

Impact of erosion of confidentiality on psychotherapy

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Published in September, 2000 issue of Briefings, newsletter of the Division of Clinical Practice of the Calif. Psychological Association

How much has the erosion of confidentiality changed psychotherapy? Is it possible that, without our noticing, the progressive loss of confidentiality has gradually altered psychotherapy to such a degree that, at least in its psychoanalytic variant, it has lost its substance and retains only its superficial form?

These questions arise as one compares current laws, practices, and ethics with those of 20 years ago. At that time, it seems to me, practices and ideas that are now accepted, even praised, were regarded in the psychodynamic community as misguided at best and willfully destructive at worst. Students and teachers treated confidentiality as a first principle, with something of the sacred about it. Therapists who failed to treat confidentiality as a fundamental principle--who, for example, readily endorsed the reporting of child abuse--were felt to lack either the intellectual subtlety or the strength of character necessary to fulfill the therapist's calling. Dedication to absolute confidentiality, it seemed to us in training, separated those who saw therapy as an ordinary mode of interpersonal helpfulness from those who grasped its deeper nature. If these attitudes now seem arrogant and a bit naïve, they also embodied a profound effort to understand and to internalize the modes of behavior required of an interpretive therapist.

This passionate concern for confidentiality, ironically, had only a little to do with wishes to protect the patient's privacy. And it had nothing to do with our judgments of our patients' worthiness or of the relative justice of concealment and revelation; on the contrary, we tried to set aside all such considerations while acting as therapists.

Instead, confidentiality took its importance from the psychoanalytic model of the mind and its view of how interpretive therapy helps. According to this model, as is well known, each person recoils from aspects of himself or herself and, over time, develops intricate techniques of turning a blind eye to these frightening wishes and feelings. Quarantined and barred from awareness, these wishes and feelings persist in an un verbalized, ungraspable form. All the same, their presence constantly makes itself felt, in the form of stunted actions, meager satisfactions, suffocating constraint, shame, foreboding, anxiety, depression, and the rest. Tied in this knot, the patient comes to the therapist, whose job it is to help him or her find his or her way back to the quarantined parts of himself or herself, which in the full light of day lose their dreadful countenance. The vicious circle of affect and defense loses its grip.

As Bollas and Sundelson (1995) argue persuasively, if there is any truth in this model, then interpretive therapy depends on a unique stillness in the therapist's mind, which the patient gradually comes to share. This requirement is imposed by the two great obstacles to curative self-discovery: the patient's guilt (and shame) and the nonverbal, ungraspable nature of what needs to be uncovered. The therapeutic process, therefore, seems certain to be aborted if societal judgment lurks in the background, confirming the patient's resolution to keep hidden things out

of the dialog. And the therapist must achieve an “evenly hovering attention” that seeks ambiguity, avoids closure, and strives solely for understanding. Without this unique state of mind, and the firm boundary between the therapeutic dyad and the social world that makes it possible, the thoughts of both participants will slide toward judgment, moral evaluation, or ameliorative action, each of which crowds out interpretive understanding.

Can this still be done? Do therapists and patients still have access to this domain, free of judgment and action? Given the erosion of confidentiality, and particularly Tarasoff and abuse-reporting requirements, one must doubt it (Karbelnig, 1999).

For example, imagine a male patient says, “Last night, my daughter made a big fuss because she wanted her mother to bathe her. It ticked me off.” Within a firm boundary of confidentiality, the therapist’s thoughts might run, “What other material does this bring to my mind? What connection might it have with what came before and what he has gone on to say? What reactions am I noticing in myself? Could this be connected to the patient’s feeling exposed and intruded upon here and his angry struggle against that?” However, given child abuse reporting requirements and their powerful emotional impact, the following thoughts are likely to arise, and perhaps to take over: “How old is his daughter? Is it appropriate for him to bathe her? Did he insist on bathing her against her wishes? Was the patient sexually aroused? Should I ask more about this, or should I be careful *not* to embark on an investigation? I need to review the law on this. Have I adequately informed the patient about reporting requirements, and does he understand them?” Given the subtle interactive influences in a psychotherapy, this fundamental shift in the therapist’s thinking seems certain, over time, to affect the patient’s. (Although I am discussing psychoanalytic therapy here, I believe many of these points apply equally well to other modalities.)

There can be no complete solution to this problem. For one thing, no therapist can be indifferent to the profoundly damaging things his or her patients may do to themselves or others and therefore there can be no pure train of associations in a therapist’s mind. (And it is worth mentioning that there have always been other powerful intrusions into the therapist’s thoughts, such as, “What will my supervisor think?”) In addition, society is unlikely ever to allow us inviolable confidentiality. But much can be done to reduce the intrusion we now experience. Laws and their impact are not unalterable. We need a dialog and debate within the psychotherapeutic community. Far too often, therapists quietly accept the recommendations of risk management consultants, Child Protective Service workers, and so on. Or even worse, in a reverse of the “risky shift” studied by social psychologists, therapists amplify each other’s anxiety then seek out the safest course of action, which is often the least protective of confidentiality. So far, the primary alternative to these has been a frightened, lonely, internal struggle to reconcile law, risk, and therapeutic technique.

Pope and Vasquez (1999), in a book cited approvingly in the Board of Psychology Update, leave no doubt about where they stand:

If we, as a profession and as individual practitioners, are to address the possible conflicts between the law and the welfare of our clients, one of the initial steps is to engage in frequent, open, and honest discussion of the issue. The topic must be addressed in our

graduate courses, internship programs, case conferences, professional conventions, and informal discussions with our colleagues. (p. 22)

Such a discussion, no doubt, would bring to light disagreements about the proper conduct of therapists. But if areas of agreement could be hammered out, it would constitute a new community standard of care, which would immediately legitimize new interpretations of the laws and in due time would likely lead to changes in the laws themselves.

Bollas, C. & Sundelson, D. (1995). The new informants: The betrayal of confidentiality in psychoanalysis and psychotherapy. Northvale, NJ: Jason Aronson, Inc.

Karbelnig, A. M. (1999). Assaults on privacy: Reflections on the erosion of confidentiality in psychotherapy. Calif. Psychologist, May/June 1999, 34-37.

Pope, K.S. & Vasquez, M.J.T. (1999). Ethics in psychotherapy and counseling (2nd ed.). San Francisco, CA: Jossey-Bass.