

1985

Privacy, Confidentiality, and Autonomy in Psychotherapy

William J. Winslade

Institute for the Medical Humanities, University of Texas Medical Branch at Galveston

Judith Wilson Ross

UCLA School of Medicine

Follow this and additional works at: <https://digitalcommons.unl.edu/nlr>

Recommended Citation

William J. Winslade and Judith Wilson Ross, *Privacy, Confidentiality, and Autonomy in Psychotherapy*, 64 Neb. L. Rev. (1985)

Available at: <https://digitalcommons.unl.edu/nlr/vol64/iss4/4>

This Article is brought to you for free and open access by the Law, College of at DigitalCommons@University of Nebraska - Lincoln. It has been accepted for inclusion in Nebraska Law Review by an authorized administrator of DigitalCommons@University of Nebraska - Lincoln.

William J. Winslade*
Judith Wilson Ross**

Privacy, Confidentiality, and Autonomy in Psychotherapy

TABLE OF CONTENTS

I.	Introduction	579
II.	The Concepts of Privacy and Confidentiality	580
	A. Background and Overview	580
	B. Privacy	583
	1. Law	584
	2. Economics	585
	3. Anthropology	586
	4. Philosophy	588
	5. Psychology	590
	6. Summary: Core Concepts of Privacy	593
	C. Confidentiality	594
III.	Privacy and Confidentiality in Law	597
	A. Constitutional Law	597
	B. Tort Law	598
	C. Privilege Law	599
	1. <i>In Re Lifschutz</i>	600
	2. <i>Caesar v. Mountanos</i>	603
	3. <i>Tarasoff v. Regents of the University of California</i>	604
IV.	Privacy and Confidentiality in Psychotherapists' Professional Ethics Codes	606
	A. Overview of Ethics Codes	606
	B. Form and Content of Confidential Information	609
	C. Occasions for Disclosure	615

* William J. Winslade, Associate Professor of Medical Jurisprudence, Institute for the Medical Humanities, University of Texas Medical Branch at Galveston. B.A. Monmouth College (1963); Ph.D. Northwestern University (1967); J.D. UCLA Law School (1972); Ph.D. Southern California Psychoanalytic Institute (1984).

** Judith Wilson Ross, Senior Editor, UCLA School of Medicine, Adjunct Lecturer, UCLA Department of Psychiatry. A.B. St. Lawrence University (1958), M.A. UCLA (1961).

D. Consent and Notice of Limitations of Confidentiality	616
E. Summary	617
V. Privacy and Confidentiality in the Therapeutic Relationship	619
A. Psychotherapy	619
B. The Psychodynamics of Privacy and Confidentiality in Psychoanalysis	630
VI. Conclusion	635

I. INTRODUCTION

This Article adopts an interdisciplinary approach to the problems of personal privacy and confidentiality in psychotherapy. The contributions of law, economics, anthropology, philosophy, and psychology are discussed briefly to throw some light on complex aspects of privacy and confidentiality. In addition, specific ways in which privacy and confidentiality function in psychotherapy are described to help clarify the general concepts. Conceptual clarification is, however, only one theme. The central issue is the relationship between the psychotherapist and patient with regard to the control of and authority to control access to personal privacy and disclosure of confidential information. Authority and control are examined in the context of legal, ethical, and psychodynamic considerations.

We argue that, although patients relinquish their personal privacy to therapists, patients hold the right to control access to personal privacy, as well as to control further disclosure of confidential information revealed in therapy. This right is limited only by external restrictions imposed by the state for protection of public health or public safety. Therapists may claim that their patients' right to confidentiality should be respected, but the therapist's claim is derived from the patient's right; it is not an independent right of the therapist. Although in the law of psychotherapist-patient privileges the patient clearly holds the right, therapists sometimes have difficulty grasping or accepting this idea. This Article explains *why* rights of privacy and confidentiality belong to patients. Therapists who refuse to acknowledge in theory or honor in practice such rights fail to respect the autonomy of their patients.

To elucidate the function of privacy and confidentiality within the psychotherapeutic relationship, we must first clarify the core concepts of privacy and confidentiality from the perspectives of different disciplines and then apply them to the therapeutic setting. Subsequently, we analyze certain jurisprudential and professional assessments of the significance of privacy and confidentiality in the therapeutic endeavor. Finally, we discuss how privacy and confidentiality function in clinical

practice and how they are understood in therapeutic theory. Our goal is to bring out how respect for patients' autonomy is shown in part by respect for patients' rights of privacy and confidentiality.

II. THE CONCEPTS OF PRIVACY AND CONFIDENTIALITY

A. Background and Overview

The 1890 publication of Warren and Brandeis' article, *The Right to Privacy*,¹ heralded a peculiarly American involvement with privacy that has flourished for nearly a century.² Legal scholars, philosophers, psychologists, economists, sociologists, political scientists, anthropologists, and psychotherapists plumbed the depths of privacy from their respective disciplinary perspectives, and surfaced with surprisingly conflicting accounts of its meaning, value, and function. The ordinary language concept of privacy emerged as a mysterious and complex concept. These disparate views suggest:

- 1) That privacy is always self-regarding or that it may include others in some kind of group or communal privacy;
- 2) That privacy is freedom from external intrusion or freedom from external prohibition;
- 3) That privacy is a moral virtue or a social vice;
- 4) That privacy is an act of choice or an inevitable and inescapable human condition;
- 5) That privacy is a basic need and an evolutionary strategy or an economic luxury; and
- 6) That privacy is itself a fundamental human value or is only a collective word for and reducible to other fundamental human values.

This swirl of ideas suggests that privacy is what philosophers term an essentially contested concept, capable of holding many meanings, including contradictory ones, and serving many purposes. In its ambiguity lies its strength, for its defenders are many even though they disagree with one another about its specific meaning. Further, it is through their disagreement that many of the dimensions of privacy are revealed. We cannot expect here to resolve these inherently contradictory ideas about the concept of privacy. Privacy is an elusive concept even beyond its essentially contested nature because of its complex connections with other equally perplexing concepts, such as freedom, the self, autonomy, solitude, and secrecy. These connections are even more difficult because the word "privacy" derives meaning from ordinary language, but has been shaped by the technical lan-

1. 4 HARV. L. REV. 193 (1890).

2. It has been pointed out in an excellent article, Schoeman, *Privacy: Philosophical Dimensions*, 21 AM. PHIL. Q. 199, 202-03 (1984), that prior to the Warren and Brandeis article the jurist James Fitzjames Stephen, the novelist Henry James, and the journalist E.L. Godkin had published important notions about the nature and right of privacy. But Warren and Brandeis gave prominence to privacy and their article has been the point of departure for subsequent scholarly debate.

guages of law and, more recently, of psychology. The ordinary and technical concepts overlap in use. Even when speaking carefully, we are likely to use "privacy" variably to refer, for example, to a state of mind (private thoughts), a specific place (the home is private), freedom from intrusions (procreation involves private decisions), control over exposure of the body (nude-bathing is a private activity), and disclosure of information (tax information is private).

In addition, the meaning of "privacy" slips away from us because it is tempting to blur the distinction between *privacy* and a *right of privacy*.³ This tendency is explained in part by the fact that we are usually interested in privacy only insofar as it is or should be a moral or legal right, and are therefore only concerned with those manifestations of privacy that *lie within* moral or legal concerns. Beyond that we often assume implicitly that privacy, if not always a right, is always beneficial, forgetting that privacy for the only person on a desert island is a fact, not a value, a right, or even a pleasure.

We cannot doubt that privacy exists; but to provide a full articulation of its value is another matter. The struggle to discover and elucidate the value of privacy underlies much of the writing on this subject, especially in the past twenty years.⁴ It is difficult to draw conclusions from this body of literature because privacy has so many different manifestations. Refusing to allow, without permission, the use of an individual's photograph in an advertising campaign is a long distance from being ultimately unable to convey fully the subjective understanding of one's own experience to a therapist. Each discipline approaches privacy from its own perspectives, values, and interests; the result is that no meta-view can do full justice to or fully integrate the insights of each. It is possible, however, to focus on a limited area of human activity and attempt to see how the various analyses of privacy provide us with a richer understanding of that activity and of the role of privacy and confidentiality within it.

Confidentiality has generated less interest than has privacy. Although many persons are concerned about confidentiality in everyday life (e.g., keeping secrets), by contrast to privacy very little analytical writing about it has appeared until recent years. Theoretical discussions about the meaning or value of confidentiality have not been common.⁵ Most literature pertains to practical debates about

3. See generally, Gavison, *Privacy and the Limits of Law*, 89 YALE L.J. 421 (1980).

4. Some of the recent literature in this area includes the following: R. BELLAH, *HABITS OF THE HEART* (1985); J. BENSMAN & R. LILIENFELD, *BETWEEN PUBLIC AND PRIVATE (THE LOST BOUNDARIES OF THE SELF)* (1979); S. BOK, *SECRETS* (1982); D. O'BRIEN, *PRIVACY, LAW, AND PUBLIC POLICY* (1979); R.E. SMITH, *PRIVACY* (1980); *THE PHILOSOPHICAL DIMENSIONS OF PRIVACY: AN ANTHOLOGY* (F. Schoeman ed. 1984) [hereinafter cited as F. Schoeman].

5. See Winslade, *Confidentiality of Medical Records*, 3 J. OF LEGAL MED. 497 (1982), and Winslade, *Confidentiality*, 1 ENCYCLOPEDIA OF BIOETHICS 194 (1978), and ar-

professional-patient relationships or individual versus institutional interests in the control and disclosure of personal information.⁶ Recent interest in the scope and limits of confidential communications centers on policies pertaining to confidentiality, especially in the context of medical records, rather than on the meaning or value of it.⁷ It seems that most writers have taken for granted that the concept of confidentiality is clear, that its value is well-established, and that the only question remaining is how much confidentiality should be protected or restricted. There are, however, a growing number of empirical studies on the value of confidentiality in psychotherapy.⁸

This neglect of confidentiality in the privacy literature is unfortunate for a substantial portion of the conceptual confusion in these analyses results from the telescoping of privacy and confidentiality. *Private*, according to Eric Partridge, derives from the Old Latin *privuus*, "taken in isolation, singular, owned by one person."⁹ *Confidential*, on the other hand, refers to having faith or trust in another with respect to the preservation of private information. Although in daily conversation we often use these words interchangeably (as in "it was private information" or "it was confidential information"), these linguistic origins suggest some greater purpose of differentiation for ordinary use. *Personal privacy* has to do with one's self, with an individual person; *confidentiality* has to do with *another or others*.

It could be argued that the exclusive use of "privacy" to refer to the individual is narrow and misguided. It might be conceded that "privacy" does apply to an individual's thoughts, feelings, or fantasies, but it is also claimed that it applies to relationships as well. For example, one might distinguish between privacy *in* a therapeutic relationship and privacy *of* the relationship. The former refers to the private thoughts, feelings, fantasies, dreams, etc., that are disclosed to the

titles cited therein. Some of the ideas developed in this Article were presented in a preliminary form in those articles.

6. An important earlier overview article is Slovenko, *Psychotherapy and Confidentiality*, 24 CLEV. ST. L. REV. 375 (1975). See also Note, *Status of the Emergency Room Psychotherapist: Privacy Rites*, 30 UCLA L. REV. 1316 (1983).
7. A recent discussion that advocates the need for legislative polices to protect the confidentiality of medical records is found in Gellman, *Prescribing Privacy: The Uncertain Role of the Physician in the Protection of Privacy*, 62 N.C.L. REV. 255 (1984). For a legislative proposal that stresses patients' right of access to medical records, see Note, *Toward a Uniform Right to Medical Records: A Proposal for a Model Patient Access and Information Practice Statutes*, 30 UCLA L. REV. 1349 (1983).
8. See, e.g., Appelbaum, *Confidentiality: An Empirical Test of the Utilitarian Perspective*, 12 BULL. AM. ACAD. PSYCHIATRY L. 109 (1984); Shuman & Weiner, *The Privilege Study: An Empirical Examination of the Psychotherapist-Patient Privilege*, 60 N.C.L. REV. 893 (1982); Lindenthal & Thomas, *A Comparative Study of the Handling of Confidentiality*, 168 J. NERVOUS & MENTAL DISEASE 361 (1980).
9. E. PARTRIDGE, *ORIGINS* (2nd ed. 1959).

therapist; the latter to the limitation of access of others to the relationship or information about the relationship. One might say that the "plumbers" who invaded the files of Lewis Fielding, Daniel Ellsberg's psychoanalyst, invaded the privacy of the relationship—just as they would have invaded the privacy of the relationship if they had used electronic devices to eavesdrop on the sessions. We prefer to say, however, that the "plumbers" invaded the privacy of Ellsberg and the privacy of Fielding, as well as violated the confidentiality of the psychotherapist-patient relationship. They violated the privacy rights of each man because they did not respect the confidentiality of the communications that occurred in the therapeutic sessions.

Our principal concern in this Article is *personal* privacy, and, in particular, aspects of personal privacy that are manifested in the revelation of thoughts, feelings, dreams, associations, and other mental phenomena that emerge in psychotherapy and psychoanalysis. That this is an *aspect* of the concept of privacy is without doubt; that it is an essential feature of the concept of privacy is also clear. We are not claiming that it is the whole of the concept of privacy. Even when "privacy" is used to refer to a relationship or group, that which enjoys privacy is treated as a singular subject that limits the access of others to its operations, activities, or even its existence. We do not deny that "privacy" can be meaningfully applied to entities other than individuals. It is just that in the psychotherapeutic relationship personal privacy is that which, in the first instance, belongs to and issues from the person in therapy. Confidentiality pertains to that information that is disclosed by the patient to the therapist that otherwise might remain private.

Privacy and confidentiality are alike in that each stands as a polar opposite to *public*: what is private is not public, and what is confidential is not public. Yet privacy and confidentiality are not the same. That which is private is isolated, is singular, is owned by or belongs to one. That which is confidential is shared and, though it still belongs only to one party, it is trust in the other that ensures that ownership. Personal privacy is logically and temporally prior to confidentiality, for the content of confidentiality is relinquished personal privacy.

B. Privacy

Privacy is both a fashionable and fundamental concern. It has captured the attention of many different writers and thinkers, including academicians, jurists, journalists, and politicians. Its fundamental aspects are captured by its relationships to liberty, freedom, self-definition, self-realization, and even self-preservation. There is a widespread but variant use of privacy in many different fields, including law, economics, anthropology, philosophy, and psychology. By first looking at the ways in which these disciplines characterize pri-

vacy, we will be able to identify certain dimensions of the concept critical to our concerns.

1. *Law*

In federal constitutional law, privacy frequently functions as an aspect of individual freedom or autonomy, although it may also include the autonomy of couples or of families.¹⁰ The privacy protected by constitutional law may be seen as the right to make certain kinds of decisions and to act upon them.¹¹ The kinds of decisions that fall within this concept of privacy are those that have to do with the kind of life the individual wishes to lead, such as whether one wishes to marry,¹² to have children,¹³ or to rear children in specific ways.¹⁴ Because Supreme Court decisions do not tell us *exactly* what kind of decisions fall appropriately within this sphere, it is not clear what is the critical aspect of the constitutional right of privacy. What can be noted is that it is invoked only when the individual (or couple) wishes to keep the government from restricting what he wishes to do. In that sense, the individual (or family-group) moves about accompanied by a metaphorical zone of privacy. Any activity that falls within that zone may not be restricted by government. This zone of privacy does not include everything that the individual chooses to do, but only those actions that are appropriate to the privacy zone.¹⁵ Thus, privacy in constitutional law has two important aspects: (1) it prohibits government from inhibiting certain actions; and (2) the actions that are protected stem from individual decisions about the kind of personal life that the individual chooses to lead, particularly in the context of home and family.¹⁶

In tort law, privacy is more often characterized by the idea of the

-
10. In *Griswold v. Connecticut*, 381 U.S. 479 (1965), the seminal case espousing a constitutional right to privacy, the Court held that a Connecticut contraception statute violated a married couple's right to privacy.
 11. There are two other areas in which concerns with privacy are evoked under the Constitution. One is the fourth amendment's prohibition of illegal searches and seizures. The other is the fifth amendment's protection against self-incrimination. However, the major interest in privacy (as delineated in *Griswold's* "right of privacy") lies in the area of decisions relating to personal autonomy and the fifth and fourteenth amendments' protection of liberty rights.
 12. *Loving v. Virginia*, 388 U.S. 1 (1967).
 13. *City of Akron v. Akron Center for Reproductive Health*, 462 U.S. 416 (1983); *Roe v. Wade*, 410 U.S. 113 (1973).
 14. *Pierce v. Society of Sisters*, 268 U.S. 510 (1925); *Meyer v. Nebraska*, 262 U.S. 390 (1923).
 15. For a thoughtful attempt to define the contours of the constitutional right to privacy, see Karst, *The Freedom of Intimate Association*, 89 YALE L.J. 624 (1980).
 16. If this seems vague, it is an accurate perception. The Supreme Court has not yet definitively articulated what kinds of decisions, other than procreational ones, lie within this zone.

individual's right not to have information about him exposed to others or not to be unduly intruded upon by others.¹⁷ Here, the "zone of privacy" is more like a "circle of privacy" that surrounds the individual or group. Whatever the individual or group is doing, including simply *being*, at any given time, assuming that it is not being conducted in full view of the public, lies within the circle of privacy. Because it is private, no one is entitled to take information in any form from within the circle or, having taken it, to circulate it to the public. Unlike the constitutional law concept, this view of privacy is not concerned with external prohibitions of actions, but rather with external appropriations or intrusions. You may not enter the circle, either by physical or observational means, nor may you take information about it elsewhere. This kind of privacy is concerned with the circulation or publication of photographs or other personal information. Unlike constitutional privacy, which concerns *restrictions* on an individual's privacy, tort law focuses on *invasions* of an individual's privacy. Tort law conceptualizes privacy in terms of the locational context, and constitutional law in terms of the nature of the decisions or actions. The assessment of the value of privacy differs in a comparable way: tort law protects privacy in order to protect individual sensibilities or economic interests, whereas constitutional law purports to protect the individual's need to make certain fundamental human decisions, and thus to define himself in a self-chosen way. Robert Gerstein, in his characterization of "the private life," attempts to combine both tort and constitutional concepts of privacy, for the individual always takes his private life with him; both the location and the activities within it.¹⁸

2. Economics

Economists usually cast their concern with privacy in terms of private information and structure their discussions almost exclusively in terms of personal information as a commodity with a potential for economic value. Because they are interested in the efficient use of information as an article of commerce, some advocate public policies that would provide maximum access to information with provision for appropriate financial incentives and reimbursement policies.¹⁹ When information is viewed as a valuable economic commodity, any attempt to protect the information may be seen as a negative value. Thus it is with those economists who equate privacy with secrecy. In an eco-

17. See generally LeBlang, *Invasion of Privacy: Medical Practice and the Tort of Intrusion*, 18 WASHBURN L.J. 205 (1979).

