THE MEANING OF THERAPEUTIC LEAKS IN PSYCHOTHERAPY: WHY THERAPISTS GOSSIP

LONNIE PRINCE

THE MEANING OF THERAPEUTIC LEAKS IN PSYCHOTHERAPY: WHY THERAPISTS GOSSIP

A dissertation submitted to
The Sanville Institute
in partial fulfillment of the requirements
for the degree of
Doctor of Philosophy in Clinical Social Work

By

LONNIE PRINCE

June 23, 2012

CERTIFICATE OF APPROVAL

I certify that I have read THE MEANING OF THERAPEUTIC LEAKS IN PSYCHOTHERAPY: WHY THERAPISTS GOSSIP by Lonnie Prince, and that in my opinion this work meets the criteria for approving a dissertation submitted in partial fulfillment of the requirements for the degree of Doctor of Philosophy in Clinical Social Work at The Sanville Institute.

Whitney van Nouhuys, PhD — 3/5/12
Whitney van Nouhuys, PhD, Chair — Date

Samoan Barish PhD — 3/8/12
Samoan Barish, PhD, Faculty — Date

3/5/12
Valory Mitchell, PhD, External Member
Professor of Psychology, California School of Professional Psychology at Alliant University

Whitney van Nouhuys, PhD — 3/5/12
Whitney van Nouhuys, PhD, Academic Dean — Date

ABSTRACT

THE MEANING OF THERAPEUTIC LEAKS IN PSYCHOTHERAPY:
WHY THERAPISTS GOSSIP

LONNIE PRINCE

This qualitative study explored how therapists experience, describe and think about the experience of casual anecdotal leaks, referring to the phenomenon of discussing patients outside of formal consultation. The following questions were addressed: What were the specific contexts in which this occurred? What feelings came up in the aftermath of them? Were there particular types of patients who evoked this behavior? Did the therapist feel therapeutic leaks helped and or hindered the work and if so, how?

Semi-structured interviews were conducted with nine participants, all of whom had been in practice for at least fifteen years. Content from the interviews was analyzed according to Glaser and Strauss' method of constant comparison.

Results indicated that all participants engaged in discussion of patients regardless of how strictly they felt they adhered to the principle of confidentiality. The participants expressed some discomfort at talking about their own experience, but none felt that harm was done to the patient. The context of the leaks seemed as important, if not more so, than the leaks themselves. The findings of this study indicate that casual anecdotal breaches are a way of re-establishing the emotional equilibrium for the therapist when strong counter-transference feelings arise.

DEDICATION

This dissertation is dedicated to my husband, Mal Singer. I could never have taken on this challenge without his continued love and support.

ACKNOWLEDGMENTS

I would like to thank Dr. Whitney van Nouhuys who has been with me from the very beginning until the very end. Her patience, support, and high standards have been invaluable and I feel so grateful to have had the opportunity to work with her and learn from her.

I would like to thank Dr. Samoan Barish who has been so encouraging and enthusiastic about my research. Her warmth and creativity helped me so much during this process.

I would like to thank Dr. Valory Mitchell who so generously agreed to be my external reader and whose comments and clarity were greatly appreciated.

I would like to thank Tina Casenza who was always available for help with any questions. Her generosity and good humor made me feel a real part of the Sanville community.

I would like to thank Dr. Angeleen Campra for her incredible patience, knowledge, and overall expertise in dealing with all the technical problems I encountered along the way. She always made time for me regardless of how busy she was and was a calming presence when I wanted to throw my computer off the nearest bridge!

I would like to thank all the participants in this study for taking the time to be part of my research and who were open and honest in their responses. They made the task that much easier.

I would like to thank Dr. Gareth Hill for being my consultant in my beginning years at Sanville and whose wisdom and empathy enabled me to become a better clinician.

Finally, I would like to thank my community of family and friends who cheered me on from the beginning and whose enthusiasm never flagged.

Thank you all from the bottom of my heart.

TABLE OF CONTENTS

ABSTRACT iii
DEDICATION iv
ACKNOWLEDGMENTS v
CHAPTER 1: INTRODUCTION 1
The Problem and Background 2
The Place of the Courts Regarding Confidentiality 6
Protection of Confidentiality 6
Tarasoff Act 8
The Research Question 9
Significance of the Study 10
CHAPTER 2: LITERATURE REVIEW 12
Gossip From a Social Science Perspective 13
Gossip as a Means of Social Cohesion and Power 13
Gossip as Malicious Intent 18
Gossip and Curiosity 19
Gossip and Intimacy 19
Social Scientists' Conclusions 20
Gossip and Literature 21
Confidentiality in Psychotherapy 24
Social Work Codes of Ethics 24
Current Views on Confidentiality From Psychoanalytic Literature 27
Research Studies on Breaches of Confidentiality 32
Psychoanalytic Underpinnings for the Current Research Study 39
Envy 49
Anxiety/Transitional Phenomena 51
Drive Theory/Aggressive and Sexual Instincts 52
Isolation 53
Conclusion 54

CHAPTER 3: METHODS AND PROCEDURES....56
Methodological Approach and Research Design....56
Participants....57
The Sample....57
Criteria for Selection....58
Recruitment....59
Data Collection: The Interview....59
Procedure....60
Topics of the Interview Guide....61
Data Analysis....63
Procedure for Data Analysis....64
Presentation of the Data....65
Reliability and Validity....65
CHAPTER 4: FINDINGS....67
Participants....69
Examples of Gossiping....70
Participants' Stated Beliefs About Confidentiality....71
Findings: When Participants Breach Confidentiality....75
Themes Which Served as a Backdrop to the Research Topic....76
Context of Leaks....76
Affective Responses to the Interview....78
Reasons for Therapeutic Leaks....79
Patients Most Talked About....79
Most challenging.....79
Children and adolescents.....81
Deep connection.....83
Famous patients.....84
Therapists' Counter-Transference Feelings and Needs....86
Dilution of intimacy.....86
Need for soothing....88

Venting/discharging. 88
Feelings of inadequacy and helplessness. 90
Exhibitionism. 92
Bonding. 93
Isolation. 94
Competition/envy 95
Summary 96
CHAPTER 5: DISCUSSION 97
Review of the Findings 97
Discussion of Secondary Categories 98
Discussion of the Primary Categories 99
Patients most discussed. 100
Therapists counter-transference feelings and needs. 101
Relevance of Findings to the Literature 103
Reflections on Therapeutic Leaks 105
Theoretical Frameworks for Discussion 106
Kohut's Self-Psychology Model 106
Self-object and self-object transference. 107
Mirroring and the mirroring transference. 107
Idealizing and the idealizing transference. 108
Twinship and the twinship transference. 108
Empathy. 109
Relevance of Kohut's concepts to the findings. 109
Attachment Theory and Winnicott 111
Limitations of the Study and Implications for Future Research 113
Concluding Thoughts 114
APPENDIX A: RECRUITMENT LETTER 117
APPENDIX B: RECRUITMENT AD FOR NEWSLETTERS 119
APPENDIX C: LETTER TO PROSPECTIVE PARTICIPANTS 120
APPENDIX D: INFORMED CONSENT FORM 122

APPENDIX E: SCREENING FORM 124
APPENDIX F: INTERVIEW GUIDE 125
APPENDIX G: PROTECTION OF RESEARCH PARTICIPANTS APPROVAL 127
REFERENCES 128

CHAPTER 1: INTRODUCTION

This qualitative study explores how therapists describe the experience of discussing patients outside of formal consultation. What are the specific contexts? What feelings come up in the aftermath? Are there particular types of patients who evoke this behavior? Does the therapist feel this helps and or hinders the work and if so, how?

