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A risk of confidentiality

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The concept of confidentiality is examined from its absolute position espoused by some psychoanalysts to the many exceptions to this position allowed by others. The suggestion made in this paper is offered as a psychoanalytic one which urges us to see confidentiality as posing risks in both positions, that is, the absolute and the necessary exceptions. Confidentiality is representative of many, if not all, of the rules and methods that are implicit in the conduct of an analysis and thus may well be taken for granted. The suggestion offered is for a periodic re-examination of the implicit background of psychoanalysis.

Introduction

The idea of a 'background' is prominent in certain philosophical circles **(Searle, 1992)**, but it is often a rather elusive idea to define. It has to do with the tacit assumptions or things taken for granted in any situation from a social gathering to a workplace. These assumptions are said to be both basic and not in need of attention being paid to them. Such a background operates, say, when we go to a restaurant and assume that there will be a menu of sorts, that we can purchase food and that a bill will be offered to us: all things that need not be spoken of overtly. We can imagine such a set of assumptions in many other normal situations, and it takes no stretch of our imagination to see how it may apply to psychoanalysis and psychotherapy. These last examples are somewhat notorious in that they claim to want to draw attention to even the most minor of issues, yet they too have a host of unspoken and taken-for-granted ideas. Over time the ordinary and accustomed ways in which we as analysts and therapists operate become so routinized that they fade into the background and no longer become issues of concern and attention. With such comfort and convenience a certain risk may become operative.

In a previous submission I discussed how the development of the rules of psychoanalysis have led to a sort of moral commitment to their adherence **(Goldberg, 2001)**. Such a commitment tends to give these (often implicit) rules a certain air of absoluteness which may, in turn, detract us from analyzing them. Rather than our becoming alert to every nuance of analysis we allow our routine to fade into the background.

There should be little doubt that many if not all of the tried and true principles of psychoanalysis may profit from being subjected to periodic re-examination and scrutiny to see if their status remains as telling and relevant today as it did when

first developed and observed. This sort of re-evaluation has been brought to bear on such issues as frequency of visits, the use of the couch, self-disclosure etc., and, more often than not, it leads us regularly to confusion and debate rather than to certainty and closure. This unhappy endpoint would, however, appear to be quite unlikely with an issue such as confidentiality, an issue claimed to be 'a basic patient's right and an essential condition for effective psychoanalytic treatment and research', as so stated in the *Ethics case book of the American Psychoanalytic Association* **(Dewald and Clark, 2001)**. This particular case book is meant to serve as a guideline of general principles. It proceeds to present a series of potential problems for all sorts of ethical dilemmas with those concerning confidentiality offering enough exceptions to this aforementioned basic right to cause consternation to any psychoanalyst or psychotherapist. I should like to develop the idea of the fading of ideas into the background utilizing this assumption of a basic right of confidentiality. My aim is to demonstrate that this basic belief has allowed us to fall back on an absolutist position which in turn carries a risk of its own while its relativistic counterpart is equally problematic.

The exceptions to the maintenance of confidentiality in psychoanalysis range from disguised supervision, to insurance reports, to communication to lawyers and courts, to talks with family members, and on to publications in professional journals and the lay press. These are all defensible and desirable. One immediate response to this plethora of possible breaches in confidentiality is a conviction that there are no easy answers. Yet another response is admirably presented in a book by Bollas and Sundelsen who offer a compelling case to support the claim that: 'a patient who sees a psychoanalyst is guaranteed that absolute confidentiality is assured and maintained, [and] then the door is shut to any and all requests from third parties for clinical notes and testimony by the clinician' (**1995**, p. 155). The single exception allowed by the authors is for consultation with a supervisor with the patient remaining anonymous. That exception is allowed for the benefit of the patient alone.

In order to handle the inevitable pressures brought upon a therapist for breaks in this absolute position, the authors offer the position of 'social therapist' as one (in sharp contrast to a psychoanalyst) who both treats the patient as well as actively intervenes in the patient's life. The book insists that one cannot practice psychoanalysis with the basic premise of free association if one does indeed step outside of this fundamental rule, and it bemoans the sad state of much of today's analysis which seems to regularly betray such an absolute condition. Such betrayals other than consultations are seen as done for the benefit of third parties.

