Ethical dilemmas in psychoanalysis

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Confidentiality is posited as a fundamental ethical rule in our discipline; however, among the various psychoanalysts there are important differences in scope. For some, the prerogative of preserving patient privacy has no limits. Others, however, raise the need to reflect and take a position on various situations in which confidentiality may run the risk of becoming blurred.

On the one hand, the analytic training itself requires supervisions and presentations of clinical material, actions that involve the patient beyond the work in the office. Not even the generation of knowledge in psychoanalysis is foreign to the issue of confidentiality. The publications of clinical material that allow testing the theoretical principles and analytical practice are considered essential elements for the development of the discipline. However, facing these issues, important ethical questions arise that converge in a basic question: how to transmit knowledge regarding the understanding of clinical material in psychoanalysis without violating the confidentiality of patients?

Other controversial situations for ethics take place in clinical practice and its possible link with third parts. This includes the relationship of the analyst with other professionals who also treat the patient, the response to the demand of reports of patients by health insurance or educational institutions, in the case of working with children; or, in another order, declarations for judges or lawyers.

Faced with this reality, several authors have raised the need to give place to an open discussion about the ethical dilemmas that are often present in our discipline. The psychoanalytic literature, in its attempt to open paths of reflection and offer solutions to this issue, presents different perspectives and postures, some of which generate frank confrontations. This text is intended to be a pointing list as an invitation to exchange ideas.

Absolute or relative confidentiality? From psychoanalysis and legal systems.

IPA promulgates as an ethical principle of every analyst respect for the confidentiality of patient information and registration, but a confrontation has been raised as to the

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conception and scope of this basic rule. In this divergence, Bollas (Bollas and Sundelson, 1995, cited by Goldberg, 1996) and Gabbard (2000) emerge as representative of a radical position regarding the patient's privacy in analysis and the need to isolate the analytical pair as an essential condition for practice.

These authors (in Goldberg's review, 1996) note difficulties in the confidentiality of the legal system in the United States, which they assume to be hostile to psychoanalysis. They emphasize that from 1976, therapists of patients with violent intentions are required by law to protect potential victims by alerting them or contacting authorities. They also mention the existence of laws that reach all disciplines (teachers, pediatricians, and psychoanalysts) and that require reporting cases of physical neglect or sexual abuse in children. They also add, with great concern, the subject of psychotherapeutic treatments financed by health insurance, which demand reports describing the patient's symptoms throughout the process.

Faced with these situations, the authors propose to detach emphatically psychoanalysis (which they call "private psychotherapy") from other therapies (classified as "social therapies") which consider that they could be subject to legal information requirements and to be in contact with reports for lawyers and health insurance. In an extremely critical posture to what he assumes as a true betrayal of psychoanalysis, Bollas departs from any contact of our discipline with non-psychoanalytic institutions as incompatible with practice.

In this perspective, he conceives the supervision of clinical material as the only exception allowed for confidentiality. He argues that it must be done with the condition of masking the identity of the patient, and adds that although this implies an action that introduces the presence of a third part in the analytical pair, is the only one that, in his opinion, is performed for the benefit of patient. On the other hand, every other situation is classified by the author as "a betrayal to the patient, which destroys psychoanalysis" (Bollas, 1999), and is conceived only for the benefit of third parts. This conception, however, is not unanimous. Goldberg (1996) notes that, according to the Ethics case book, reports to health insurance, among other situations, can also be considered for the patient's benefit.

Bollas (1999) points to certain professional relationships in which confidentiality is legal and enforceable (lawyer-client, journalist-source), and encourages psychoanalysts to take a politically active position in this regard. Reinforcing this position, Slovenko (1974, quoted by Golberg, 2004) argues that without the privacy of priests and lawyers, therapists are adrift in an ethical uncertainty.