18. See Gerstein, *California's Constitutional Right to Privacy: The Development of the Protection of Private Life*, 9 HASTINGS CONST. L.Q. 385 (1982).

19. For a particularly clear exposition of this point of view, see Posner, *The Right of Privacy*, 12 GA. L. REV. 393 (1978).

conomic analysis that looks to utilitarian, socially-oriented goals, privacy is detrimental to efficient development.

Other economists, however, although doubtful about the long-run usefulness of a privacy ethic, theorize that privacy may have greater value to the individual.²⁰ In Jack Hirschliefer's analysis, privacy is defined in its simplest sense as meaning mine, as opposed to yours.²¹ Privacy requires the individual to keep others from invading what is "his" and, because privacy is the appropriate breeding ground for autonomy and equality, to keep the individual from intruding upon what belongs to "others." It is "internalized respect for property" that "permits autonomy to persist within society."²² This analysis of privacy also attempts to unify the two senses of privacy as protection from external intrusion and protection from external prohibitions. Because Hirschliefer starts from a sociobiological orientation, he argues for the instrumental value of privacy. Here, privacy is a strategic choice for a certain kind of society that, from a moral perspective, may or may not be desirable, but that "works" (at least for a given period of time). Hirschliefer's arguments about the biological use (and evolutionary success) of privacy provide an interesting parallel to psychological assessments of the use of privacy, which will be discussed below.

Although these two economic views differ in many respects, they both proceed from a sense of privacy as protection for an individual's property interests. They do not really differ even in their assessment of the results of a privacy ethics of "mine, not yours." The former sees privacy as diminishing community goals; the latter a way of heightening individualism, which of necessity ultimately subordinates and thus diminishes community goals.²³

3. *Anthropology*

Anthropologists' interest in privacy is, interestingly, delineated by their view of the function of gossip. Where the economists view privacy as a hindrance to the free flow of information, anthropologists see gossip as an illustration of the use of personal information for attaining prestige. Anthropologists have studied cultures in which people are in competition with one another for status positions, when status can be affected by the individual's ability to acquire and willingness to disseminate private information. This competitive view of laissez-faire information mongering suggests that privacy, far from being

20. See Hirschliefer, *Privacy: Its Origin, Function & Future*, 4 J. OF LEGAL STUD. 649 (1980).

21. *Id.* at 650.

22. *Id.* at 657.

23. The tension between individual and community goals is examined from a sociological perspective in R. BELLAH, *supra* note 4.

inevitable, may be endangered.²⁴

The value of privacy, in this view, is entirely a matter of self-interest. That is, one obtains success or status by protecting one's own privacy as much as possible while trying to invade others' privacy as much as possible. Thus, the value of privacy depends entirely on the position in which one stands. My privacy is my gain, and your privacy is my loss. One's right to privacy translates as a right either to disadvantage others by withholding information from them, or not to be disadvantaged oneself because one is protected from having to disclose information.

Other anthropological views of privacy have focused on the cultural relativity as to what behavior is kept private and, suggesting the view that the need for privacy is inherent, the various ways in which privacy is created in cultures that have no easy privacy because of population density and inadequate natural resources. Thus, it is typically theorized that some cultures have developed intricate and ritualized exchanges between people in order to permit the individual to keep his own perceptions or attitudes hidden. When all one's actions are observed, rituals permit one to be psychologically removed from view, without respect to whether the knowledge that is being hidden would, if known, affect either the individual's power or his vulnerability. Here privacy serves neither to prevent intrusion nor to encourage individual autonomy; neither to retard economic efficiency nor to protect ownership values. Instead, this privacy seems a defensive posture that enables the individual to keep himself separate and separated from others. It is related to the economic sense of "mine, not yours," insofar as it serves a psychological value of self-definition by negation or default: the individual is able to define himself by what "others" do not know.²⁵

Doi, however, does not subscribe to such a view.²⁶ He states that the Japanese do not value personal or individual privacy. His contention is that ritualized behavior functions to develop and maintain close ties with the other members of the group through which one's own sense of self is created. He adds that the Japanese do not aspire to Western individual freedom or uniqueness of self because their sense of meaningful existence lies within the network of close relationships. Thus, ritual may in some instances provide a cover for individualism and in others may substitute for it.

24. See, e.g., R. ROSNOW & G. FINE, RUMOR AND GOSSIP: THE SOCIAL PSYCHOLOGY OF HEARSAY (1976); Abrahams, *A Performance Centered Approach to Gossip*, 5 MAN. 290 (1970).

25. See, e.g., Murphy, *Social Distance and The Veil*, 66 AM. ANTHROPOLOGIST 1257 (1964), reprinted in F. Schoeman, *supra* note 4, at 34-55.

26. See T. DOI, THE ANATOMY OF DEPENDENCE 28-65 (1973).

4. *Philosophy*

It is, perhaps, the philosophers who have written most extensively and most disparately about privacy, its meaning and its value. Here the views range from privacy as an inescapable aspect of the human condition to the right to privacy as an essentially empty category; from stark reality to total illusion. Existential philosophers never tire of reminding us that human subjectivity is inexhaustible. In a sense, then, human beings are confronted with an inescapable privacy because there is limited access from outside (scientific objectivity) and limited capacity for disclosure to others (possibilities of human communication), or even for access to oneself, of one's inner thoughts, feelings and fantasies.²⁷ This is an ontological or metaphysical truth that tells us something about the way things are, given the nature of human beings. However, the fact that each of us has, whether we like it or not, this subjective, ontological privacy does not necessarily imply anything about the value of privacy. This view does have something in common with the economic/sociobiological view delineated by Hirschliefer insofar as it suggests that biologically mandated characteristics (those that are "hard-wired," in Hirschliefer's terminology) must serve some important survival strategy. Thus, even if the condition of privacy is inevitable, the question of how it serves survival purposes remains open.

Philosophers who see the right to privacy as an illusory or empty concept or at least reducible to other more basic concepts,²⁸ point out that the most common feature in discussions of the right of privacy is the inability for anyone to agree on the content of privacy. They see this as an appropriate state of affairs, for in their view privacy has no unique moral content, but is merely a catch-all phrase for other specific rights having to do with personal and property rights. Yet, as Reiman has noted,²⁹ it is as reasonable to say that personal and property rights derive from the right of privacy as to say that the right of privacy is the derivative (and therefore empty) category.

A third group of philosophers, represented by Jeffrey Reiman³⁰ and James Rachels,³¹ attempts to capture the core aspects of privacy by assessing the interests that privacy serves; i.e., what does privacy achieve? Although their analyses have no direct connection either to

27. See D. O'BRIEN, *supra* note 4, at 10, where the author, though not an existentialist, argues persuasively the centrality of this quality of privacy.

28. Judith Jarvis Thompson is the primary proponent of this view. See Thompson, *The Right to Privacy*, 4 PHIL. & PUB. AFF. 295 (1975).

29. See, e.g., Reiman, *Privacy, Intimacy and Personhood*, 6 PHIL. & PUB. AFF. 26, 27 (1976).

30. *Id.*

31. See, e.g., Rachels, *Why Privacy is Important*, 4 PHIL. & PUB. AFF. 323 (1975).

the sociobiological view or to the existentialist "nature-of-man" view, their conclusions would appear to serve both those perspectives.

Rachels argues that privacy is valuable because it allows us to control the information that others have about us and therefore permits us to shape the nature of our relationships with others. Privacy "allows us to maintain the variety of relationships with other people that we want to have."³² This analysis, similar in many ways to Posner's conception of privacy as the control of valuable information, asserts that *intimacy*, which is highly valued, is made possible by the individual's ability to disclose information about himself to some but not to all. Unlike Posner, Rachels insists that the primary value of the information lies with the individual rather than with *others*, but apart from that, each uses a scarcity model to talk about the value of privacy. Rachels does not, however, equate privacy with intimacy. Rather, he sees privacy, i.e., the control over release of personal information, as the ground upon which all relationships are formed. The degree to which the individual chooses to release information about himself (i.e., the degree to which privacy is relinquished) determines the kind of relationship that the individual will have, be it intimate or distant.

Reiman finds Rachels' view unappealing, not least because it results in finding that "the value and substance [of intimacy] lies not merely in what I have but essentially in what others do *not* have."³³ Reiman finds this market value concept of intimacy demeaning because it reflects a shopkeeper's mentality, and because a *right* to privacy cannot be founded on such shabby ground (although it would do well enough for an *interest* in privacy). He criticizes Rachels' view by pointing out that it is the context in which people share personal information, not the sharing of the information itself that constitutes the source of intimacy. Reiman uses the example of psychoanalysis as a relationship in which substantial personal information is relinquished but which does not thereby become an *intimate* relationship (within the customary meaning of the word, relating as it does to friendships, family, and other loving relationships). Such a relationship is *personal* but not *intimate*. Reiman takes intimacy to mean the mutual desire to share and the actual sharing of experiences over a broad range of activities in a caring, loving context. Intimacy has to do with *caring about another*, not about "swapping information," as he characterizes Rachels' view. But, there is clearly no way to ground or to define privacy as "caring about another" and thus, although intimacy is an important value, privacy cannot be valued solely on its account, nor a right to privacy granted on its behalf.

Instead, Reiman argues that the right of privacy rests in the princi-

32. *Id.* at 329. See also Fried, *Privacy*, 77 YALE L.J. 475 (1968).

33. See Reiman, *supra* note 29, at 17.

ple of respect for others and the value of autonomy. By virtue of privacy ("a social ritual" by which one may keep information about oneself hidden from others), the individual is able to conceive of his existence as his own. Privacy, contends Reiman, "is necessary to the creation of 'selves' out of human beings."³⁴ Like Rachels, Reiman characterizes privacy as control over information about oneself, but unlike Rachels, Reiman believes that control is used to provide self-definition. Privacy then permits self-definition by means of separation from others.³⁵

5. *Psychology*

Psychologists of all theoretical persuasions have grappled with the meaning and value of privacy. They have, however, achieved no more agreement about conceptual content than have commentators from other disciplines, although they generally take privacy to be intrinsically related to the individual's psychological sense of himself as separate from others. The belief that "privacy is meaningless before self-consciousness emerges"³⁶ is typical of this underlying understanding.

An early paper by Alan Bates assesses the usefulness of privacy as a primary phenomenological construct in social psychology.³⁷ This essay is remarkable for the span of its coverage. In a scant five and one-half pages, it catalogs privacy as: an individual's feeling that others should be excluded from what is of concern to the individual; a feeling that others have a right to exclude; the metaphorical "central room in the house of the self to which no other person can be admitted and from which the self can never fully emerge"; a tri-partite concept including the kinds of things or the content that is protected by privacy, the prevention of intrusions by specific others, and the context in which the content is protected; a tri-partite concept having private, public, and individual aspects; a buffer between social pressures and individual responses; a means of protecting vulnerability; as a sanctuary for psychological healing; and as a commodity that must be neatly balanced for healthy personhood (too little privacy results in over-stress, too much in a failure to engage in the world). Bates concludes that privacy would be an extremely valuable construct for social psychology because it lends itself admirably to empirical research, appearing as it does everywhere. However, it is just this grab-bag idea of privacy that makes study of the topic so frustrating. Nonetheless, the accordion nature of the privacy concept, demonstrated so well by this paper, reinforces the intuition that privacy is an exceptionally basic

34. *Id.* at 39.

35. *Cf.* Karst, *supra* note 15, at 11, who argues that privacy serves intimacy and intimacy serves self-definition through relationship.

36. Bates, *Privacy—A Useful Concept*, 42 SOC. FORCES 429, 431 (1964).

37. *Id.*

concern: so basic to human nature that its manifestations bubble up across the breadth of landscape, defying neat groupings or obvious commonalities. In some non-metaphorical sense, privacy is deeply connected with the well-spring of humanhood.

Barry Schwartz takes a very different approach to privacy.³⁸ He conjectures that "sanctuary" is the core concept of privacy, and then proceeds to observe the multiple manifestations of privacy in society. In seeking to determine how privacy or separation serves the interests of union or integration, he initially characterizes privacy as a means of sanctuary from difficult personal relationships or other situations that serve to make life at least temporarily unbearable. He expands his characterization to include privacy as a method of obtaining and maintaining status divisions and of avoiding the control of others. He is concerned with the tension between separation and union, and argues that it is access to privacy that "makes intense group affiliations possible."³⁹ Curiously, he also insists that humans are "naturally given to intrude upon" the privacy of others, and that sanctuary or separation from the external world is possible only if the super-ego releases the person from its worldly observations.

Privacy, then, comes not simply as separation from others but also as separation from our own worldly judgments of ourselves. Privacy here suggests some kind of naked confrontation with one's elemental self, and thus it is not surprising that Schwartz's view of privacy is strangely ambivalent. The need for privacy is conditioned by a hostile or at least harrasing and invasive world from which one cannot escape (for it exists without us as well as within us), but must escape. Although privacy provides calmness, healing, and "a haven in a heartless world,"⁴⁰ once gained it provides yet another burden, for privacy past the moment of healing causes man "to become a burden to himself: He becomes his own audience to performances which are bound for tedium."⁴¹

Where Bates sees the multiple value of privacy, Schwartz seems to see privacy as a necessary condition to existence in a nightmare where the nightmare is the only game in town. This bleak view of privacy is unusual in a discipline where privacy is more frequently seen as an unquestioned positive value.

Winicott⁴² typifies this latter view when he asserts that the capacity of the individual to be alone "is one of the most important signs of maturity in emotional development."⁴³ He is not concerned with the

38. See Schwartz, *The Social Psychology of Privacy*, 73 AM. J. SOC. 741 (1968).

39. *Id.* at 751.

40. See, e.g., C. LAIRD, *THE CULTURE OF NARCISSISM* (1979).

41. Schwartz, *supra* note 38, at 751.

42. Winicott, *The Capacity to Be Alone*, 39 INT. J. PSYCHO-ANAL. 416 (1957).

43. *Id.* at 29.

actual state of being alone, or even with toleration of solitude, for, as he comments, an individual in solitary confinement may not be alone. Further, though he may tolerate the solitude, he may not have the capacity for being alone. The capacity for being alone is developed by being alone with another person present and matures into a capacity to be actually alone. This aloneness that Winicott values is closely allied to the psychological self-separateness that Reiman describes as the core purpose and value of privacy.

A related view of privacy among psychologists is that expressed by Ekstein and Caruth.⁴⁴ They point out that the traditional view of psychotherapy has been that the therapist works to get the patient to reveal his secrets and that when those secrets are revealed, then the patient is on the road to recovery. This view of privacy as secrecy makes privacy, or a need and desire for privacy, the mark of a less mature state. The mature individual shares with others, for "[t]he shared aspect is the more mature aspect . . . [of] the private experience."⁴⁵ This view (which is very different from Ekstein and Caruth's, but suggestive of the "let-it-all-hang-out" position of the 1960's and 1970's) identifies privacy negatively with secrecy and with alienation.