An outline of the problem

If one were to line up and list the rather ordinary requests and demands for breaks in confidentiality, they would fall into two categories. The first would have to do with those which would benefit the treatment, the second with those which would benefit others but may either harm or benefit the treatment. For Bollas and Sundelsen the first category would have but one entry: that of consultation with a colleague or supervisor with an adequate disguise of the patient. For many others, as in the *Ethics*

case book, there are a host of situations which do ultimately benefit the patient, such as informing insurance companies, albeit at a price. For the most part the second category is filled with benefits for others with an undetermined harm to the patient. The absolutarian standard of Bollas and Sundelsen is both reassuring and comfortable. But one should wonder. In a very telling quote from a psychoanalyst who struggled with a law prohibiting psychiatrists from testifying without a patient's permission, we read, 'this honorable attempt to protect the patient misses the essential point that he [the patient] may not be aware of unconscious motives impelling him to give permission'. One might also exchange that quote to end with 'to conceal information'. And one may extend that dilemma to include the psychiatrist in the exchange. Without in any way diminishing the passion and point of the absolute stance on confidentiality, one should surely wonder if such a stance also serves to bypass unconscious motives in the therapist in the guise of a noble pursuit.

Our two suggested categories divide along the line of a concentration on the effectiveness of the treatment with particular concentration on transference-countertransference issues in contrast to a separate focus upon ethical issues involving a concern for the greater good. Thus a betrayal of a patient who was about to harm someone, as in the Tarasoff decision (Bollas and Sundelsen, **1995**, p. 4), is a clear step away from the patient on to the protection of society. In contrast to this breach, one could readily see how writing up a patient for publication while getting the permission from the patient to do so (Dewald and Clark, **2001**, p. 30) is a step aimed at both aiding patients and benefiting the greater good. However, the separation into the two categories may be a clue to one risk of confidentiality: a clue offered by the slight chink in the absolute armor of Bollas and Sundelsen: the consultation.

Case illustration

Phil was a lawyer in analysis who, after a rather productive period in treatment which had resulted in a significant diminution of his presenting complaint of depression, came to somewhat of a standstill in his analytic work. Phil's analyst was troubled over the lack of progress in his otherwise valued patient, and he sought private consultation with a supervisor whom he had often gone to for assistance. Phil's analyst felt that he had much profited from this supervisory visit and returned to his patient with some new insights and vigor. Phil himself could not help but be aware of this change in his analyst's stance, and the analysis seemed now to proceed in a most promising direction. Shortly after this period of improvement, Phil asked his analyst why and how he accounted for this alteration in the treatment and even went so far as to enquire if the analyst had sought outside help. The analyst confessed—if that is the proper word—and Phil became outraged at what he felt was a breach of confidentiality. He had always felt this analysis to be a contract of privilege and privacy, but also he had thought of his analyst as possessed of all the knowledge necessary for his treatment. He was deeply disappointed.

Although this patient had in no way been identified to the supervisor and so clearly fell into the category of permissible breaches of confidentiality, it seems

difficult to distinguish the issue from similar such actions, inasmuch as Phil had no concern as to his being identified. In this particular case there was a wonderful opportunity offered to analyze the patient's overidealization of his analyst and to work through the ensuing de-idealization. In retrospect Phil and his analyst saw this period of analysis as a moment of positive progress. Phil felt he could see the similarity in his rage at his father's shortcomings, and his analyst felt that he could better struggle with his own conflicts about needing help and having to do things on his own. This mutual benefit from the breach seems to suggest more such benefits from some other breaches with minor and major differences. This sort of consultation is the sole exception to confidentiality allowed, and it seems to hinge on helping the patient without revealing his identity. These two parameters seem worthwhile, but it remains to be seen if they can serve as guidelines to the entire problem around confidentiality.

The crucial distinguishing point about this case surely has to do with the analyst's own psychology. Perhaps an analyst less able to struggle with his own inadequacies would not seek supervision, would pursue a different and less rewarding therapeutic action or would even discontinue the analysis. If we focus upon this single but crucial point, we may be able to construct a number of scenarios in which the analyst, constrained by confidentiality, would fail to do something which might benefit the treatment. Some of these scenarios could include identifying the patient as well. The inclusion of the third party does not come without a series of problems and risks and even opportunities.

