Why Clients Should Not Take Psychotherapists into Their Confidence

James (Jim) B. Gottstein

The editors would like to invite readers to respond to the following thought-provoking piece by Jim Gottstein, Esq. It is quite literally disquieting that our work has become increasingly threatened by the pressures to release private information about our patients. Jim's points are in line with those of Bollas and Sundelson in "The New Informants" (1995, Jason Aronson). Please take the time to respond to Jim's piece with your experiences of these threats and how you have managed them in your work with patients or, if you are a patient, how these pressures have made (or not made) their way into your treatment. We look forward to your responses and hope to print some of them in our next issue.

The assertion that clients should not take psychotherapists into their confidence is provocative. It is meant to be. As an attorney, I have experienced and heard about far too many instances of psychotherapy confidences being breached to the extreme detriment of the client to be sanguine. Most psychotherapists are aware of *Tarasoff*-type reporting requirements and are also aware that client confidentiality has been made secondary to getting paid by third party payors. The problem is far more pervasive than that. I think it is fair to say that, with the exception of unique programs such as Volunteers In Psychotherapy in Connecticut, where confidentiality is taken extremely seriously, a psychotherapy client never has any reasonable assurance that confidences will be maintained. This can have disastrous consequences.

This is in sharp contrast to the impression given that confidences will be maintained. For example, in holding that there is a privilege against disclosure of psychotherapy information in federal courts, no less an authority than the United States Supreme Court has stated:

> "Effective psychotherapy...depends upon an atmosphere of confidence and trust in which the patient is willing to make a frank and complete disclosure of facts, emotions, memories, and fears. Because of the sensitive nature of the problems for which individuals consult psychotherapists, disclosure of confidential communications made during counseling sessions may cause embarrassment or disgrace. For this reason, the mere possibility of disclosure may impede development of the confidential relationship necessary for successful treatment.
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> [I]f the purpose of the privilege is to be served, the participants in the confidential conversation 'must be able to predict with some degree of certainty whether particular discussions will be protected. An uncertain privilege, or one which purports to be certain but results in widely varying applications by the courts, is little better than no privilege at all.'"

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At the same time, the Court said:

> "Although it would be premature to speculate about most future developments in the federal psychotherapist privilege, we do not doubt that there are situations in which the privilege must give way, for example, if a serious threat of harm to the patient or to others can be averted only by means of a disclosure by the therapist."

In coming to its conclusion that there should be a federal court psychotherapist privilege, the *Jaffee* Court relied on the existence of such privileges in one form or another in all 50 states. However, a perusal of just a small sampling of states reveals the following exceptions:

- In a proceeding to terminate parental rights
- All proceedings where competency is at issue
- Where the psychotherapist thinks their client should be hospitalized
- Circumstances under which privileged communication is abrogated under the law (whatever that means)
- Where the interest of justice would be served (whatever that means) when someone is charged with homicide or injuring person
- Court-ordered examination
- When the validity of a Will is at issue
- If a person's mental condition is raised
- In criminal cases of necessity (whatever that means)
- Witness against a criminal defendant

With respect to this last one, a majority of state courts have held that a criminal defendant, upon a preliminary showing that the records likely contain exculpatory evidence, is entitled to some form of pretrial discovery of a prosecution witness's mental health treatment records that would otherwise be subject to an "absolute" privilege.

Section 4.02 of the American Psychological Association's *Ethical Principles of Psychologists and Code of Conduct*, Standard 4.02 states, in part:

> "4.02 Discussing the Limits of Con-

fidentiality (a) Psychologists discuss with persons (including, to the extent feasible, persons who are legally incapable of giving informed consent and their legal representatives) and organizations with whom they establish a scientific or professional relationship (1) the relevant limits of confidentiality and (2) the foreseeable uses of the information generated through their psychological activities. (See also Standard 3.10, Informed Consent.)
(b) Unless it is not feasible or is contraindicated, the discussion of confidentiality occurs at the outset of the relationship and thereafter as new circumstances may warrant."

