



*The Why of Sharing
and Not the What:
Confidentiality and Analytic Purpose*

In a series of papers over the past decade, Allannah Furlong has examined some of the technical stresses inherent in the classical psychoanalytic frame and their clinical and ethical implications. Here she discusses confidentiality as a beleaguered aspect of the analytic frame. In the early 1990s, the legal fallout from the recovered-memory debate brought sharply into focus the dubious probative value of using in court “evidence” from the psychotherapeutic process. Defendants in sexual-assault trials began seeking access to the personal files of complainants. Bioethical conceptions of informed consent threatened to become the standard for all professional work. As a result, the psychoanalytic frame was placed at risk of distortion and collapse. In this chapter, Furlong reasons from the inside out the clinical and theoretical foundation for confidentiality as it is actually practiced in the psychoanalytic situation, the better to distinguish the specific implications for clinical work of sharing it with colleagues and with third parties.

CHAPTER 4



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Confidentiality and Analytic Purpose

Allannah Furlong

When analysts speak to each other and the public about confidentiality, contradiction and confusion may ensue. Part of the problem stems from the fact that we have been using terms borrowed from other disciplines, such as law and medicine, which are foreign to our technique and to our theory and which if applied to our domain actually misrepresent, and do violence to, our work. If we are to make any sense of confidentiality in the analytic setting, distinctions need to be drawn with respect to related concepts, such as secrecy, anonymity, privacy, and the privilege of nondisclosure before the courts.¹ None of these related terms, nor even much of our own public discourse on confidentiality, has derived from psychoanalytic thought. Moreover, the exact contours of confidentiality are more meaningfully understood as context-sensitive rather than absolute.

We need to situate our use of the term “confidentiality” with respect to the specifics of psychoanalytic work: the dynamic unconscious, transference and countertransference, and interpretation. What we mean by “confidentiality” needs to derive from these specifics. In fact, it seems that it is not our definition of confidentiality that sets us apart from the practice of other professionals but only our pretense

¹I have tried elsewhere to explain to a nonanalytic reader why a quasi-absolute privilege for psychoanalytic treatment, consistently shielding the integrity of clinical work, is far more likely to promote than to detract from the truth-seeking judicial process (Furlong, 2003).

to a more stringent observance. Is what we espouse simply a super version of the confidentiality offered by other health-care professionals, or does it take on a specialized meaning in the context of psychoanalytic treatment?

Let me pause to address an unwarranted embarrassment about the complexity of the psychoanalytic setting, an exaggerated shame when we compare psychoanalysis to other scientific disciplines. Physicists have known for many years that light behaves like a wave in some circumstances, like a particle in others. Perhaps we should not be astonished by this observation since it is characteristic of all material objects to vary, sometimes radically, under different conditions. The three steady states of matter—solid, liquid, and gas—attest to the dramatic effect on molecular behavior from changes in temperature. Yet we can define an essential “sameness” to the elements of the periodic table by reference to their atomic weight and structure despite significant variations in appearance and behavior under different conditions.

Confidentiality also comes in a number of different sizes and shapes, each one an adaptation to a particular therapeutic context and aim (see for example the Canadian Psychiatric Association’s position paper “Shared Mental Health Care in Canada” by Kates et al., 1996). This does not mean that confidentiality needs to be a concept impossible to define or ethically contradictory. I will argue here that much of our current discourse completely misrepresents, to paraphrase Bollas (1987), the “unspoken known” of our practice and of our implicit conceptualization of confidentiality.

The Concretization of Confidentiality

Jean Laplanche (1993) has criticized what he calls the “metaphysical temptation” present in some contemporary psychoanalytic thought, whereby notions that began as adjectives or verbs mutate into nouns, substances. Confidentiality has tended to become conceived of as a thing in itself instead of a qualification of the analytic relationship; this state of affairs is known among philosophers as “reification,” and “hypostatization.” If we go back to fundamentals, we would be hard-pressed to see anything inherently sacred about confidentiality aside from the purpose it serves. It is a technical means, not a moral goal. A protection of the information circulated in the consulting room, the primary rationale for confidentiality in psychoanalytic treatment, pro-

motes the free-association process in the patient and analyst. By reminding ourselves of the function of confidentiality as an essential characteristic and containing property of the framework, we are brought back to its *purpose* in permitting safe and uncontaminated movement from inchoate experience to thought experiment and eventual mentalization by the patient-psychoanalyst dyad.

