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Expanding the Domain Privacy, Secrecy, and Confidentiality

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Over the last ten years we have seen an increasing acceptance of the general idea of working with parents of child patients. What remains as an area of controversy is the question of whether and how much therapists should work concurrently with the parents of adolescent patients. Questions cluster around the issue of confidentiality and lead to the even larger issue of conceptualizing the developmental goals of the phase of adolescence.

Let us start with a clinical vignette: Jake was a high school senior preparing to leave for a prestigious university, his father's alma mater. He was in turmoil, determined to leave but clearly unready to do so. His parents took it for granted that Jake would follow in the family tradition and wanted treatment to help him "pull himself together and get on with his life." As the work proceeded, it became apparent to Jake and me that removal of the obstacles to his further development would require much more than self-control and immediate effort. When Jake and I met together with his parents to discuss this, his parents expressed concern and support, but at home they told Jake they were profoundly disappointed in him and expected him to try harder.

Jake was hurt and angry, but he shifted his rage to his girlfriend, whom he had encouraged to go out with another boy, and to me. He raged for weeks, broke up with his girlfriend, and began hinting at thoughts of killing himself. I noted this and asked Jake whether he was planning to kill himself, perhaps, to punish his girlfriend and me. Jake said he had been thinking about using one of his father's guns to blow

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An earlier version of this essay, titled "Separateness and Sharing," has been presented in numerous locales.

his brains out against the windows at the entrance to my office "so everyone will see how terrible and useless you are!"

Jake had an active suicide plan, and I was especially concerned when he mentioned using his father's gun. I told him that I thought he was in danger of killing himself, and asked what could be done to help him stay alive. Did his parents know that he was suicidal? "Hell no," Jake shouted, "and if you tell them I'll have you sued for breaking confidentiality. You promised me that everything I say is confidential. So now you're a liar too!" We'll return to Jake later, but his challenge is one many child analysts have had to face with little support from theory or standard practice.

In 1911, Freud said that development in a child can take place only "provided one includes the care it receives from its mother" (p. 220). Many years later, **Winnicott (1965)** said that there is no such thing as a baby; there is only a mother and a baby. Between those two comments and in subsequent years, there has been a neglect of the role of parent work in the analysis of children and adolescents. In a review of our book on parent work, **Yanof (2006)** describes this as "a subject that is almost never written about in psychoanalysis, even though … [it] is one of the most commonly encountered aspects of treating child patients" (p. **1437**). We think that many child therapists have actually worked with parents one way or another for a long time— see Anna Freud's analysis in the 1920s of Peter Heller **(Heller, 1990)**—but have not had a theoretical model within which to legitimize doing so or to make sense of the sometimes profound therapeutic outcomes we see. **Rosenbaum (1994)** describes an absence of clear technical guidelines; **Hirshfeld (2001)** talks about parent work in child therapy and analysis as a subject of controversy that has remained neglected and inconspicuous in the literature; and Erna Furman (**1996**, **1999**) writes about the impact of not working with parents and suggests sources of resistance in analysts to doing so.

We have talked and written since 2001 about an evolving model of parent work, and summarize our views in our book *Working with Parents Makes Therapy Work* **(K. Novick and J. Novick, 2005)**. The model asserts that parent work is substantive and legitimate and makes use of the full repertoire of psychoanalytic interventions. Progression through the phases of the child's treatment affects and is dynamically affected by interaction with the parent work. Parental consolidation in the phase of parenthood may also be profoundly affected by the child's forward developmental movement.

Many have said that adolescents are largely untreatable. We addressed this issue in 1982 and discussed it again when we wrote,

> It is noted by many that a majority of adolescents withdraw early in treatment. Those who stay are said to be unable to form a workable transference or transference

> neurosis, and very few adolescents reach a point of mutually agreed termination. **Bios (1980)** summarized his years of experience with adolescents with the statement that a transference neurosis cannot be formed until the close of adolescence, a remark which echoes the view stated earlier by Berman that "the adolescent does not have the capacity to regress and develop a transference neurosis" **(Panel 1972)**. This generally-held pessimistic view is highlighted by the remark attributed to Anna Freud that "we might have to face the fact that adolescents are not truly analyzable" [Novick and Novick, **1996**, p. 128].