In light of the multitude of exceptions to confidentiality swallowing the rule, psychotherapy clients can have no assurance that their confidences will be kept and should be so informed. Does this really mean clients should not take psychotherapists into their confidence as suggested by the title? Not really. They can reasonably decide that the benefits outweigh the risks. However, the risk of severe adverse consequences, such as incarceration, loss of children, loss of autonomy, and ruinous financial losses are realistic possibilities and quite common. I advise extreme caution to clients when such possibilities are a reasonable prospect.

Is the plethora of ways in which psychotherapeutic confidences are breached a state of affairs with which psychotherapists should be comfortable? I think not.

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1. See www.ctvip.org
2. *Jafee v. Redmond*, 518 US 1 (1996)
3. *Id*

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Obituary of Wayne Fenton, M.D.

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Even three months after Wayne Fenton's murder on September 3, 2006, and after attending his funeral along with over 800 others, I still cannot absorb the horrifying reality that Wayne is gone. Wayne was only 53 when a 19-year-old "hard-nosed" ice hockey player pummeled him to death in his office. Wayne had met with him in consultation for a local psychiatrist and had told the patient's father he would try to persuade him to take oral medication for his psychotic disorder. The patient called later, pleading for a second appointment. Apparently, Wayne was concerned enough that he talked the situation over with his wife, who volunteered to go with him and stay in the waiting room, but Wayne decided this would not be necessary. His death has stirred the anxieties of the mental health community. Listservs are filled with discussions of potentially violent patients and how best to protect oneself from harm.

Wayne Fenton presenting at the 1994 ISPS meeting in Washington, D.C.

Wayne was a dynamo, always a rising star. He had published over fifty research papers on schizophrenia and related topics along with many textbook chapters. He could be counted on to give a polished and erudite keynote address, as he did at the 1997 ISPS conference in London. He had become a highly-esteemed second in command at the National Institute of Mental Health, and frequently served as a consultant on especially difficult patients. He consulted to troubled hospitals as well. Newspaper articles about his murder quote a 2002 interview he gave to the Washington Post, on the lack of appropriate care for those with schizophrenia, "All one has to do is walk through a downtown area to appreciate that the availability of adequate treatment for patients with schizophrenia and other mental illnesses is a serious problem in this country….We wouldn't let our 80-year-old mother with Alzheimer's live on a grate. Why is it all right for a 30-year-old daughter with schizophrenia?"

Wayne's self-confidence and firmness were always impressive. When the Medical Director of Chestnut Lodge, Dexter Bullard, Jr. (Rusty), was diagnosed with lung cancer, he named Wayne as the next Medical Director. He handled the job beautifully, rapidly getting the hospital's finances on much firmer ground.

Wayne joined the National Institute of Mental Health staff in 1999 as Director of the Division of Adult Translational Research and Associate Director for Clinical Affairs. He supervised the development of diagnostic instruments and interventions for mental illnesses, especially schizophrenia. He aimed to establish standard outcome measures of cognitive ability in those suffering from schizophrenia to find treatments which would improve cognitive impairment. Additionally, he served as Deputy Editor of Schizophrenia Bulletin and served as a consultant to the Department of Justice, Civil Rights Division. He was active in the National Alliance on Mental Illness, serving on its Scientific Council.

As NIMH's liaison to the American Psychiatric Association and World Psychiatric Association, he helped shape the research agenda for the forthcoming DSM-V diagnostic manual. He also worked to enhance training opportunities in patient-oriented research for psychiatrists, to develop and promote a neuroscience middle school curriculum, and to launch new NIMH treatment development initiatives. He received many national awards, including regular recognition in the Best Doctors in America.

Wayne had arrived at Chestnut Lodge from Yale, working as Thomas McGlashan's assistant at the Research Center. They co-authored many papers and book chapters together, many in the American Journal of Psychiatry. Examples include "Long-term residential care: Treatment of choice for refractory character disorder?," "Risk of schizophrenia in character disordered patients," "The prognostic significance of obsessive-compulsive