Goldberg (1996), on the other hand, emerges as a representative of a more relativistic approach, although without ignoring that in this issue of confidentiality there are no simple answers. On the one hand, it agrees with the authors mentioned in the need for a more active stance of psychoanalytic institutions in order to legalize greater confidentiality. It also agrees that the incursions into the patient's privacy generate conflict with therapeutic purposes in psychoanalysis, but instead of closing the door, raises the possibility of questioning the implications of each of these situations in each analytical process.

This author (1996, 2001) argues that the entry of a lawyer or health insurance into the analytical dialogue turns this dialogue into a three-part conversation, and assumes that sometimes the analysis could not continue without this connection. In this perspective, he strongly questions the absolutist model proposed by Bollas. He understands that it creates a reinsurance framework for the analyst, but conceives it as a withdrawal or as a concealment that hinders the possibility of questioning and analyzing in each situation, and without preconceived value judgments, the nature that charges the participation of a third part for the analytical process and for each member of the pair.

Accepting the complexity of this issue and the need to be cautious in the face of these incursions, Goldberg (2001) refuses to assume confidentiality as an automatic mandate, and argues that in psychoanalysis every situation is subject to inquiry and interpretation. He argues that risks are not present only in the relativistic stance he maintains, but that there are problematic situations of practice in which to refuse *a priori* the participation of a third part by an automatic mandate of confidentiality, can also imply a performance of the analyst. He adds that, according to the particularities of the case, the analyst could be confabulating with the patient, both in maintaining confidentiality and in breaching it.

On the other hand, he notes that the confidentiality rule in our discipline begins with the exception of allowing the patient's material to be exposed for supervision. He conceives that these actions - conditions unavoidable for his own analytical formation - open a gap from which confidentiality as an absolute value slips into a terrain of inaccuracies. In this sense, he mentions all other exceptions that may arise in an analytical process: exchanges of the analyst with a treating psychiatrist, conversations with members of the patient's family, reports for insurance, communications to lawyers or at a trial. In another order, he proposes to consider also the presentation of the clinical material and its publication in professional or other non-specialized media.

Further complicating this theme, Argentine psychoanalyst Andrea Rodríguez Quiroga (2012) states that any exposure of the material psychoanalytic approach of a patient requires to consider among the ethical issues the legal system and the prerogatives of practice in each region. A study cited by this author (Garvey and Layton, 2005) shows that these two regulatory frameworks vary in the different regions, do not always converge and sometimes enter into frank contradictions. This research mentions that in Brazil an informed consent of the patient is required to make professional exchanges even within the mental health teams. In the United States and Germany, however, confidentiality extends to health teams if they are small groups of supervision or discussion, but this situation, which is enabled by the legal system, is considered a lack of confidentiality by professional standards, which require informed consent.

Leibovich de Duarte (2006) states that, in the face of this series of contradictions and disagreements between the prerogatives of psychoanalysis and the legal systems of each region, it is currently the professional organizations themselves that establish codes of ethics that regulate their activity.

In addition to the debate that can be generated in relation to the different criteria presented on this subject, perhaps it is also worth asking ourselves to what extent our practice is involved in vicissitudes or contradictions more or less close to those considered. That is to say: are there in our environment laws that generate conflict with professional confidentiality in psychoanalysis? And if there are, in what conditions do they reach us?

Other questions arise from the above: how do we solve the request for reporting to an institution that finances the treatment of the patient, other treating professionals or an educational institution in the case of working with children or even with adolescents? How do we find ourselves being summoned to testify in a trial for judges and / or lawyers? How do we comply with our obligations to the law with our vote of confidentiality to the patient, in these and other incursions in which we are asked to leave the office?

In addition, by adding complexity, it may be possible to consider certain circumstances in which exit from the practice may lead to exchanges that generate a real contribution to our understanding of the conflicting patient and the work itself in the session. I think, for example, in some meetings with teachers or institution to which children or even adolescents attend in analyzes that display particularly in the educational setting symptoms or difficulties of a different order.

