

HIV, Confidentiality, and Duty to Protect: Considerations for Psychotherapists in the Age of Treatment as Prevention

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Confidentiality and duty to protect are complex issues for psychotherapists treating clients with HIV. The application of the Tarasoff ruling to situations involving HIV has long been debated with questions about how the Tarasoff principles of identifiability of the victim, foreseeability of harm, and necessary protective action apply to HIV within the context of psychotherapeutic relationships. The complexity of these debates is compounded by advances in HIV medicine including the availability of antiretroviral therapy and pre- and postexposure prophylaxis in addition to the current state of knowledge about treatment as prevention. The purpose of this article is to revisit Chenneville's (2000) decision-making model on HIV, confidentiality, and duty to protect in the age of pre- and postexposure prophylaxis and antiretroviral therapy. This revised model may serve as a critical framework for psychotherapists providing services to clients with HIV.

Clinical Impact Statement

Question: What is the applied clinical practice question this article is hoping to address? This article addresses clinical practice questions regarding how to address the confidentiality versus duty to protect dilemma facing clinicians treating a client with HIV who engages in behavior that may pose a risk of HIV transmission to others. **Findings:** How would clinicians meaningfully use the primary findings of this article in their applied practice? This article presents a decision-making model for clinicians to use when faced with the confidentiality versus duty to protect dilemma surrounding the treatment of clients with HIV. **Meaning:** What are the key conclusions and implications for future clinical practice and research? We conclude clinicians should use a decision-making model that takes into account advances in HIV medicine when addressing issues related to HIV, confidentiality, and duty to protect. **Next Steps:** Based on the primary findings and limitations of this article, what are future directions to be explored in clinical practice and research? Research is needed to explore the impact of using a decision-making model in situations surrounding HIV, confidentiality, and duty to protect on clinicians, their clients, and the therapeutic relationship.

Keywords: HIV, psychotherapy, ethics, Tarasoff, decision-making model

Most mental health professionals (MHPs) are familiar with the landmark Tarasoff case wherein a client at a university counseling center made statements to his psychologist indicating intent to harm a fellow student, Tatiana Tarasoff (Tarasoff v. Regents of the University of California, 1974, 1976). The psychologist reported the situation to campus police who detained the client but released him after determining Tarasoff was not at risk, given that she was vacationing out of the country at the time. Upon her return, the client killed Tarasoff. Her parents sued the university, claiming that Tarasoff or her parents should have been warned of the

client's threats. Initially, the Supreme Court of California ruled in favor of the parents, stating that the psychologist had a "duty to warn" Tarasoff or her parents (Tarasoff v. Regents of the University of California, 1974). Later, the "duty to warn" was replaced with a "duty to protect" when the appellate court ruled that MHPs must take reasonable steps to protect potential victims of harm (Tarasoff v. Regents of the University of California, 1976). Under this ruling, reasonable steps may include warning the potential victim or others, notifying law enforcement, or other steps such as civil commitment. Subsequent to the Tarasoff ruling, many states passed laws specifying the conditions under which a Tarasoff liability exists (Bersoff, 2014). Among these state laws and in relevant case law, several factors emerged as relevant when determining the application of Tarasoff principles to individual situations—foreseeability of harm, identifiability of the victim, and the impact of disclosure.

Many MHPs oppose the duty to protect imposed on them, given its potential negative impact on the therapist–client relationship. In fact, Bersoff (2014) argued that Tarasoff is "bad law, bad social

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science, and bad social policy” (p. 461). The application of Tarasoff to situations involving HIV has received even greater opposition. Nonetheless, questions persist about whether or not there is a legal duty to protect among MHPs treating a client with HIV (CWH) who is engaging in behaviors that may place others at risk for contracting HIV. Parenthetically, although we use CWH in this article, we acknowledge there are other linguistic diversity/preferences in terminology (e.g., clients living with HIV). Advances in HIV medicine, including the availability of antiretroviral therapy (ART) and pre- and postexposure prophylaxis (PrEP and PEP), complicate the Tarasoff principles of foreseeability of harm and protective action in situations involving HIV. Following a description of the HIV epidemic in the United States, ethical and legal issues facing MHPs treating CWH, and advances in HIV medicine, we propose a revision of [Chenneville’s \(2000\)](#) HIV, confidentiality, and duty to protect decision-making model.