Even earlier, Anna **Freud (1958)** and Peter Blos, Sr. **(1962)** expressed doubt about the feasibility of psychoanalytic work with adolescents. Whether one accedes to the pessimism or not, no one disputes that adolescents are difficult and stressful to work with. Our experience and that of our colleagues over 40 years at outpatient and inpatient facilities and agencies confirms that there is a high turnover of workers with young people, and many who remain find treatment methods that distance them from the adolescent, such as medications and schedules of behavior modification or group coercion. We suggest that if we expand the domain and include substantive concurrent work with parents as integral to the treatment of adolescents, then we can increase the rate of success and increase retention of adolescent workers.

Perhaps the major objection raised by many therapists to working with the parents of their adolescent patients is the issue of confidentiality. Therapists worry about the patient's security of communication and relationship and about losing his or her trust. Can the therapist rely on his or her own discretion to protect the young person's privacy? Analysts have traditionally solved this problem by avoiding parent work and restricting the definition of treatment goals to the youngster alone. Discussions by **Rosenbaum (1994)**, E. **Furman (1999)**, and R. Furman (personal communication, **2001**) describe and deplore this situation and chart a course for further work in this area. Erna **Furman (1995)** notes, "When we disregard the parent, we leave out crucial parts of the child's self, sometimes the best parts, and when we treat the parent and disregard the child, we commit the same mistake" (p. 27). Avoidance of parent work also leaves out the substantive issue of parental anxieties about losing their child and the dynamic interaction between parents and adolescents throughout treatment.

Dual Goals of Treatment

Our suggested solution is to posit that the treatment of child and adolescent patients always has dual goals: restoration of the child or adolescent to the path of progressive development and, simultaneously, restoration of the parent-child relationship to a

lifelong positive resource for both. When we suggest dual goals for any treatment, that is, when we explicitly include restoration of the parent-child relationship and growth in parental development in our shared aims, the legitimate field of the work is expanded and the central parental concern that they will lose their child is opened for discussion.

Nevertheless, the issue of confidentiality is genuine. We know that we have to devise techniques that protect the patient's privacy, help parents tolerate the frustration of not knowing everything, foster greater communication and sharing between parents and adolescent, and redefine separateness and separation from them.

The Distinction Between Privacy and Secrecy

We talk with parents and adolescents from the beginning about the difference between privacy and secrecy. Privacy is a given of mental life and a right related to mutual respect between separate individuals. Secrecy is motivated withholding that is often hostile and can carry a connotation of knowledge used to feel powerful in relation to excluded others. Differentiating between privacy and secrecy gives the therapist a needed vocabulary to explore family secrets, parents' secrets, and the adolescent's secrets. Failure to make the distinction leaves the analyst vulnerable to a silent countertransference, an internal resistance to engaging with areas of the patient's privacy, which then can have the destructive impact of turning private matters into powerful secrets.

We assure the parents that we will use our regular meetings together not only to follow what is happening at home and in their parenting but also to facilitate communication between them and their child. We point out to both the parents and the adolescent that the inner drama is similar for us all; the scenarios are of love, death, birth, creativity, frustration, jealousy, wishes, rivalries, mastery, and so forth. The patient's own version of the story is private; the details belong to him or her, and we are committed to providing a safe, private space for the adolescent to explore his or her own particular inner world. Again, we emphasize that therapy does not consist of a secret exchange from which parents are excluded; rather, it is a safe place where the teenager can learn about, explore, and expand his or her private inner world. The inner world is a potential source of love, creativity, and competence. This private space must be protected and respected, and the adolescent will learn how to be in charge of his or her privacy, including how to use and share parts of this world in the most adaptive way. We have found that, as adolescents feel more secure in the distinction between secrecy and privacy, they can share aspects of their treatment in a helpful way with their parents.