Analysts have resisted third-party reporting, not so much to safeguard patient privacy as such but because of the insidious effects of outside pressure on the freedom of patients' associations and on the benevolent neutrality of our listening. It is in permitting the suspension of reality claims that confidentiality takes on unique importance to the psychoanalytic relationship and not as a transcendent moral claim. If confidentiality is asserted as an "absolute" value that we must obey without reference to context and function as part of ongoing real psychoanalytic relationships, then it risks becoming a "thing-presentation" rather than a "word-presentation." It will be recalled that for Freud (1915) the unconscious is synonymous with isolation from the network of verbal associations.

Let us examine a typical definition of confidentiality by which analysts try (impossibly) to measure themselves. An exemplary definition appeared in a recent issue of *The Canadian Psychiatric Journal*: "Confidentiality can be defined as the ethical, professional, and legal obligation of a physician not to disclose what is communicated to him or her within the physician-patient relationship" (Chaimowitz, Glancy, and Blackburn, 2000, p. 900).²

One has only to scratch the surface of this type of definition to realize that it cannot guide psychoanalytic work. Almost literally a promise of secrecy, confidentiality conceived of in this way is a point of honor more or less identically applicable to a number of health- and nonhealth-professional relationships. Nor can confidentiality, as practiced by psychoanalysts, be viewed as primarily a protection of patient privacy, however crucial privacy is in its own right to individual psychological autonomy and integrity. There are a number of aspects of the practice of confidentiality in our discipline that all

²A similar definition can be found in the Health Information Privacy Code of the Canadian Medical Association (1998), which states:

[The] "duty of confidentiality" means the duty of physicians and other health professionals in a fiduciary relationship with patients to ensure that health information is kept secret and not disclosed or made accessible to others unless authorized by patient consent [p. 998].

psychoanalysts basically "know" but that cannot be shoehorned into the ethical categories of other mental-health professions: that psychoanalytic confidentiality is not equivalent to secrecy; that patient privacy is only part of what is at stake in psychoanalytic treatment; that confidentiality in our field serves treatment integrity rather than patients' interests in the lay sense; that in order for confidentiality to be waived, patient consent is a necessary, but not sufficient, condition; and that the boundaries of confidentiality can, and often must, extend beyond the dyad.

I will try to show how we are led to a necessary triangulation of confidentiality among psychoanalysts. For a number of reasons inherent to the psychoanalytic relationship, psychoanalysts must share information about their patients and themselves with other analysts or foreclose entire sectors of their clinical comprehension and interpretive reach. They must share for the sake of the integrity of the treatment in its aim of unraveling unconscious derivatives, whereas automatic disclosure based on patient consent can lead us into unsuitable applications of contemporary ethical principles.

We have all too often reified confidentiality in one corner of our mind as an ethical ideal that has been pulled free from its therapeutic function and then enshrined as a moral precept owed in an absolute fashion to the patient. Yet as students of unconscious communication, we know that context is everything, that meaning can never be divorced from the transference-countertransference field, and that patients and analysts are perfectly capable—by means of the irrepressible inventiveness of primary-process thought—of disguising selfish, and even reprehensible, motives in apparently ethical behavior. We know that patients are often the most eager accomplices in undermining the confidentiality of their treatments, as they attempt to engage us as white knights against the dragons of their imaginary and real universes. It is quite possible to find ourselves asserting confidentiality against the patient's protests, against even what she believes to be her best interests. This is odd behavior if we subscribe to the idea that patients can waive their claim to confidentiality. This apparent contradiction dissipates *if confidentiality is understood as a factor contributing to the integrity of the psychoanalytic relationship, safeguarding the analyst's, as well as the patient's, mental freedom and honesty.*

I propose that we regard confidentiality as a "skin" rather than as a "lock." It must breathe, be flexible to context, and, if need be, stretch to contain therapeutic work in extreme situations. Both skins

and locks act as containers, but whereas the former is a porous, dynamic membrane enveloping the entire therapeutic unit, the latter is a mechanical device, impervious to ambiance or relationship, designed exclusively for the protection of the patient in whose hand the “key” allegedly lies. It seems wrongheaded to overemphasize the concrete content of what is divulged outside the therapeutic relationship at the expense of the contextual and relational import of that content.