HIV Epidemic in the United States

Originally termed gay-related immune deficiency, HIV was introduced in the United States as a gay disease, which was particularly problematic, given that this erroneously pointed to the risk for HIV acquisition laying with identity instead of behavior, thus perpetuating stigma and discrimination directed toward sexual and gender minority communities. This was the beginning of the health disparities that have come to define the HIV epidemic in the United States. Calling for greater attention to HIV comorbidities and the contextual factors associated with HIV-related health disparities, [Pellowski, Kalichman, Matthews, and Adler \(2013, p. 1\)](#) described HIV as a “pandemic of the poor.” HIV disproportionately affects marginalized communities (e.g., racial/ethnic and sexual/gender minorities, economically disadvantaged). Structural and economic factors contribute to, and perpetuate, HIV-related stigma, which persists despite advances in HIV medicine. Syndemic theory has been used to describe the social and environmental factors that contribute to HIV comorbidities and their impact on people with HIV (PWH; [Brennan et al., 2012](#); [Singer, Bulled, Ostrach, & Mendenhall, 2017](#)). A recognition of the contextual factors affecting the HIV epidemic is important for understanding the reasons for nondisclosure of HIV status to sexual partners.

Ethical and Legal Issues

Confidentiality is a core value of MHPs. Indeed, privacy and confidentiality are among the standards included in the [American Psychological Association’s \(APA, 2017\)](#) Ethical Principles of Psychologists and Code of Conduct. Maintenance of the therapeutic relationship requires trust, and confidentiality between MHPs and their clients helps to foster trust. Trust is especially important for CWH who may fear stigma and discrimination associated with their disease status. The merits of confidentiality notwithstanding, some situations necessitate disclosure. As outlined in the notorious Tarasoff ruling, MHPs have a duty to take reasonable actions to protect third parties when it is known, or should be known, that a client poses a serious risk of harm to others ([Tarasoff v. Regents of the University of California, 1974, 1976](#)). Although the [APA \(1991\)](#) does not support a duty to protect being imposed on psychologists in situations involving HIV, case law is varied in

terms of the application of Tarasoff to situations involving HIV with some judges ruling in favor of confidentiality and others ruling in favor of disclosure to third parties (see [Chenneville, 2000](#)).

Although foreseeability of harm, identifiability of the victim, and the impact of disclosure are important factors when determining whether or not a duty to protect exists and what constitutes reasonable action(s), there are some important differences in the application of these elements to situations involving clients who threaten physical violence compared with those who engage in behaviors that may place others at risk of HIV transmission. For example, foreseeability of harm must take into consideration advances in HIV medicine including treatment as prevention (TaSP), PEP, and PrEP (discussed below) as well as specific sexual behaviors. For example, condomless anal sex increases risk for HIV transmission, particularly for the receptive or bottom partner. Disease management should be considered a mitigating factor when assessing risk and determining necessary protective action.

HIV criminalization laws also should be taken into consideration when thinking about the impact of disclosure in situations involving HIV. As of 2011, 67 laws criminalizing potential exposure to HIV had been enacted across 33 states in the United States ([Lehman et al., 2014](#)). Similar laws exist in other countries throughout the world. Typically, cases involve sexual behavior without disclosure of HIV status even in cases where the risk of HIV transmission is negligible. These laws are highly debated with many public health advocates and professional organizations, including the [APA \(2016\)](#), strongly opposing such laws and calling for their abolition given the fact that they further stigmatize marginalized communities, serve as a barrier to testing and treatment, and do not take into account advances in HIV medicine.

HIV Treatment as Prevention

TasP refers to HIV prevention strategies involving the use of ART. It has long been established that ART is effective for reducing viral load, an important prognostic indicator for PWH. The landmark 2011 HIV Prevention Trials Network 052 study provided groundbreaking and significant support for TasP as a prevention strategy ([Cohen et al., 2011](#)). The PARTNER Study provided further evidence that PWH with suppressed viral loads as a result of effective ART treatment cannot transmit HIV to others ([Rodger et al., 2016](#)). Outside the scope of committed romantic partnerships, TasP has been shown to be effective at the community level. In a study conducted in South Africa, increasing ART coverage within the local community significantly reduced the rates of HIV transmission between noncommitted sexual partners ([Tanser, Bärnighausen, Grapsa, Zaidi, & Newell, 2013](#)). TasP has been demonstrated as an efficacious strategy in reducing HIV transmission and has even been expanded to include combined behavioral strategies ([Kalichman et al., 2018](#)). As a result of these and other studies, it is now accepted that ART can be used to prevent onward HIV transmission. Thus, despite implementation challenges, HIV testing and treatment is considered an important public health intervention ([Knight, Small, Thomson, Gilbert, & Shoveller, 2016](#)).