Ekstein and Caruth also identify privacy with secrecy. They point out that the Latin derivation of *secret* is "to separate or to put apart." This is, of course, almost identical with the Latin derivation of *private*: "singular or separate." Thus, keeping secrets is a way of separating oneself and telling secrets is a way of relating to others. Using this as the focal point for characterizing the therapeutic experience, the authors are able to illuminate the extremely paradoxical nature of the process. If the purpose of therapy is to help the patient develop a sense of self, "a mind of his own," then the process itself exemplifies this conflict over withholding and sharing, over being separate and being joined. If the patient must keep his secrets in order to maintain his separateness from the therapist, then the goal he seeks will evade him, for his goal is to have his separateness without having to protect it by isolating himself in his privacy. If he relinquishes his secrets in order to give up his isolation and reaches for the goal of chosen separateness, he loses the sense of separateness that privacy gives him. This is because the secrets that he withholds, regardless of their content, are in fact his sense of himself as a separate person. Thus, "[t]he therapeutic task of the patient, therefore, is to retain just enough of the secret self to remain separate and independent, and to become just enough of a 'secret sharer' to relate to others."⁴⁶

Secrets here are not guilty secrets and the telling of secrets is not

44. See Ekstein & Caruth, *Keeping Secrets*, in *TACTICS & TECHNIQUES IN PSYCHOANALYTIC THERAPY* 200 (P. Giovacchini ed. 1972).

45. Tauber & Green, *quoted by* Ekstein & Caruth, *supra* note 44, at 202.

46. Ekstein & Caruth, *supra* note 44, at 204.

confession. The substance of what is kept private or secret is not so important as the very fact of its being hidden from others. Secrets and secrecy are the initial acts of separation and individuation in the child. But separation is replaced by isolation, if fusion with others (as opposed to sharing with others) is seen as the only alternative. Separation or privacy is here seen as the alternative to sharing; isolation is the alternative to fusion. In isolation, one has no sense of connections to others; in fusion, one has no sense of one's own edges or boundaries. Privacy and sharing, on the other hand, articulate the boundaries of the self *and* the network of relationship.

6. *Summary: Core Concepts of Privacy*

Throughout these summaries of representative privacy analyses there is the dominant sense that one key aspect of privacy is self-regarding, having only to do with the individual and with the quality of the individual's existence as it is determined by his self-perception. In constitutional law, the kinds of decisions protected by privacy show deep connections to self-definition, especially with respect to procreation. In tort law, privacy protects personal sensibilities so that individuals may choose how others view them (i.e., so that each person may choose how his self is to be defined). Economists recognize privacy as the method defining the difference between self and others, and their differing values of privacy are a function of their differing commitments to group or individual goals. Anthropologists agree that the fundamental nature of privacy in disparate cultures universally serves self-definition. Many philosophers are inclined to look for the value of privacy in the creation of personal relationships, although they do not agree about how privacy functions. Nonetheless, although some argue that privacy serves intimacy and through intimacy the self is defined, and some argue that privacy directly serves self-definition through autonomy and respect for persons, all would agree that self-definition is the result.

Although the psychologists do not always go beyond self-definition as privacy's achievement, Ekstein and Caruth do isolate a rich sense of the ambiguity of privacy. Privacy as secrecy both permits self-definition, which makes relationships with others possible, and demands isolation, which makes relationships with others impossible. The individual's realization of this ambiguity takes him beyond self-definition to self-realization or self-integration. Self-realization, the child of secrets kept and revealed, of privacy preserved and relinquished, enables choice, the goal of the therapeutic enterprise.

In discussing the role of privacy in the psychotherapeutic relationship, we are concerned with privacy as a self-regarding concept. That is, a person's privacy is something that he can preserve by not granting access to others or by not disclosing personal information such as

thoughts, sensations, feelings, memories, or fantasies. Privacy here refers to a state of the self, and the ability to grant or restrict access to that state; to be separate or joined without risking isolation or fusion, is the goal of psychotherapy. From this perspective, privacy is the field of the analytic endeavor, not, however, in the sense that privacy must be relinquished to or invaded by the therapist in order for the patient to achieve individuation. Quite the contrary, the patient's privacy must be respected, even honored by the therapist, so that the patient's *choice* to relinquish his privacy permits the recognition that what is lost is information, but not self; what is gained is integration of the self.

C. Confidentiality

Confidentiality is a less problematic concept than privacy, but it is desirable to clarify and explore its value more fully than is commonly done. The legal status, psychological significance, and ethical value of confidentiality are not coextensive with privacy, and confidentiality conflicts have been obscured by the tendency to use the terms as if they were interchangeable.

Unlike privacy, confidentiality does not refer to self-concerns at all. Confidentiality presupposes a relationship between two (or more) persons, one of whom exposes himself or herself in some way to the other(s) or discloses personal information to the other(s). An expectation of confidentiality arises out of a special relationship between the person who relinquishes privacy and the recipient of it. Confidentiality may be expected because the recipient promised it (e.g., a secret shared with a friend), because the law recognizes it (e.g., lawyer-client communications are privileged), or because professional ethics demand it (e.g., psychotherapists may not gossip about their patients). Privacy is relinquished in such special relationships because confidentiality is assured. That certain information is confidential means that it will not ordinarily be disclosed to persons outside the relationship. Thus, by receiving or requesting private information, the recipient is *obliged* to accept its confidential nature. The recipient may, sadly, violate the trust that is placed in him or her, but may not decide whether or not confidentiality applies. Confidentiality is logically dependent upon relinquishing privacy and it is important to recognize the priority of privacy and the derivative nature of confidentiality.

Confidentiality has been defined by Willis Ware as follows:

- (1) Status accorded to data or information indicating that it is sensitive for some reason, therefore needs to be protected against theft or improper use, and must be disseminated only to individuals or organizations authorized (or privileged) to have it;
- (2) by extension, status (sometimes assured by law) accorded data or information that reflects an understood agreement between the person furnishing

the data and the person or organization holding it that prescribes the protection to be provided and the dissemination and use to be permitted; and

(3) a legally recognized relation between certain individuals (e.g., lawyer-client) that privileges communications between them from disclosure in court. (Sometimes, confidential information is legally required to be given in exchange for some benefit, privilege, right, or opportunity; sometimes it is voluntarily given.)⁴⁷

Ware's definition, which is widely used in discussions involving confidentiality of medical records, is somewhat problematic when applied to the psychotherapeutic relationship because of its passive construction. In both (1) and (2), he states that "confidentiality" is "status accorded to data or information," but he does not clarify who accords the status. In (2), he states that law sometimes assures the confidential status, but this suggests that it is not law that *accords* or grants the status.

The status cannot simply flow from the fact that the information the person chose to reveal was "private," i.e., information about himself, his thoughts, feelings, and fantasies. All private information that is shared or divulged does not become confidential information. If a person chooses to announce his unusual sexual orientation, for example, on the radio, on a billboard, or in a street corner speech, the information, though private in its origins, is not confidential.

Confidentiality flows not simply from the character of the information but from the context of the disclosure and from the nature of the relationship between the discloser and the recipient of the information. If an individual sits down beside a stranger and begins to divulge private information, there is no expectation of confidentiality, for *confidentiality*, as in its linguistic origins, assumes a relationship to another *with trust*. Between strangers, there is no implicit trust. Yet, confidentiality is not divorced from the nature of the information revealed, for if one of two persons in an intimate, trusting relationship tells the other that he has bought a new car, such information alone would not be construed to have the status of confidential information. To be considered confidential, the person would be required to request expressly confidentiality or to make a broader disclosure that renders the discloser vulnerable in some way (e.g., "I told my child that I had no money for his education, but the truth is I just spent all my money on a new car.").

Thus, confidentiality can be better described as the status of sensitive, potentially harmful, or embarrassing private information disclosed within the confines of an intimate relationship. The underlying assumption of this definition is that the person who is the subject of the information expects to be able to control further disclosure of the

47. Ware's definition is set forth in A. WESTIN, *COMPUTERS, HEALTH RECORDS AND CITIZEN RIGHTS* 348 (1977).

information to all others by invoking its confidential status. Expectation of control lies, it should be reiterated, with the person who reveals the information, not with the person who receives it. Of course the recipient of confidential information can betray the trust upon which the relationship is built, or can decide that disclosure better serves the person's interests. In this sense, the person who has provided private information cannot control it. But, insofar as disclosures are based on the assumed nature of the relationship, no further disclosures are legitimate unless the person who has made them authorizes redisclosures.

Relationships in which persons share information meriting confidentiality are not limited to reciprocal familial or amicital ones. There is as well a distinct group of what might be called intimate relationships with one-way revelations. They are exemplified by the clergyman-penitent, the doctor-patient, the attorney-client, and the therapist-patient/client relationships. These relationships are distinctive in that they are occasioned by one person's perceived need of help. Thus, the patient/client is in some way vulnerable and enters into the relationship in order to find protection or aid. Second, all these relationships involve disclosures of private information by one party, but not by the other. At least on the surface, these relationships appear to lack the mutuality of genuine intimacy.

Having given the priest-penitent relationship over to the jurisdiction of God, the law construes the latter three to be fiduciary relationships. The fiduciary nature implies that the relationship is unequal in terms of power: that the doctor, attorney, or therapist must adopt a protective attitude in order to avoid taking undue advantage of the patient/client. This paternalistic bias, deriving from law's generally accurate perception of the power relationships of this sub-group, is problematic with respect to confidentiality, for it implies that the control over confidentiality lies with the dominant, non-revealing party, not with the subject of the information.

Because the import of the confidentiality lies with the individual's control over personal/private information, professionals in relationships of a fiduciary character need to be particularly scrupulous in conveying to patients or clients the limits of confidentiality and the implications of disclosures and redisclosures. If a person is willing to relinquish some aspects of his privacy, it cannot be conditioned only on the basis of his receiving some specific gain (improved physical or mental health, or relief from legal problems). The person's decision to relinquish privacy must, as well, be fully informed by a need for confidentiality and an understanding of the probable boundaries of confidentiality. The professional cannot, simply from a paternalistic position, assume or decree that relationships must or should be airtight. Control over confidentiality of information (except in those ar-

as where statutes or judicial decisions interpose other boundaries) lies with the client. Both privacy and confidentiality lie within his or her purview, and are occasioned by his or her autonomous action. Acknowledging the patient/client's control of privacy and confidentiality is a manifestation of respect for an autonomous person.

The fiduciary aspect of the professional-client relationship pulls in the direction of paternalistic protection of the clients interest, whereas the confidentiality dimension rests upon recognition of client autonomy. It is not surprising, therefore, that some professionals think they should control confidentiality. For example, the professional or a fiduciary may sincerely believe that it is in the client's best interest to, say, preserve confidentiality when the client as an autonomous agent prefers to give it up. In this context the client rather than the professional should make the decision, even if it may not be in the client's best interests.

III. PRIVACY AND CONFIDENTIALITY IN LAW

The purpose of this section is to discuss briefly the standard legal approach to privacy and confidentiality in the psychotherapeutic context. We provide a selective analysis of certain key cases to illustrate how certain courts have sought to deal with privacy and confidentiality in psychotherapy. Others have argued more fully and in detail the extent to which constitutional law protects privacy and confidentiality in psychotherapy.⁴⁸ A recent article claims that although there is some legal protection for confidentiality in psychotherapy, the law falls short of providing adequate protection.⁴⁹ Our aim in this section is to discuss only a limited aspect of the legal issues, that is whether the rights to privacy and confidentiality are personal and held by the patient or whether the rights are inherent in the relationship.

A. Constitutional Law

In 1965, Justice Douglas, in *Griswold v. Connecticut*,⁵⁰ found that a "penumbral emanation" of the Bill of Rights included (or implied) a right of privacy. At issue in *Griswold* was a Connecticut law forbidding any person to use contraceptives, to advise others about the use of contraceptives, or to supply others with contraceptives. In this case, the Court saw the right of privacy as the married couple's right both to make "private" decisions about procreation and to make them in the

48. See, e.g., Smith, *Constitutional Privacy in Psychotherapy*, 49 GEO. WASH. L. REV. 1 (1980).

49. See Sloan & Hall, *Confidentiality of Psychotherapeutic Records*, 5 J. LEGAL MED. 435 (1984). See also Applebaum, *Confidentiality in Psychiatric Treatment*, in 1982 AM. PSYCHIATRIC ASSOC. ANN. REV. (L. Grinspoon ed.).

50. 381 U.S. 479 (1965).

privacy of their own home. Subsequently, the right of privacy has been applied in a number of other cases, but it has less frequently applied to couples and more often to single individuals, particularly with regard to matters of marriage and procreation.⁵¹ *Roe v. Wade*,⁵² the case that led to the legalization of abortion, is a notable exception. In that case, the right of privacy appears to adhere to the doctor-patient relationship. However, in the recent case of *Akron v. Akron Center for Reproductive Health*,⁵³ the Court explicitly granted the abortion right to pregnant women despite the fact that it also reaffirmed *Roe v. Wade*.

In *Whalen v. Roe*,⁵⁴ the Court specifically addressed the status of "informational privacy," and whether one had a right to maintain the confidentiality of personal information revealed in a professional-client relationship. Although there is language in the opinion that acknowledges a privacy interest in personal information,⁵⁵ the Court stops short of recognizing a constitutional right in informational privacy, especially if the state takes appropriate steps to protect the information. Thus, although the past eighteen years have seen a substantial number of Supreme Court decisions invoking a constitutional right of privacy, none of them has established a right of privacy for the patient with respect to psychotherapists' disclosures of information gained in the therapeutic relationship. *Roe v. Wade* locates the privacy right in the doctor-patient relationship, but this conceptualization, which has been severely criticized by most legal scholars, is not compelling.⁵⁶ Further, it applies only to the privacy of the decision, not to informational privacy.

B. Tort Law

In 1977, an important confidentiality/privacy case was decided in New York. *Roe v. Doe*,⁵⁷ involved a psychiatrist and a psychologist who had written a book that included case histories. Although names were not used, the information in the case histories was drawn directly from therapeutic sessions. Doe had been in therapy with the psychiatrist and upon hearing about publication of the book (eight years after the therapeutic relationship had been concluded), she protested the breach of confidentiality.

51. See, e.g., *Eisenstat v. Baird*, 405 U.S. 438 (1972); *Loving v. Virginia*, 388 U.S. 1 (1967); *Skinner v. Oklahoma*, 316 U.S. 535 (1942).

52. 410 U.S. 113 (1973).

53. 462 U.S. 416 (1983).

54. 429 U.S. 589 (1977).

55. *Id.* at 605.

56. See, e.g., Ely, *The Wages of Crying Wolf: A Comment on Roe v. Wade*, 82 YALE L.J. 902 (1973).

57. 93 Misc. 2d 201, 400 N.Y.S.2d 668 (Sup. Ct. 1977). See also A. BROOKS, LAW, PSYCHIATRY AND MENTAL HEALTH SYSTEM 342 (1974).

Most previous New York cases on therapeutic confidentiality and disclosure had turned upon whether there was in fact a physician-patient relationship or whether the disclosures that were made were in fact truthful. However, in this case neither of these matters was at issue. Doe had been Roe's patient and her complaint was that the disclosures were altogether too true. Although the psychiatrist had sought consent from the patient during the period of therapy, the patient had not consistently given consent. The court found that there was a contract between the patient and doctor with respect to the disclosure of information:

a physician, who enters into an agreement with a patient to provide medical attention, impliedly covenants to keep in confidence all disclosures made by the patient concerning the patient's physical or mental condition as well as all matters discovered by the physician in the course of examination or treatment. This is particularly and necessarily true of the psychiatric relationship
⁵⁸

The court found further that the psychiatrist did violate the patient's right of privacy by failing to respect the patient's expectations of confidentiality. In its analysis of the case, the court treats confidentiality as an adjunct of the patient's right of privacy, not as a separate concern. That is, what is violated is not the patient's expectations of confidentiality but her right of privacy, for privacy had been relinquished only on the condition of confidentiality.

The absence of a specific right to privacy makes the constitutional cases problematic, for it is not always clear what privacy construct the court has in mind when they invoke a privacy right. The New York court in *Roe v. Doe* found that the patient had a right of privacy, although it was different from the Supreme Court's delineation of a privacy right that related only to governmental intrusion with decision making. It is not clear exactly where the court finds New York's right of privacy. For, although it appears to be related to tort claims, there is a specific denial that the case recognizes a common law right of privacy.⁵⁹ Instead, the court found that the right arose from public policy regulations "which bar a physician from disclosing a patient's confidences; and the implied promise of confidentiality which every physician makes to his patient."⁶⁰

C. Privilege Law

California added a specific right of privacy to its state constitution in 1972.⁶¹ Any breach of confidentiality by a therapist would be, pre-

58. *Roe v. Doe*, 93 Misc. 2d 201, 210, 400 N.Y.S.2d 668, 674 (Sup. Ct. 1977).

59. *Id.* at 212, 400 N.Y.S.2d at 676.

60. *Id.* at 213, 400 N.Y.S.2d at 676.

