Clinical practice in couple and family psychology (CFP) requires special consideration with regard to documentation. Individual sessions with family members, collateral contacts, and requests for records can pose dilemmas and require greater attention to risk management. Please see Kaslow, Celano, and Stanton (2005) and Patterson, Claiborne and Russaw (2013) for a more detailed discussion. From an ethical, clinical, and legal perspective, it is clear that clinical records must be kept for each case we open and agree to treat. The aphorism “If it’s not written, it didn’t happen” applies. When treating a couple, family, or parent child dyad conjointly, systems theory informs us that the group is the client, rather than the individuals we are treating. This can involve complex decisions regarding precisely whom to treat, in which combination, how often, who holds the legal privilege, and what type of records to keep. Fundamentally, the question of fidelity to our client unit leads us to ask: How can we serve the best interests of the couple or family unit when individuals may have competing interests? As we begin treatment with a couple as the client, for instance, we initiate a clinical record containing standard intake information, an assessment, and a treatment plan (separate records under HIPAA are not being considered here). These involve what we would include for an individual client: background information, consent forms, telephone and e-mail contacts, completed tests and inventories, consultation notes about the case, and other ancillary information. We know that the couple possesses the legal right (privilege) to this information and it may be subpoenaed through a court order. Anyone else we might include in a session of couple therapy for any reason (children, parents, etc.) is not our client but a collateral contact, and this information should also be part of the clinical record. Should we change format (see Gottlieb, 1995; Gottlieb, Laser, & Simpson, 2008) from the couple to family or individual therapy (after considering ethical issues such as confidentiality and multiple relationships), the couple record should be closed and another one started for the new client unit.

Other situations must also be considered, such as when we arrange to have an individual session to build rapport, to assess a partner more carefully as an individual, or if a critical issue such as domestic violence arises. It may not be advisable for the other partner to have access to the information obtained in the individual session. Records of separate sessions should not be co-mingled; in other words, separate records are advised for individual sessions, even when the primary treatment modality is conjoint couple therapy. This protects the individual who may have expressed concerns that would embarrass them or even put them in danger if revealed to their partner.

It is also fairly common for an individual to reveal a secret that would be important to address in conjoint therapy (such as an affair) either in an individual session, by phone, text, or e-mail, or in an informal situation such as while waiting for the partner to arrive to the session. Our policy on secrets is best covered during the informed consent process, and is obviously a sensitive ethical and clinical matter. The legal concern is that if the therapist chooses not to be the one to divulge the secret, it should not be part of the conjoint clinical record which both partners can access.

From this brief discussion it is apparent that treatment planning, record keeping, and confidentiality in couple, parent-child, and family therapy raise complex clinical, ethical, and legal issues, and a high level of competence is needed in order to navigate successfully and serve the best interests of clients.

REFERENCES