Fifteen-year-old Steven was having trouble waking up on time in the morning, and this became a battle with his parents. I wondered why he couldn't share with his

parents how hard he was struggling in his treatment to deal with some very difficult feelings—so difficult that sometimes he dreaded waking up. When Steven was able to share this, he and his parents could work together on ways to make the mornings more manageable. He was proud of being able to say as much as was helpful and not feel compelled to say everything or get into a battle with his mother in order to keep the details of his inner life private.

When parents have secrets, there is corresponding work to do to help them find appropriate ways and timing to talk to their child about the parts of the issue that are impeding progression for the adolescent. This was the situation with Ben's parents, who understandably felt that issues in their marriage before Ben's birth were irrelevant to him. However, analysis demonstrated that reverberations from old events were significant in the present and needed to be acknowledged.

Ben was a 19-year-old sophomore in the musical theater department of a local college. He was the youngest of three sons, ten years younger than the next oldest. There was clearly an underlying story about his conception because he had no idea why there was such an age gap between him and his brother. From early childhood he had shown marked talent in singing and dancing; in third grade he set his sights on a Broadway career. He was the lead in all his school productions, won places each summer at highly competitive performing arts programs, and despite his youth had already played the lead in the department's annual major production.

This department was very good but not the best to which he had been accepted. His parents had insisted that he was too young to live farther away, that he had separation problems, and they implied that they could not afford the tuition at a better school. However, the two older brothers had been fully supported in their college studies at prestigious East Coast universities. This pattern was established early on; for many years, resources were poured into supporting the two older boys, but they were grudgingly doled out to the youngest. This had been an issue during the evaluation, when Ben's parents balked at paying for intensive treatment. Despite their awareness of his serious depression and the availability of an unusually generous insurance program, they haggled over the fee and the frequency of sessions. They agreed to have Ben start treatment out of concern for his suicidal potential as his depression deepened and because the analyst suggested that the entire situation could be reevaluated at the end of the school year, seven months on.

Ben responded quickly. His depression lifted, and the story emerged of his being controlled, teased, and depreciated by his adored older brothers, who were clearly envious of his talents. The parents seemed to have done nothing to protect him but went out of their way to minimize his achievements and compensate the brothers for his success. Ben was convinced that any success would evoke envious attack from his brothers and lack of protection or collusion from his parents. He began to

articulate his feeling that he was an unwanted stepchild who could remain part of the family only by blunting his talents and curbing his desires.

At this point the therapist suggested a meeting with the parents and told Ben that he wanted to explore this pervasive dynamic and find out the reason for the age gap between Ben and his siblings. Ben was invited to attend, but he declined, because he worried that his parents would feel inhibited by his presence. At the meeting, the parents expressed their relief at Ben's recovery and wondered whether treatment could end in a few months. The therapist acknowledged their relief but said that he was concerned by an emerging picture of Ben stopping himself from fully succeeding. The analyst talked about the impact of the brothers, their envy and hostility toward Ben's success, Ben's love for them and fear of hurting them, and Ben's love for his parents. He added that their support of his treatment and their evident relief at his recovering better spirits attested to their love for Ben. The parents seemed very moved by this comment, as if no one had ever articulated love between Ben and his parents.

The analyst then asked about the age gap; was there a story behind the ten-year difference? Both parents blushed, stalled, and said that there was still pain and confusion around that issue, and they would rather not discuss it. They said that they had talked about this in their own therapy, so it was dealt with. The analyst said, “I understand your reluctance to talk about something painful, but this is something that may help Ben; it is the brave and responsible thing to do. Sharing it with me so that I can better understand Ben is important, and it will probably eventually enhance your relationship with him.” The mother said, “He's right. It's like a boulder in the road; we need help to move it.”

Work with the parents over the subsequent six months is condensed in the following account of the secrets that emerged amid great emotion, resistance, and relief. The first secret emerged in the first few weeks, when the mother told of a time when the marriage was in a crisis, the father was having an affair, and they were heading for divorce. She thought that a baby might bring them back together, so she tricked her husband into having unprotected intercourse, and she conceived. She said, “I think that Ben always reminds me of that terrible time and of my deception.” The father at first denied ever thinking of it, but then he remarked thoughtfully, “I think I always resented Ben, as if he had stopped me from staying young forever.”