61. CAL. CONST. art. I, § 1. See generally Cope, *Toward a Right of Privacy as a Matter of State Constitutional Law*, 5 FLA. ST. U.L. REV. 704 (1977).

sumably, easily located as a violation of this right.

Three California cases have attempted to clarify the meaning and status of confidentiality in the therapeutic setting, but the constitutional right of privacy either did not apply or did not prevent disclosure. The first, *In re Lifschutz*,⁶² was decided before California had included the right of privacy in its constitution. The second, *Caesar v. Mountanos*,⁶³ was subsequent to the addition of the California constitutional right to privacy, but was decided in a federal court and the California privacy right was not relevant. Both cases, however, address the question of whether the therapist may maintain confidentiality even when the patient, at least implicitly, requests that privileged information not be treated as confidential by entering litigation in which his mental condition is an issue. The third case, *Tarasoff v. Regents of University of California*,⁶⁴ addresses the question of the state's authority to require a therapist to override a patient's expectations of confidentiality without the patient's permission or consent and potentially over the patient's objection. The state constitutional right of privacy was not invoked in this case either.

Although *Lifschutz* further reinforces the idea that confidentiality is controlled by the patient as an extension or adjunct to his right of privacy, *Caesar* confuses the issue and *Tarasoff* explains something about the limits of the patient's control. Subsequent cases and statutes have suggested that the benefits to be obtained by assuring full control of confidentiality in therapy by the patient are outweighed by the risks inherent in such a policy.⁶⁵ *Tarasoff*, subsequent cases, and child abuse reporting statutes make it clear that selective governmental incursions into the patient's control over information disclosure will receive judicial approval. These statutes and rulings, however, do not give rise to any support for the position that the therapist has any right to decide, on his own, when confidentiality should be breached. In that respect, California law has continued to support the patient's control of confidentiality. If incursions are to be made, it will be the government who will decide when they are justified, even though it makes the therapist its agent in pursuit of confidential information.

1. In Re Lifschutz

This 1970 case was occasioned by a civil law suit, in which Mr. Housek sued Mr. Arabian, claiming damages as a result of an alleged assault. When Housek's deposition was taken, he acknowledged hav-

62. 2 Cal. 3d 415, 467 P.2d 557, 85 Cal. Rptr. 829 (1970).

63. 542 F.2d 1064 (9th Cir. 1976).

64. 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (1976).

65. For an analysis of these cases see Winslade, *After Tarasoff: Therapist Liability and Patient Confidentiality*, in *PSYCHOTHERAPY AND THE LAW* (L. Everstine ed. (in press)).

ing been in psychiatric treatment with Dr. Lifschutz for six months, ten years previously.⁶⁶ Arabian subpoenaed Dr. Lifschutz and his records, but when Lifschutz appeared, he refused to turn over any records and he further refused to provide any information about Housek, including whether Housek had ever been his patient. Dr. Lifschutz claimed that by refusing he was protecting his right of privacy, his patient's right of privacy, and his right to practice his profession effectively.⁶⁷ He claimed further that he was being discriminated against, in that the state did not require clergymen to breach the patient's confidentiality.

The Superior Court ordered Lifschutz to testify and produce relevant records, reasoning that the psychiatrist-patient privilege did not apply since Housek himself had placed his mental condition at issue by bringing the suit.⁶⁸ Lifschutz again refused to testify, claiming that absolute confidentiality was essential to the effective practice of psychotherapy. Lifschutz was found in contempt of court and imprisoned, and a decision was issued on his appeal from the contempt charges.⁶⁹

California had no psychotherapist-patient privilege statute until 1960. Prior to that, only the physician-patient privilege had protected patients in therapeutic relationships, and then only if the therapist was a medical doctor. Between 1960 and 1965, psychologists were given the same status as attorneys with respect to privileged communication.⁷⁰ Psychiatrists continued to be included in the doctor-patient privilege, which held a lesser degree of protection. In 1965, a new law repaired this inequity and psychiatrists and psychologists both were included within the psychotherapist-patient privilege.⁷¹ The source of this privilege was drawn "primarily from the psychological needs and expectations of patients" in therapy.⁷² Both the *Lifschutz* court and Dr. Lifschutz himself agreed about the patient's need for this assurance. However, the court found the therapist could not claim that his privacy was being violated because the therapist's privacy was not at issue. The privacy *and the confidentiality* at issue were solely the patient's.⁷³

Lifschutz contended further that in order to practice therapy effectively, the therapist needed total control over the confidentiality of information. Here again, the court acknowledged that where the patient does not consent to further disclosure, then perhaps the therapist

66. *In re Lifschutz*, 2 Cal. 3d 415, 420, 467 P.2d 557, 559, 85 Cal. Rptr. 829, 831 (1970).

67. *Id.*

68. *Id.* at 420-21, 467 P.2d at 559-60, 85 Cal. Rptr. at 831-32.

69. *Id.* at 421, 467 P.2d at 560, 85 Cal. Rptr. at 832.

70. *Id.* at 422 n.3, 467 P.2d at 560 n.3, 85 Cal. Rptr. at 832 n.3.

71. *Id.* at 422 n.3, 467 P.2d at 560-61 n.3, 85 Cal. Rptr. at 832-33 n.3.

72. *Id.* at 423, 467 P.2d at 561, 85 Cal. Rptr. at 833.

73. *Id.* at 423, 467 P.2d at 561-62, 85 Cal. Rptr. at 833-34.

could not be required to disclose.⁷⁴ However, where the patient himself is requesting (or at least not opposing) disclosure, the therapist cannot set himself against the patient's wishes because the control of privacy and confidentiality lies with the patient.⁷⁵ Although the court did not specifically say so, it is apparent that it understood the issue to rest on the patient's choice among various options. He may keep his disclosures of private information to the therapist secret or, in the interests of some more important endeavor, such as litigation, he may have them disclosed further. The therapist, who has no goals with relation to this patient other than improved mental health functioning, is in no position to judge whether or not the patient (or former patient, in this case) will find the disclosure of the sought after information damaging or, even if it is damaging, that the damage is not justified by other gains that he seeks within the confines of the lawsuit.

The court's response to Lifschutz's claims that he had been denied equal protection is extremely interesting with respect to the state's view of the therapeutic process. Although it is true that there are significant similarities between the psychotherapist-patient relationship and the clergyman-penitent relationship, and Lifschutz claimed that it was the modern equivalent, the court asserted that the religious aspects of the latter made it possible for the legislature to make legitimate distinctions.⁷⁶

This is the weakest part of the *Lifschutz* decision, for it suggests that the court is not sure why religion would make a difference, even as it suggests that the legislature would know why. The greatest weight is finally given to the fact that because the church compels the clergyman not to reveal the secrets of the confessional, a state requirement to disclose, even at the penitent's request, would place the clergyman in a direct conflict between church and state.⁷⁷ Psychotherapy, even in its organized, institutional form, could not make such a weighty demand upon its practitioners. Because psychotherapy has been willing and even anxious to identify itself with medicine and other scientific endeavors, it is regarded within a secular framework. Religion, attached as it is to the mysterious and spiritual values of life, can make a greater claim to protect interests as fundamental as privacy. There can be no greater priority than the salvation of one's soul; the pursuit of mental health is but one of any number of acceptable goals, and professional paternalism is not here an appropriate stance.

The final point the court makes in this decision is that since only the patient and not the party seeking disclosure knows what informa-

74. *Id.* at 427, 467 P.2d at 564, 85 Cal. Rptr. at 836.

75. *Id.* at 433, 467 P.2d at 568, 85 Cal. Rptr. at 840.

76. *Id.* at 428-29, 467 P.2d at 565-66, 85 Cal. Rptr. at 837-38.

77. *Id.*

tion lies within the boundaries of confidentiality, the burden is upon the patient to object to any disclosure that is sought.⁷⁸ The privilege against disclosure "is to be liberally construed in favor of the patient,"⁷⁹ but the burden of protecting the information, once he has called it into question, belongs to the patient. The court points out that even when disclosure is requested by the patient, there are numerous protections remaining for the information.⁸⁰ Only relevant information need be revealed, information can be revealed in restricted forms (e.g., *in camera*), and the court itself may exclude or limit information to be offered.

2. Caesar v. Mountanos

The facts of this 1976 case are almost identical to those of *Lifschutz*. Dr. Caesar was requested to testify in a personal injury lawsuit instigated by his former patient with regard to two accidents (one before she began psychotherapeutic treatment with Dr. Caesar, and one after) in which she claimed damages resulting from emotional and mental distress.⁸¹ Dr. Caesar did testify that the litigant had been his patient, that he had seen her for a specific period of time, and that he had an opinion as to the relationship between her emotional state and the automobile accidents. However, he refused to give any further information about that opinion or its contents. He was found guilty of contempt, and appealed to the United States District Court and the United States Court of Appeals. Both courts held that the right of privacy does not provide absolute protection of confidentiality in the psychotherapist-patient relationship.⁸² The appellate court's decision is very deferential toward the decision in *In re Lifschutz* and asserts that, in spite of the developments in constitutional law and the right of privacy that had occurred in the intervening years, the *Lifschutz* analysis of the case was correct.⁸³

Yet, in spite of this claim, the decision in *Caesar* does show a drawing back of the court, not in terms of the results it reaches, but in terms of the conceptual analysis of the right of privacy upon which its decision rests. In *Lifschutz*, both Lifschutz himself and the court distinguished between Lifschutz's privacy rights and the privacy rights of Lifschutz's patient. The decision affirmed that Lifschutz had no privacy right in the case for it was not his privacy that had been breached.

78. *Id.* at 436, 467 P.2d at 571, 85 Cal. Rptr. at 843.

79. *Id.* at 437, 467 P.2d at 572, 85 Cal. Rptr. at 844 (quoting *Carlton v. Superior Court*, 261 Cal. App. 2d 282, 288, 67 Cal. Rptr. 568, 572 (1968)); *Newell v. Newell* 146 Cal. App. 2d 166, 177, 303 P.2d 839, 847 (1956)).

80. *Id.* at 437, 467 P.2d at 572, 85 Cal. Rptr. at 844.

81. *Caesar v. Mountanos*, 542 F.2d 1064, 1065 (9th Cir. 1976).

82. *Id.* at 1066, 1067-68.

83. *Id.* at 1067-68.

On the other hand, his patient Mr. Housek did have a privacy interest and thus a confidentiality interest which he could control as he saw fit. In *Caesar*, however, this analysis no longer fits. Here the right of privacy was construed to be a "conditional right of privacy encompassing the psychotherapist-patient relationship."⁸⁴ The privacy, and thus the confidentiality, no longer belonged to the patient. Instead, it belonged to the relationship, and the relevant legal question is whether the state can oblige both patient and therapist to sever the bond of confidentiality in the interest of the "state's compelling need to insure the ascertainment of the truth in court proceedings."⁸⁵

This conceptual shift from the right of privacy as an individual matter to a group or relationship matter is occasioned primarily by the United States Supreme Court decision in *Roe v. Wade*.⁸⁶ This decision, which resulted in the practice of abortion on demand, has confused fearfully and perhaps compromised the notion of what is meant in constitutional law by the right of privacy. By characterizing the issue as one that involved the woman's right of privacy, but in which the decision to abort belonged to the physician because it is a medical decision, the Court was left with a right of privacy that referred *not* to the individual but to the doctor-patient relationship. The backwash of this clearly erroneous and improper concept of the right of privacy is seen in the *Caesar* court's characterization of privacy. There is some suggestion in the concurring/dissenting opinion by Judge Hufstедler that *Caesar's* patient was herself reluctant to have *Caesar* testify and that the case, unlike *Lifschutz*, represents the patient's indirect attempt to exercise control over the confidentiality of the relinquished privacy.⁸⁷ If so, then that would contribute further to the court's notion of a right of privacy belonging to the therapeutic relationship, for *Caesar* and his patient would have been joined in their opposition. However, as we pointed out earlier, the recent *Akron* decision, though still muddled, does seem to clarify privacy as a personal right rather than a right arising out of the doctor-patient relationship.

3. *Tarasoff v. Regents of the University of California*

The *Tarasoff*⁸⁸ case differs greatly from *Lifschutz* and *Caesar*, for it does not depend upon the patient-litigant exception for its explanation. *Tarasoff* involved the state's willingness to use the therapist as

84. *Id.* at 1070.

85. *Id.*

86. 410 U.S. 113 (1973). *But see Akron v. Akron Center for Reproductive Health*, 462 U.S. 416 (1983), the recent Court decision that held that the right to abort resides in pregnant women, not their physicians.

87. *Caesar v. Mountanos*, 542 F.2d 1064, 1074-75 (9th Cir. 1976).

88. *Tarasoff v. Regents of the Univ. of Cal.*, 17 Cal. 3d 425, 433, 551 P.2d 334, 342, 131 Cal. Rptr. 14, 22 (1976).

its own agent when the patient/client in the therapeutic relationship appears to be likely to harm some identifiable third party. In this case, the patient himself had not entered any form of litigation, had not requested the disclosure of information, had not consented to the disclosure, and may not even have been informed that there was any possibility of such a disclosure. The patient relinquished his privacy on the assumption that he controlled confidentiality, but the state intruded upon the relationship by demanding that the therapist breach the confidentiality under the mantle of the state's police power.

The facts of the *Tarasoff* case are so well known that only an outline will be included here.⁸⁹ Prosenjit Poddar, a young man from India, was a student at the University of California at Berkeley. He fell in love and became obsessed with a young woman named Tatiana Tarasoff. This love was unrequited and Poddar, as a result of deepening depression, sought counselling at University of California Berkeley Student Health Services. When his therapist became alarmed at the nature of his threats toward Tatiana, the therapist informed the University police, who subsequently questioned Poddar and warned him to stay away from Tatiana. The police did not, however, apply for emergency evaluation and treatment under the applicable California laws regarding involuntary hospitalization. Poddar broke off the therapeutic relationship and, several months later, murdered Tatiana. Her parents then sued the police, the therapists, and the Regents of the University of California on the grounds that the therapists had a duty to protect Tatiana from Poddar.

The case went twice to the California Supreme Court in an attempt to determine whether or not the Tarasoffs had any cause of action; i.e., whether in fact there was any duty on the part of the therapists, the police or their employers, the Regents of the University of California, to warn Tatiana or her family.⁹⁰ In the second opinion, the court concluded that the therapist did have a duty to protect threatened third parties because of the special relationship that existed between the therapist and patient.⁹¹ The police, however, did not have such a duty because no special relationship existed between them and the patient.

The issue of breach of confidentiality was but one of many topics brought to the court's attention by the defendants. The court pointed out that the legislature had acknowledged the patient's rights to privacy and the social importance of preserving confidentiality in the therapeutic endeavor by establishing a broad psychotherapist-patient

89. See generally Winslade, *Psychotherapeutic Discretion and Judicial Decision: A Case of Enigmatic Justice*, in *THE LAW-MEDICINE RELATION: A PHILOSOPHICAL EXPLORATION* 139 (S. Spicker, J. Healey & H. Engelhardt eds. 1981).

90. *Tarasoff v. Regents of the Univ. of Cal.*, 17 Cal. 3d 425, 435, 551 P.2d 334, 343, 131 Cal. Rptr. 14, 23 (1976).

91. *Id.* at 440-41, 551 P.2d at 346-47, 131 Cal. Rptr. at 26-27.

privilege.⁹² However, it had included exceptions to that privilege, including Evidence Code, section 1024:

There is no privilege . . . if the psychotherapist has reasonable cause to believe that the patient is in such mental or emotional condition as to be dangerous to himself or to the person or property of another and that disclosure of the communication is necessary to prevent the threatened danger.⁹³

The court stated unequivocally that the patient's right of privacy is not absolute, for "[t]he protective privilege ends where the public peril begins."⁹⁴ But, unlike *Caesar*, the court did not suggest that the right of privacy lies with the psychiatrist or within the therapeutic relationship. Psychiatrists must violate the patient's expectations of confidentiality, but it is not because *they* (necessarily) feel that such breach is appropriate. It is that the state requires it of them.⁹⁵ Thus, if only indirectly, the *Tarasoff* decision reinforces the idea that confidentiality in the therapeutic situation is controlled by the person who has relinquished his or her privacy. If the confidentiality is to be breached, it must be done either upon the request of the patient or at the demand of the state. The therapist has no right to control confidentiality, for confidentiality is but an adjunct to the patient/client's right of privacy and to violate it would be to deny respect for the patient/client as an autonomous being.⁹⁶ The law denies any manifestations of paternalism in this area, even its own. When the state intrudes, it does so on the basis of its police powers, not its *parens patriae* powers. What it refused to itself, it does not grant to psychotherapists.

IV. PRIVACY AND CONFIDENTIALITY IN PSYCHOTHERAPISTS' PROFESSIONAL ETHICS CODES

A. Overview of Ethics Codes

The psychotherapist's concerns with privacy and confidentiality are reflected in the ethical codes of the various professional associations. This section will analyze the codes of the American Psychiatric Association,⁹⁷ the American Psychoanalytic Association,⁹⁸ the Ameri-

92. *Id.* at 441, 551 P.2d at 347, 131 Cal. Rptr. at 27.