I am conceptualizing the experience of discussing patients outside of formal consultation as a form of gossiping behavior. According to the American Heritage Dictionary (1992), gossip is defined as "rumor or talk of a personal, sensational or intimate nature" (p. 783), The root of gossip comes from god and *sibb*, which means kinsman. The derivation also relates to god parent or close friend or companion. In using the term gossip, I am referring to the act of talking about or discussing clients outside of formal consultation. I will also use the terms "anecdotal therapeutic leaks" and "breach of confidentiality." Since this is a common phenomenon despite ethical, legal, and theoretical injunctions against it, my purpose is to understand its meaning and function.

There are many different ways of gossiping within the framework of psychoanalysis. Some forms of gossip are extreme. These can be harmful to both patients and the profession and happen infrequently. I will give some examples of this further on. Other forms of gossip, what I refer to as anecdotal leaks, may or may not be harmful. They happen often and yet are rarely spoken about. Rather than simply pathologizing gossip, my aim is to understand the need we, as therapists, have to do it.

An example from my own life will illustrate what I mean. A patient of mine was concerned about her baby's sleep issues, and worried about the potential repercussions in terms of brain development. Her anxiety was a source of intense suffering for her. While this was happening, I spent time socially with a young couple who had a baby. I brought up the sleep issue with them, mentioning that I was working with someone who was struggling with it. They did not have the same concerns and seemed more relaxed. Although I did not give any other identifying information about my patient, I later felt I had been inappropriate in speaking about this at all. Upon reflection, I understood that I, who was having strong counter-transference feelings towards my patient, was unconsciously seeking a comforting perspective from these young parents. I did, in fact, feel less anxious after hearing their perspective, and it helped me feel more grounded in the therapy work.

The Problem and Background

Robert Langs (1973), known to be rigorous in his stance regarding the therapeutic frame, has this to say about therapists who talk about their patients:

> One should never discuss patients with friends or family, even if names are not used: all too often, I have heard of situations in which information was revealed which led to correct though inadvertent identification of an unnamed patient. Such violations of confidentiality are not only destructive to the patient, they also give the field of psychotherapy a poor and questionable reputation. Beyond this, such remarks are unnecessary and usually reflect unresolved problems in the therapist. In fact, most discussions of patients between therapist and their professional colleagues

> are motivated by neurotic needs rather than constructive ones. These inappropriate unconscious motivations include the need for reassurance through the phallic exhibitionism of successes, and masochistic, guilty punishment-seeking reporting of failures. Such discussions may also reflect grandiosity, insecurity, hostility towards one's patient, or an erotization of one's work. Even telling one's wife about one's patients, a common form of leakage, is unnecessary and a burden and source of confusion for her. (pp. 61-62)

He does not mince words. Langs (1973) takes issue with any kind of breaches, be they anecdotal or more serious. He states unequivocally that there is no situation in which talking about one's patients serves to benefit the work and also claims that leaks give the practice of psychotherapy a dubious reputation. Movies and television illustrate the problem when they portray psychotherapists as gossipers with little regard for their patients' confidences.

An egregious example of this occurs in the HBO series "The Sopranos" (Chase & Van Patten, 1999). While Dr. Melfi, the psychiatrist who is treating Tony Soprano, is having dinner at her consultant's home, the two of them engage in a discussion about her patient. To make matters worse, the consultant is also Tony's next door neighbor. Though there are several other people at the table, both analysts show little or no concern for the privacy of the patient.

Of course, these are just fictional characters. Nevertheless, these images lend credence to Robert Langs' (1973) assertion. Someone contemplating seeking

treatment might think twice about it if these depictions represent how therapists actually behave.

Casual gossiping about patients and leaks in confidentiality do occur frequently. I have observed that while spending time with colleagues, or even at dinner parties, there is a tendency to discuss one's patients. In the minds of the therapists involved, these leaks do not constitute harm. They do not include names and are usually of an anecdotal nature. It is unlikely that such behavior would be grounds for being brought before an ethics committee, and yet, these leaks do run contrary to the promise of absolute confidentiality. If confidentiality is the cornerstone of our profession, how and why do so many of us violate it?

My interest in this study stems from various experiences in which I have been a party to leaks or I myself have leaked information about a patient without the patient's knowledge or permission. Why did this happen? Were these leaks necessarily harmful? Is it unrealistic or even impossible to impose a rule of absolute confidentiality? Do these third party communications serve a higher purpose that needs to be clarified?

Two particular situations involving a breach heightened my interest in researching the topic of therapeutic leaks. In the first, I had referred the husband of a patient of mine to a good friend and colleague. One evening while we were having dinner she said she wanted to talk to me about the case. I immediately felt uneasy because I did not want to hear information that might intrude on my own work. I mentioned this to her but she was insistent. My misgivings were validated when she went on to talk about the husband's complaints and wanted me to "encourage the

wife" to be less controlling. I felt manipulated and impinged upon. Even more importantly I recognized that I had been part of a breach that violated my ethical responsibility.

In the second situation, another colleague had referred her individual patient and her patient's partner to me for couples counseling. Whenever the colleague and I would meet, she would want to talk about my work and let me know things about her patient that had never been discussed in the couples therapy. What was I to do with this information? I could not bring it up in the couples work and yet I was affected by it. Again, I felt pressured and puzzled by my colleague's need to talk to me about her patient.

These two examples show how therapeutic leaks can be intrusive and not helpful, especially when there is a shared patient. For the most part, however, the types of leaks discussed in this study take place with someone who has no prior knowledge of the patient/s and therefore the impact is quite different. It is this type of anecdotal leak that is the focus of my research.

A great deal has been written about the importance of maintaining confidentiality, but little has been written about the casual, anecdotal leaks that occur frequently. Is it because there is a sense of shame? Is it because most therapists feel that no harm is done if identifying information is withheld? Or is it because by gossiping, some other internal experience is satisfied? These are just a few of the questions I explore in this study.

Freud, the original architect of psychoanalysis, encouraged therapists to treat any material that occurred in the sessions as confidential. Yet according to Lynn

and Valliant (1998), Freud admitted that he had a hard time keeping confidences. Ellman (1991) stated that "Freud was a highly variable analyst who frequently disregarded (or violated) his own suggestions" (p. 285).

Freud had three basic tenets regarding the practice of analysis. The first was about the analyst's anonymity and complete restraint of reacting emotionally to the patient's material. Second, he recommended that an analyst should refrain from directing his patient in any way. Third, the analyst must preserve the patient's confidentially (Lynn & Vaillant, 1998, p. 165).

Despite these tenets, according to Lynn and Valliant (1998), there were various contradictions in the way Freud handled confidentiality. For example, he occasionally involved himself with his patients' families. He did not always maintain anonymity when talking about his patients and he revealed confidential material in both his writings and with colleagues. Nevertheless, he understood the importance of confidentiality even if he did not always follow his own recommendations.

The Place of the Courts Regarding Confidentiality

Protection of Confidentiality

In his review of the history of the concept of confidentiality in psychoanalysis, Tomlinson (2003) describes the environment in which psychoanalysis began as significantly different from what is expected by today's standards. He states that the Hippocratic Oath was basically the main tenet. One section of the oath states:

> What I may see or hear in the course of the treatment or even outside of the treatment in regard to the life of men, which on no account one must spread

abroad, I will keep myself holding such things shameful to be spoken about. (as cited in Tomlinson, para. 7).