Presentation and publication of clinical material: agreements and ethical discrepancies

A difficulty that arises before the mandate of confidentiality refers to the presentation and publication of clinical materials. There is a coincidence in the value of these actions for the advancement of our discipline. Given that the theoretical validation of psychoanalysis is possible as a function of practice, the documentation of clinical cases is an important contribution to its evolution. However, Rodríguez Quiroga (2012) notes that for a long time he has been alerted to the insufficiency of clinical materials for study and research, which generates an important problem for analytical training. This author formulates some possible causes that intervene in this situation: the care of the patient and their intimacy, the difficulty of the analyst to expose himself in his work, and the absence of a resolution about the appropriate form of presentation of the clinical material. Several questions have been raised about how to solve the ethical dilemma raised between the need for publication and, at the same time, the obligation to preserve the patient's privacy. Although there seems to be no solution to this confrontation, there is a coincidence that the alternative of not publishing clinical material is not a viable option (Goldberg, cited by Gabbard, 1997, Gabbard, 1997, 2001).

Rodríguez Quiroga (2012) emphasizes two principles in common, which arise from a survey carried out by Garvey and Layton (2005) in several institutions of the IPA: 1) the obligation of analysts of the same organization or a team to keep in reserve confidential information of the practice; and (2) the need to preserve patients' anonymity when the

material is exposed to a wider audience, whether in presentations, publications or research.

However, even following these principles, discrepancies arise as to the appropriate form for the presentation and publication of the material. One of the topics of debate is the validity of the disfigurement of these. Goldberg (cited by Gabbard, 1997), on the one hand, questions that the clinical materials are presented with insufficient disfiguration, and at the same time manifests the risk of masking or disguise as a resource, considering that this modality can be removed from the reality of the patient and get to generate a story about a fiction.

These assessments are confronted by Gabbard (1997), who points out that it is impossible to have evidence that shows how a material is disfigured, and defends, instead, the idea that a well-disguised can constitute a good exposition of what which really happens in an analytical process. This author agrees with the model of the American Psychoanalytic Association, which aims to minimize the biographical information of the patient in order to avoid identification and, instead, aim to account for the analytical process with a detailed presentation of the dialogue in the session, maintaining unchanged desires, fantasies and conflicts (Gabbard, 1997). Although the mentioned expressions show that this author is prone to the disfiguration of the material, he also argues that the objective of the disguise is that the material cannot be identified by anyone other than the analyst and the patient himself (Gabbard, 1997).

This conception strikes me in many ways. On the one hand, it seems to imply that the disguise of the material is addressed to third parts and not to the patient himself, who could identify himself in it. I wonder, then, if, prior to the presentation or publication of the material following this criterion, this analyst does not somehow consider a certain treatment of this situation with the patient involved as long as this can be recognized in the material exposed. And on the other hand, I wonder: would it not be possible, or perhaps desirable, on certain occasions, to think of a form of disfiguration of the material that tends to prevent the patient from being able to recognize himself in it?

Beyond these assessments, which perhaps refer to topics that are more explicit in other texts of the author, Gabbard (1997) raises some lines that in his opinion preserve the patient's anonymity while giving rise to the scientific interest of presentation and publication. These are: not to include more information than necessary, to disfigure elements that can lead to patient identification, display a vignette instead of extensive materials and avoid writing about ongoing treatments. He also proposes that when writing about a clinical entity can expose a case composed by characteristics of several patients, except that this disfigurement does not lead to errors of information; and adds the possibility of agreeing the presentation with another colleague who appears as author or as coming from a group of analysts, so that both identities - the patient's and the analyst's - are masked.

In reference to limitations on the presentation or publication of clinical reports, Goldberg (2004) proposes that all possibilities posed for safeguarding confidentiality would be valid

for materials of patients outside the analytical environment, which excludes candidates' processes, although these would be a very valuable literature for psychoanalysis.