93. *Id.* at 442, 551 P.2d at 347, 131 Cal. Rptr. at 27.

94. *Id.* at 441-42, 551 P.2d at 347, 131 Cal. Rptr. at 27.

95. *Id.*

96. *See, e.g.,* *Bellah v. Greenson*, 73 Cal. App. 3d 911, 141 Cal. Rptr. 92 (1977).

97. AM. PSYCHIATRIC ASS'N, THE PRINCIPLES OF MEDICAL ETHICS WITH ANNOTATIONS ESPECIALLY APPLICABLE TO PSYCHIATRY (1981) [hereinafter cited as APA].

98. AM. PSYCHOANALYTIC ASS'N, PRINCIPLES OF ETHICS FOR PSYCHOANALYSTS AND PROVISIONS FOR IMPLEMENTATION OF THE PRINCIPLE OF ETHICS FOR PSYCHOANALYSTS (1983) [hereinafter cited as AM. PSYCHOANALYTIC ASS'N].

can Psychological Association,⁹⁹ the American Association for Marriage and Family Therapists,¹⁰⁰ the California Association of Marriage and Family Counselors,¹⁰¹ and the National Association of Social Workers.¹⁰²

In spite of the intensive interest in privacy and the right to privacy that appears in academic literature, the therapists' Codes of Ethics express their concern not for privacy but for confidentiality. Both the social workers' and the psychiatrists' codes use the word "privacy," but the former equates and the latter confuses privacy with confidentiality.¹⁰³ A comparison of each group's principles regarding confidentiality reveals that all are committed to safeguarding confidential patient information. Subtle differences in attitudes toward confidentiality do exist, however.

The 1981 version of the American Psychological Association's Confidentiality Principle specifies that the psychologist has a "primary obligation" to respect confidentiality, and that disclosure should be made "only with the consent of the person or the person's legal representative, except in those unusual circumstances in which not to do so would result in clear danger to the person or to others."¹⁰⁴ This contrasts with the earlier versions in which confidential information was "not communicated to others unless certain important conditions are met."¹⁰⁵ Only one of the "important conditions" included consideration of the patient's consent, and that dealt not with therapy clients *per se*, but with clients who were research subjects and whose identity was not to be revealed unless they had consented to the disclosure.¹⁰⁶ The 1981 revision, making the patient's consent the primary condition of disclosure, may indicate that psychologists have a new and heightened concern with the patient/client's autonomy in the therapeutic situation.

The American Psychiatric Association's *Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry*, are note-

-
99. AM. PSYCHOLOGICAL ASS'N, *Ethical Principles of Psychologists*, 36 THE AMERICAN PSYCHOLOGIST 633 (1981) [hereinafter cited as AM. PSYCH. ASS'N].
 100. AM. ASS'N FOR MARRIAGE AND FAMILY THERAPY, ETHICAL PRINCIPLES FOR FAMILY THERAPISTS (1982) [hereinafter cited as ASS'N M.F. THERAPY].
 101. CAL. ASS'N OF MARRIAGE & FAMILY COUNSELORS, ETHICAL STANDARDS FOR CAMFC COUNSELORS (1978) [hereinafter cited as CAMFC].
 102. NAT. ASS'N OF SOCIAL WORKERS, CODE OF ETHICS: PROFESSIONAL STANDARDS (1980) [hereinafter cited as NASW].
 103. The social workers state: "The social worker should respect the privacy of clients and hold in confidence all information obtained in the course of professional service." NASW, *supra* note 102, § II (H). Cf. APA, *supra* note 96, at § 4(2) ("A psychiatrist may release confidential information" but must apprise the patient "of the connotations of waiving the privilege of privacy.").
 104. AM. PSYCH. ASS'N, *supra* note 99, Principle 5, at 635-36.
 105. AM. PSYCH. ASS'N, THE STANDARDS FOR PSYCHOLOGISTS 4 (1979).
 106. *Id.*

worthy for their ambiguous attitude toward confidentiality. The Code (section four) states that a physician "shall safeguard patient confidences within the constraints of the law."¹⁰⁷ But the Annotations state, first, that the psychiatrist "must be circumspect in the information that *he/she* chooses to disclose,"¹⁰⁸ and then adds that he "may release confidential information only with the authorization of the patient or under proper legal compulsion."¹⁰⁹ Thus, the Annotations fully confuse the question of who controls disclosures in the absence of legal requirements. The first sentence implies therapist control through therapist choice/discretion. The second sentence (which immediately follows in the annotations) states that the patient or state controls. A further difference is in sentence one's use of "information" and sentence two's use of "confidential information." These two sentences can be made consistent if they are interpreted as follows:

A physician divides the personal information he has about his patient into two categories: that which is merely personal and that which is confidential. He may disclose the merely personal information if it seems appropriate to do so. He may disclose the confidential information only if the patient authorizes the specific disclosure.

It should be noted that the Code clearly does not mandate disclosure when patient authorization is given. The conditional *may* is used, implying, in accordance both with the preceding sentence and a later comment, that discretion is permissible and non-disclosure to protect patient interests should be given priority.

The American Psychoanalytic Association's *Principles of Ethics for Psychoanalysts* has the most succinct statement and least qualified attitude toward confidentiality. In a general statement about the responsibilities of the psychoanalyst, the code insists upon substantial leeway for professional discretion when "the interests of the patient conflict with the welfare of the community at large"¹¹⁰ When a conflict occurs, the analyst is required to weigh the consequences of any action and arrive at a judgment that is based on all the considerations. The Association acknowledges that, although the analyst's primary duty is to the patient, he does have secondary duties to the "well-being" of the community.¹¹¹ However, the extent of these duties is not specified except insofar as section six on confidentiality does so. There the psychoanalyst is forbidden, "[e]xcept as required by law," to reveal *any* "confidences entrusted to him in the course of his professional work, or the particularities that he may observe in the characters of his patients."¹¹² This suggests that the duties "to the welfare of

107. APA, *supra* note 97, at 5.

108. *Id.* at 6.

109. *Id.*

110. AM. PSYCHOANALYTIC ASS'N, *supra* note 98, at § 2.

111. *Id.*

112. *Id.* at § 6.

the community at large" include no more than that which law mandates. Beyond legal requirements, the analyst is permitted no discretion with respect to disclosure of confidential information.

The Code of Ethics for Social Workers,¹¹³ *The Ethical Principles for Family Therapists*,¹¹⁴ and *Ethical Standards for California Marriage and Family Counselors*,¹¹⁵ all assert the importance of confidentiality and the responsibility of the professional to respect and protect it. In spite of the general similarity among the six versions of the principle of confidentiality, there is substantial variation among the groups with respect to the specific details of assuring respect for confidentiality. The codes consider differing confidentiality problems for both adults and minors, and cover a variety of categories, conditions, and responses to confidentiality. Categories include confidentiality of: 1) information; 2) personal observations; 3) information provided by others about the client; 4) written, visual, or audio records; and 5) tests. Settings in which disclosures may occur include: 1) teaching (including use of case histories, student observations, and supervision of trainees); 2) writing; 3) reports; 4) interprofessional relationships; and 5) research.

The codes propose two major methods of accommodating the necessity for violating the patient/client's expectations of confidentiality: 1) requiring the patient to give informed consent to disclosure; and 2) requiring the therapist to explain the limits of confidentiality.

B. Form and Content of Confidential Information

All six professional codes are concerned with protecting confidential information revealed in the course of therapy. *Information* may refer to all knowledge that the therapist has about the patient, regardless of its source, or it may refer only to the specific information that the patient gives to the therapist, either verbal or written (e.g., tests). The codes themselves do not clarify which one is meant. Information may be preserved in a recorded form (writing or electronic recording), but it may also exist only in the therapist's memory. It may arise from the patient's confessions, the therapist's interpretations or observations, tales told by others about the patient/client to the therapist (e.g., information provided by other family members or by other professionals).

Conflicts about confidentiality of information may arise in numerous settings that cannot be clearly resolved by the ethics codes as they stand. Because of this, both psychiatrists and psychologists have prepared commentary books that interpret the codes in response to spe-

113. NASW, *supra* note 102, at § II(H).

114. ASS'N M.F. THERAPY, *supra* note 100, at § 4.

115. CAMFC, *supra* note 101, at § 6.

cific questions. These commentaries help to understand the boundaries of the concern with disclosure of confidential information.¹¹⁶

One such problem area is that of the patient who is involved in both individual and group therapy with the same therapist. A confidentiality problem might arise if the psychiatrist were to disclose information he had gained during the individual therapy to the members of the therapy group. In this situation, the question necessitates considering whether private disclosures made to a psychiatrist in one therapeutic setting are coterminous with private disclosures to the same psychiatrist as well as to others in another therapeutic setting. It would appear that the patient's disclosures in each setting would depend upon separate expectations of confidentiality, and that disclosures should not be made from one to the other. The patient's initial decision to relinquish privacy would depend upon his perception of the expected benefits and the degree of perceived vulnerability in each setting. It seems obvious that the risks and benefits in the different setting, even though both were "therapeutic," might be perceived as being different. The therapist might believe (even correctly) that a disclosure of information gained in one confidential setting would be of significant benefit to the patient if made in another setting which promised further confidentiality. Yet, the psychiatrist's overriding the patient's expectation, i.e. his expected ability to control release of information, would clearly be paternalistic, and therefore inappropriate.

The reply actually given by the ethics committee forbade the disclosure unless "the patient had been previously informed that this was part of the treatment contract," or unless "the potential for serious harm was very great."¹¹⁷ The former exception accepts a very low level of consent to disclosure and is thus of dubious ethical value. If privacy and confidentiality, especially in the therapeutic setting, are as critical as most therapists and most writers contend, then requesting a patient to give blanket consent to disclosure is inappropriate. In this instance (which, it should be noted, involves information that, if withheld, "would be destructive to the therapy group"),¹¹⁸ the psychiatrist is permitted to violate the patient's confidentiality when honoring it would be harmful to the group's integrity. This is not a disclosure that is permitted in order to avoid physical harm to identified third per-

116. See, e.g., AM. PSYCHIATRIC ASS'N, OPINIONS OF THE ETHICS COMMITTEES ON THE PRINCIPLES OF MEDICAL ETHICS, WITH ANNOTATIONS ESPECIALLY APPLICABLE TO PSYCHIATRY (1979) [hereinafter cited as APA OPINIONS]; AM. PSYCHOLOGICAL ASS'N, CASEBOOK ON ETHICAL STANDARDS OF PSYCHOLOGISTS (1974) [hereinafter cited as AM. PSYCH. ASS'N CASEBOOK]. The 1974 CASEBOOK updates the original edition, published in 1967.

117. APA OPINIONS, *supra* note 116, § 9-B, at 23.

118. *Id.*

sons. Rather, one patient's expectation of confidentiality is being sacrificed to the well-being of a group.

Even charily permitting such disclosures by psychiatrists suggests a fairly paternalistic view of the relationship between the psychiatrist and his patients. The Committee does not even consider the suggestion that the patient be requested to consent to the specific disclosure or to choose between permitting the disclosure and withdrawing from the group.¹¹⁹

On the other hand, a situation in which a client confesses to the psychologist that he has committed a murder is handled very differently by the ethics committee of the American Psychological Association.¹²⁰ The psychologist had asked the committee whether he could legitimately accept the patient without appearing to condone the murder, whether he should encourage the client to confess to the police, and whether he himself should report the man's act to the authorities. He adds the information that there is no reason to suppose that the client will ever be suspected of committing the crime. The psychologist is advised by the committee that it is permissible to take on the person as a client if the psychologist thinks he can be helpful, and that he should ascertain whether in his state he has any legal duties with regard to reporting. The committee concludes that "in reaching such a decision it is necessary to take into account responsibilities to both the profession and the community."¹²¹ Although this opinion, like the former one, suggests that the decision to disclose confidential information is one that the therapist must himself make by balancing his various duties, the only positive requirement to disclose in this case is based on external considerations: legal necessity. The general principle of confidentiality set forth by the American Psychological Association suggests that a disclosure other than a legally mandated one would be justified only by the expectation of a "clear danger to the person or others,"¹²² and it is in this context that the psychologist should balance the interests of the profession, community, and patient. This implies a higher commitment to the patient's control of confidentiality than is exhibited, for example, in the psychiatrists' code. In fact, although the Committee's opinion regarding the murderer appeals to the requirements of law as a justification for the disclosure, an earlier section of the code states that when the law is in conflict with an ethical standard, the psychologist should adhere to the professional code and attempt to resolve the conflict with the legal system, not simply to accept its mandate. Thus, a strict interpretation

119. *Id.*

120. AM. PSYCH. ASS'N CASEBOOK, *supra* note 116, at 29-30.

121. *Id.*

122. AM. PSYCH. ASS'N, *supra* note 99, Principle 5, at 636.

of the code would suggest that the psychologist should err on the side of refusing disclosure in the absence of patient consent.

Psychiatrists are permitted to release confidential information in the event that it is necessary to protect the patient or the community from imminent danger. This, however, permits discretionary disclosures that, at least in California, might result in legal action against the psychiatrist for a violation of confidentiality if the imminent danger were mistakenly predicted and if some harm came to the patient as a result of the disclosure. In *Bellah v. Greenson*,¹²³ a psychiatrist was sued for failing to inform a young woman's parents of suicidal tendencies. The court, however, found that he had no duty to warn others of the patient's dangerousness to herself.¹²⁴ This is distinguished from the duty to take appropriate action to protect threatened third parties. For in that instance what is being invoked indirectly is the state's police power, whereas a requirement to warn in the case of the patient's dangerousness to herself would be an indirect invoking of the state's *parens patriae* power. Where individual autonomy is to be respected, the *parens patriae* power cannot be invoked.

The psychoanalyst's code states that revealing the patient's confidences is permitted only when it is required by law.¹²⁵ However, in a different section, it states that any conflict between community welfare and patient interests must be weighed by the analyst.¹²⁶ In this section of the code, no reference is made to legal requirements as "trumps" for decisionmaking.¹²⁷ The analyst is apparently expected to use his professional judgment to determine when patient interests are of greater importance than legal requirements. A further suggestion that law is not to be considered a "trump" is included in the exhortation that the analyst, if required to testify in court, should reveal no more than is absolutely necessary and "should make use of all legal means to safeguard his patient's confidentiality."¹²⁸

The 1983 edition of the psychoanalysts code includes the following provision: "When a psychoanalyst uses case material in exchange with colleagues for scientific, educational or consultative purposes, he should exercise every precaution to assure that, unless specifically authorized by the patient, the identity of the patient is not revealed."¹²⁹ This provision permits a psychoanalyst to use *information* that is revealed in confidence and that concerns "particularity that he may observe in the character of patients," *without patient knowledge or*

123. 81 Cal. App. 3d 614, 146 Cal. Rptr. 535 (1978).

124. *Id.* at 620-22, 146 Cal. Rptr. at 539-40.

125. AM. PSYCHOANALYTIC ASS'N, *supra* note 98, at § 6.

126. *Id.* at § 2.

127. *See generally* R. DWORKIN, *TAKING RIGHTS SERIOUSLY* (1977).

128. AM. PSYCHOANALYTIC ASS'N, *supra* note 98, at § 6.

129. *Id.* at § 6.

consent so long as the patient's identity is not revealed. In this respect patient autonomy and confidentiality is overridden by professional interests.

Family therapists are expected to maintain confidentiality except in the presence of "clear and immediate danger,"¹³⁰ as opposed to psychologist's "clear danger."¹³¹ Even in the case of a clear and immediate danger, disclosure is limited to "appropriate professional workers, public authorities or others designated by law,"¹³² or to members of that group as well as the concerned individual and appropriate family members.¹³³

Social workers have the most liberal standards, for they permit unconsented to disclosures whenever there are "compelling professional reasons."¹³⁴ No further explanation of this phrase is given, but other sections of the NASW Code suggest paternalistic justifications,¹³⁵ in spite of the code's general dictum that "the social worker should respect the privacy of clients and hold in confidence all information obtained in the course of professional service."¹³⁶

Beyond the general concern with protecting the personal information that the patient/client has disclosed in the course of therapy, the codes speak to the importance of the professional's safeguarding the observations that the therapist has made with regard to the patient's character. They seek to protect the interpretations as well as the raw data of any tests that are given,¹³⁷ written, visual, or audio records,¹³⁸ and information about the patient/client given to the therapist by third parties.¹³⁹

Only the psychiatrists' and psychoanalysts' codes mention specifically that the obligation to safeguard confidential information refers not only to the patient's confidences but also to the therapist's observations. The psychoanalyst's code, for example, speaks of "the particularities that he may observe in the characters of his patients."¹⁴⁰ It is not clear whether the other codes would consider such observations to be within the ambit of "protected client information," or whether they would be considered, because they are the therapist's thoughts and feelings, to be the *therapist's* private information, protected by *his* right of privacy, rather than by the patient/client's confidentiality.