Ben's mother laughed and said, “Is that why you had the affair?” The father answered, “Didn't you know? You think that young airhead could hold a candle to you?” They laughed, she cried, and they left holding hands after promising to talk to Ben about those troubled times.

His parents had seldom attended Ben's performances, even though they did not live very far away, which hurt and confused him. Work in his treatment addressed his

responsibility to interest them in his current life and achievements and his conflicts over including them and telling them how important they were to him.

A few years later, the therapist received a note from Ben. It contained a newspaper clipping praising his performance in an off-Broadway musical. At the bottom, Ben wrote, "My parents were at the opening. For this and other things, many thanks" **(K. Novick and J. Novick, 2005)**.

Confidentiality and the Hierarchy of Treatment Values

As we have worked to understand our experience in treating adolescents, we have realized that there is a hierarchy of clinical values that we apply to treatments of patients of all ages. The establishment of safety—for the patient, the parents, the therapist—is paramount in our view. It is in the best interests of the adolescents that they be kept safe from harm to themselves or others. Those working from an adult-only model assert that confidentiality is the core value of psychoanalysis; it is the defining sine qua non of psychoanalytic treatment (O'Neil, **2007**).

Differentiating as we do between privacy and secrecy helps us define confidentiality as basic but contingent in the hierarchy of treatment values. Confidentiality should be maintained in support of privacy, not as a reflexive collusion with secrecy. The human need for guidelines can sometimes be intensified by analysts creating a rigid analytic superego that imposes rules in a blanket fashion **(Novick and Novick, 2003)**. Current writers, such as **Goldberg (2007)**, make a similar point about issues such as confidentiality that "insinuate" themselves into "correct" therapeutic technique without adequate examination. Our goal is to make any secrecy a legitimate object of analytic scrutiny and understanding, so that the patient and his or her parents can find their way to fruitful sharing and communication of whatever is important to each and all of them. The analyst's task is to support these goals by respecting the privacy of thoughts and feelings in all the multiple alliances while examining actions with the patient and parents in their respective arenas of work together.

When we become aware, often through the revelation of a secret by a child or adolescent, that parents and children are out of touch with each other, our consciousness is raised to listen for opportunities to address the issue. At other times, dangerous actions or planned actions by an adolescent demand direct intervention in the form of discussion with the patient about how he or she is going to enlist needed assistance or support from parents or other adults. The point is that confidentiality is not a fixed attitude that takes over all other clinical values, but rather it contributes to safety and comfort for all parties in the therapeutic situation as a dynamic dimension of joint investigation.

Adolescence is a time when patients are at high risk of serious, even lethal harm to themselves or others. We may see this in suicide or murder, auto accidents,

substance abuse, sexually dangerous behavior (unprotected sex, pregnancy, prostitution), perversion, eating disorders, criminal behavior such as delinquency or property destruction, and cults and gangs. It is essential that the burden of these possibilities not be carried by the analyst alone. Often a referral comes at a point of parental helplessness, and parents wish or expect the therapist to be the police, the priest, the enforcer of good behavior. When this expectation is combined with the adolescent's need to protect his or her idealizations of the parents by making the treatment fail, the situation becomes untenable and dangerous **(Novick and Novick, 1996)**.

In line with the psychoanalytic axiom differentiating thoughts and actions, we are explicit with adolescents and their parents that thoughts are private, actions are public. When teenagers do something that endangers themselves or others, it does not fall under the mantle of confidentiality but is something that we will discuss with the patient in terms of how to talk with his or her parents or some other adult about the situation. Self-injurious activities, risk-taking behavior, and suicidal gestures and actions are all possible candidates for joint disclosure to parents or other authorities. This calls for fine judgment on the part of the therapist and is one of the areas of greatest stress during treatment of young people. But setting the conditions explicitly at the beginning reassures the analyst, parents, and usually the adolescent patient that the therapist will be realistic and do his or her best to keep the situation safe and secure.