For example, when a man reveals fantasies of brutally attacking his estranged wife, some contemporary ethicists might view this admission as creating the following dilemma for the clinician: Should I betray his confidence in alerting the authorities or his wife? Yet research has shown that third-party warnings are ineffective in averting violence (Stone, 1988; Dietz, 1990; Slovenko, 1998b). Realistically, this content cannot be judged out of a context, a context that includes the patient’s mental status, his accessibility to interpretation and ability to stand back from his aggressive impulses, his depth of commitment to psychological treatment or his capacity to benefit from it (or both), the treatment setting in which the revelation takes place, and the quality of the therapeutic relationship. Most experienced clinicians would not frame the problem as an opposition between the patient’s interests and third parties. Most clinicians naturally conceptualize confidentiality as integral to treatment integrity, so they would be more likely to posit the issue raised by a patient’s violent fantasies in clinical terms: Is the current treatment plan adequate in the present context to protect the patient from a violent acting out? Violence is not only dangerous to other people; it is equally disastrous to the patient by virtue of concomitant treatment failure, legal repercussions, alienation from family and community, deep despair and regret over the often irreparable consequences of his actions, and potential suicide.

The confidentiality question is best posed uncluttered by secondary legal or social claims: in the present context, should a “third”—professional, family member, or institution—be involved so as to ensure that the patient’s aggressive impulses receive optimal treatment? In arguing for fidelity to clinical goals, I am attempting to rehabilitate the traditional backbone of mental health guidelines, which has been vitiated by the antipsychiatric movement of the 1970s and also in the wake of the famous, but much misunderstood, Tarasoff California Supreme Court decision. Slovenko (1998a, 1998b) and Stone

(1988) have shown that this legal decision and a number of academic criticisms of allegedly paternalistic and patriarchal professional attitudes and past psychiatric abuse of civil rights have had unfortunate defensive effects on clinical practice.

The Specific Function of Confidentiality in the Analytic Process

Freud pointed out that the patient’s attempt to shield secrets under any guise—altruistic, patriotic, or otherwise—quickly creates a logjam in the free flow of ideas. Defining confidentiality as a promise to “never tell anything” outside of the relationship could risk the same effect since it doesn’t take into account the impact of the outsider’s listening on the combined freedom of thought in the analyst and freedom of speech in the analysand. In other words, it does not take into account the *purpose* of the outsider’s listening. When we swear our allegiance to “absolute” confidentiality, it makes far more analytic sense to interpret this as faithfulness to an ideal of analytic listening rather than as a concrete question of information passing outside of the dyad. The confidentiality of the process is there to unfetter the patient’s discourse and the analyst’s reverie. *The circulation of information outside the dyad need not be toxic, may or may not disrupt the analytic couple’s openness to new meaning. Key to contamination and inhibition of analytic work is whether or not disclosure continues to serve an analytic end.*

Confidentiality is not so much an ethical matter as a clinical one, the final arbiter of ethical decisions being faithfulness to clinical considerations in the context of our best theoretical understanding. Regarding the narrower issue of patient consent for presentation or publication, Robert Michels (2000) has arrived at a similar conclusion: “The question of autonomy makes clear that consent is as much a clinical as an ethical issue” (p. 369).

Confidentiality in the analytic setting is an inherent part of an offer of a containing space. This containing function should not be mistaken as hermetic. It is not mainly insofar as it “creates an atmosphere of trust” that confidentiality is to be appreciated. Derived from the willingness to treat all confidences with the same benevolent neutrality, a specifically psychoanalytic technical aim, confidentiality’s true function is to allow new signification to be generated out of the

patient's communications to his analyst. By shielding the relationship from outside pressures, confidentiality adds to the "as if" atmosphere of the session. Encouraged to say anything coming to mind—his trust, yes, but also possibly his hate and his lack of confidence toward us—confidentiality ensures that none of the patient's material will have repercussions on either the relationship with us or on his life outside our office. New suppleness arises in dealing with awkward ethical decisions when we discard the notion of confidentiality as an oath of nondivulgence and recast it as a protective shield for an analytic mode of listening.

Rather than akin to secrecy, is not our promise of confidentiality more properly constituted as a promise to *contain, associate to, and cathect the ongoing generation of meaning within sessions*? It is as a filter against third-party requests to examine clinical material for nonanalytic ends, not as moral code of secrecy, that confidentiality supports the breaking down of old links and the evolution of new ones. The word "secret" comes from *secernere*, which means "to set apart," suggesting hidden, separate, and split-off; whereas "confidentiality" derives from *com* ("together," "with") and *fidere*, meaning to "have confidence in" (Little, Fowler, and Coulson, 1973). We have here a historical reminder that the natural movement of confidentiality is relational sharing, quite the contrary of the blocked communication supposed by secrecy.