130. ASS'N M.F. THERAPY, *supra* note 100, at § 4.

131. AM. PSYCH. ASS'N, *supra* note 99, Principle 6, at 636.

132. CAMFC, *supra* note 101, at § 6.5.

133. ASS'N M.F. THERAPY, *supra* note 100, at § 4.3.

134. NASW, *supra* note 102, at § II.H.1.a.

135. *Id.* at 6, § II.H.3.4., & 6, § III.J.2.

136. *Id.* at § II(H).

137. *See, e.g.*, AM. PSYCH. ASS'N, *supra* note 99, at 636.

138. *See, e.g.*, NASW, *supra* note 102, at § II.H.5.

139. *See, e.g.*, AM. PSYCHOANALYTIC ASS'N, *supra* note 98, at § 6.

140. *Id.*

The psychiatrists' ethics committee opinions and the psychologists' casebook do not contain any cases that would clarify this ambiguity, although one case does suggest that the information would be considered the property of the therapist rather than of the patient/client.¹⁴¹ In this query to the psychiatrists' ethics committee, the problem involved a consultant's report that had been requested by the treating psychiatrist. The treating physician had released the report to the parents of a child patient and the ethics committee concluded that such a release was inappropriate. The information about the patient was not within the patient's zone of confidentiality, but within the consultant's, and the psychiatrist had a duty to protect the consultant's disclosures.

The psychologists' code expresses special concern that there be adequate protection for storing or disposing of records, but does not speak to the information within or derived from tests (i.e., the tests themselves as well as the interpretations). This is surprising since psychologists in particular are likely to do extensive testing, and the information contained in the raw data as well as the interpretations could conceivably be harmful to clients if not held within the shield of the patient's confidentiality. It is possible that they are not mentioned because they are thought to be the therapist's property, rather than the client's, and thus do not fall within confidentiality concerns. However, an ethics committee query about a nursery school's request for IQ scores that were gathered as part of a psychologist's research project produced a remarkably pragmatic response. The giving of the IQ scores, or at least information about them, was considered to be acceptable as a "common practice," for "when one obtains research subjects from a school or other agency, he is expected to reciprocate with information that may help the agency or its clients."¹⁴² The information, of course, may also hurt the clients, but this response suggests again that the results of test scores are not thought to be information within the client's zone of confidentiality.

The marriage and family counselors' code also mentions specifically the safe storage or disposal of records.¹⁴³ In addition, the California Association cautions that test scores and raw data can be released only "to persons who are qualified to interpret and use them properly."¹⁴⁴ This further reinforces the probability that therapists generally do not believe that information obtained by testing belongs to the client or is to be protected by his confidentiality rights, since it is likely that in most circumstances the client would not be considered qualified either to interpret or to use them properly.

141. APA OPINIONS, *supra* note 116, at 22.

142. AM. PSYCH. ASS'N CASEBOOK, *supra* note 116, at 30.

143. ASS'N M.F. THERAPY, *supra* note 100, at § 4.2.

144. CAMFC, *supra* note 101, at 15.1.

C. Occasions for Disclosure

Confidential information, in spite of all the talk about its never being released without consent except in cases of imminent danger, is regularly released: in reports, in insurance claims, to other professionals, in educational settings (including verbal or written presentation of case histories, trainee observations of interviews/therapy sessions, and supervisor observation of trainee work), in research presentations, and even when patient's complain about their therapist's unethical behavior. Most of the ethics codes deal with at least some of these disclosures, but none deals with all of them or even a majority of them. The problem of using confidential information in case studies comes up again in these codes. The psychiatrists acknowledge forthrightly that it is very difficult to provide sufficient disguise, and that in many instances, scientific accuracy must be sacrificed to respect the patient's confidentiality.¹⁴⁵ The ethics committee points out that some psychiatrists try to get patient consent, but they do not suggest that this is either a useful or an adequate remedy to the violation of confidentiality.¹⁴⁶ The Psychiatrists' Code of Ethics requires disguise, but does not mention consent.¹⁴⁷ Likewise, the psychoanalysts' code requires consent only if patient identity is revealed, but not if patient information is used.¹⁴⁸

The failure to use blanket consent as an easy response to a very difficult problem may mean that the Psychiatrists' Code takes confidentiality more seriously than do the other therapists' codes that address this question. Or, it may reflect a more authoritarian view in which the psychiatrist decides what degree of disguise is or should be adequate. Both psychologists and marriage and family counselors permit disclosure of confidential information in case studies if the client provides consent or if the information is adequately disguised. They do not require *informed* consent, nor do they suggest what would constitute an "adequate" level of disguise. Social workers make no specific comment on this point, although the "compelling professional reasons" that justify unconsented to disclosure could presumably cover the training and educational value of case histories.

Confidential client information is regularly disclosed to other professionals without specific consent. In practice, blanket consent to such disclosure is often requested. However, the codes themselves imply that the patient/client's decision to reveal private information to one professional is considered a legitimation of further disclosure to any other professional who is involved in the therapy. The psycholo-

145. APA OPINIONS, *supra* note 116, at 23.

146. *Id.*

147. APA, *supra* note 97, at 4.3.

148. AM. PSYCH. ASS'N, *supra* note 99, at § 6. See also *supra* text accompanying notes 125-28.

gists' code stresses that information is shared only for professional purposes and only with the people involved in the case.¹⁴⁹ The California marriage and family counselors, similarly, disclose information only to "professional persons involved with the case."¹⁵⁰ Social workers, on the other hand, extend confidentiality to "confidences shared by colleagues in the course of their professional relationships and transactions."¹⁵¹ This peculiar manner of phrasing the problem of confidentiality in intra-professional disclosures suggests that the information contained within the "confidences" does not refer to relevant information for other professionals involved in the case, but rather to the intra-professional gossip that is inevitably exchanged among therapists. It is unclear why these disclosures should be made without the patient's consent.

Although the psychiatrists' ethics committee stated that the patient's expectations of confidentiality in the individual therapy situation could not be identified with his expectations in the group therapy,¹⁵² this transfer of confidentiality to a limited group of other professionals is routinely accepted in the codes. Although pragmatic considerations would certainly justify this exchange of information, the code's failure to explain the rationale for the exception to unconsented disclosures suggests that here again the therapist implicitly accepts a concept of privacy and confidentiality that is very paternalistic, leaving the therapist to be the judge of when the patient's expectation of confidentiality is justified and when it can be ignored. In practice, this avowal of limited disclosure to other professionals is widely abused, with violations ranging from cocktail party anecdotes (neither consented to nor adequately disguised), to case conferences in which no attempt is made to alter any details of the patient/client's life, and even the name is often revealed. The ethics codes appear to be specific about the limits of unconsented disclosure to other professionals but, in practice, the idea of professional loyalty seems to be a stronger ethical code than respect for patients' autonomy.

D. Consent and Notice of Limitations of Confidentiality

The two primary methods of releasing information that lie within the patient/client's claim of confidentiality (other than as a result of legal requirement) include requesting consent and initially notifying the patient of the legitimate expectations of confidentiality in the therapeutic setting. Although the codes do refer to consent, and even to written consent, they do not ever refer to informed consent. Whether in a therapeutic, research, or a combined setting, the phras-

149. AM. PSYCH. ASS'N., *supra* note 99, at 636.

150. CAMFC, *supra* note 101, at § 6.2.

151. NASW, *supra* note 102, at § II.J.2.

152. APA OPINIONS, *supra* note 116, at 23.

ing of the codes suggests that most therapeutic professional groups believe disclosure of confidential information can be legitimated by blanket consent, and that specific, informed consent is not necessary for the release of confidential information. Only marriage and family counselors and social workers include in their codes a specific requirement that the client be informed in advance of the limits of confidentiality.¹⁵³ In the case of the California marriage and family counselors, this requirement is joined to one requiring written consent for all disclosures.¹⁵⁴ The Psychiatrists' Code does require psychiatrists to explain to patients the implications of waiving "the privilege of privacy."¹⁵⁵ Apparently, this applies only to those situations in which disclosure has been specifically requested by the patient in connection with insurance, employment, or legal actions initiated by the patient.

The question of informing patients about disclosures that might be required by law has been actively debated in recent years, especially with respect to the *Tarasoff* case and recent California child abuse reporting statutes.¹⁵⁶ It is interesting to note that, although psychiatrists, psychoanalysts, and psychologists all accept the necessity to disclose information without consent as a result of legal requirements, they do not believe that ethical practice demands that they inform their patient/clients of the possibility of legal or discretionary disclosures, either in general or in the instant case.

E. Summary

The ethical codes of all six of these professional groups consist of brief statements of principles, as well as rules of conduct. The rules are usually not elaborated very thoroughly but they often appear to be in conflict with the principles. Because they appear in an ethical code that would be expected to contain principles of equal importance or value, rather than principles *and* rules, these conflicts make it difficult to understand exactly how thorough the various professions' commitments to confidentiality are, for the principles typically speak of an overriding concern for confidentiality and the rules speak to various exceptions, without acknowledging that they are exceptions. Yet, the members must use them as they stand when trying to determine what constitutes ethical conduct.

The principles of the codes state a "primary obligation" to confidentiality¹⁵⁷ and to safeguarding information.¹⁵⁸ The therapist "may

153. CAMFC, *supra* note 101, at § 6.3; NASW, *supra* note 102, at § II.H.2.

154. CAMFC, *supra* note 101, at § 6.4.

155. APA, *supra* note 97, at 6 (§ 4.2).

156. *See, e.g.,* *People v. Stritzinger*, 34 Cal 3d 505, 668 P.2d 738, 194 Cal. Rptr. 431 (1983). *See also* Britz, *Reporting Child Abuse and Confidentiality in Counseling*, THE JOURNAL OF CONTEMPORARY SOCIAL WORK 83 (1985).

157. AM. PSYCH. ASS'N, *supra* note 99, at 635.

not reveal the confidences entrusted to him . . . except as required by law."¹⁵⁹ Therapists "communicate information about clients to others only after obtaining appropriate client consent,"¹⁶⁰ and "hold in confidence all information obtained in the course of professional service."¹⁶¹ Yet, this noble commitment to confidentiality appears somewhat less elegant when the rules apply (or fail to apply) the principles.

More often than not, the codes seem to suggest an unwritten and paternalistic assumption that the therapist has two roles with regard to the patient's expectations of confidentiality. First, the therapist serves as a mediator between the patient and others, who for various reasons, want access to information about the patient/client. In this role, the gaining of a patient/client's consent for a disclosure is more or less likely depending upon the nature of the therapist's presentation. Second, the therapist decides where the patient/client's best interests lie (or where his worst ones do not lie), and makes unconsented to disclosures of confidential information when they seem, in the therapist's professional judgment, to be appropriate. This paternalistic interpretation of the demands of a "primary obligation to confidentiality" does not "enhance the dignity"¹⁶² of the patient/client, nor demonstrate respect for the "worth, dignity and uniqueness of all persons."¹⁶³

There is an inevitable contradiction in the therapeutic relationship. It needs to acknowledge that both therapist and patient/client are individuals of equal worth and value, as well as embody the understanding that it is a fiduciary relationship in which, in some respects, the partners are not equal. The ethical codes' full acceptance (in principle) of the demand of confidentiality reflect that sense of the patient/client as an autonomous being of equal respect and value to the therapist. The therapist's discretion to override confidentiality, either by making unconsented to disclosures or by acquiring a negligible level of consent, reflects the sense of the patient/client as a person who needs to be taken care of; whose best interests can be better judged by others. The ambivalence of the codes also reflects this dual assessment of the patient/client's status.

An ethical code that operates on an assumption that the limits of confidentiality often rest with the recipient of the information will be hard pressed to reconcile an assumption that the person who has relinquished his privacy is an autonomous and equal person who has every

158. CAMFC, *supra* note 101, at § 6.1

159. AM. PSYCHOANALYTIC ASS'N, *supra* note 98, at § 6.

160. ASS'N M.F. THERAPY, *supra* note 100, at § 4.3.

161. NASW, *supra* note 102, at § II.H.

162. AM. PSYCHOANALYTIC ASS'N, *supra* note 98, at § 1.

163. NASW, *supra* note 102, *Preamble*, at iii.

reason to expect that the relinquishment of privacy does not eliminate his control over the confidential status of the information. The therapist who understands that the confidential status of the information does not lie within his/her judgment will be obliged to protect what the patient wants protected and to release what the patient wants released, assuming competence and understanding on the part of the patient, even if that does not accord with the therapist's idea of what is in the patient's best interests. The codes operate on the assumption that therapy cannot flourish without therapist-protected confidentiality, and that is doubtless true. But, they fail to understand that although it is the therapist who must protect the confidentiality, it is the patient who should decide whether the information is confidential.

V. PRIVACY AND CONFIDENTIALITY IN THE THERAPEUTIC RELATIONSHIP

A. Psychotherapy

The development of the psychotherapist/patient privilege in California is instructive in that it so clearly demonstrates the ambiguities of the connections between therapeutic practice and medical practice. Initially, the only privilege that applied in psychotherapy was the doctor-patient privilege. As a result, only psychotherapists who were also medical doctors (usually psychiatrists) were able to promise any degree of confidentiality. When the number of psychologists increased they were able to organize effectively for political action and to obtain passage of a new statute, the psychologist-patient privilege, providing for substantial protection of client confidentiality. In fact, the new legislation exceeded the doctor-patient privilege in its degree of protectiveness. Psychiatrists, who had had an advantage over psychologists because of the doctor-patient privilege, now found themselves at a disadvantage, and the result in 1965 was the passage of the psychotherapist-patient privilege statute,¹⁶⁴ which included within its ambit all psychiatrists, psychologists, and marriage and family counselors licensed by the state. The new statute provided more protection than the older doctor-patient privilege, but less than either the spousal privilege or the clergyman-penitent privilege.

Here the therapeutic privilege, like therapy itself, can be seen to lie midway between medical practice and personal relationships. It is that mid-point status that makes the therapeutic relationship so difficult to characterize, for its internal expectations and its external form borrow from both. It is like the doctor-patient relationship with all its inheritance of paternalism and the professional distance of science. But it is also like the marital relationship, with its implications of in-

164. 1965 CAL. STAT. c. 299, §§ 1010 to -26.

tense personal involvement, of partnership, and of equality. With the clergyman-penitent relationship, it shares a concern with guilt, emotional distress, and the re-birth (in a secular sense) of the person.

This triple (and sometimes contradictory) nature of therapy accounts for much of the confusion about the role of privacy and confidentiality in the therapeutic relationship. Often the claims about privacy and confidentiality arise from a conceptualization of the relationship that is drawn from the medical model: the therapist who is obliged to calculate and to act to protect his patient's best interests. At other times, the conceptualization more closely parallels the personal relationship model, wherein the therapist is obliged to respect the client's autonomy and the client's right to make decisions that he knows the therapist thinks will be harmful to him. Even the language demonstrates the conflict about the character of the therapeutic relationship: we know that the professional involved is a therapist, but the second party is variously referred to as the patient, the client, and, in psychoanalysis, the analysand. Uncertain of (or in disagreement about) the relationship to the therapist, the professional cannot find a name for his partner.

Therapists' and patients' ideas about both privacy and confidentiality are affected by this uncertainty, but there are some commonly held attitudes about the nature of the therapeutic relationship. The therapeutic relationship, like the doctor-patient relationship, requires the patient to relinquish his privacy. However, unlike most doctor-patient encounters, the kind of information divulged is usually far more personal (and in that sense more private), and of greater quantity and scope. Both patient and therapist expect that the patient will be obliged to lose, or at least relinquish, much of his privacy. Some therapists will expect their patients to make no attempt themselves to control the loss of privacy (for example, when they advise the patient to say whatever comes to his mind in the free association process). Others are prepared to sit with a patient for an indefinite period with no words exchanged on the assumption that the patient's sense of when and what private information needs to be revealed must be respected, not only because it demonstrates respect for the person's autonomy, but also because respecting the patient's decision not to reveal any personal information may itself be therapeutic. But regardless of the degree of loss, all expect that the patient must, as a condition of the therapeutic process and in expectation of therapeutic benefit, eventually relinquish some privacy.

When the patient in the traditional doctor-patient relationship provides the physician with private information, it is typically information about the body and its processes, health, daily living habits, or current symptoms and stresses. Although the information is personal, private and even, sometimes, frightening, it is not usually shameful or

guilt-producing. It is information of the body, not of the soul. The information that is typically given over in the therapeutic encounter, on the other hand, is of a different sort. It is related to the individual's inner sense of himself and results in the display of his secret thoughts and feelings: his perceptions of his own shame and guilt to the therapist. This is necessary privacy. It is information that no one could ever have access to unless the patient chose to reveal it. Such a patient is in a difficult position, for he lets loose his hold on this information in face of the fear of being criticized and judged by the therapist and is additionally made more vulnerable because he can be exploited or harmed by the information that he himself has provided. In the therapeutic process, the patient is, in a sense, asked and expected to sow the seeds of his own potential destruction.