Case illustration

Dr G is analyzing a very volatile patient who has been placed on psychotropic medication by a consulting colleague of Dr G's. Much of the time of the hours of the patient had been devoted to the lambasting of the psychopharmacologist by the patient who accused him of being cold, insensitive and downright sadistic. Some of this doctor's interventions seem to be more harmful than helpful and even undermining of the therapeutic work with Dr G. Finally Dr G called his colleague and asked about the interactions with the patient. Much to his surprise, he learned that this other doctor has been a model of propriety and correctness and much of the patient's vituperative attack on this man had been misplaced and distorted. Dr G now compares this hostility toward his colleague with the overadoring attitude that the patient has toward him and reluctantly becomes aware of the development and maintenance of a split transference involving these two therapists. Indeed, most of the negative feelings that may have been directed to Dr G have been directed to and drained off to the psychopharmacologist. Dr G realizes that he has enjoyed and participated in this arrangement, but he wonders if this problem would not potentially exist in any analysis wherein one set of feelings are successfully diverted to a figure outside of the analysis. However, something about this seemed different. There was a real bona fide connection between these two doctors, since Dr G had felt a need to be in touch with his patient's medication management, and he had made it a rule not to abdicate what he felt was a necessary responsibility. One of Dr G's other colleagues

divorced himself entirely from the pharmacological management of his patients, but Dr G felt that position for himself made him more anxious and unable to intervene when necessary. More than that, he felt that his patient wanted him to be connected with the psychopharmacologist, and the conversation that resulted from his phone call was a necessary part of the treatment.

This case of a consultation with an identified patient opens the door a bit further than the single crack offered by Bollas and Sundelsen in the previous case, but the door should not be taken as a window of opportunity to dispense with confidentiality. Rather it might allow us to better understand the analyst's need to connect outside of the consulting room; a need that is especially notable in cases of a split transference.

Case illustration

Mrs S had been a child of an early divorce followed by a quick remarriage of her mother to a man who sexually abused Mrs S. Mrs S had endured this childhood trauma in complete silence, since she was convinced that reporting her stepfather's behavior to her mother would be overwhelming to this fragile woman who had suffered enough from her first marriage. This vow of silence and secrecy followed all through her adult life and was especially maintained in her weekly visits to her own father. That relationship was a loving and enjoyable one, but one equally captured by secrecy and concealment, inasmuch as Mrs S's mother could not tolerate the idea that her daughter was happy with her ex-husband, the biological father of Mrs S. Thus the stage was set for Mrs S to live a life of compartments and concealments, a life which later manifested itself in addictive and delinquent behavior. By no means could one directly correlate such concealment and secrecy with the later delinquency, but it did seem to live on in much of this behavior.

Mrs S had treatment before coming to Dr B, but she assumed from the start that he would never report anything about her to anyone; and Dr B happily joined in this assumption. He soon learned of both her repeated delinquency and misbehavior and its parallel concealment from both her husband and her long list of therapists. She recreated the sad configuration of her childhood of her not telling her mother about either father or stepfather, both of whom seemed to enlist her in somewhat pleasurable and forbidden behavior. This, not surprisingly, was also recreated in the transference with the analyst either being unconsciously invited to collude in misbehavior (as described in a previous publication **(Goldberg, 1999)**), or assigned the role of the knowing but mute parent.

As the patient's delinquency decreased in treatment and soon disappeared entirely, she became more and more depressed, and her legal problems now took center stage. She asked Dr B to write a letter to her lawyer, and he referred her to a legal consultant for this help. It soon became clear to Dr B that only he could offer the necessary material for a legal defense, and he reluctantly did write a letter. Shortly after that, the patient's mother inexplicably asked the patient if her stepfather had ever abused her. The patient was flabbergasted at the truth finally coming out, and both she and Dr B wondered if some change had occurred within her that communicated itself to others: a change of bringing a split-off aspect of herself into an integrated whole.

Of course, this seemed only a speculation that could not be verified, but it started the treatment on the road to integration.