Since Freud was a medical doctor first, his training was from a European medical perspective. There was not much written about the early years of psychoanalysis with regard to confidentiality. There was no protection with regard to court proceedings and Tomlinson (2003) states that it was by and large left to the physician's discretion.

Minutes from the earliest meetings of the Vienna Psychoanalytic Society in 1906 indicate that some attempts were made to hide the identities of the patients being discussed. Talk among colleagues, however, occurred frequently, and some of it was written about or recorded.

Tomlinson (2003) recommends a close reading of Freud's 1913 article "On Beginning the Treatment" with regard to confidentiality, in which Freud advises that not only the analyst refrain from talking about the work, but the patient as well. Freud believed that revealing information was disruptive and potentially harmful to the treatment. Tomlinson states:

> In assessing how confidentiality was handled in the first half century of psychoanalysis, we face one enormous problem of psychoanalytic historiography: An adequate and comprehensive history of clinical practice and technique during the first decades of psychoanalysis remains to be written. In addition, much of the relevant information may be presumed to have been orally transmitted, yet our knowledge and records of this oral history are thin. (p. 146)

Up until 1952 there were no court cases involving confidentiality, which Tomlinson (2003) believes demonstrates that "confidentiality was by and large well maintained" (p. 146). Then, in 1952, the first case, Binder v. Ruvell was tried. At stake was the issue of ordering the treating psychiatrist, Dr. Roy Grinker, to release information about his patient. Judge Harry M. Fisher ruled that the patient/psychiatrist communications were protected from disclosure, and that they were to be distinguished from patient/physician communications (Koggel, Furlong, & Levin, 1994).

Tarasoff Act

The Tarasoff Act in 1976 was a major blow to the concept of confidentiality. It was a response to the case of a student murdered by another student who was in therapy at the time. The parents of the murdered girl sued, claiming that the victim could have been warned beforehand by the therapist of the murderer. The California Supreme Court stated:

> When a therapist determines . . . that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim against such danger. The discharge of this duty may require the therapist . . . to warn the intended victim against such danger or others likely to apprise the victim of the danger, to notify the police, or to take whatever other steps are reasonably necessary under the circumstances. (Tarasoff v. Regents of University of California, 1976)

Bollas and Sundelson (1995) argue that legislation permitting or requiring the release of confidential information puts the whole practice of psychoanalysis in

jeopardy. They state that the slightest possibility that information might be leaked to authorities profoundly affects the flow of free association, which is at the heart of analysis. Free association requires a completely safe environment. Communications are often symbolic and not meant to be taken literally. Thus, any thought that the information could be reported is the death knell of the analysis (pp. 59-60).

The Research Question

The purpose of this study is to explore how and why therapists gossip about their patients. What are the specific contexts and internal psychological mechanisms that cause this to occur?

The following questions are addressed in my research: When speaking about a patient in an anecdotal manner, what was the subjective experience being evoked? Were there specific contexts in which this happens, (e.g. talking with partner after work, conversation over dinner with colleagues)? What feelings came up about this? Was there a particular type of patient or situation in which this is more likely to happen (e.g. a patient who evokes anger, anxiety, or sadness, or a patient who is famous)? Did the therapist feel this interfered with or benefited the work? If so, in what way?

Using a grounded theory approach (Strauss & Corbin, 1998), this study focused on the therapist's experience of anecdotal therapeutic leaks. The data consisted of in-depth interviews with nine psycho-dynamically-oriented therapists. Each therapist was asked to consider a time or times when they "gossiped" and the possible reasons behind it. The "constant comparative method" of qualitative data analysis as described by Strauss and Corbin (1998) was used to analyze the data.

Significance of the Study

A great deal has been written about the need for confidentiality in the practice of psychotherapy. The guiding principle is that without this promise, the therapy will be severely compromised. Very little has been written about the fact that despite this principle, therapists break the rules of confidentiality in different ways.

Serious breaches can involve legal action. A case in point is described by Jane Burka (2008), who is herself an analyst. During the course of her own treatment, Burka learned that her analyst was having an affair with one of his other patients. This prompted her to end her work with him despite the fact that she had found it helpful. In the aftermath, she learned that he had been discussing her with this other patient and had revealed intimate details of her analysis.

She eventually sued and was awarded monetary damages. This was a situation in which serious damage was done with no regard at all for confidentiality. Thankfully this kind of breach is rare, yet it does cast a shadow on the profession as a whole.

However, many breaches are not so serious, and bringing attention to this subject may help therapists think about these casual breaches with a fuller awareness. If the internal pressures to speak about a client in casual ways were better understood, then perhaps these leaks could be better contained. On the other hand, since it is such a common occurrence for therapists to engage in third party communications, maybe we need to rethink the idea of confidentiality. Within certain parameters, the sharing of privileged information might be considered a

useful part of the work. Therapists do not like to think of themselves as breaching confidentiality. It suggests a lack of containment or control that may be considered shameful in an area fraught with ethical and legal ramifications. Perhaps for this reason, it is not widely written about. Yet, in my experience, it is something that goes on all the time. Why is that? Even Freud himself could not maintain absolute confidentiality. Are we, as therapists, setting a standard that is not realistic?

There are those who believe that gossip provides certain benefits. Fonseca, (1982) points out that there is a difference between malicious gossip and innocent communications. She suggests that gossip has other functions, such as a need for soothing, or validation. Fonseca agrees that it is the moral obligation of the therapist

> never to speak indiscriminately about his patients but, never to speak about them at all, except in clinically aseptic circumstances, is to fuel the middle class illusion of the benignly aloof, self-contained superior who succeeds in tracing a neat line between private and professional lives. (p. 357)

This study attempts to clarify and understand the phenomenon of the gossiping that occurs so frequently in the field of psychotherapy. The seriously harmful leaks such as the one Burka (2008) experienced are less ambiguous and not the focus of this study. These more casual leaks, however, are both more prevalent and relatively unexplored. My goal has been to shed light on the topic of therapists' casual breaches. My hope is to increase understanding of therapists' conscious and unconscious motivation, as well as the harm and/or the usefulness of this type of communication.

CHAPTER 2: LITERATURE REVIEW

This study explores why therapists gossip about their patients. What are the contexts and internal mechanisms that cause this to occur? For the purpose of this study, I have called these communications leaks, gossip, and breaches of confidentiality. In using these terms, I am referring to the casual anecdotal breaches that occur frequently with colleagues or in social situations. This study does not explore the more egregious leaks in which legal action might be taken.

There is a great deal written about confidentiality in psychotherapy but very little of it has to do with the casual types of gossiping that happens frequently. Most of the literature on confidentiality concerns very serious breaches such as sexual or financial violations. Why has more attention not been paid to the phenomenon of casual leaks? The purpose of my research is to increase understanding of this relatively unexamined phenomenon and perhaps shed some light on why it has remained outside of professional inquiry .

The literature review is divided into five sections. In the first two sections I explore the topic of gossip from an anthropological, sociological, and literary perspective. In the third section I discuss the history of confidentiality and its importance in the field of psychotherapy. In the fourth section, I discuss research studies pertaining to therapeutic leaks. Finally, in the fifth section, I review the psychoanalytic literature that speaks directly to this topic.