PrEP is a TasP strategy whereby someone without HIV takes antiretroviral (ARV) medication *before* exposure to HIV to reduce their risk of HIV infection. Currently, Truvada is the only medi-

cation approved to be used as PrEP (National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention [NCHHPT], 2018). When taken consistently, PrEP reduces the risk of HIV infection from sex by 99% (NCHHPT, 2018). Similarly, consistent PrEP use reduces the risk of HIV infection from intravenous substance use by 74% (NCHHPT, 2018). A recent meta-analysis found PrEP to be a safe and effective strategy for all populations (Fonner et al., 2016), not just high-risk populations (Jiang et al., 2014). Research also suggests that PrEP may be used for selection of sexual partners (i.e., biosorting) to reduce the risk of HIV transmission (Martinez & Jonas, 2019).

PEP is another TasP strategy where people without HIV take antiretroviral medication *after* being exposed to HIV (within 72 hrs) to reduce their risk of infection. PEP is currently recommended for emergency situations such as exposure to HIV through sex, sharing needles, or sexual assault (NCHHPT, 2018). PEP was initially used with health care workers to reduce infection from occupational exposure to HIV (Dolezal et al., 2015). In an earlier study, researchers identified that PEP resulted in an 81% reduction in HIV infection following occupational exposure to HIV (Katzenstein et al., 2000). Later, PEP would be determined as safe and effective for HIV prevention for nonoccupational exposures (Kahn et al., 2001; Schechter et al., 2004).

Despite the efficacy of PEP and PrEP as TasP strategies, awareness of these methods remains low among the general population. PrEP awareness ranged from 21% to 39% among participants in two recent studies (Dolezal et al., 2015; Eaton et al., 2017). PEP awareness also remains below 50% (Dolezal et al., 2015). Consequently, the use of these strategies is relatively limited. A recent study reported only 4.6% use among Black men and transgender women who had ever had sex with a man (Eaton et al., 2017).

Decision-Making Model

The APA (1991) has resolved that a duty to protect third parties from HIV infection should not be imposed on psychologists. Although the APA (1991) outlined criteria for permissive disclosure in certain cases based on legislative considerations, we argue that disclosure to sexual partners is not warranted in consensual sexual relationships given current advances in HIV medicine. Because of medical advances, HIV is now considered a chronic disease that can be treated as opposed to a deadly illness (Deeks, Lewin, & Havlir, 2013). With proper treatment, PWH can now expect longevity similar to people who do not have HIV. Further, HIV prevention should not be the sole responsibility of PWH. Rather, the responsibility should be shared given that traditional (e.g., condoms) and novel (e.g., PrEP) HIV prevention methods exist, yet some still believe the responsibility for HIV prevention lies only with PWH (Young, Flowers, & McDavid, 2016). Advocating for personal responsibility in sexual relationships should not be perceived as blaming the victim because there is no victim in sexual encounters between consenting adults, and such activity should not be framed as criminal. Victim blaming in the context of HIV transmission ignores the complexities involved in sexual relationships (Persson, 2014). For all of the reasons described earlier, we do not support disclosure to consensual sexual partners even when legally permissible but do recognize that a duty to protect (not warn) may exist legally or may be professionally and morally desirable. Therefore, we propose the use of a decision-

making model to determine reasonable steps for minimizing the risk of HIV transmission.

Ethical decision-making skills can support behavior that is consistent with the profession's moral principles (Knapp, VandeCreek, & Fingerhut, 2017). Based on a review of studies on the science of morality, Knapp et al. (2017) concluded that knowing and doing do not always correspond. Impartial decisions do not come naturally, and decision-making is often influenced by emotion. In describing the importance of decision-making skills and based on the work of Haidt (2001) and Kahneman (2011), these authors further described the importance of slow, deliberate, and conscious thought in the face of ethical dilemmas as opposed to the fast and automatic thinking that occurs without effort. With regard to context, Knapp and colleagues (2017) suggest ethical decision-making skills are important when ethical or legal standards are silent or require professional judgment, or when ethical standards conflict with the law. Certainly, the application of Tarasoff principles to situations involving MHPs treating CWH requires ethical decision-making skills.

