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## Psychoanalytic Professional Ethics and Patient Confidentiality

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### Abstract

Professional ethics are a foundational principle of our clinical practice and all human relations. The efficacy of the analytic clinical situation is predicated upon the fundamental rule of free association –i.e., full and open disclosure of all that occurs to the patient during the hour. The safeguard and pre-condition for this disclosure is absolute respect for and protection of the confidentiality of patient communications. The accepted standards of this protection are presented and discussed.

L'éthique professionnelle est une fondation principale de notre pratique clinique et de toutes relations humaines. L'efficacité de la situation analytique dépend de la règle fondamentale de l'association libre – c'est-à-dire la révélation complète et ouverte de tout ce qui vient à l'esprit du patient pendant la séance. Les conditions de cette ouverture sont la protection et le respect absolu pour la confidentialité de la parole du patient. Les standards acceptés de cette protection sont présentés et discutés.

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The ethical stance and requirements of the analytic clinician go far beyond the pragmatic level of a set of professional obligations or commitments. Professional ethics are a foundational principle of our clinical practice and, indeed, of all human relations. The philosopher, Emmanuel Levinas, defined ethics as *responsibility for the other* and described it as *the first philosophy*. He believed that the encounter with the face of another human being initiates a ‘summons’ to become aware of one’s caretaking and therefore ethical responsibility for the other. (See Chetrit-Vatine, 2014, p. 5). This formulation, rooted in the infant’s helplessness and need and inevitably evocative of memories of one’s own infantile helplessness, is reminiscent of Freud’s (1895, p. 318) assertion in *The Project* that “*The initial helplessness of human beings is the primal source of all moral motives.*”

An important aspect of this initial, infantile helplessness was examined by the French psychoanalyst, Jean Laplanche (1987), who argued that the primal situation that exists between infant and adult caretaker, which he called *The Fundamental Anthropological Situation*, and will later be reinstated in the analytic situation is inherently “asymmetrical and seductive in so far as it is based on an encounter between, on the one hand, an adult world endowed with a sexual unconscious and adult sexuality and, on the other, a human infant endowed with psycho-physiological montages that are both immature and susceptible to being affected by this adult world on which he or she is totally dependent.” (Chetrit-Vatine, 2014, p. xix). As a consequence, the adult world that is responsible for the infant is confronted with the challenge of whether to assume or decline the responsibility that this helplessness and dependency elicits and requires.

Laplanche (1987) has proposed that a similar condition of enigmatic messages and asymmetrical need – at the level of unconscious infantile sexuality - is reinstated in the creation of the analytic situation. For the patient, the latter contains an internal demand for psychic work analogous to that required by the mother-infant relationship. For the analyst, this demand imposes an ethical responsibility for the wellbeing of the patient that includes respectful opacity (i.e., analytic neutrality and abstinence), the offer of a space for the experience and emergence of the not yet known or once known but now forgotten, interpretive assistance to help articulate and come to know the not yet or no longer known and the maintenance of clear boundaries around privacy and confidentiality. It also requires that the analyst try to tolerate and face the truth without untoward action of whatever feelings and experience emerge in the course of the treatment.

In a pragmatic sense, the creation and maintenance of an analytic process requires full disclosure on the part of the patient without conscious suppression or censorship. In Freud’s (1913) essay on technique, “On Beginning the Treatment,” where he described the fundamental rule of psychoanalysis - say everything that comes to mind *without exception* (pp. 134-137) -, he made it clear that nothing was to be exempt from disclosure in the process of free association:

“It is very remarkable how the whole task [of analysis] becomes impossible if a reservation [to speak one’s thoughts freely and completely] is allowed at any single place. But we have only to reflect what would happen if the right of asylum existed at any one point in a town; how long would it be before all the riff-raff of the town had collected there? I once treated a high official who was bound by his oath of office not to communicate certain things because they were state secrets, and the analysis came to grief as a consequence of this restriction. Psychoanalytic treatment must have no regard for any consideration [that would allow evasion of the basic rule], because the neurosis and its resistances are themselves without any such regard.” (pp. 135-136). No doubt Freud, who was a physician and had taken the Hippocratic Oath, assumed that the analyst had a reciprocal obligation. If the patient was required to tell all without regard for social conventions or personal comfort, then the analyst, like the priest in the confessional, was obliged to hold whatever was told or occurred in the privacy of the consulting room in the strictest of confidence.

Without this safeguard of absolute privacy protection of the patient's disclosures, psychoanalytic treatment becomes impossible. In America, this principle was upheld in US Federal Court in a famous case (Jaffe vs. Redmond), in which a police officer shot and killed a man who was committing an armed robbery. Although the police officer was found to be operating within the accepted principles involving the use of force by law enforcement officers, he was nevertheless sued by the deceased thief's family for a civil rights violation.