Both analysts agree that the method for preserving confidentiality should be chosen by the author for each case, based on clinical considerations, and they are not unaware that each presents its own difficulties, implications and limitations. It is also alert to the risks that exist today, as to the ease of access to publications that may have people outside the professional field through cyberspace. Based on the above mentioned complexities, the authors mentioned encourage analysts to reflect and generate a debate to achieve new strategies that point to an integrative perspective of the production of scientific knowledge in psychoanalysis. In the Journal for the moment, it is considered as editorial policy a series of alternatives to be taken into account in the preparation of written works, and those who include clinical material are requested to report on the method chosen for the protection of patients' privacy. In case you have opted for a written consent, you also have the possibility of requesting your presentation.

Some questions may remain pending in the light of the above: Is there an established criterion in our environment as to what measures to take to preserve the identity of the patient in a work involving him in the presentation of clinical material? It is necessary to unify a criterion in this sense? Do we share in this respect the laws in force in our environment for doctors and / or psychologists, or are there certain rules peculiar to psychoanalytic institutions?

Informed Consent: Diverse Perspectives and Ethical Dilemmas

Request the patient an informed consent is posed in different professional fields as a valid option for the presentation and publication of papers, as well as for the use of clinical materials for research. However, in psychoanalysis this procedure has generated controversies regarding its ethical implications and its effects on the analytical process.

In his position as editor of the Journal of Psychoanalysis, Gabbard (2001) rejected a statement by the International Committee of Medical Editors (2000) that the clinical accounts should not be disguised, but should be appealed to consent Informed of the patient. The author does not accept this criterion as adaptable for psychoanalytic writings because, in his view, leaving aside the disfigurement of clinical material is not considered the protection of the patient's privacy, which is the objective. However, Gabbard assumes the consent request as a complementary option that can be handled in certain situations.

Rodríguez Quiroga (2012) has carried out an extensive review of the psychoanalytic literature about diverse perspectives on this subject. He pointed out that the ethical principles of IPA 1993 lay down rules concerning the humanitarian values of psychoanalysis and professional obligations to patients, but did not specifically mention informed consent. In contrast, the author refers to some psychoanalytic organizations for which this procedure is not alien. He mentions that the codes of ethics of the Association of Psychologists of Buenos Aires (1993), the Association of Argentine Psychiatrists (1991)

and the American Psychological Association (2010) suggest that professionals ask patients for informed consent to start a psychotherapeutic and / or psychiatric treatment, and that the American Psychoanalytic Association (1983) extends this approach also to the analysts in training. Although it is not clear from the text that in these organizations this resource includes the possibility of presentation and publication of clinical material, this author postulates that informed consent is a right for patients and a duty for analysts and researchers.

Those who share this position consider that the request for informed consent implies respect for the autonomy of the patient, and that the analyst has no right to violate confidentiality if the patient does not consent to it. In this context, it calls for self-determination of patients for their decision. The fact that they do not always give their consent is considered in this perspective as a proof of their autonomy.

The main controversy regarding the request for consent to the patient is whether this is a possible procedure in the analytical situation. On this point, Gabbard (2000) finds many difficulties. First, in contrast to the position of self-determination of the patient, the author considers that the decision of this patient is not alien to the influence of the transferential vicissitudes, so it cannot be considered an objective and rational decision.

Based on this conception, Gabbard (2001) understands that the acceptance or not of the patient can have variations according to different stages of the analysis, and that according to the ethical norms, this one could revoke its consent at any moment, if it wishes. Taking into account this situation, the author warns about the ambivalences that can generate this device in both members of the analytical pair. He also adds that while consent implies that the material to be exposed is to be read by the patient before its presentation or publication, this fact exposes the author to the possibility of revising parts of the manuscript that may be objected by the patient, which inevitably conditions the transmission of the analyst.