Chenneville (2000) proposed a decision-making model for MHPs faced with the HIV, confidentiality, and duty to protect dilemma, which included three steps: (a) determine whether disclosure is warranted by assessing the identifiability of the victim and foreseeability of harm; (b) refer to ethical guidelines of the profession, and (c) refer to state guidelines. Taking into consideration advances in HIV medicine, we propose a revision of Chenneville's (2000) model using principle-based ethics as a guiding theoretical framework and the application of the five-step model outlined by Knapp et al. (2017) to situations involving HIV, confidentiality, and the duty to protect.

Based on the work of Sir William David Ross, principle-based ethics focuses on guiding moral principles. This framework is consistent with the APA (2017) Ethics Code, which outlines the following as the guiding principles to which psychologists should aspire: beneficence and nonmaleficence, fidelity and responsibility, integrity, justice, and respect for people's rights and dignity. Similar to other problem-solving models, the five-step ethical decision-making model involves: (a) identifying or scrutinizing the problem, (b) developing alternatives or hypotheses, (c) evaluating or analyzing options, (d) acting or performing the best option, and (e) evaluating the outcomes (Knapp et al., 2017). This model is intended to help MHPs reach a good decision defined as an impartial decision that is consistent with the moral values and principles of the MHP, has a good chance of success, is preferable to any alternatives, infringes minimally on any competing principles, and minimally negatively affects the client.

Step 1: Identify or Scrutinize the Problem

Consistent with the Tarasoff ruling, the identifiability of the victim and the foreseeability of harm should be considered during Step 1. When assessing the identifiability of the victim, the MHP should assess whether the identity of the sexual or needle-sharing partner is known. In some situations, the identity of the sexual or needle-sharing partner is known to the client but not the MHP. In other situations, the sexual or needle-sharing partner is not known to the client. When assessing foreseeability of harm, MHPs should examine the client's behavior and factors that may influence behavior such as personality characteristics and motivational in-

fluences. In addition to examining sexual behavior (e.g., sexual practices, condom use) and substance use, which may directly (e.g., needle-sharing practices) or indirectly (e.g., effect of substances on inhibitions) affect HIV transmission risk, MHPs should assess HIV disease management behaviors such as ART adherence, medical monitoring, and viral load status. MHPs also should review the ethical guidelines related to confidentiality, including what constitutes necessary disclosures, set forth by their profession (e.g., APA Ethics Code for psychologists) as well as their profession's position on HIV disclosures and HIV criminalization laws if such positions exist. As noted above, the APA opposes HIV criminalization laws (APA, 2016) and has resolved that a duty to protect third parties from HIV infection should not be imposed on psychologists (APA, 1991). Finally, MHPs should review their state's laws regarding confidentiality and duty to protect. Edwards (2010) provided a catalog of state laws related to Tarasoff. Typically, state laws fall into one of three categories: (a) mandatory confidentiality, (b) mandatory disclosure, or (c) permissive disclosure whereby disclosure is permitted but not required. MHPs also should consider HIV criminalization laws when examining the impact of disclosure on a client.

Step 2: Develop Alternatives or Hypotheses

This step is a brainstorming phase during which MHPs should consider all the available options. MHPs should avoid dichotomizing decisions at this stage (e.g., maintain confidentiality or warn third party) and should reserve judgment about alternatives until Step 3, at which time each option will be evaluated or analyzed to determine its viability. MHPs should consider all possible alternatives, taking into account that the ability to generate useful solutions is affected by cognitive and emotional factors. For example, situations involving HIV may require MHPs to examine their own biases or misconceptions. Consultation with other MHPs (or others) with HIV expertise may be beneficial at this stage. In situations involving HIV, alternatives may include but not be limited to notifying public health officials, helping the client to engage in protective behaviors (e.g., ART adherence, partner selection, condom use), or helping the client to disclose to sexual partners or examine the reasons for nondisclosure.