No matter how anyone may evaluate this particular act of breaking confidentiality (i.e. the letter to the lawyer), it would be problematic to classify it as derailing or damaging the analysis. Nor is it possible to say that it could have been completely avoided, yet have the treatment continue. However, it may serve to once again blur this distinction between acts focused solely on helping the patient and those that go outside of the treatment in both openly identifying the patient and enlisting others: the latter ostensibly for the greater good of society. The claim that one can rationalize many breaches of confidentiality by insisting that ultimately this is for the good of the patient, a claim disputed by Bollas and Sundelsen, is readily available in this and any case that allow the person to get the necessary treatment or to continue treatment. For Mrs S the involvement of the lawyer allowed her to continue in treatment. One must wonder if the retreat to absolute confidentiality is but a place for the analyst to hide, especially from analyzing the nature of the third party involvement.

Discussion

The exceptions that have developed over the years to the physician-patient privilege are considered by some to be so plentiful that the entire concept is without significance (Slovenko, **1974**, p. 650). When one is invited to consider all the exceptions to both the privacy of the patient and the ethical requirements demanded of the clinician, there may be little room left for this 'privilege' which is supposed to allow individuals to withhold information especially from the courts but also to a variety of interested parties. Without this privilege, enjoyed readily by priests, spouses and lawyers, therapists are set adrift in a sea of ethical uncertainty. We quickly lose sight of our fundamental focus and become amateur ethicists and moralists.

To rescue ourselves from the life of bewilderment, we adopt rules of conduct such as in HIPAA which enable us to feel both honest and helpful, and surely one of the best of these rules is that of confidentiality. As the rule becomes confining and difficult to maintain, we begin to modify it. One modification is to obtain a patient's permission to break a confidence. Unfortunately we have learned that patients are often unable to be free enough of transference issues to be in a position to really give informed consent. A patient may agree because of a positive feeling or disagree because of a negative one, while neither would accurately reflect an objective and rational decision. Another modification offered to aid our uncertainty is that of patient disguise, especially in terms of consultation or publication in professional journals. But this last is limited to patients who are not in the field and/or will not 'come by such writing' (Bollas and Sundelsen, **1995**, p. 189). That, of course, excludes what might be a valuable literature on the analysis of psychoanalytic candidates. At each and every turn we seem to confront a problem that either seems more inhibiting of our practice or of our freedom to function as members of a free society. If we limit ourselves to issues that deal only with the patient and the analyst, our first category, there probably can be no opening to a third party without a variety of implications: both good and bad. If we open the door to issues that go beyond the patient and

the analyst, our second category, there can be no easy guideline to what is and is not allowable. I should like to propose a trial of a psychoanalytic solution to the quandary.

If we return to the fundamental thesis of the two books that compose the bulk of references in this essay, it is that one must try to shut the door to any and all requests for information and intrusion by third parties. Ethical problems present themselves when the door is completely shut, but less so by far than when it is allowed to be ajar. Substituting 'social therapists' as doorkeepers seems one form of solution that effectively bypasses rather than solves the problem. The shut door is an absolute position that devotes itself to the patient's welfare. The open door is a relative position that makes for the introduction of interests that may coincide with or override those of the patient. However, it may also be helpful to make a psychoanalytic assessment of the inclusion of the third party without any preconceived value judgments.

The concept of a split transference, a vertical split as conceptualized in self-psychology, directs our attention to a divided set of feelings: one group directed and focused upon the analyst, another devoted to an area of concern and/or behavior in persons and issues outside of the analysis. One obvious solution to this divide is to bring the split-off material into the analysis and on to the person of the analyst. This is not always an easy accomplishment, and sometimes an analyst may unwittingly keep the material out of the analysis. One interesting aside here is that of a case in analysis for approximately eight years without ever mentioning to his analyst that he regularly stole books from his university bookstore. In a subsequent treatment he realized that this first analyst had communicated non-verbally to him that she could not handle that information. Thus we see that it is up to the analyst to somehow allow the split-off material to participate in the analysis. This rather simple idea goes far beyond the analyst's willingness to listen to warded-off material, inasmuch as some of this sometimes presents itself only in the form of behavior, as witnessed in the above-noted book thief, as opposed to ideation. There are patients who must be seen as unable to talk, rather than as unwilling to do so. They are prone to inviting the analyst to collude with them rather than to interpret what they cannot speak of.

