). Regardless of the clinician’s theoretical orientation, mental care professionals strive to provide quality care while maintaining and valuing the person, content, and therapeutic relationship.

The principle of nonmaleficence means “do no harm” and requires mental health care professionals to “attempt to

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prevent harm to clients and third parties as long as doing so does not present the professional with significant risks or costs, and the benefits that clients or others would receive are not outweighed by the risks or costs incurred by the professional” (Melchert & Patterson, 1999, p.180). If a treating clinician shares the commonly held view that avoiding harm to others is a more compelling responsibility than the responsibility of benefiting patients, then they are likely to breach confidentiality when faced with the HIV/AIDS-related ethical dilemma of confidentiality (Melchert & Patterson, 1999). However, there are mental health professionals who err on the side of confidentiality and will not, unless mandated by state law, break mental health professional-patient confidentiality. It is argued that those mental health professionals who break confidentiality to protect and avoid harm to third parties are causing more harm than good as there is a possibility that breaking confidentiality “could result in harm to the client, who may experience extreme distress at the violation of trust, and, possibly, rejection by the threatened partner” (Hughes & Friedman, 1994, p.3).

Here lies the core of the ethical dilemma: should mental health care professionals maintain confidentiality or should they risk confidentiality and possibly cause harm to their patients to protect unsuspecting sexual partner(s)? To some mental health professionals, resolving this ethical dilemma is rather simple, but to others it is a complicated and often times, an unclear and painstaking process. Resources for mental health professionals in this circumstance appear to be limited to the APA Ethics Code and state laws. Both literature and the Ethical Principles of Psychologists and Code of Conduct (APA Ethics Code, 2002) maintain that legal mandates supersede ethical guidelines. However, not every state has a law surrounding the issue. Therefore, it is the clinician’s responsibility to resolve this ethical dilemma.

Maintaining Confidentiality (APA Standard 4.01)

The Ethical Principles of Psychologists and Code of Conduct (APA Ethics Code, 2002) address confidentiality in Standard 4.01:

Psychologists have a primary obligation and take reasonable precautions to protect confidential information obtained through or stored in any medium, recognizing that the extent and limits of confidentiality may be regulated by law or established by institutional rules or professional or scientific relationship.

The APA has specified their position on breaching confidentiality with an HIV/AIDS patient. They state that “no legal duty to warn should be imposed, and if such legislation is imposed, disclosure by the therapist should occur only after (a) a known partner is identified to be at risk, (b) the partner is not himself/herself aware of the risk, and (c) the patient has not been willing to tell that individual

directly” (Huprich, Fuller, & Schneider, 2003).² The Tarasoff ruling states that “when psychotherapist determines, or pursuant to the standard of his profession should determine, that his patient presents a serious danger of violence to another he incurs the obligation to use reasonable care to protect the intended victim against such danger” (DiMarco & Zoline, 2004, p.69).

The Tarasoff ruling in 1976 is a major legal aspect that demands attention when addressing the HIV/AIDS-related ethical dilemma of confidentiality. Although some situations may meet the Tarasoff requirement for duty to warn, some argue that the issue of HIV/AIDS is simply not applicable. However, as important as the Tarasoff ruling is, many states have not adopted Tarasoff, thus placing professional responsibility on the treating mental health professionals to resolve the dilemma (Corey, Corey, & Callanan, 2007). Those advocating for the maintenance of confidentiality argue that clinical mental health professionals are non-medical professionals, and therefore, “cannot legitimately be held responsible for making an assessment of dangerousness, since the diagnosis is a medical one” (DiMarco & Zoline, 2004, p.69). This view is in stark contrast to mental health professionals who maintain that it is their responsibility to breach confidentiality and reveal the danger that results from some patients that may not honestly disclose their HIV/AIDS status. These mental health professionals actively advocate breaching confidentiality in such situations to protect others from potential harm (DiMarco & Zoline, 2004). The best course of action on ethical dilemmas is often achieved after a careful evaluation of personal and professional values and review of the ethical guidelines and legal mandates.

Confidentiality is viewed as an essential component in therapeutic relationships. Mental health professionals often reassure patients that the therapeutic relationship and the therapeutic environment is safe, open, and most importantly, confidential. The literature states that “without assurance of confidentiality, patients may be hesitant to seek treatment because of fear of stigmatization” (Chenneville, 2000, p.661). As previously stated, breaches of confidentiality may cause harm to patients. Research shows that the “ultimate question is not whether to breach confidentiality but rather how to protect third parties without destroying the therapeutic alliance between clinician and client” (Chenneville, 2000, p.661). In terms of the HIV/AIDS-related ethical dilemma of confidentiality, the literature encourages mental health professionals to consider less intrusive means of dealing with the HIV/AIDS-related ethical dilemma of confidentiality, such as persuading the patient to self-disclose to their sexual or needle sharing partner(s) (Corey et al., 2007).