Subsequent to shooting this man, the police officer developed psychological symptoms and sought psychotherapy. The prosecuting attorneys in the civil rights violation case, claiming the right to discovery of the facts, persuaded the court to subpoena the officer's therapist's treatment notes. The therapist claimed patient confidentiality and refused to comply. She was held in contempt of court and threatened with prison. Her appeal to her state appellate court was denied. She then went before the US Supreme Court and her action was upheld in a landmark decision. The Supreme Court ruled that *the right to confidentiality of patient communications in therapy was so central to the fact and potential success of treatment, that it generally superceded all other rights, including that of the discovery of facts by the lawyers of the plaintiff.*

This principle and the rationale behind the Jaffee-Redmond decision has remained the standard used in assuring patients' rights to privacy of therapy communications in all subsequent US Federal court decisions. It is in the same spirit as these legal findings that the Ethics Principles of both the IPA and APSA state that if there is a conflict with local reporting laws or other legal requirements, an analyst may justifiably defy those laws, if he or she feels that to comply with them would harm or endanger the patient's rights to absolute confidentiality of therapeutic communications.

But how then do we view this foundational principle in the light of another professional necessity and 'good,' that of the need to communicate our experiences with other analysts and therapists so that ideas may be discussed and debated, experiences shared and the field may advance to the benefit of our patients?

Consultation, supervision and clinical seminars are common activities in our educational models and daily professional life. We all attend congresses and other professional meetings where papers are given that include clinical case material. The ethical principle that obtains for the audience in all of these situations is that *the same level and obligation of confidentiality and respect for patient privacy exists for the consultant, supervisor, or seminar and audience member as for the treating analyst.*

Simply put, this means not to talk about what is discussed or takes place within sessions to anyone, except for the strictest and most professionally limited and necessary reasons. It is for this reason that at IPA and APSA Congresses we ask attendees not to speak, write about or communicate in any public place or manner the personal or clinical details of what they have heard presented. In the age of blogs, twitter and the internet, observing this stricture has become a matter of the greatest importance.

But what of the presenting analyst who reads or publishes a paper? The accepted standard of confidentiality, one referred to and used by all the major journals in our field, is that *either* the analyst obtains informed consent of the patient for use of the material *or* the material is presented in such a way that the identity of the patient cannot be recognized by a third party (Gabbard & Williams, 2001). Obviously, the patient may come across and recognize him or herself in a published paper, and this may prove difficult for the analyst and treatment. However, if the disguise to third party recognition is observed in the presentation, such an occurrence does not constitute an ethical violation.

The choice of informed consent or disguise to third parties remains a complex and subtle matter. On the one hand, it may be an unwarranted imposition to have an analyst interrupt the patient's natural trajectory of the treatment to announce that he or she is planning to speak or write about the analysis and request permission to do so. On the other hand, if a patient discovers that his or her analyst has published or presented

material about their analysis without notice or consent, a strong negative response might ensue.<sup>2</sup> It is also debatable in any given instance as to whether, given the transference and its unconscious dimension, informed consent is even possible. And of course, the analyst's wish to speak or write about the treatment, in addition to being a legitimate scientific activity, might also be scrutinized by the analyst as a potential actualization, enactment or carrier of elements of the countertransference.

Clearly, there are no easy answers as to how to proceed, although proceed we must. Bion often reminded us that in psychoanalysis the most we can do is to try to 'make the best of a bad situation' and this may be one of them. When confronted with the problem of case reporting and confidentiality, perhaps the most an analyst can do is to be aware of their ethical requirements and responsibilities and try to do what seems most appropriate in each particular situation.

A final related matter that sometimes comes up for Societies and institutes is the question of what the ethical considerations are when considering whether or not to allow non-analysts and non-clinicians to attend analytical clinical presentations and case discussions. Analysts and candidates are bound by the Ethical Standards of our profession. Non-analyst, non-candidate clinicians are bound by the Ethical Standards of their professional disciplines. Do these match the stringency of our own? If not, then there is a possibility that these attendees at our clinical exercises might not act in accordance with our Ethical Standards.

Lay analysts and lay analytic candidates would fall within and be bound by analytic Ethical Codes and Standards, but non-analyst, non-clinicians – e.g., academics from a non-clinical discipline who are interested in learning about analysis and applying it to their work in other fields – constitute a separate and unique category. While we may trust in their good judgment and general discretion, they may not be bound by a professional ethical code that is as stringent as our own. In such cases, where a similar code of Ethical conduct is not in place, it may be reluctantly necessary to ask them to recuse themselves from the clinical discussion or presentation.

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<sup>2</sup> See for example the case of the writer, Phillip Roth (Mosher & Berman, 2015).