If the analyst betrays the confidence of a patient by opening the door to a third party, he is essentially enacting but probably no more than if the door is effectively barred. Both closing and opening are actions, but one is regularly more prized than the other. We are regularly lulled into thinking that silence, like inactivity, is the proper atmosphere for analytic work, but there is no guarantee that free association prospers in a field of such deprivation. Surely some patients may do well with a more responsive analyst, even though some analysts may feel most patients do best in those original parameters of conduct. Just as surely there may be patients who do better by the action of an analyst who opens the door to consultants, pharmacologists, lawyers and the like. The crucial issue is that of analyzing the action. I suspect this central element is one that is ignored or neglected by the assumption of some absolutarian posture. If we are convinced that confidentiality is an absolute and basic right, we become seduced into believing that it is beyond investigation and interpretation. It

runs the risk of fading into the background and only being attended to in its breaches. Unfortunately, too often such attention is composed of worry over ethical issues rather than of a careful examination of the transference implications of the presence of a third party. Of course, a relativist position invites other sorts of dilemmas.

The action of an analyst who breaks the bond of confidentiality is best thought of as one kind of enactment that demands investigation and interpretation rather than as an error of commission worthy of condemnation. This sort of stance treats analysis as an activity that corrects itself by the process of interpretation rather than one of adherence to a set of procedures and rules. Of course we may not always be able to effectively understand and interpret our actions, but we are always better off wondering why we do what we do rather than chastising ourselves for our supposed errors.

The entrance of a lawyer or an insurance company into the sanctity of the analytic dialogue, however welcome or unwelcome, turns the two-person dialogue into a conversation of three parties. Many times the analyst is blind to the transference implications of this entrance, but many other times the analysis will not or cannot proceed without such a connection. There need be no automatic injunction against the analyst examining privately or openly what this third person means to him as well as what that presence means to the patient. The exclusion of the lawyer or the insurance company may offer a feeling of comfort or smugness, but such exclusion could well assist in the analyst's remaining unaware of his unconscious motives in such rigorous rule adherence.

Summary

Absolute positions are snares that routinely betray their dangers by the introduction of selected exceptions. This is seen in the assumed and inviolate absolute basic right to confidentiality which begins with an exception allowed to consultation with a colleague and then proceeds to a list that seems to have no end. We soon seem to leave the arena of our expertise and move to one of the study of ethics. This is no brief against the proper concern with ethics but rather is an alerting call to our having missed the point. Once we do become alert to our standing in the wrong place, we tend to go back, to retreat to our absolutarian stance. Both directions, that of exceptions and that of retreat, make for a neglect of our work as analysts.

Embracing confidentiality as an absolute right runs a risk of allowing unconscious material which could be brought into the analysis to remain outside as split off and unintegrated. In one sense, an analyst may collude with a patient in maintaining confidentiality as well as in breaching it. The former stance is supported by our established procedures and is certainly one best embraced by our profession, but it is not one that should be immune from psychoanalytic enquiry. Opening the door to third parties is a move decried by our established procedures and is certainly a move to be very cautious in considering. However, it too should not be classified as a prohibition without exceptions. Both stances are too risky. Everything in analysis is to be seen as an interesting site for investigation and interpretation.

Conclusions

Psychoanalysis sits uneasily between an allegiance to a proper way to function and an openness to a variety of paths which can lead to a form of methodological anarchy. My personal solution to this delicate balance is to see analysis as an heir to the field of American pragmatism. What is demanded of us is an ever-ready alertness to whatever we may feel is taken for granted, all the while recognizing that we may need to abandon our yearning for something that we can all agree upon as grounding our enquiry (Goldberg, **2002**, p. **249**). Just as absolute positions raise problems so too do relative ones. Pragmatism is not relativism, since at times the pragmatic path may espouse an absolute stand.

A re-examination of the promise of confidentiality as an absolute right of patients results in the same opening to uncertainty as happens in the re-examination of many of the seemingly unalterable rules and procedures of psychoanalysis. This sort of house cleaning can be upsetting to many of us who take comfort in the supposed proper conduct of an analysis under proper conditions. However, it is equally likely to cause a reconsideration of what many feel is the more correct and proper pursuit of psychoanalysis, that is, the understanding of a patient in depth. There may be no single road to achieve such a goal.

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