Among the various social science disciplines, certain repetitive themes emerge in the consideration of gossip, such as power, group cohesion, gender differences and intimacy. The psychoanalytic literature, while identifying similar

themes, uses language that is very specific to psychoanalysis. Since this study has been about exploring the psychological motivations for gossip, I have defined and used terminology that is psychoanalytic in nature for the actual research.

Although the content of gossip is generally thought to be about people's private lives, in some of the literature it is understood to include impersonal content. This makes it difficult sometimes to decide what is and what is not gossip. For the purposes of this study, however, gossip about people and relationships that the therapist has learned in the context of the clinical hour are the focus of attention.

Gossip From a Social Science Perspective

Gossip has been around since time immemorial and is a topic of great interest to social scientists. Besnier (1989), an anthropologist, points out that a universal definition of gossip is impossible because of the "context-dependent" nature of it. He states, "Indeed, an adequate definition of gossip must take into account the dynamic and shifting nature of the category" (p. 320). Gossip, he suggests, is hard to document because it takes place in small intimate groups, and outsiders (anthropologists) are usually not admitted into these discussions. Nevertheless, he feels that gossip is a key to understanding culture because it provides a window into the structure and hierarchy of group dynamics.

Gossip as a Means of Social Cohesion and Power

Anthropologist Max Gluckman (1963) regards gossip as a means of maintaining group cohesion, moral action and exertion of control without face-to-face confrontation. Gossip, he claims, is a way of using power to maintain moral and social order that serves an important and positive function. People fear being

ostracized by their peers, and gossip, or the fear of being gossiped about, influences their behavior.

In the Introduction to his book with Aaron Ben-Ze'ves, *Good Gossip,* Robert Goodman (1994), a sociologist, discusses how gossip, when analyzed, teaches us so much about the society we live in. Much like Gluckman (1963), he points out that gossip can enhance friendships, strengthen group cohesion, and convey information. Gossip can provide a binding and a bonding function. People who gossip together are part of an "exclusive club" which leads to feelings of intimacy and kinship.

Historian Sylvia Schein (1994), looking at how gossip functioned during medieval times, concurs with the previous authors. Information during medieval times was conveyed through word of mouth. There was no way to check on its accuracy. Telephones, computers, televisions and all the ways that we now get our information did not exist. The insular quality of the medieval society increased gossip's power. People rarely travelled and even if they did, it was not very far. This heightened the power of gossip and thereby its threat. Gossip was an effective form of social pressure that led individuals to conform to group standards, thus facilitating group cohesion. Schein states that gossip was sometimes "motivated by feelings like spite, envy, revenge, or frustration," but it was also "motivated by a keen and healthy interest in one's neighbors or friends" (Schein, p. 145).

In contrast to the previous authors' more positive views on gossip, Paine (1967), a British anthropologist, sees gossip as a way for individuals to sabotage others. People, according to Paine, use gossip to promote their own agendas, which

undermines group harmony. And yet, as Besnier (1989) points out, both positions are true of gossip. He states:

> At the root of the various questions that anthropologists have addressed on the issue of gossip is the basic recognition that gossip occupies a pivotal position between the sociopolitical structure of the group and the agency of particular members of the group. Thus, gossip can enhance social structure and perpetuate the status quo, but it can also be used by individuals to bring about more or less fundamental and lasting changes. (p. 280)

Like Schein (1994), de Sousa (1994), a philosophy professor, equates gossip with power. He states, "It differs from ordinary power as information differs from brute force, but it is power nevertheless" (de Sousa, p. 25). He refers to gossip as a "subversive form of power" used by those who are weaker against those who are more powerful. Because women have traditionally been the "weaker" members of society, claims de Sousa, they are regarded as bigger gossips. He feels that gossip can be empowering for the more oppressed members of society.

Emler (1994), a professor of social psychology, suggests that gossip is necessary for the human collective to function. By this, he is referring to how individuals adapt to group norms. While he agrees that gossip can be malicious and destructive, it also has positive aspects. He states: "Gossip, at its most basic level, can be regarded as the human equivalent of primates' 'social observation', it is the dissemination of knowledge about social structure" (p. 132). Social observation leads to social action. Individuals seek power through social assertion within their own group He further states that, "Each individual will draw upon accumulated

knowledge of others based on either its own past exchanges or encounters with those others or its observations of those interactions" (p. 133). Thus Emler, like the others who have been reviewed, sees gossip as a source of power as well as a means of maintaining group standards.

While acknowledging the more sinister aspects of gossip, for the most part the authors I reviewed suggest that gossip is an essential part of the human experience. Gossip can be the engine through which people adapt and comply. Carried to extremes, this can be stultifying, but at the same time, without some concern about what others think, there would be less incentive to behave in the best interests of the group.

Gossip From a Gender Perspective

Gossip has been mostly associated with women; the word itself usually refers to a woman or women's behavior, and calling someone a "gossip" carries a negative connation. Despite the fact that gossip is practiced by both sexes, this view persists. As I mentioned, de Sousa (1994) believes that given women's lower status in society, gossip was a means of exerting some power within the larger group.

The social scientists I reviewed suggest that gossip provides an important societal function and they do not, for the most part, pass judgment. This is not the case from a religious perspective, however. Much of gossip's bad reputation derives from scripture in both the Old and the New Testaments. An example from the Old Testament appears in Proverbs 11:22 (King James Version), "Like a gold ring in a swine's snout is a beautiful woman without discretion." The New Testament defines gossip as malicious and sinful, calling it a serious transgression. In 1 Timothy 5:13,

St. Paul admonishes young widows, saying that they, "who learn to be idlers gadding about from house to house, are not only idlers but gossips and busy bodies saying what they should not." As these quotes suggest, the perception was that women were the ones more likely to gossip than men.

Schein (1994) and de Sousa (1994) explain that because women's roles were so restricted, gossip became one of the only means they had of exerting power, and even though gossip seemed to be more of a feminine occupation, the reality was that men and children gossiped as well. In fact, gossip was a preoccupation among all classes, genders, and ages. Nevertheless, men's gossip was thought to be more like "idle talk," while women's gossip had "well defined motives and objects; the object was more often than not political, social or domestic power" (Schein, 1994, p. 153). De Sousa (1994) notes that it is now generally acknowledged that men gossip as much as women, but that the content of the gossip is different.

Like Schein (1994) and De Sousa (1994), Ben-Ze'ev (1994), a professor of philosophy, agrees that there are differences in the ways women and men gossip. He observes that men and women actually gossip the same amount, but that the content of the gossip may differ. Women, he says, tend to talk more about other people while men might talk about politics and sports.

Ben-Ze'ev (1994) believes that cultural expectations shape how we gossip. Traditionally women were occupied with family and friendships, while men were not supposed to be interested in such matters. Men might talk about the prowess of a particular athlete, or discuss work issues. This is still considered gossip in the broader sense. Of course women discuss these matters as well, and men do speak

about other people's personal lives. These ways of gossiping are fluid . Yet, the perception that women gossip and men do not persists. Despite the different content, "gossip is a culturally dependent phenomenon," a "basic human need," and present in all cultures (p. 20).

Gossip as Malicious Intent

Goodman (1994) writes in the introduction to his book *Good Gossip*, that "Traditional moral codes . . . Christian, Jewish and no doubt others as well . . . condemn the practice of gossip and incorporate various forms of punishment that are designed to discourage it" (p. 1). Dunking stools, fines, and floggings were some of the ways society punished those who gossiped.