Step 3: Evaluate or Analyze Options

At this step, MHPs should evaluate the options generated in Step 2 by considering the potential advantages and disadvantages of each alternative, keeping in mind the characteristics of a good decision described earlier. Given the dilemma in question, MHPs should pay special attention to choosing an option that negatively affects the client minimally and that minimally infringes on competing principles. In other words, if the MHP determines that disclosure of HIV status is warranted, they should take care to ensure that disclosure minimally infringes on confidentiality and has only minimal negative effects on the client. As noted earlier, we do not support disclosure to sexual partners for reasons previously cited. However, disclosure to public health authorities may be required in some states. In such situations, MHPs should share minimal information (i.e., only what is absolutely necessary to protect a third party). Knowledge of advances in HIV medicine will be particularly important for MHPs at this stage given HIV

transmission risk may be negligible for clients with suppressed viral loads and the availability of HIV prevention strategies, including PEP and PrEP, shift perceptions of responsibility related to sexual behavior between consenting adults.

Step 4: Act or Perform the Best Option

At this stage, the MHP must act on the decision. Implementation of a decision can be as important as the decision itself. Given the sensitive nature of the HIV, confidentiality, and duty to protect dilemma, tact and sensitivity will be extremely important. Again, knowledge of advances in HIV medicine will be important to be effective at this stage. For example, if a MHP decides assisting a client with ART adherence is the best option for reducing HIV transmission risk, then they will need to be familiar with best practices for promoting adherence among PWH.

Step 5: Evaluate the Outcomes

Using the characteristics of a good decision in mind, MHPs should evaluate both the short-term and long-term outcomes associated with the decision. In some cases, this may lead to returning to Step 3 and choosing another solution. This process should be viewed as dynamic as opposed to fixed or linear. In cases involving HIV, short-term consequences may include ART initiation or adherence and condom use. Long-term consequences may include negligible HIV transmission risk to others as a function of viral suppression and disclosure to sexual partners resulting in increased support (in some cases), decreased liability (in states with active HIV criminalization laws), and HIV testing (and possibly treatment when test results are positive) for sexual partners.

Case Vignettes

The application of the five-step decision-making model is explored using case vignettes in the following text. Tables 1 and 2 provide a summary for Case A and Case B, respectively.

Case A.

Jasmine is a 22-year-old woman with HIV. Although she is under the care of an infectious disease physician and has been prescribed ART, she does not always adhere to the medication regimen and, as a result, her viral load is not suppressed. Jasmine is very private about her diagnosis due to a fear of being stigmatized. Recently, Jasmine starting dating a man with whom she is sexually active. Her boyfriend does not know her HIV status and refuses to use condoms despite her encouraging him to do so.

In Step 1 (Identify or Scrutinize the Problem), the MHP should assess the identifiability of the sexual partner and the foreseeability of harm. In this case, the identity of the sexual partner is known. Risk factors for HIV transmission include the fact that Jasmine's viral load is not suppressed as the result of poor ART adherence and that she engages in condomless sexual intercourse. The MHP also should consider ethical standards and state laws in Step 1. In this case, confidentiality is the primary ethical concern. The MHP works in a state with permissive disclosure laws.

Step 2 (Develop Alternatives) involves generating options for protective action. In this case, alternatives include (a) notifying public health authorities for the purpose of initiating partner notification services; (b) working with Jasmine to improve ART

Table 1
Application of the Five-Step Model to Case Vignette A

Step 1: Identify or scrutinize the problem		
Is the identity of the victim known?	Yes	
What factors increase the risk of HIV transmission?	Detectable viral load as a result of poor ART adherence and condomless sex	
What ethical standards are at the issue?	Confidentiality	
What state laws exist?	Permissive disclosure	
	Step 2: Develop alternatives	Step 3: Evaluate options
Option A	Contact the public health department for partner notification services	HIV testing for sexual partner (pro) Negatively impact therapeutic relationship (con) Does not address risk factors (con)
Option B	Work with the client to address barriers to ART adherence and condomless sex	Minimizes risk of transmission (pro) No opportunity to sexual partner to be tested for HIV (con)
Option C	Encourage and work with the client to disclose to her boyfriend	May result in HIV testing (pro) Opportunity for information sharing about PrEP (pro) Does not address ART adherence or risky sexual behavior (con) Disclosure may increase social support (pro) Disclosure may result in rejection (con)
Option D	Assist with disclosure by having client bring boyfriend in for a session	May result in HIV testing (pro) Opportunity for information sharing about PrEP (pro) Does not address ART adherence or risky sexual behavior (con) Disclosure may increase social support (pro) Disclosure may result in rejection (con)
Option E	Work with the client to encourage her boyfriend to use PrEP	Disclosure required (pros and cons as described above)
Step 4: Perform the best option		
Best option is a combination of Options B, C, and, depending on client preference, D.		
Step 5: Evaluate the outcomes		
After evaluating outcomes, the MHP may want to return to step 3 to determine next steps.		