The uni-directionality of the disclosures results in a non-mutual relationship. If both therapist and patient had access to private information about the other, then their power would be matched, though each would remain vulnerable to the other's actions. Reiman contends that it is exactly this non-mutuality in the therapeutic relationship that makes it impossible for there to be any genuinely intimate relationship between therapist and patient, arguing that intimacy (and privacy) depends upon the context of a "caring" relationship.¹⁶⁵ Others contend, however, that there is an intimacy to the therapeutic relationship in spite of the inequality of disclosure. Stone speaks of therapy as a "palpable human relationship" of "intimate separation."¹⁶⁶ Ekstein, on the other hand, suggests that the therapeutic relationship demands distance from the person, but intimacy with the material.¹⁶⁷ Ekstein and Caruth further elaborate this concept of separate intimacy as an acknowledgment that "true closeness, as opposed to fusion, can only exist where there is separation, that is, two separate individuals."¹⁶⁸ Here the concept of the relationship is based not upon a paternalistic association, but rather one in which the therapist helps the patients to maintain their separateness, thus permitting true intimacy.

But whether the relationship is characterized as intimate or distant, the non-mutuality of the personal revelations leaves the patient at a disadvantage in that he has increased vulnerability to harm should the information be used by the therapist against him, or should it be disseminated to third parties who might cause him harm by their use of it. Because of the content of the the information, harm might

165. Reiman, *supra* note 29, at 33-34.

166. L. STONE, *THE PSYCHOANALYTIC SITUATION: AN EXAMINATION OF ITS DEVELOPMENT AND ESSENTIAL NATURE* (1962), cited by Ekstein & Caruth, *supra* note 44, at 206.

167. Ekstein, *Psychoanalytic Reflections on the Emergence of the Teacher's Professional Identity*, 1970 *Reiss-Davis Clinic Bulletin* 7.

168. Ekstein & Caruth, *supra* note 44, at 206.

be of a highly subjective nature. Broadcasting information about a patient's medical condition might cause discernible financial harm or disruption of personal relationships. However, the disclosure of information about a patient's fantasies and feelings might result in severe emotional distress solely because others had been told what had been revealed only for the purposes of therapy, even when the disclosure results in no external disjunctions of any sort or is a disclosure without personal identification.

The expectations of therapy play a considerable role in the patient's perceptions of privacy and confidentiality. The patient who goes to his physician with fevers, lumps, rashes, or pains does not construe the relationship to be one in which he may *choose* to reveal or not reveal such information as he has about his physical condition or complaint and still expect that the physician will help him to regain his health. Although patients very often do withhold information from their physician because of fear of serious illness, nonetheless they are aware that the physician must be provided with all relevant information in order for him to do his job. There is no comparable understanding in the therapeutic relationship. First, neither therapist nor patient may be clear about what the patient expects to gain from the therapy. Second, neither may be certain about what information is relevant. But, more important, the relationship between the expected benefits and the personal information may be very unclear to the patient and, since the information is likely to be embarrassing, shameful, and potentially harmful, the patient has every reason to be reluctant to expose it to the eyes and ears of the therapist who, at least initially, is not an intimate.

As a result, the therapist has a very high interest in being able to promise to the patient total confidentiality. First, the therapeutic process requires a high degree of privacy disclosures. In addition, the promise of confidentiality helps to bond the intimacy of the therapeutic relationship in its implication that the patient may place his full trust in the therapist, thereby reducing the sense of inequality or vulnerability. Therapists understand this dual need for confidentiality and often are inclined to promise, at least by implication, far more than they can deliver. The patient who enters the therapeutic relationship often has no sense of what kind of disclosures might be made of the information that he has revealed to the therapist. Although physicians have in recent years been obliged by legal statutes and judicial decisions to enter into much more specific "contracts" with patients by ensuring that they have provided informed consent to receiving health care, that concern has not significantly penetrated therapeutic practice. Some have argued that genuine informed consent is impossible because the therapist has little if any way of judging what risks are likely for any given patient. Some commentators advo-

cate that the therapist routinely have the patient execute a very specific informed consent to therapy that includes the itemization of all possible disclosures of confidential information that could be made without patient consent.¹⁶⁹ But the practice of providing such disclosure is unusual, not the least because therapists feel that to tell patients of risks that are very unlikely is unreasonable and would have, especially in an initial interview, a chilling effect upon the patient's willingness to make disclosures that would be necessary and appropriate to therapy or even to pursue a course of therapy.

It is in the doctrine of informed consent that contemporary courts and legislatures have spoken most tellingly about the physician's obligation to make of his patient an equal in the doctor-patient relationship. Informed consent places the decisionmaking responsibility squarely in the hands of the patient, rather than with the paternalistic physician who "knows" what constitutes the patient's best interests. That it has made so little headway in therapeutic practice is interesting, not the least because the therapist-patient relationship is much more likely to be based, at least theoretically, upon an egalitarian rather than a paternalistic concept. The failure and resistance of therapists to pursue informed consent with respect to confidentiality as a prelude to therapy is probably due primarily to the fear that patients will withhold critical personal information. This is thought to be possible not because of therapeutic resistance, but because of fear of mandated third party disclosures that will not contribute to the sought-after therapy benefits. For example, a patient who does have a potential problem with child abuse is unlikely to believe that report to a government agency will help in resolving the problem.

Frequently, therapists claim that an absolute promise of confidentiality must be made to the patient in order for the therapeutic relationship to be effective. However, as the court in *In re Lifschutz* pointed out, therapists have never been able to practice with a guarantee of total confidentiality,¹⁷⁰ so it is unclear why they think that it is impossible to proceed with less than such a guarantee. In fact, although claims of the need for total confidentiality are common, there are frequently implicit acceptances of necessary disclosures by therapists, especially with respect to information shared within the therapeutic community. The implicitness of this can be seen in the codes of ethics of the various therapy professions which assert assurances of confidentiality, but also include numerous exceptions.

In an article written by a sub-group of the California State Psychological Association's Committee on Privacy and Confidentiality, it is argued that, in spite of all the lip service paid to the value of confiden-

169. Everstine, *Privacy and Confidentiality in Psychotherapy*, 35 AM. PSYCHOLOGIST 828, 831-33 (1980).

170. *In re Lifschutz*, 2 Cal. 3d 415, 438, 467 P.2d 557, 573, 85 Cal. Rptr. 829, 845 (1970).

tiality, "in respect to psychotherapy, little confidentiality exists."¹⁷¹ They conclude that the only hope of salvaging confidentiality is if legislatures provide protection for therapists by means of a therapist-patient privilege whose scope is equal to that of the clergy-penitent privilege. In the absence of such reform, they further suggest that therapists ask themselves very hard questions about what they have to offer to patients if the relationship places the patient at some risk as a result of laws requiring the therapist to disclose private information.¹⁷²

These authors are concerned only with disclosures made in the wake of government regulation, and their contention that confidentiality has been largely overrun is not entirely overstated. The number of people to whom disclosures can be made is considerable. Assuming that there is no attempt to acquire blanket consent about disclosure prior to or at the beginning of therapy, unconsented to disclosures might be made to other professionals, para-professionals, students, third-party insurers, family members, law enforcement agencies, social service agencies, and threatened third parties. It is, of course, always possible for the therapist to request consent before making any disclosure, thus permitting the patient to retain his control over the relinquished private information. But that control exists only if the therapist is then willing to abide by the patient's decision. In some cases, that decision would not be legally possible for, even if the patient refuses to consent, disclosure might be legally required, for example, in cases of suspected child abuse or dangerousness to identifiable third parties or court subpoenas.

Perhaps the area in which the most questionable violations of confidentiality occur is that of professional gossip. With respect to gossip, professionals frequently deliver far less confidentiality than they could legitimately have promised. Therapists are known to talk about their patients not infrequently, primarily to other therapists in both social and professional settings. Olinick attempts to distinguish between the social and professional settings of patient disclosures. He suggests that in social settings, some gossip, for example the casual case vignette, is essentially benign, but that other forms are not, calling up issues of envy, power, guilt, and moral superiority.¹⁷³ He theorizes that the gossiping therapist may often be motivated by the loneliness and isolation of his profession; the tension of isolation is relieved by the forbidden sharing of information.¹⁷⁴ But he is more interested in the dyadic relationship between he-who-tells and the curious he-who-listens. When the pair are joined in this disapproved

171. Everstine, *supra* note 169, at 838.

172. *Id.* at 828-29.

173. Olinick, *The Gossiping Psychoanalyst*, 7 INT. REV. PSYCHO-ANAL. 439 (1980).

174. *Id.* at 441.

activity, they take on a "reciprocal kinship" that permits them to "expose themselves each to the other, through the medium of the third person who is being gossiped about."¹⁷⁵ This gossip is motivated by inappropriate or unacceptable interests, such as regression and status-seeking behavior. Olinick concludes that the gossiping therapist's unresolved "intercurrent stresses of living" force him to seek a partner with whom he can "projectively identify," and that the patient data is the coin of this realm.¹⁷⁶

In attempting to provide a preliminary taxonomy of gossip, Olinick separates "scientific" communications from prattle, and casual loose talk from benign and malicious gossip. He argues that a therapist who is having difficulty with a patient will seek professional consultation, but that a therapist who is having difficulty with his life will seek or provide professional gossip.¹⁷⁷ By playing gossip off against consultation, he appears to be legitimating the latter by comparison with the former. However, in either case, one is left with a patient who has not authorized disclosures to anyone for any purpose and who has been promised confidentiality. Olinick's conception of these disclosures suggests that he sees the control over confidentiality to lie with the therapist. Thus, gossip, which is done for personal reasons is inappropriate, even though it is not malicious, because it does not facilitate analysis. Consultation, which is done for professional reasons, is acceptable and probably admirable because it does aid the therapy process.

Fonseca disagrees with Olinick's assertions about the difference between acceptable and unacceptable disclosures to other therapists.¹⁷⁸ She believes that disclosures, albeit discriminating ones, must inevitably be made by therapists because the idea of the "benignly aloof, self-contained superior who succeeds in tracing a neat line between private and professional lives" is no more than a "middle-class illusion."¹⁷⁹ She suggests that disclosures between professionals (whether in the apparent form of consultation or gossip) can serve other purposes, including the establishing of personal and professional alliances and effecting social control. But like Olinick, Fonseca equally assumes that an unconsented to disclosure serving legitimate therapist interests and having no malicious basis is acceptable, although malicious or "envy-inspired" disclosures are always despicable, according to her view. They are dysfunctional because the therapist "if branded as a gossip may be discredited and lose actual or potential clients."¹⁸⁰ This pecu-

175. *Id.*

176. *Id.* at 442.

177. *Id.* at 444.

178. Fonseca, *Letter to the Editor*, 9 INT. REV. PSYCHO-ANAL. 355 (1982).

179. *Id.* at 356.

180. *Id.* at 357.

liar therapist-centered charge underscores a concern with confidentiality as a tool of the therapist, not of the patient. Any analysis of professional gossip that attempts to legitimize or to find acceptable some gossip forms assumes that the boundaries of confidentiality are mapped by the therapist.

Caruth asserts that the phenomenon of psychoanalytic gossip (Olinick's "loose-talk" category) in which the patient is neither identified nor identifiable does violate the analyst's obligation to preserve confidentiality.¹⁸¹ However, she accounts for its occurrence among otherwise highly competent and ethical analysts by positing that gossip serves to reduce anxiety created in the therapist "by the threat of fusion in the counter-transference."¹⁸² She suggests as well other functions served by gossip, but in explaining, she makes no claim that the disclosures can ever be justified.

The largest category of professional disclosures usually distinguished from gossip is that of case presentations, either in oral or written form. In this instance, the competing interests are usually characterized as patient confidentiality and scientific knowledge, although it is certainly possible, as Fonseca charges, that many case presentations are made less in the interest of science than in pursuit of personal aggrandizement, curiosity, or the experience of shared eavesdropping.¹⁸³ However, even when education most clearly appears as the primary motive (e.g., textbooks, teaching situations), there is a substantial question about whether such disclosures, even if consented to or disguised, can be justified.

Francis contends that because "the contemporary zeitgeist favors exposure of the private and the personal," the physician should be very reluctant to release any confidential information, even if the patient has consented to it.¹⁸⁴ He distinguishes between "convergent" disclosures, which are made solely to provide additional benefit to the patient, as in consultant disclosure, and "divergent" disclosures, which are disclosures made for other purposes, such as education or pursuit of knowledge.¹⁸⁵ He asserts that consent to divergent disclosures may be especially suspect because of the inherently coercive nature of health care settings and because any disclosures that do not directly benefit the patient must, to be justified, be motivated by altruism. Although Francis does not insist that a physician should *refuse* to disclose when a patient has requested or consented to a disclosure that the physician thinks is not in the patient's best interests, he does claim

181. E. Caruth, *Counter Transference and the Gossiping Therapist* (1982) (unpublished paper).

182. *Id.* at 8.

183. See Fonseca, *supra* note 178, at 355.

184. Francis, *Of Gossips, Eavesdroppers & Peeping Toms*, 8 J. MED. ETHICS 134 (1982).

185. *Id.* at 139.

that there is "an element of ethical speculation in accepting without the most careful thought, and long discussion with the person involved, a consent to serious self-detraction."¹⁸⁶

Francis's position is an intriguing one, for he suggests at least a semi-paternalistic role for the physician to protect the patient from the physician's power. This makes some sense when the disclosures are sought by physician B and physician A may provide protection by way of serious explanation and discussion. However, in the therapeutic process, the therapist must protect the patient from the therapist; i.e., from himself. Such divided loyalties are unlikely to provide much in the way of reliable protection for the patient. Francis's characterization of divergent disclosures as essentially altruistic is an important one. Of course it is possible that patients may wish to consent to such disclosures for non-altruistic reasons, e.g., exhibitionism, status-seeking, or other motives. But the therapist can and should provide appropriate interpretations to the patient of such behavior. Still, the opportunity to act altruistically ought not to be denied to the patient simply because there is too much ambiguity in the situation to be able to sort out the "true" motives with certainty.

In addition, it is clearly impossible to provide effective training and education for new therapists if case presentations may not be made. The parallel problem in medicine has been, of course, the struggle with vivisection and medical experimentation. In a period with a different cultural ethos, the poor, the powerless, and the deviant might ultimately serve the purposes of scientific knowledge and learning, with or without consent, with or without any commitment to altruism. But our current ethos is not as permissive in this area. As a result, the use of case histories gained under either an explicit or implicit promise of confidentiality must be questioned. How is a request for the patient's altruism to be understood or informed? In *Roe v. Doe*,¹⁸⁷ consent was requested but, according to the psychiatrist's report, one day consent was there; another day it was not. In that case, the educational or scientific value of the book was never established and the judge suggested that it would be extremely difficult to do so. But suppose it had been of obvious and extreme value? Has the therapist the right to decide that the value of knowledge for mankind is more important than the patient's claim of confidentiality? It is very difficult, even impossible, to argue that the therapist does not in this situation have split loyalties and that for him to decide that it would be in the patient's best interests to be altruistic or to decide that the patient's best interests are of less importance than the furtherance of scientific knowledge would be unethical.

186. *Id.* at 140.

187. 95 Misc. 2d 401, 400 N.Y.S.2d 668 (Sup. Ct. 1977).

Disclosure to third party insurers shares an element of coercion with disclosures among and between professionals. Given the costs of medical care, it is not entirely inaccurate to say that access to a service cannot entirely be separated from payment for the service. A patient who consents to disclosures for purposes of payment may be saying that consent is effectively the only method of access to the service. This is at least a semi-coercive situation, which is not improved by the fact that consent is usually given in blanket form. In this situation, the patient has no idea either of what specific information will be disclosed or what will be the further fate of those disclosures. The implication is that no disclosures will be made beyond the insurer, but that is not necessarily true, even though mental health records are generally provided better protection than are medical records. Since the therapist is better informed about the degree of disclosure that insurers will require, it would appear to be a part of his fiduciary duty to the patient to explain in advance of disclosures or of signed consents the extent of disclosure that may be requested. Should the therapist subsequently suspect that necessary disclosures might in fact be harmful to the patient, it would be appropriate to advise the patient of these concerns, permitting him to decide again whether he wishes to request reimbursement.

It has been reported that a medicaid audit suggests the extent to which confidentiality can be lost because of third-party payers.¹⁸⁸ In an audit procedure, a number of psychiatric patients were randomly selected for interviews and the records of a second randomly selected group were read and copied by non-physicians, and reviewed by psychiatrist consultants. Patients were not informed prior to the audit of the possibility that they would be interviewed or that their records would be read. It is not entirely clear why there was a failure to give notice to the patients. The ostensible reason was that the therapists were afraid that prediscussion with patients would suggest to the auditors that the therapists were trying to "prep" the patients and predetermine the outcome of the audit. On the other hand, the authors are extremely insistent about the need for total confidentiality. They contend that "merely the idea that someone might have access to intimate materials precludes meaningful psychotherapy from taking place."¹⁸⁹ This strong position suggests that they might have feared that by notifying a number of patients (most of whom would *not* be interviewed or have their records reviewed) they would destroy or severely compromise the possibility of meaningful therapy.