Ben-Ze'ev (1994) claims that analyzing gossip can teach us a great deal about human behavior. It also provides an individual the opportunity to compare his experiences with others, which can raise self-esteem, although usually due to the misfortunes of others. He also recognizes that gossip has usually been associated with malicious intent but he adds that "Typical gossip is an idle, relaxing activity whose value lies in the activity itself and not the achievement of external ends." Further more, "Gossip is usually relaxing and effortless and, like games, often relieves people of daily tensions" (p. 13).

Like Freud (1900) and Olinick (1980), who will be discussed later, Ben-Ze'ev (1994) likens gossiping to joke telling. He points out that they are both activities that strengthen social bonds and to an extent undercut social restrictions. With both gossip and jokes there is a surprise element, though with joking this is more obvious. Abrahams (1970) concurs that there is a link between gossip and joking.

Gossip and jokes both share the need for an intimate context and an outlet for aggressive impulses.

Perhaps because gossip is tied to aggressive and sexual impulses it tends to have a "bad reputation." Topics that are tied to our instinctual behavior are considered dangerous and, therefore, should not be discussed.

Gossip and Curiosity

According to Ben-Ze'ev (1994) gossip is a basic human need. We learn about how other people live, which satisfies our curiosity and serves to help us understand ourselves better. He suggests that the need to hear about the intimate and private aspects of other people's lives is at the very core of gossip.

Collins (1994), coming from a sociological perspective, describes gossip as informal discourse with its own rules of etiquette and, generally, as anecdotal. Unlike Ben-Ze'ev (1994), Collins defines gossip as dealing with only personal information. It is different from discourse in that it deals with personal and private aspects of people's lives. The people with whom we gossip tend to be close to us and tend to have similar values as well. She feels that gossip occurs because of normal human curiosity. She adds that because it occurs within the personal realm, gossip has become known as a "feminine" activity and thus trivialized.

Gossip and Intimacy

Gossip satisfies one's "tribal needs," the desire to be part of the group. Not only can gossip strengthen friendship, but as Ben-Ze'ev (1994) suggests, it can also create new friendships. He quotes Tannon who says that, "telling secrets is a privilege and even an obligation among friends" (Ben-Ze'ev, p. 16).

Collins (1994), like Emler (1994), believes that gossip is a way of understanding our society. "Gossip," she says, "gives us generalizations, not universal laws, and gossip teaches us about other people in particular, which together with general understanding helps us develop empathy, a morally crucial ability" (p. 112). Through the act of gossiping, we learn to put ourselves in the other person's shoes.

Gossiping, by its very nature, serves to create bonds between people. After all, with whom do we gossip? We gossip with close friends or people we might want to connect with. When we gossip, there is a sense of exclusivity, shared values, and belonging, which makes it a very compelling activity.

Social Scientists' Conclusions

Most of the social scientists whose works I have reviewed see gossip as a complex individual and social phenomenon, with positive and negative functions. Paine (1967) is the exception in that he sees gossip as mostly malignant. He suggests that people gossip to undermine others and thus promote their own agendas. This is consistent with the Judeo-Christian view, that gossip is a serious moral transgression.

While many authors included in this review noted that gossip has traditionally been associated with women, they acknowledge that both sexes gossip, though often about different things. Women's gossip tends to be more relational while men's gossip is more about activities or work related topics. They feel that this is culturally determined since women through the ages have been restricted to domestic activities while other avenues were closed to them.

Despite its mostly negative reputation, gossip fulfills a basic human need and is prevalent in all cultures. It exists throughout the world and is a source of comfort and excitement. It can be used for malicious purposes, but is also an important way for people to feel connected to each other.

Gossip and Literature

Like the social scientists, Spacks (1985), coming from a literary perspective, agrees that gossip can be "distilled malice" wreaking havoc with reputations and providing a sense of power to the gossiper. It can harm one's competitors and ease feelings of envy and rage. But, she points out that this type of gossip is rare.

Through her analysis of letters, biographies and novels, Spacks (1985) shows how gossip in literature becomes "acceptable as an object of observation, sometimes of condemnation; an educative discourse; as analogue for narrative procedures . . . Gossip, like sex, thrives on the page" (p. 261). She believes that gossip is an integral part of life, stating:

> Literature, transforming gossip's preoccupations and dramatizing its operations, testifies to its powerful forms of survival. As a model of narrative exchange, gossip provides an interpretive tool for analysis of texts. Fostering re-descriptions of reality, it allows fiction-makers to utilize its often subversive possibilities. Gossip gives voices to the dominated as well as the dominant; literature lets these voices be heard. . . . Gossip surveys the field through a peephole, but sees a great deal; its perspective shows the world from a new angle. (p. 263)

The same reasons people gossip in the real world prevail in fictional accounts. Power, intimacy, control, social cohesiveness, inclusion, and curiosity operate in literature as they do in real life. Through gossip, fictional and otherwise, we learn about ourselves and the culture within which we live.

The most common form of gossip is "idle talk" with no particular intention other than to pass the time and "protect ourselves from serious engagement with one another" (Spacks, 1985, p. 5). Spacks believes that idle gossip can sometimes be harmful, but usually the primary aim is to "solidify a group's sense of itself" (p. 5). In other words, idle gossip is most often benign and rarely meant to be malicious. I believe that this type of gossip is what Ben-Ze'ev (1994) was referring to as "men's gossip."

Spacks (1985) distinguishes idle from truly malicious gossip and adds a third category as well, which she calls "serious" gossip. Serious gossip is intimate and occurs in a private and safe context. Usually there are only two or three people involved and the "participants use talk about others to reflect about themselves, to express wonder and uncertainty and locate certainties, to enlarge their knowledge of one another" (p. 5). With regard to anecdotal therapeutic leaks, this last category seems most apt.

Spacks (1985) suggests that the fascination with gossip resembles the fascination with pornography in that it has a strong voyeuristic component. As uncomfortable as it may be to admit, there is curiosity about what really goes on behind closed doors. Certainly, as therapists, we are privy to the secrets of our

patients' lives and there may be a voyeuristic element in the intimacy of the therapeutic container.

According to Spacks (1985) the hermeneutic contribution of gossip in literature lets us see different perspectives of the same story, which can potentially enlarge our understanding of ourselves and others. Hermeneutics refers to the fact that one cannot understand the context of an event without considering the individual parts, nor the individual parts without seeing the context in which they occur. Thus, one interpretation no longer suffices. In literature, gossip becomes a device through which one learns about others from different vantage points. Each gossiper has his or her own subjective experience of events. The same can be said of psychotherapy. Each therapist and each patient has his own subjectivity through which he interprets the world. By analyzing gossip within the framework of the novel, and, by extension, the framework of psychotherapy, one is more able to understand how gossip can serve specific psychological functions, such as aggression, dependency, trust, and a yearning to belong within the specific context in which it occurs.

That gossip may express this yearning to belong and the need for closeness is reminiscent of Winnicott's concept of play (1965). Gossip, like play, can harken back to the earliest attachment, the mother/infant dyad, and the feelings of intimacy and safety that come from that experience. Gossip as a form of play can give a sense of freedom from conventional social restrictions and provide an opening to our authentic selves. Insofar as it does this, it also allows us to connect to our creativity and spontaneity, without which one cannot feel fully alive.