Rodríguez Quiroga, however, maintains a radically different view, which I transcribe below: "the discussion prior to publication is another valuable example of co-construction of the material to be presented, which may or may not result in modifications by the patient, minimizing The risk of potential negative reactions and even place to possible positive consequences "(Rodríguez Quiroga, 2012: 975; own translation).

Face to this perspective, I allow myself to express new questions about the effects that this situation can have on the work of the analytical couple and on the presentation of the material itself: how can we not consider the incidence or perhaps the distortion that this resource can generate in the exposition of the story of a session or of an analytical process? Could it be that after the participation of the patient we can get to omit in the text key vicissitudes of the treatment for the impossibility to bring to light fantasies, affections or experiences that the patient rejects? How can we make known the patient's difficulties in detecting his or her conflictive, failed analytic experiences or even certain countertransferential aspects that can be lived with great intensity? Will it become a risk of this procedure the possibility of showing only that material in which, beyond vicissitudes of

the resistances, the patient has been receptive and the treatment successful? How, then, could we discuss and learn from unrealized analytic processes?

In an attempt to alleviate the difficulties involved in including consent in analytic practice, Gabbard (2000) reflects on the possibility of incorporating it into the preliminary interviews, so that it is established as part of the framework. However, this option does not convince the author because he believes that the proposal could affect the course of the analysis and induce the patient to retain information. It proposes, instead (2001), the alternative of considering the advantages of being requested after the conclusion of the analysis, but it is suggested that some interviews may still be necessary so that the patient can process the meaning of this request.

In spite of its controversies, in an earlier text this author identifies situations in which this resource seems advisable to him as a rule for the presentation of the material. These include: 1) cases in which the patient may have access to psychoanalytic publications, 2) patients who are candidates, and 3) situations in which the material refers to someone known or from the field of mental health. In all of them, it recommends that consent be in writing, rather than verbal agreement (Gabbard, 1997).

Rodríguez Quiroga (2012) questions the negative impact that the request for consent may have for the patient is emphasized, and instead refers to authors (Kantrowitz, 2005; Lipton, 1991) who point out possible positive effects. In this sense they refer to the patient's perception of the analyst's ethics, the importance of the analytic process itself to help others, and the feeling of collaborating in the advancement of knowledge.

With the aim of minimizing the vicissitudes and ambivalences that can lead to the inclusion of the request for consent in clinical practice, this author makes proposals that involve the care centers of psychoanalytic institutions. In this sense, she states that these entities may ask the people who come to receive care if they wish to collaborate with the investigations that the institutions carry out. Concerned about the management of the patient's material in the training institutes, she believes that this way one could overcome a first obstacle to this problem.

On the other hand, Levine and Stagno (2001) argue that the request for informed consent may turn out to be an unethical act, inasmuch as it places the patient in a situation of vulnerability. These authors propose to reserve this resource to identifiable materials whose publication is considered essential for scientific purposes, or when doubts remain in the text about the patient's anonymity. They also assume that in both situations what would be ethically appropriate would be to request consent when the manuscript was already prepared.

Instead, they postulate, as an alternative, the need to work the manuscript to achieve anonymity in the material without requiring the consent of the patient, who would not be identifiable. They indicate that in this case the absence of a request for consent could not be considered an ethical fault, insofar as it is assumed based on the principle of less harm to the patient. These authors propose two concomitant ways to confirm the preservation of

anonymity: 1) ask colleagues to review the text before their presentation, and 2) consider the editor's appreciation, who may request further modifications in this regard.

According to Levine and Stagno (2001), the formal ethical principles guiding the clinical attitude should be considered in terms of a context in which are included several factors that must be taken into account. In this sense, the authors conveyed the difficulty of adhering to a radical stance in this area, and aim, instead, to maintain confidence in the professional criterion - guided by the principle of protection of persons - without the need to resort to an absolute model that may interfere in the therapeutic processes or limit the opportunities of the professional to transmit their clinical experience. ◆

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