Actively setting dual goals for any treatment, which include restoring the parent-child relationship to open-system transformative capacity, allows us to promote and support the parents' primary responsibility for their child. We work hard in the initial phases of treatment to place the parents in their rightful central position in the mental and emotional life of the child and the child or adolescent in the center of the parents' consolidation in the phase of parenthood. Secrecy between parents and children interferes with these aims. Many experiences, thoughts, and feelings in the lives of parents and children are private and therefore not each other's business, but the presence of secrets usually indicates the operation of pathological defenses or ways of relating that are very salient to the work of treatment. Parents who “don't want to know” are defensively abdicating their rightful role, often by externalizing responsibility onto the therapist to deal with unpleasant or painful issues in the child. We can describe our techniques for dealing with secrets in general terms as keeping safety and responsibility in the hands of parents, where they belong, even if this takes a long time to establish or reestablish throughout a treatment.

Knowing that the analyst will work to keep the adolescent safe, differentiating between privacy and secrecy, promotes trust that thoughts and feelings will be respected as belonging to one's private mental life. This allows gradual relaxation into sharing them with the analyst. Progress along the developmental line of the

sense of self includes increasing reliance on the privacy of one's mind and the right to choose to share it with another.

With this in mind, let us return to Jake, who threatened to blow his brains out with his father's gun. As noted earlier, I asked whether his parents knew that he was suicidal. “Hell no,” Jake shouted, “and if you tell them I'll have you sued for breaking confidentiality. You promised me that everything I say is confidential. So now you're a liar too!” I reminded Jake (and myself) that the initial discussions had stipulated that all Jake's thoughts and feelings were private, but actions that posed a threat to his safety or to others took precedence; everyone was then responsible for ensuring his safety. I suggested that Jake start by telling me about his father's guns and whether he had access to them. Jake's anger subsided, and he told me more calmly that his father was a gun collector, with everything from modern assault rifles to flintlocks from the eighteenth century. Most of the guns, especially the historical weapons, were kept in a locked display case, but Jake knew where the key was, and he had recently noticed that there were always other guns lying around. “Is this a message?” Jake wondered, and I wondered why his father had never mentioned the guns in the parent sessions. Jake agreed that he needed help and that his parents should know his current suicidal state. He said he would speak with them right after the session. I said I would call him in a couple of hours to hear how it had gone and what was happening.

On the phone, Jake said that his parents seemed to be avoiding him, breaking off the conversation when he said he needed to have a serious talk with them. He was relieved when I suggested a joint emergency meeting for that evening, at which Jake could tell his parents of his unbearable stress, his wish to please them, yet his helplessness to do so. His hurt and anger and wish to kill himself felt like his only way out of the situation. His plan was to do it with one of his father's guns, so he needed his parents to take responsibility for suicide-proofing the house.

At the meeting, which the parents attended only under pressure from me, they first said that Jake was not serious, that he was being dramatic to manipulate both me and them in order to avoid his responsibilities. I stated that I felt otherwise, that I was convinced that Jake would kill himself if his parents did not listen and take the danger seriously. They could demonstrate that they believed him by locking up the guns, keeping the ammunition in a separate place, and putting the keys to the gun case in their safe. I said that I was inserting a note that day into Jake's file, describing the danger of suicide and stating that the need to seal off access to the guns had been discussed with Jake's parents.

The parents were taken aback, then agreed to lock up the guns as suggested. I privately thought they were initially motivated as much by potential social embarrassment as by genuine concern for Jake, but their actions were critical to protecting

him. A few weeks later, they gave indications of greater investment as parents when they said to me and then to Jake that they realized that his attending a particular college was not as important as his survival. After this, Jake said that he no longer needed to attend the weekly parent sessions. “I trust you,” he said, “and besides I think that they have their own issues to deal with.” Among the many issues that affected their parenting was the repetition of how they were treated by their parents, especially during their high school years. As the work with Jake and, separately, with his parents, progressed, they all became closer and more loving than at any time earlier in his adolescence.