Confidentiality in Psychotherapy

An understanding of major ethical, legal, and clinical perspectives on confidentiality contributes to the context in which the research questions in this study are to be explored. The principle of maintaining confidentiality, as well as deviations from that principle in practice, has been present in the field of psychotherapy since its beginnings. In his text *On Beginning Treatment* (1913/1988), not only did Freud advocate for the analyst to preserve confidentiality, but for the patient to preserve it as well. Despite this, Lynn and Valliant (1998) report that Freud communicated with people known to his patient in 23 of 43 cases between 1907 and 1939, and that this was done without the patients' consent. These same authors report that about 47% of Freud's patients said he shared information concerning other patients with them. Tomlinson (1994) states that Freud's making and breaking of his recommendations has been a subject of great interest. He quotes Anton Kris (1994) who states,

> I believe that Freud's failure to acknowledge his breaking of the rules should be understood not only as the result of egotism, counter-transference and fear of the unethical misuse of technical freedom but (also) as the result of a divided allegiance between his sense of what was needed by his patients and his determination to promote and preserve the scientific standing of psychoanalysis. (p. 661)

Social Work Codes of Ethics

Codes of Ethics governing the professional practice of psychotherapy address the importance of maintaining confidentiality. The National Association of Social

Workers Ethics Code (2008, Section 1.07), for example, states that the right to privacy must be respected unless otherwise stipulated. The social worker should protect all information obtained in the course of professional services. This is true except when serious harm is threatened to self or others. Even then, the least amount of information should be divulged. Further, the social worker must inform clients about any confidential information which is divulged. In section 1.07 (i), it clearly states that the social worker must not discuss confidential information in public or semi-public places such as restaurants or hallways.

According to the Clinical Social Work Association Code of Ethics revised 1997, reviewed and approved 2006:

> Clinical social workers have a primary obligation to maintain the privacy of both current and former clients, whether living or deceased, and to maintain the confidentiality of material that has been transmitted to them in any of their professional roles. Exceptions to this responsibility will occur only when there are overriding legal or professional reasons and, whenever possible, with the written informed consent of the client(s).

These rules are explicitly stated:

> a) Clinical social workers discuss fully with clients both the nature of confidentiality, and potential limits to confidentiality that may arise during the course of their work. Confidential information should only be released, whenever possible, with the written permission of the client(s). As part of the process of obtaining such a release, the clinical social worker should inform the client(s) about the nature of the information being sought, the purpose(s)

for which it is being sought, to whom the information will be released, how the client(s) may withdraw permission for its release, and, the length of time that the release will be in effect.

b) Clinical social workers know and observe both legal and professional standards for maintaining the privacy of records, and mandatory reporting obligations. Mandatory reporting obligations may include, but are not limited to; the reporting of the abuse or neglect of children or of vulnerable adults; the duty to take steps to protect or warn a third party who may be endangered by the client(s); and, any duty to report the misconduct or impairment of another professional. Additional limits to confidentiality may occur because of parental access to the records of a minor, the access of legal guardians to the records of some adults, access by the courts to mandated reports, and access by third party payers to information for the purpose of treatment authorization or audit. When confidential information is released to a third party, the clinical social worker will ensure that the information divulged is limited to the minimum amount required to accomplish the purpose for which the release is being made.

c) Clinical social workers treating couples, families, and groups seek agreement among the parties involved regarding each individual's right to confidentiality, and the mutual obligation to protect the confidentiality of information shared by other parties to the treatment. Clients involved in this type of treatment should, however, be informed that the clinical social worker cannot guarantee that all participants will honor their agreement to

maintain confidentiality. (Clinical Social Work Federation, 1997, III Confidentiality)

Current Views on Confidentiality From Psychoanalytic Literature

In addition to rules regarding confidentiality in both the ethical codes and legal precedents, which were discussed in Chapter 1, there is a considerable body of clinical literature that discusses the concept of confidentiality in psychoanalytic psychotherapy. Some psychoanalytic authors question the ethics of any breaches of confidentiality. Others look at the complex ethical dilemmas involved in considering if and when to discuss confidential material outside of the analytic relationship.

Christopher Bollas, a noted British psychoanalyst, and David Sundelson, an attorney, published a book entitled, *The New Informants* (1995). They perceive considerable confusion in the mental health professions regarding confidentiality, and make the point that psychoanalytically oriented therapists must guard against any demands for information from outside sources. Even when it is a case of criminal activity or threats to self or others, the therapist must suffer the anxiety of holding the information in the service of the analytic work.

On the other hand, they recommend that another type of therapist, what they call a "social therapist" would be more like an advocate and as such would "carry out practical solutions that would help resolve the problem" (Bollas & Sundelson, 1995, p. 159). With a social therapist, it would be understood that criminal activity would be reported according to the specific laws.

Bollas and Sundelson (1995) are of the opinion that analysis cannot be effective if the client does not have the right of absolute confidentiality. In a deep

analysis, clients are encouraged to speak about their most private fantasies and associations, which would be highly inappropriate in almost any other context. The analyst listens to these disclosures as symbolic communications from the unconscious. Without the promise of absolute confidentiality, free association and fantasy material would be adversely affected.

These same authors suggest that psychoanalysis must become an "independent discipline and profession that generates it own standard of ethics" (Bollas & Sundelson, 1995, p. 167). Other professionals, such as lawyers or clergymen already have the right to maintain absolute confidentiality, why should clinicians not have that same right?

Furlong (2003) suggests that the meaning of confidentiality must derive from psychoanalytic thought, which is a specific context unto itself. She is referring to such concepts as transference, counter-transference and the dynamic unconscious. Without regard for these basic analytic ideas, confidentiality loses its specific meaning. She states:

> Confidentiality has tended to become conceived of as a thing in itself instead of a qualification of the analytic relationship. . . . If we go back to fundamentals, we would be hard pressed to see anything inherently sacred about confidentiality aside from the purpose it serves. It is a technical means, not a moral goal. (p. 41)

Further on she states: "It is in permitting the suspension of reality claims that confidentiality takes on unique importance to the psychoanalytic relationship and

not as a transcendent moral claim" (p. 42). In this position, she agrees with Bollas and Sundelson (1995).

In essence, Furlong (2003) sees the work of psychoanalysis as mostly symbolic and involving subjective experiences of both analyst and patient. She asserts that confidentiality is necessary to maintain the integrity of the analytic dyad, and proposes that it be regarded as a "skin" as opposed to a "lock." This type of containment or holding would require flexibility within the context and in certain cases, an ability to "stretch" to meet more extreme circumstances.

When an impasse occurs in the treatment, Furlong (2003) believes that discussing the problem with another set of "analytic ears" can be helpful. She asks, *"When viewed in this way, the ethical criterion for disclosure becomes: will it further the analytic listening and thus treatment, or is it for unrelated purposes which may disrupt this listening?"* (p. 47; italics in original).

O'Neil (2007) asserts that there is an implicit understanding among mental health professionals to maintain confidentiality. The issue of privacy concerns not only the patient but the therapist as well. Although privacy is not always explicitly stated, it is "the privacy of the analytic space, the analytic couple and their dialogue that confidentiality protects" (p. 691). She expands on this theme, pointing out that during the course of analysis, the therapist uses his own subjective experience. Confusion can arise as to what is the patient's material and what is the analyst's, given that there is "a permeable boundary between the patient material and the analyst's thinking" (p. 703).