² Although this article was written before the publication of the APA’s 2002 Ethics Code, the authors indicate that their analysis “have not been substantially altered by the 2002 Ethics Code revisions” (Huprich et al., 2003).

Generally, confidentiality (APA Standard 4.01 “Maintaining Confidentiality, APA 2002) should be maintained except in circumstances in which a patient’s behavior poses physical danger to others or one’s self. Since mental health professionals have a legal duty to protect and warn, it is imperative that mental health professionals are familiar with the ethical guidelines and legal mandates. Mental health professionals’ duty to warn and protect is “especially difficult because counselors face not only ethical and legal issues surrounding confidentiality of client communications but also specific statutory prohibitions against disclosures of HIV information” (Corey et al., 2007, p.252). Each state differs in their statutory prohibitions. For instance, Pennsylvania law mandates that mental health professionals “may not break confidentiality to warn that a client poses a threat to others through HIV/AIDS” (Corey et al., 2007, p. 252). On the other hand, some states (e.g. Montana and Texas) provide legal protection for mental health professionals who break confidentiality to warn third parties of possible harm (Corey et al., 2007). There is no apparent consensus on what most states legally mandate regarding disclosure of HIV/AIDS to a monogamous partner.

A recent study by Pabian, Welfel, and Beebe (2009) showed that an average of 76.4% of surveyed mental health professionals were incorrect when asked to select the one statement that most accurately described their state’s law regarding duty-to-warn. The study also found that the mental health professionals had inaccurate interpretations of situations involving duty to warn. It is important that mental health professionals continue to educate themselves regarding ethical and legal dilemmas.

While the “duty to warn” concept is generally accepted in the mental health care field in the areas of homicidal and suicidal intent, and child and elder abuse, some mental health care professionals argue that “the risk that HIV-positive clients pose to others is fundamentally different” and consequently, “HIV-positive clients’ rights to confidentiality outweighs the benefits of breaking their confidentiality to warn third parties of their possibility of contracting HIV” (Melchert & Patterson, 1999, p.180). Similar to Principle A: Beneficence and Nonmaleficence, the ethical dilemma becomes whether to maintain confidentiality or break it to protect third parties from possibly contracting HIV/AIDS. In fact, a person is at risk for contracting HIV when engaging in unsafe sexual behavior, it is not certain that the person will indeed contract HIV. Therefore, it is hard to conclude that imminent physical injury will occur (Huprich, Fuller, & Schneider, 2003). The literature suggests that mental health care professionals should advise and actively work with their patients to either terminate their risky sexual and needle sharing practices or inform the potential victim(s) (Melchert & Patterson, 1999). The American Psychiatric Association Ad Hoc Committee of AIDS Policy (1988) further specified that it is ethically permissible to notify an identifiable person if the patient refuses to self-disclose to a partner(s) in which unsafe sex practices are being employed (Melchert & Patterson, 1999).

Mental health professionals need to make various decisions when assessing risky behaviors among their HIV/AIDS patients, including breaching confidentiality to reveal the HIV/AIDS status to a partner and how to discuss the importance of safer sex practices. To aid mental health professionals in making these decisions, Knapp and VandeCreek (1990) suggest three levels of risky behavior. ‘Low-Risk Behavior’ is casual contact where breaching confidentiality may not be an issue. These behaviors include kissing, human bites, and tattoos. ‘Intermediate-Risk Behavior’ is engaging in safe sex, but without informing the partner of the risks involved. ‘High-Risk Behavior’ is unsafe sexual contacts and sharing needles (Knapp & VandeCreek, 1990). This rating system can be used to help mental health professionals make decisions about breaching confidentiality by helping them decide which situations are the most serious and perhaps more likely to necessitate a breach in confidentiality.