In this instance, patients had signed a standard blanket consent

188. Shwed, Kuvin & Baliga, *Medicaid Audit: Crisis in Confidentiality and the Patient-Psychiatrist Relationship*, 136 AM. J. PSYCHIATRY 447 (1979).

189. *Id.* at 448.

form to release "any information needed" for the claim.¹⁹⁰ Although the therapists had accepted the signed consents, they apparently had not made any attempt to educate their patients about the implications because of their belief that a promise, explicit or implicit, of total confidentiality needs to be made to the patient in order to insure the trust needed for the therapeutic process.¹⁹¹

There is no question but that third party payers are insufficiently sensitive to the issue of patient confidentiality and they are inclined and perhaps willing to sacrifice confidentiality to efficiency and profits. Nevertheless, it is not necessarily the case that review is always destructive to all therapy. Therapists' inclinations to demand total confidentiality as a prerequisite for therapy, a requirement that they may selectively breach to serve their purposes or their assessment of their patients' interests, implies that the therapeutic process does not take place in a social context where competing claims can and do exist. In addition, it suggests that all patients are practically incapacitated with respect to acknowledging real life claims and therefore notice cannot be provided. Although it is probable that notice of audit interviews and record reviews might cause anxiety or even set back the therapeutic course for some, that does not necessarily hold true for all patients. Further, the patient who is interviewed or who finds out that his records have been reviewed will surely feel less sense of loss or betrayal if he is on notice that such a disclosure is possible.

Rosner, in discussing an experimental program designed by Aetna Life and Casualty Company and the American Psychiatric Association, points out that two years after the company began having psychiatrists fill out special medical reports on "questionable cases" for reimbursement, patients were still neither being given notice nor being asked for informed consent, although the company reported that they were continuing to work on that aspect of the program.¹⁹² He charges that, although insurer, therapist, and patient all have legitimate interests in the status of the information, only the insurer and the therapists had been involved in the design of the program and, in effect, only their interests were given consideration. Rosner's criticism of this interest balancing clearly shows how the paternalistic role of the therapist is interposed between insurer and patient. The paradigm of the therapist-as-mediator works, however, only if the therapist has no concerns other than the well-being of his patient. That the transaction is required in order to ensure payment to the therapist demonstrates the unworkability of the paradigm. The numerous problems in this system developed by Aetna and the APA are almost

190. *Id.*

191. *Id.*

192. Rosner, *Psychiatrists, Confidentiality and Insurance Claims*, 10 HASTINGS CENTER REP. 5 (1980).

uniformly problems for the patient. For example, detailed individual records, which may or may not be accurate, and whose existence the patient knows nothing of, are provided to government agencies, including law enforcement agencies, on request and are also subject to subpoena. Alan Stone, who helped work out the plan with Aetna for the APA, responded to Rosner.¹⁹³ But his response inadvertently reinforces Rosner's criticism by acknowledging that in devising the system, threats to confidentiality were considered by psychiatrists and insurers to be less important than the need to eliminate abuse by health care providers.¹⁹⁴ Stone implies that patients would have agreed with them if they had been there. But they were not there. The claim of the therapist is that he can speak for the patient because it is the therapist who does, or should, control the confidentiality of information, not the patient.

B. The Psychodynamics of Privacy and Confidentiality in Psychoanalysis

In any form of psychotherapy, the patient gives up privacy for the hope of relief from conflicts, suffering, and pain. But the process of revelation is itself painful; thus defended against and blocked. In addition, the fear of reprisal for the evil content that has been or could be revealed further fuels the fear of disclosure. Because of all this, the therapist not only provides the sound proof sanctuary of the office, but also often explicitly acknowledges the confidentiality of the private information that is disclosed. This acceptance of confidentiality is an incentive for the patient to relinquish his privacy. Therefore, confidentiality is a cornerstone of trust in the psychoanalytic relationship.

In psychoanalysis there is a particularly strong demand for the patient to relinquish his privacy because of the role that free association plays in the analytic process. Free association provides access to the patient's unconscious fantasies and desires. In saying whatever comes to his mind, reporting dreams, mentioning apparently trivial thoughts, feelings, and fantasies, etc., the patient relinquishes the privacy of his mind to the analyst. A fundamental assumption of psychoanalysis is that patients have feelings, beliefs, and desires that are so shameful and embarrassing or painful to the patient that he represses them and is unable to consciously formulate, much less acknowledge them, as his own. But, through the process of free association, some of these unconscious feelings and desires are revealed to both the patient and the analyst. Thus, by giving up privacy that had previously been inaccessible even to the patient's conscious mind, information becomes available to both patient and analyst. Complete access to the unconscious is impossible, but one goal of analysis is to maximize the uncov-

193. Stone, *Correspondence*, 11 HASTINGS CENTER REPORT 44 (1981).

194. *Id.* at 45.

ering of unconscious thoughts. Therefore, minimizing privacy of the mind maximizes the communication of information germane to the psychoanalytic process.

Some would argue that the degree of privacy that is relinquished must be matched or exceeded by the degree of confidentiality that is promised. The claim that the offer of confidentiality must be absolute is, perhaps, most often made by psychoanalysts. The Ethics Code of the American Psychoanalytical Association, for example, is the most succinct in its claim that analysts should honor confidentiality except when required to disclose information by law.¹⁹⁵ Dr. Lifschutz claimed in court and continued to claim some years later that confidentiality was so important to the analytic process that information should not be disclosed even when the patient requested and the legal system insisted upon disclosure.¹⁹⁶

Few therapists have specifically supported Lifschutz's contention that the privilege should be the therapist's, not the patient's. However, many therapists in practice see requirements of confidentiality and the permissibility of disclosure in the absence of patient consent as a prerogative of the therapist. They contend that therapists do and should control disclosure of confidential information by making individual decisions about which disclosures are appropriate ones, that is "in the patient's best interests," and by disclosing information in those cases without providing either specific notice or consent.

This position is illustrated by Szasz's definition of confidentiality as "the therapists' respect for the patient's confidences."¹⁹⁷ His concept of confidentiality is that confidentiality is the *status* of private information that the patient has provided the therapist in exchange for a promise of help or relief of symptoms. The Szasz definition, unlike ours, requires the therapist to decide what information shall have confidential status; we require the patient to make this decision. Szasz goes further by insisting that respecting the patient's confidences means not using information against the patient's best interests (as determined by the analyst), *as well as* using such information to help the patient, *even without the patient's consent*.¹⁹⁸

In a 1972 symposium a number of analysts addressed the topic of the special role of confidentiality in psychoanalysis.¹⁹⁹ Interestingly, the three primary speakers differed on their view of the function of confidentiality. Marcowitz contended that confidentiality exists to

195. AM. PSYCHOANALYTIC ASS'N, *supra* note 98, at § 6.

196. Personal communication to the authors.

197. As quoted by R. LANGS, in *THE THERAPEUTIC INTERACTION* 414 (1976).

198. *Id.*

199. Watson, "Levels of Confidentiality in the Psychoanalytic Situation," *Scientific Proceedings, Spring Meeting of the Am. Psychoanalytic Ass'n, Washington, D.C., May 1971*, 156-76.

guarantee that "there should be no danger of further distress from the possibility of the analyst's exposure of the patient to anyone else."²⁰⁰ Joseph Lifschutz explained that he had avoided testifying because a breach of confidentiality would have damaged "the patient and the practice of psychotherapy and psychoanalysis."²⁰¹ Finally, Jay Katz argued that the "promise of confidentiality safeguards the analytic process; . . . confidentiality is an essential component of our technique whose guardian . . . must be the analyst."²⁰²

Confidentiality is variously seen to be a way of reducing patient stress, a method of preventing harm to the individual patient, as well as to the entire practice of psychotherapy, and a tool that safeguards the analytic process. In all of these descriptions, confidentiality is something that is to be controlled by the analyst for his own purposes. He is the guardian who chooses to disclose or not to disclose depending upon his assessment of benefit to the patient, to the analytic process, or to the therapeutic field. This sharply contrasts with the idea that confidentiality expresses the *patient's* control over his loss of privacy. The difference between these views has implications for analytic practice.

The analyst's acceptance (rather than promise) of confidentiality does serve to encourage patients' revelations and to protect patients from harm. It is because the patient has made or is willing to make revelations that can be harmful to him that he *expects* confidentiality. The relationship is not a contractual one in which the analyst offers specific results if the patient agrees to follow certain rules. The destination of the analytic journey is unknown to both analyst and patient. If the analyst were in a position to guarantee a specific conclusion,

200. *Id.* at 157.

201. *Id.* at 159.

202. *Id.* at 163. At another place, however, Katz took the position that "[t]he final decision about the privilege, though, belongs to the patient," and Katz would not delegate this power to the analyst in the guise of protecting the patient. In closing, Katz noted that "Psychoanalysts have learned much about the misuse of omniscience, especially in situations where one party is given authority to make decisions for others. I do not see [analysts] as their analysands protectors In that context the right to self-determination, however irrational the decisions, belongs to the analysand - for psychoanalysts in the 'psychoanalytic situation, we are not our brothers' keepers — we are only their interpreters." *Id.* at 166.

It appears, then, that Katz is pulled between the fiduciary image of the analyst as guardian of confidentiality and the recognition that the analysand has the last word and the final decisions about control. Katz has long been a critic of physician paternalism and advocate of patient autonomy, as is illustrated in his thoughtful and probing book. J. KATZ, *THE SILENT WORLD OF DOCTOR AND PATIENT* (1984). But Katz does not completely escape from the ambivalence that physicians feel about giving up power and control over patients' preferences. When, after conversation between patient and physician fails to produce a consensus and they still disagree, Katz seems to waiver in his commitment to the ultimate authority of the patient. *See, e.g., id.* at 163.

then it might make sense to argue that control of confidentiality lies with him for only he can decide whether a particular disclosure would be more or less likely to hurry the patient along his promised route. But the analyst neither can nor ought to make such a promise or predicate such a relationship.

One can contrast the analyst-patient relationship with an "ordinary" intimate relationship. In relationships between close friends or lovers there is a mutual exchange of information. There is no expectation that all information that is disclosed between them carries an obligation of confidentiality. Rather, because of the mutuality, each is expected (and each expects the other) to use reasonable judgment about what must be treated as confidential, what may be the subject of Olinick's "prattle, or loose casual talk."²⁰³ The friend or the lover might well disclose information if he thought it were in the other's best interests. Such discretion can be tolerated because of the mutuality of the relationship: not only the mutual affection, but the mutual vulnerability.

In the analyst-patient relationship, on the other hand, there is no comparable mutuality. The analyst, as a matter of principle, is bound to keep from the patient as much as is possible any sense of the analyst as a private individual. Whereas the patient is expected to minimize his privacy, the therapist is obliged to maximize his in order to use the patient's fantasies about the analyst as a way of furthering the transference. This imbalance, which is different from the inequality that makes the relationship a fiduciary one, affects the way in which confidentiality operates in the relationship. It is doubtless true that therapists could be as sensitive and responsible as lovers and friends. Indeed, they may even be *more* sensitive and responsible in determining what information should be maintained as confidential and what information may be acceptably and even usefully disclosed. Nevertheless, the lack of mutuality in the relationship does not permit that structure unless analyst and patient specifically agree to such an interpretation.

David Beres, along with many other analysts, contends that an engagement between patient and analyst around issues of disclosure distracts from the analytic process and interferes with the transference.²⁰⁴ Stone presents a useful example of these concerns in his discussion of what happens when a commitment to the absolute value of confidentiality conflicts with the psychiatrist's obligation to "expose those physicians deficient in character and competence."²⁰⁵ This conflict specifically emerges when a therapist is told by a patient about sexual misconduct by a prior therapist. Usually, according to

203. Olinick, *supra* note 172, at 439.

204. Cited by Watson, *supra* note 199, at 163.

205. APA, *supra* note 97, at 2.

Stone, the psychiatrist fails to pursue this ethical violation because it would require a violation of patient confidentiality or, in the case of many psychoanalysts, because requesting the patient to waive confidentiality would interfere with transference and counter-transference.²⁰⁶ His interpretation suggests, again, that among psychoanalysts confidentiality serves the interests of the therapeutic process as the analyst perceives them, with no opportunity for the patient even to have a voice in priorities or directions. In practice, of course, confidentiality in these cases serves to protect not only the analytic process but also the therapists who engage in unethical behavior. Only the patient remains unprotected.

Respect for the patient is an integral part of the therapeutic process. We are concerned with privacy as a vitally important aspect of human life because privacy is so integrally connected with individuality and the integrated self. When the confidentiality that is directly tied to privacy ceases to operate directly to further that respect for persons but instead operates indirectly (by directly serving the analytic process which, it is assumed, well serves self-integration) there is too much opportunity for paternalistic interventions that denigrate the patient's importance as a person of equal value. If the ultimate purpose of therapy is to enable the patient to make choices freely, to disclose his privacy or not as he wills, then the analyst's imposition of his own preferences about confidential communications does not serve that purpose well simply because confidentiality is inextricably bound up with the question of privacy. In psychoanalysis, the patient has the right to determine the content and nature of his analysis. Hence patients can properly ask the analyst to reveal confidential information and analysts should honor that request. They need not, of course, honor it mindlessly. The patient needs to receive the therapist's explanation of how the disclosure might operate against the patient's interests. It does not necessarily follow that the patient will be hampered in his cooperation with the analytic process. In fact, an analyst who refused to honor a patient's request to disclose confidential information, for example in a court of law, might stimulate resistances in the patient to free associate or even consciously to withhold information. The meaning of the patient's request for disclosure as well as the meaning of the analyst's disclosure should be explored in the analysis, but the final decision to disclose ultimately belongs with the competent patient.

Robert Langs asserts that:

[Modification in the confidentiality of the analytic situation] regardless of its justification, compromises the therapeutic qualities of the analytic field and negatively affects the image of the analyst It is rather striking that the

206. Stone, *Sexual Misconduct by Psychiatrists: The Ethical and Clinical Dilemma of Confidentiality*, 140 AM. J. PSYCHIATRY 195 (1983).

analytic literature characteristically tends to favor the psychoanalyst, his rights and his needs, while viewing the patient as the one in difficulty; yet, with the issue of confidentiality, the situation seems to be reversed, in that the consensus is that the analyst's rights and needs have no claim, while those of the patient must prevail.²⁰⁷

Langs is disturbed by this tendency to deviate from his theoretical model in which confidentiality is absolute and may not be modified either by patient or analyst. Yet, he neglects to acknowledge the extensive deviations from confidentiality that appear to meet with acceptance from the field as long as the analyst has determined that disclosure would be in the patient's best interests. His contention that "the introduction of such [deviations] will have a significant influence on the patient and analyst, the analytic interaction and process, and the therapeutic outcome"²⁰⁸ is perhaps true, but that is not to suppose that the influence will be negative.

Insisting that the competent analytic patient (and merely the fact of being in analysis does not compromise the patient's competence) be given notice of legally required disclosures and be permitted to consent to or to refuse discretionary disclosures that the analyst thinks appropriate seems to accord with the spirit and the goals of the analytic process. It reduces the sense of mystique and it eliminates some of the analyst's control. But within the theoretical constraints, the analyst's control ought to be limited to the power that the patient believes the analyst has because of the effect of the transference. It need not extend to actual control. Privacy and confidentiality are the grounds and the well-springs of the process of the integration of the self. The revelation of private and confidential information is essential for that process. But privacy and confidentiality should be controlled by the patient, not by the therapist.

VI. CONCLUSION

In this Article we have sought to accomplish the following goals:

1. To clarify and distinguish the concepts of privacy and confidentiality;
2. To compare and contrast how these concepts are viewed from the perspectives of law, economics, anthropology, philosophy, psychology, and psychoanalysis;
3. To examine how legal regulation shapes our perceptions and experiences of privacy and confidentiality;
4. To assess the strengths and weaknesses of the attempts made in codes of professional ethics to recognize and protect privacy and confidentiality;

207. See R. LANGS, *supra* note 197, at 414-15.

208. *Id.* at 415.

5. To explore psychodynamic issues generated by our concern for and valuing of privacy and confidentiality in psychotherapy in general and in psychoanalysis in particular.

It is hoped that the Article has, to some degree, achieved each of these separate objectives. And further, that the interconnections among concepts, legal regulation, moral exhortation, and clinical practice make explicit the overriding conclusion about privacy and confidentiality in psychotherapy and psychoanalysis: that the patient rather than the therapist should have the first and last word about privacy and confidentiality. Between the first and last word, however, there should be opportunity for the therapist to offer interpretations to assist the patient in achieving insight as well as in making his or her own personal decisions.

But therapists must respect the autonomy and rights of patients while helping patients achieve the understanding they need to fully and responsibly exercise their capacities as both thinking and feeling persons. The therapist must avoid the temptation of thinking that his or her judgment, even wisdom, should be substituted for the patient's preferences.