The model of working with parents of children and adolescents in treatment that we are suggesting is not prescriptive. We are not replacing a prohibition against such work with a demand that all treatments of children and adolescents must include parent work to be effective. We work with what people bring, what they are capable of, what they can tolerate. We start with them where they are; sometimes adolescents refuse to allow us to see their parents regularly or even to meet them. Many adolescents and their parents have internalized the powerful Anglo-American and psychoanalytic view that successful adolescent development means physical separation; having and keeping secrets is a means, endorsed by teenagers and their parents alike, to facilitate separation. They often believe that any genuine communication between parent and child or therapist and parents threatens the developmental thrust and may lead to a regressive inability to separate. The separateness of all individuals from birth on is conflated with separation, which often follows a culturally- and economically-based timetable.

We have noted (DeVito, Novick, and Novick, **1994**, **2000**) that most adolescent therapists and theorists have held definitive views that the goal of adolescence is separation; that normal adolescents need to keep thoughts, wishes, and activities secret from parents as part of the separation process; and that adolescents need allies in the inevitable clash of generations, the normal need to rebel against all authorities. Each of these views has been axiomatic, both in child analytic education and indeed in the cultural view of adolescence, and each has influenced technical choices in how adolescent treatments are designed. With this standard concept of adolescent development, parental intrusion and inability to separate are seen as the major obstacles to adolescent treatment and growth. Many analysts who work with adolescents therefore regularly refer parents to another clinician.

Our view of adolescence is different. We see the major developmental tasks for both parents and children as involving transformation of the self and the relationship, in the context of separateness rather than separation, particularly physical separation. Therefore, we think the adolescent's analyst should be responsible for protecting the privacy of the patient while supporting improved communication

between parents and child and analyzing obstacles to free exchange. We can help parents deal with feelings of exclusion by reminding them of the treatment goal of greater closeness with their children. It is another chance to introduce the concept that development does not mean their child just grows away from them. Rather, it means that they and their child create new ways to be close at the new level. This is particularly important in relation to adolescents.

With our emphasis on transformation of the parent-child relationship rather than separation, the goal for parents and adolescents becomes integration of the new reality perceptions of self and others into the representational world. In relation to parents, the goal is to transform the relationship into one that can incorporate the realities of biological and psychological change in both adolescence and middle age. Parents and adolescents have the difficult task of realigning the two major self-regulatory principles, the pleasure and reality principles. The new realities of adolescence have to become the major sources of pleasure and self-esteem.

Physical separation, for instance when older adolescents go to college, is not necessarily the best or only method for accomplishing these goals; indeed, physical separation may solidify pathological, closed-system methods of self-regulation or delay open-system transformative growth. Unfortunately, it is the external physical separation of college entrance that has taken on the cultural status of the rite of passage into adulthood (DeVito et al., **1994**, **2000**). This traditional Anglo-American reliance on physical separation to accomplish psychological tasks has been incorporated into psychoanalytic theory and then reexported into mainstream culture, so that parents and adolescents alike expect young people to want to leave, be completely separate, and have secret lives that their parents don't know about or even feel they have any right to share.

Our understanding is that socially validated secrecy actually retards development in that it allows young people to create the illusion of rebelling. They can thereby avoid the transformative necessity of directly engaging with parental values and taking responsibility for their own actions. There is a culturally determined notion that adolescence should be a time of secret rebellion. Both parents and adolescents worry that the wall of secrecy will be breached and everyone will be faced with issues that cause profound and disturbing conflicts. At the younger levels of high school and middle school, there are similar issues, which tend to take the form of rationalized “turning a blind eye,” lack of supervision and common sense on the part of parents, with denial and grandiosity on the part of younger adolescents. Nathan's analyst struggled to find a comfortable way to help Nathan's parents regain their sense of responsibility and alertness to their son's vulnerability to excitement.