Note. ART = antiretroviral therapy; PrEP = pre-exposure prophylaxis; MHP = mental health professional.

adherence and to negotiate condom use during sex which, in this case, may require both instruction and role playing; (c) working with Jasmine to disclose her HIV status to her boyfriend, which will require examining the reasons for nondisclosure and the potential positive and negative consequences of disclosure; (d) helping to facilitate disclosure by inviting Jasmine's boyfriend to a session; and (e) working with Jasmine to encourage her boyfriend to use PrEP.

Step 3 (Evaluate Options) involves examining the alternatives generated in Step 2 to determine the pros and cons of each. In this case, notifying public health authorities for the purpose of initiating partner notification services may result in HIV testing for Jasmine's boyfriend, which is a strength. However, it will not improve ART adherence or increase protected sexual contact, both of which are important for reducing risk of onward HIV transmission. Further, notifying public health authorities may harm the therapeutic relationship. Working with Jasmine to improve ART adherence and to negotiate condom use with her partner is likely to have the best long-term results in terms of positive outcomes for Jasmine as well as current and future sexual partners, but this option does not prompt HIV testing for Jasmine's boyfriend, which would yield multiple benefits (e.g., normalizing HIV testing, opportunity to provide HIV education, opportunity for information-

sharing about PrEP, opportunity to seek treatment if results are positive). Working with Jasmine to disclose to her boyfriend and helping to facilitate the disclosure process may result in HIV testing and PrEP use for Jasmine's boyfriend and may result in increased social support, but also may result in negative emotional consequences for Jasmine (e.g., rejection by her boyfriend) and also will not improve ART adherence or help her to negotiate condom use.

Step 4 (Perform the Best Option) requires the MHP to determine what action(s) seem best after a careful analysis of the potential benefits and risks of each alternative. In this case, it appears that a combination of strategies is the best (i.e., Options b, c, and, depending on client preference, d and e as mentioned earlier). More specifically, the MHP may want to simultaneously work with Jasmine on ART adherence and negotiation skills for increasing condom use during sex while also carefully exploring the pros and cons of disclosure with Jasmine and assisting Jasmine with the disclosure process should she decide to disclose her HIV status to her boyfriend. It is important to note that disclosure should never be forced.

Step 5 (Evaluate the Outcomes) involves assessing whether or not desired outcomes have been achieved. In this case, the desired outcomes are improved ART adherence, increased negotiation

Table 2

Application of the Five-Step Model Using Case Vignette B

Step 1: Identify or scrutinize the problem		
Is the identity of the victim known?	No	
What factors increase the risk of HIV transmission?	Unprotected sexual behavior	
What ethical standards are at the issue?	Confidentiality	
What state laws exist?	Permissive disclosure, HIV criminalization	
	Step 2: Develop alternatives	Step 3: Evaluate Options
Option A	Contact the public health department for partner notification services	Partner notification not likely to be successful because identity of sexual partners unknown (con)
Option B	Work with client to address risky sexual behaviors	Decreased risk for other sexually transmitted infections (pro) Opportunity for information sharing about partner selection (pro)
Option C	Work with the client to disclose to sexual partners	Decrease legal liability given HIV criminalization laws (pro) Disclosure may yield positive consequences (pro) Disclosure may yield negative consequences (con)
Option D	Support the client to maintain ART adherence	Viral suppression eliminates risk of transmission to others (pro) Client may still be legally liable under existing HIV criminalization laws (con)
Step 4: Perform the best option		
Best option is a combination of Options B, C, and D.		
Step 5: Evaluate the outcomes		
After evaluating outcomes, the MHP may want to return to step 3 to determine next steps.		

Note. ART = antiretroviral therapy; MHP = mental health professional.

skills and condom use, and, possibly, disclosure. Based on an assessment of outcomes, the MHP may want to return to Steps 2 (Develop Alternatives) and 3 (Evaluate Options) to determine next steps or may want to simply reevaluate strategies for achieving the desired outcomes. For example, if ART adherence continues to be poor, the MHP may want to implement a different intervention strategy for improving adherence. See Table 1 for a summary of this process.

Case B.