Lear (2003) believes that the problem is trying to view confidentiality as absolute. "The problem arises from a conflict between two important values. First, we need to transmit knowledge.... Second there is a need to preserve confidentiality, a need that is special to psychoanalysis" (Lear, 2003, p. 4). Lear further states: "Confidentiality is not just one value to be weighed against competing values; it is constitutive of the process itself" (p. 4). O'Neil (2007) agrees that absolute confidentiality does not make sense. She feels it is ethical for analysts to reveal patient information in their own analysis, in teaching, and in consultation as long as the patient's identity is not revealed.

However, she adds that casual consultation with colleagues or that takes place in public settings verges on gossip, (implicitly stating that gossip in this sense is improper). Ultimately, she feels that the issue of confidentiality is too vague; she suggests more room for debate and that the issue should be "expanded with a cogently worded and detailed ethics code ... with guidelines and procedures" (O'Neil, 2007 p. 704).

Allphin (2005) speaks about the ethical attitude needed for therapists to cope with dilemmas involving confidentiality. Like others writing on this topic, she notes that the laws regulating confidentiality have run counter to the "central axiom of the analytic method" (p. 460). She expands the discussion of confidentiality, however, to include therapists' need to talk about confidential material. She feels that therapists usually break confidentiality without permission from a patient when the work stirs up material that cannot be contained. They turn to colleagues for help in understanding their own feelings in order to better handle the case,

although doing so is often associated with guilt and anxiety. Allphin states that an ethical attitude involves

> struggle, shame, uncertainty, anguish and other feelings that are hard to tolerate, but must be embraced. A balance between subjectivity and objectivity must be part of an ethical attitude. Rules and regulations are important but are not always adequate for the complex situations of the analytic relationship. Integrity and morality are basic to an ethical attitude. (p. 466)

Allphin (2005) addresses breaches of confidentiality as a problem of containment when the therapist's own reactions are too much to bear. She does not comment on the legal issues but speaks from the vantage point of the transference and counter-transference in the analytic relationship. She differs from Bollas and Sundelson (1995), who feel that without absolute confidentiality, a truly deep analysis cannot occur. They believe that any discussion about a patient outside of the sessions compromises the analysis dramatically. Even if a patient threatens to harm self or others, they feel that the analyst should regard this as a symbolic statement and must suffer the anxiety and confusion rather than reveal the information to the authorities.

To summarize, while a certain level of confidentiality is implicit in the analytic contract, there is division among the authors reviewed as to how far confidentiality should extend. There are analysts who feel that any kind of breach, be it for educative purposes or getting help from colleagues with a particularly difficult patient, is wrong. Other analysts believe that without case presentations,

(using disguised case material) and discussing patients with colleagues, the analyst's growth would be severely limited.

A question remains whether therapists should have the same privileges that priests and lawyers have. If priests were allowed to reveal what went on in confession, would anyone feel inclined to confess? The confessional is a sacred space and only God, the confessor, and priest are allowed to hear what is said. Attorneys are also bound by law to protect their clients even if they believe they are guilty. Why are therapists not afforded the same privileges? My interest in the topic of casual anecdotal leaks does not have to do with whether or not they are legal or even ethical, but rather why they happen. In what way do they serve us psychotherapists and in what way do they interfere with the work of psychotherapy?

None of the authors I reviewed really speaks to this issue despite the frequency with which casual anecdotal leaks occur. By bringing this topic into focus, my intention is to understand the meanings and motivations behind breaches and, with that understanding, be more conscious of when and why they occur. This presumably would allow the therapist to reflect more on his/her own behavior and thus be more careful in his/her actions.

Research Studies on Breaches of Confidentiality

I have found no research studies on gossiping and psychotherapy and very few on the topic of therapists breaching confidentiality, except when the law necessitates it. Given the nature of psychotherapy, it is surprising how little attention has been paid to the topic of gossip. Foster (2003) points out:

> Psychology researchers have largely over-looked gossip. The volume of work on the topic is scant both in journals and, particularly, in textbooks. I have located only a single psychology textbook with gossip in the index (two pages on the topic, in passing). (p. 80)

The following research studies address my topic in only a peripheral way. They do, however, give a general sense of the types of studies that have been done with regard to breaches of confidentiality.

Nowell and Spruill (1993) conducted a study in which psychology undergraduate students were asked to self-disclose. Seventy-five students were divided into three groups. In the first group, students were assured of absolute confidentiality. In the second, students were informed that confidentiality would be upheld with the exception of harm to self or others. In the third group, students were told about various exceptions to confidentiality including child abuse, court subpoenas, and harm to self or others.

Nowell devised a questionnaire in which the students were then asked to pretend they were in therapy and to rate their degree of self-disclosure about specific issues (Nowell & Spruill, 1993). The issues included suicidal ideation, drug abuse, psychosis, anxiety and depression, and violent behavior. The results were not surprising.

The group who were promised absolute confidentiality was the most self-disclosing and the most willing to talk about information of greater severity. The second group disclosed less, and the third group was the least disclosing. The

researchers concluded that confidentiality was an important factor in how much people are willing to reveal based on the level of confidentially offered.

For her dissertation, Berry-Harris (2007), a school psychologist, did a study of the ethical guidelines among the American Psychological Association, American School Counselor Association, American Mental Health Counselors Association, National Association of School Psychologists, and the American Counseling Association. The purpose of the study was to "investigate how therapists of various professional organizations (counseling and psychological organizations) and work settings (school and community mental health settings) manage confidentiality with clients of different age groups (Berry-Harris, 2007, p. 86). A survey was sent to professional organizations and work settings via e-mail, along with a cover letter requesting volunteers for her study. Since this was a quantitative study, the questions in the survey were specific. She received 114 completed surveys from participants with a variety of ages, graduate degrees, genders, and ethnicities. The results of her study showed:

> [Confidentiality is] a positive force in therapy with regard to enhancing the trust associated with the therapeutic relationship. Breaching confidentiality is a major concern because maintaining a client's confidentiality can greatly affect the therapeutic relationship and treatment outcome. (p. 115)

Berry-Harris' (2007) study also yielded information about how confidentiality was handled among the different professional organizations, work settings, and personal styles of the individual therapists. She found differences in the ways that therapists obtained consent forms, how they discussed the issue of

confidentiality, how information was discussed with guardians when the patient was a minor, how high-risk behavior was dealt with, and how client characteristics affected confidentiality decisions.

Consistent with the psychoanalytic literature on confidentiality, Berry-Harris (2007) found that there is no consensus among the various practitioners. As she says, "the findings indicate that there are no clear, one-size–fits-all answers to confidentiality related dilemmas" (p. 115).

Social workers were not among the participants in Berry-Harris' (2007) study, but in 1988, a quantitative study was conducted by Lindenthal, Jordan, Lentz, and Thomas, designed to discover whether social workers, as compared to psychiatrists and psychologists, were more likely to breach confidentiality. The researchers used a questionnaire that included ten vignettes that had been used in a previous study with psychiatrists and psychologists. The purpose was to assess what situations might cause therapists to breach confidentiality. The participants were asked to check off what actions they might take in response to the different vignettes. Two independent raters scored the results.

The participants were drawn from a 25 percent sample, randomly chosen, of the New Jersey chapter of the National Association of Social Workers. Sixty-six people responded, which was about a 54 percent return.