Twelve-year-old Nathan talked in his sessions about his excitement in setting fires. He and his friends used butane candle lighters to scorch various materials. The

sexual excitement represented in this behavior was explored in treatment, and the analyst also raised the question of safety for Nathan and the house, asking whether Nathan was being a good parent to himself by keeping everything safe enough. Nathan began to think through how to make it safer, but this material also alerted the analyst to a possible lack of parental vigilance. The parents were still seeing Nathan as a little boy rather than as a pubertal adolescent. Keeping in mind the hierarchy of clinical values that puts safety at the top of the list, the analyst began to listen closely in parent sessions for an opportunity to address the issue of parental disengagement from Nathan.

In a parent session this issue arose first in relation to the parents' having no qualms about Nathan babysitting for a neighbor's little girl. Babysitting represented in part a progressive impulse for Nathan, in that he was seeking responsibility and earning capacity for the first time, but neither the boy nor his parents allowed themselves to think of any potential pitfalls. The therapist asked them what they thought of a pubertal boy caring intimately for a four-year-old girl. This allowed for a discussion of general difficulties in impulse control at Nathan's age, and the continuing need for parental involvement and monitoring of activities to support the development of appropriate controls. The mother then remembered her 13-year-old cousin approaching her inappropriately during a family vacation and her parents intervening. The result of this work was greater parental recognition of Nathan as he was: a person with growing strengths *and* continuing needs for his parents (K. Novick and J. Novick, **2005**, p. 125).

In this instance, the analyst did not have to address with the parents the specific behavior of fire-setting described in Nathan's sessions, but could address more importantly the general issue of impulsivity and Nathan's ongoing need for supportive supervision. This was an important shared experience for the therapist and the parents that was put to good use later in the treatment when Nathan briefly stole and shoplifted.

Working with parents has proven very effective in starting, continuing, and ending child analyses well (A. **Freud, 1970**; R. Furman, personal communication, **2001**; **K. Novick and J. Novick, 2005**). Our experience validates its worth in adolescent treatment too. When we distinguish between privacy and secrecy, place confidentiality accurately in the hierarchy of treatment values, actively assert from the beginning the dual goals of treatment, and work together with young people and their parents to transform their relationships and distinguish between separateness and separation, the task of analyzing adolescents no longer seems so difficult.

This essay is part of a continuing effort to expand the domain of psychoanalysis. The aim of our article “Reclaiming the Land” **(Novick and Novick, 2002)** was to characterize psychoanalysis once again as a general psychology. There we note,

> Defining psychoanalysis as a multidimensional theory sets us again on the path of formulating it both as a general psychology and as an ever-expanding multimodal technique. As such, we can reclaim those who are now treated only by speech therapists for relational, social and empathic disorders; or by occupational therapists for sensory integration difficulties; or by pediatricians and family physicians for anxiety, sadness, attention difficulties and more; or by psychologists for cognitive and behavioral problems; or by other specialized therapists for the sequelae to trauma, and so on. A metapsychological approach to technique combats an ever-narrowing definition of what is psychoanalytic and encompasses the whole range of psychological interventions [p. **366**].

The strategy we have used in much of our work is to look to child and adolescent analysis as a largely untapped source of insights into general psychoanalytic theory and technique **(J. Novick, 1990)**. We assume that there are continuities between the two domains, and child and adolescent analysis can illuminate issues in adult work. In our 2005 book on parent work, we looked at how we might apply the parent techniques evolved in child and adolescent work to the treatment of adults. We described assessing in adult patients the degree of internalization of parental functions such as self-care, the quality of self-regard and love, externalization of parent-child relationship patterns as distinct from transference, the role of externalized parental figures, and the achievement of the adult phase of parenthood.

But are the distinctions we are suggesting between privacy and secrecy and the place of confidentiality in the hierarchy of clinical values, particularly in work with adolescents and their parents, relevant in the treatment of adults? Recent work by O'Neil **(2007)** and others underscores the primacy of issues of confidentiality in analytic work with adults and in the teaching of adult analysis.