Maurice is a 24-year-old man. He was diagnosed with HIV as a teenager. He has been taking ART since his diagnosis, and he is under the routine care of an infectious disease physician. He is adherent to his medication regimen, and his disease is well managed. His viral load is undetectable. Maurice is not in a committed relationship but has frequent sexual encounters, often with new partners he meets online. Maurice does not always use condoms, particularly when he has been drinking alcohol. Maurice is honest about his HIV status if sexual partners ask, but does not offer this information.

In Step 1 (Identify or Scrutinize the Problem), the MHP should assess the identifiability of the sexual partner and the foreseeability of harm. In this case, the identity of the sexual partner is unknown. The only risk factor is condomless sex, which is a negligible risk given that his virus is suppressed. However, because taking into consideration ethical standards (confidentiality) and state laws is important, the MHP must consider that Maurice lives in a state with permissive disclosure laws but stringent HIV criminalization laws whereby PWH who engage in sexual behaviors without disclosure can be prosecuted for a felony offense.

Step 2 (Develop Alternatives) involves generating options for protective action. In this case, alternatives include (a) notifying

public health authorities for the purpose of initiating partner notification services; (b) working with Maurice to address risky sexual behaviors; (c) working with Maurice to disclose his HIV status to sexual partners, which will require examining the reasons for nondisclosure and the potential positive and negative consequences of disclosure; and (d) supporting Maurice to maintain ART adherence and, consequently, viral suppression, which limits HIV transmission risk.

Step 3 (Evaluate Options) involves examining the alternatives generated in Step 2 to determine the pros and cons of each. In this case, notifying public health authorities for the purpose of initiating partner notification services is not likely to be effective given that the identity of sexual partners is unknown. Even though Maurice is virally suppressed, which means he is not likely to transmit HIV to others, he is at risk for other sexually transmitted infections (STIs), which makes working with him to address risky sexual behaviors (e.g., condomless sex) important especially given that STIs may increase his risk of reinfection with a different strand of HIV because of the localized immune system activation that brings more CD4 cells for HIV to infect. Also, this option will provide an opportunity for information sharing about partner selection. Working with Maurice to maintain ART adherence and, consequently, viral suppression also will be important. Working with Maurice to disclose to sexual partners may yield positive outcomes from a public health perspective and may limit liability related to HIV criminalization laws. However, the potential pros and cons of disclosure must be explored carefully to determine if the potential benefits of disclosure outweigh the risks.

Step 4 (Perform the Best Option) requires the MHP to determine what action(s) seem best after a careful analysis of the potential

benefits and risks of each alternative. In this case, it appears a combination of strategies is best (i.e., Options b, c, and d described earlier). More specifically, the MHP may want to simultaneously work with Maurice to address risky sexual behaviors while maintaining ART adherence and also carefully exploring the pros and cons of disclosure. As noted earlier, disclosure should never be forced.

Step 5 (Evaluate the Outcomes) involves assessing whether or not desired outcomes have been achieved. In this case, the desired outcomes are a reduction in risky sexual behaviors, maintenance of ART adherence and viral suppression, and, possibly, disclosure. Based on an assessment of outcomes, the MHP may want to return to Steps 2 (Develop Alternatives) and 3 (Evaluate Options) to determine next steps or may want to simply reevaluate strategies for achieving the desired outcomes. For example, if Maurice is unwilling to use condoms or disclose his status to sexual partners, then the MHP may want to explore partner selection strategies to further minimize HIV transmission risk. See Table 2 for a summary of this process.

Conclusion

In conclusion, MHPs are encouraged to be familiar with their professional code of ethics and state laws associated with confidentiality and duty to protect as well as HIV criminalization. They also should make sure to stay up-to-date with medical advances in the area of HIV through continuing education, especially considering how rapidly things are changing in this area. However, MHPs are advised that HIV education and knowing the ethical codes of their specialization will not suffice and that there will be challenges in putting ethical codes and laws into practice. Therefore, a MHP's own problem-solving skills become imperative in how they translate these guidelines into practice. The decision-making model outlined in this article is designed to facilitate impartial decision-making. The model includes identifying or scrutinizing the problem, developing alternatives or hypotheses, evaluating or analyzing options, acting or performing the best options, and evaluating the outcomes. These steps should not be thought of as a linear path to reaching an ethical decision but, rather, as a guiding framework for a dynamic process of ethical decision-making.

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