Current Beliefs of Mental Health Professionals

Burkemper (2002) found that, in regards to maintaining confidentiality with an HIV/AIDS patient, professional ethics (as opposed to legal considerations) were most important to mental health professionals. Palma and Iannelli (2002) studied if biases held by mental health professional trainees affect their therapeutic reactivity to confidentiality with HIV/AIDS patients. They found that trainees held the highest level of therapeutic reactivity towards heterosexual male patients and the lowest level of therapeutic reactivity towards heterosexual female patients. The authors describe therapeutic reactivity or one’s willingness to breach confidentiality as a shift in willingness to maintain confidentiality. Their research also found that trainees emphasized the patient’s safe or unsafe sexual behaviors, as well as the gender and sexual orientation of the patient, when making their decisions regarding confidentiality. The study gave evidence of a bias in regards to therapeutic reactivity when the patient is gay or lesbian. Although the data shows that trainees were the most reactive towards male heterosexual patients and least reactive towards female heterosexual patients, a bias appears evident when considering reactivity towards gay male and lesbian female patients (Palma & Iannelli, 2002). The information gathered in Palma and Iannelli’s 2002 study indicated that work needs to be done to lessen the biases of mental health professionals.

Although no nationwide study was found, a 2001 study by Simone and Fulero looked at a group of Ohio mental health professionals to determine if they would breach confidentiality with their HIV/AIDS patients and found that their sample was strongly split on the issue. These mental health professionals “tended to stigmatize patients who became infected through IV drug use and homosexual contact more than they stigmatized patients who became infected through heterosexual contact and blood transfusions” (Simone & Fulero, 2001, p.433). As

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knowledge of AIDS increased, the level of stigma towards AIDS patients decreased, which in turn decreased the likelihood of breaching confidentiality. Although the mental health professionals did well on the AIDS Risk Knowledge (ARK) scale, they received a lower score on tests regarding the legal and ethical knowledge related to “duty to protect.” A lower score regarding legal and ethical knowledge regarding liability concerns was found to correspond with increased likelihood of breaching confidentiality. However, it is important to note that only 17% of respondents reported having experience with HIV/AIDS-infected patients (McGuire, Nieri, Abbott, Sheridan, & Fisher, 1995; Simone & Fulero, 2001).

Clinical Implications

There are several steps a mental health professional can take before breaching confidentiality to ensure the safety of their patient and others. An important therapeutic tool when working with HIV/AIDS patients is psychoeducation (Huprich et al., 2003). The mental health professional can recommend that the patient inform their partner about their HIV status or encourage them to refrain from engaging in sexual activity with their partner. If the patient refuses to do either of these steps, the mental health professional can then advocate for practicing safe sex. Gray and Harding (1988) suggest a “process of helping the patient take responsibility for informing a sexual partner(s).” This process includes educating the patient about the specific transmission processes and current medical advice, consulting with the patient’s primary care physician, and actively supporting the patient when they rehearse difficult communication situations (Gray & Harding, 1988).

Whereas the Ethical Principles of Psychologists and Code of Conduct (APA Ethics Code, 2002) attempts to provide psychologists with clear guidelines by which to abide, mental health professionals are often faced with uncertainty as a result of the contradictions that arise between legal mandates and ethical codes. Given that the HIV/AIDS-related ethical dilemma of confidentiality is of concern in clinical practice, the following are recommendations for mental health professionals treating HIV/AIDS infected patients (Corey et al., 2007):

1. Discuss limits to confidentiality at the onset of treatment.
2. Possess awareness of state laws in regard to disclosure.
3. Possess awareness of ethical guidelines.
4. Possess sufficient self-awareness in regard to one’s attitude, biases, and prejudices.
5. Mental health professionals should speak openly about their concerns over their patient’s behavioral practices.
6. Utilize consultation and supervision.
7. If the clinician decides to break confidentiality to protect identified and unsuspecting third parties of their risk in contracting HIV/AIDS, the clinician should advise their patient prior to disclosure both the purposes of

maintaining rapport and to attempt to obtain the patient’s permission.

8. Always follow statutory guidelines.

Before breaching confidentiality, the following is suggested for consideration (Hook & Cleveland, 1999):

1. Maintain current knowledge of the medical dimension of HIV/AIDS, including transmission.
2. Encourage patients to be retested to ensure an accurate diagnosis.
3. Maintain current knowledge of relevant existing state laws.

Conclusion

Although confidentiality in therapeutic relationships is valued and protected, there are situations in which a breach in confidentiality may be necessary and/or mandated by law. Confidentiality with a patient who has HIV/AIDS has been debated for years. When breaching confidentiality, it is important for mental health professionals to take reasonable precautions, seek consultation and supervision, and refer to and review state laws and professional ethical guidelines. These are some of the resources available for mental health care professionals to aid them in this difficult situation.

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