From our work with children and their parents, however, we have placed safety foremost in the hierarchy of clinical values. Establishing a relationship of mutual trust and respect is fundamental in treatment with people of all ages. This takes time, effort, and clinical work to achieve. Secrecy is a barrier to the development of a secure relationship. We must engage therapeutically with secrecy because of the role it can play in hostile power relationships, both within treatment and outside. Confidentiality is essential to protect the privacy of the patient, but confidentiality used in the service of secrecy can be a silent countertransference collusion with the patient's defensive effort to ward off access to the private sphere of the self. Goldberg's **(2007)** shift from morality to ethics is in line with our view that the complexity of these issues is not served by rigid adherence to generalized rules. We hope our reactions reflect the particular and specific reality of the patient's clinical situation and its needs, internally and in the treatment relationship. Within a safe

therapeutic relationship, patient and analyst can begin to explore the innermost private regions of the self, the specific, individual, and central dimensions of the personality and identity.

Mr. A entered treatment because his wife said she would divorce him if he didn't stop viewing pornographic Internet sites. Despite the risks, he often logged on at his office, where this misuse of the computer would result in dismissal. For months, he constantly brought the analysis back to these secret activities, his uncontrollable excitement, and his fear of getting caught, trying to pull me into a focus on the secrets as he variously told, withheld, hinted, and teased. As he gradually described more details, we saw that having a secret activity made him feel special, and the content of his favorite child pornography sites reinforced his sense of omnipotent power over others. We worked on the multiple determinants to his addiction, but at one point he began to express concern about telling me things, and worried that I would somehow betray him. "But," he said, "this is privileged communication, and you are legally bound to keep my secrets." I asked myself what the secret was because nothing private and authentic was being shared. I eventually said to him, "What is the big deal about your porno? Any 15-year-old can log on and masturbate just like you. What is it that you do that no 15-year-old can do? That is what we are not hearing about."

He immediately wanted to stop treatment, even inviting job offers from distant cities to force a premature termination. Months of back-and-forth followed in which he tried to pull me again into a battle over his secrets. I persisted in pointing out the material that demonstrated his capacities, competence and creativity, and how he invariably followed these moments with impulses to check porno sites, a swift masking of his positive qualities with his flashy omnipotent secrets and closed-system power struggles in the treatment. Over time we began to notice these together, and the tenor of the sessions changed. We could organize the analytic work around his conflicts over functioning in an authentic expression of his particular individuality, to be himself.

Working together in this truly private arena facilitated the emergence of memories and feelings that pointed to experiences of trauma and emotional abuse. First in the transference and dreams, then in multiple memories confirmed by his older sister, he described a situation in which his mother repeatedly used his precocious talents to show off to her friends and feed her own self-esteem. She had presented him in a way that he felt was a lie. Her "soul blind" (Novick and Kelly, 1970; **K. Novick and J. Novick, 1994**; Wurmser, **1994**, **1996**, **2007**; J. Novick and K. Novick, **1996**, **2005**) exhibitionism disguised the reality that he was a timid little boy, terrified that his refusal to perform and meet her needs would lead her to repudiate him. To be himself meant being alone, abandoned, and helpless.

In his first formulations of psychoanalytic technique, **Freud (1913)** put forth

the idea of confidentiality as one of the three defining conditions of clinical work. Freud was referring to the patient's secret about being in treatment. Nicky, an eight-year-old, had no problem letting others know he was coming to a therapist; in fact, he often brought a friend to wait while he had his session. But in his first month of analysis he articulated the distinction discussed in this essay. In response to my comment that I knew that boys often had thoughts before falling asleep, he said, “I can't talk about those things here; they're personal.” It took many months of work together for us to reach a point where he could safely share his innermost, private thoughts and feelings.

Conclusion

Building on the positive results of concurrent parent work in child treatment, we have suggested that concurrent work with parents of adolescent patients can increase the rate of therapeutic retention and success. The main objection raised to such work by analysts of adolescents is the issue of confidentiality. We suggest various ways of working with this problem, including positing dual goals of treatment, differentiating between privacy and secrecy, and building alliances between parents, adolescents, and analysts.

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