When the representational work of the analytic couple is threatened, either on the patient's side by a transference impasse or pressure to act out or on the analyst's side by a disruption in her capacity to metabolize transference and counter-transference affects, the analyst may need the opportunity of relying on other analytic ears for guidance in reinstating the containing and symbolizing function of her "analyzing capacity." Rather than be understood as an inert "setting apart," our notion of confidentiality should allow for an elasticity—at the analyst's discretion—in broadening the containing function beyond the dyad to include analytic listening "with" someone else. As an integral element in the *containing-situation*, a term I employ to distinguish it from the framework understood as the technical parameters of the dyadic relationship, we can expect the boundary of confidentiality to fall most of the time at the limit of the therapeutic couple, though this boundary can, and should be, flexible, *enlarging when needed to permit triangulation of the analytic*

listening-instrument.³ Viewed in this way, *the ethical criterion for disclosure becomes: will it further the analytic listening and thus the treatment, or is it for unrelated purposes which may disrupt this listening?*

A valuable metaphorical adjunct to our usual images of containing environment and framework has been proposed by Donnet (1995). He offers the notion of "analytic site" as a useful "figuration" of the space offered by the analyst for psychic "occupation" by the future patient. Not only is this space temporal and geographical in the way we are used to thinking of the psychoanalytic "frame," but also the notion of site includes the condensation of historical, social, and psychological "local elements" which make up the analyst's mind and personality at the time of meeting the patient. Thus, the analyst's personal metabolization of analytic theory, the conjuncture of socio-cultural representations of psychoanalysis where and when the analysis takes place, and the analyst's parting and ongoing countertransference state all are factors in the virtual-emotional landscape of the analytic site made available to the patient. Besides the heuristic value of explicitly including the individual analyst's mind as part of the therapeutic setup, this notion has the further value of encouraging us to remember that in coming into treatment the patient is hoping to grow and develop psychologically beyond the confines of his or her past. As Donnet explains,

³ The importance of regular consultation for psychoanalysts and psychotherapists has been stressed by two recent contributions on the part of Gabbard (2000) and Pizer (2000). Gabbard offers a very interesting and provocative hypothesis as to one reason why this consultation should be encouraged as part of ongoing analytic identity:

In my experience as a consultant, supervisor, and analyst, I have become convinced that the wish for specialness and exclusivity is a powerful factor in the choice of a career as an analyst or therapist. . . . We have arranged our lives so that we have a succession of one-to-one exclusive relationships guarded by the mantle of a radical form of privacy. Obviously, there is a quasi-incestuous arrangement inherent in analysis, where the secrecy of the setting can resemble forbidden activity, in reality or fantasy, with one parent or the other. Hence, I am suggesting that at some level the practice of analysis represents an unmentalized enactment of the wish to have a parent exclusively to oneself outside the awareness of the other parent. . . . Although many rationalizations are used for not seeking consultation—including lack of time, lack of money, and high regard for confidentiality—at the core of many such resistances is the wish not to have the privacy shattered by a third party [pp. 211–212].

This [transferential] movement [by the patient] to invest [the site] must be described as a use, as a potentially creative exploitation of it. In effect, as soon as transference is no longer immediately reduced to a fragment of pure repetition, we can conceptualize—and welcome it—as a fragment of [psychic] expansion [p. 39, my translation].

Without the confidential containing-situation of an interanalytic space to expand our own countertransference into, we may not always be able to allow certain patients the unique occupation of the analytic site necessary for the expression and representation of their particular unconscious conflicts.

Conclusion

I have argued that because confidentiality is an integral aspect of the containing function of the psychoanalytic situation, it does not make sense to restrict its meaning to the protection of information circulating exclusively between analyst and patient. Idiosyncratic to the study of the unconscious is the fact that therapist and patient are both, though not symmetrically nor equally, subject to the same primary processes. In a highly unique manner not to be found in the professional culture of other disciplines, the psychoanalyst cannot work continuously alone with patients because, like his patients, it is impossible for him to be always fully aware of “what he knows” unless reflected back from another. Confidentiality for the analyst is more usefully understood as including, rather than as in opposition to, the self-initiated, as needed, expansion of information-sharing into the safety of an interanalytic space, a flexible skin instead of a mechanical lock.

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