The study concluded that social workers were more likely to breach confidentiality than either psychiatrists or psychologists. The researchers explain that the more frequent breaches by social workers have to do with role conflicts. Social workers, according to Lindenthal et al. (1988), place a high value on

confidentially, but are pressured by the agencies in which they work as well as the imposed legal requirements to report certain behaviors.

In a critique of Lindenthal et al.'s (1988) study, Albers and Morris (1990) express concern about the implication that social workers are less trustworthy and that Lindenthal et al.'s findings may contribute to a misconception that the real aim of social work is to provide "mopping up service" (p. 157). Albers and Morris disagree with Lindenthal et al.'s (1988) representation of social workers tending to take a "conservative view" due to their role conflicts, role ambiguity, and inferior status.

Albers and Morris (1990) agree that confidentiality is an extremely important issue, and point out that breaches were the fifth largest complaint brought before the National Association of Social Work between 1979 and 1985. However, they point out that there is no uniformity among the three professions, (social workers, psychologists, and psychiatrists) with regard to rules governing confidentiality. In addition, they add that social workers are taught to look at the context in which problems occur as well as intra-psychic phenomena, which is different from the training psychiatrists and psychologists receive. In this way, they liken social workers to what Bollas and Sundelson (1995) refer to as "social therapists," as distinguished from clinical social workers whose work is psychoanalytically oriented and who I include in my study.

In 2007, O'Neil conducted a research survey that was designed to gather information on confidentiality among analysts in Canada, England, and the United States. The purpose of the study was to explore the ways in which international,

national, and analytic societies deal with the issue of confidentiality. A questionnaire was distributed among psychoanalytic institutes that were affiliated with the International Psychoanalytic Association (IPA). There were 55 responses to her questionnaire, which she stated was a very high rate.

O'Neil's (2007) questionnaire consisted of twenty-five questions within five categories: confidentiality and codes of ethics, psychoanalytic education, psychoanalytic practice, confidentiality complaints and ethics committees, and retirement and psychoanalytic archives.

O'Neil (2007) reports that confidentiality has come under more scrutiny in recent years, although, as others have suggested, this greater scrutiny has not yielded a one-size-fits-all recommendation. Her findings led her to speculate that analysts, depending on how long they had been practicing, have a "relativistic attitude toward patient confidentiality" (p. 698) and are also concerned about their own rights to privacy. O'Neil posits that *absolute* confidentiality could result in limiting the analyst's professional growth. She further suggests that confidentiality can only be understood in the context of psychoanalysis, which means understanding and including transference, counter-transference, and the analytic relationship. She points out that confidentiality is dependent on a psychoanalytically defined context. In other words, psychoanalysis must have its own concept of what confidentiality means, given the nature of analytic work.

O'Neil (2007) found that the psychoanalytic institutes she surveyed have made progress in the last ten to fifteen years in developing codes and ethical guidelines. There has also been progress in the establishment of ethics committees.

Despite the legal demands to report certain behaviors, there has been a move for analysts to resist reporting, even if it means putting the analyst at risk.

O'Neil (2007) recommends that the definition of confidentiality within analytic training institutes needs to be expanded and based on a "cogently worded and detailed ethics code . . . with guidelines and procedures that will ensure clear organizational policies and transparency" (Sandler, 2004, as cited in O'Neil, p. 707).

In addition, the definition of confidentiality needs to be broadened and updated with regular frequency. Analytic societies should encourage more awareness with regard to "clinical records, supervision, consultation, writing clinical material and giving evidence in court" (O'Neil, 2007, p. 707). O'Neil also recommends more research on this subject along with "scientific-educational discussion" (p. 708) at least once a year.

In a study conducted in Zululand, Zungu, (2008) surveyed the views of ten intern psychologists and registered psychologists about their understanding of the concept of confidentially. Her specific objectives were to explore whether the effectiveness of therapy is diminished when breaches occur, and whether potential clients would avoid getting help if confidentiality was not assured.

Using a qualitative research approach, Zungu's (2008) study described the participants' experiences and built theory from the interview data. In open-ended interviews, Zungu allowed the interviewees to fully describe their experiences.

Zungu found that clients were more likely to withdraw from therapy if there was a breach in confidentiality, and that when breaches did occur, the client was more likely to lose confidence in the therapist and also lose a sense of

empowerment. Her conclusion was that breaches present a serious dilemma for the practice of psychotherapy and that the guidelines for confidentiality remain ambiguous.

The studies reviewed here demonstrate the lack of consensus among the various types of therapists with regard to how psychotherapists think about or deal with the issue of confidentiality that is in keeping with the lack of consensus in the psychoanalytic literature. Some of the researchers I reviewed feel that absolute confidentiality is necessary for a deep analysis to take place. Others feel that the work can be furthered through consultation with colleagues as well as reading about the work of others in their profession. There is not a unifying set of rules among psychoanalytic associations, and even therapists within a particular professional organization do not handle issues of confidentiality in the same way.

Does the level of confidentiality affect the analytic process? The findings seem to indicate that it does. All the researchers reviewed in this current study agree that there is a need for more discussion and clarification.

Psychoanalytic Underpinnings for the Current Research Study

While the literature reviewed so far deals with confidentiality and gossip, the focus of my study is to explore some of the conscious and unconscious reasons that psychoanalytic psychotherapists gossip about their patients. I will now review the literature that addresses this issue from a psychoanalytic perspective. As I mentioned previously, little has been written about the phenomenon of therapists gossiping about their patients, despite how frequently it appears to occurs on an anecdotal basis.

Psychoanalysts Rosenbaum and Subrin (1963) discuss therapeutic leaks from a psychoanalytic point of view and in relation to the analyst's internal conflicts. They state: "Gossip, the telling or repetition of tales about others, is a universal social phenomenon which plays an important role in our present day culture as it did in times past" (p. 817). Gossip, they claim, involves a number of complex ego activities such as intimacy, identification, and fantasy, and that, generally, "gossip has a hostile intent" (p. 818).

Gossip always involves a triangular situation, the active gossiper, (the one who tells the story), the passive listener, (the receiver of the information), and the object of the gossip who is, of course, not present. The active gossiper and the passive listener create a bond of intimacy through the information being passed on (Rosenbaum & Subrin, 1963).

Freud (1905) believed that there are two instinctual sources behind gossip. The first has to do with unresolved aggression that stems from the Oedipal Complex: the unconscious wish to murder the father. The second results from sibling rivalry: a wish to destroy one's competitor. The stories of Oedipus Rex and Cain and Abel, are the archetypal examples of this. Both stories involve triangular situations in which a third party must be destroyed in order for aggressive and sexual wishes to be gratified. In other words, sex and aggression are the forces that give rise to gossip, which is an attempt to satisfy these instinctual needs.

Gossip can also be understood as a means of power. The gossiper and the listener form a union of moral superiority over the object of the gossip. This can lead to the feeling of being "better than" (Olinick, 1980). Olinick uses the Kleinian

concepts of splitting, projective identification, and envy to explain gossip on the part of the therapist, which, he maintains, is always detrimental to analysis. I will describe the terms splitting, projective identification, and envy in order to provide a context for understanding Olinick's thesis. These psychological processes may also be helpful for my research study in considering potential motivations for why therapists gossip.

Splitting is a defense mechanism that involves the unconscious externalization of the bad parts of oneself (such as aggression). By placing it outside of oneself, the bad is disowned and no responsibility for it is required. A terrifying example of this was enacted in Nazi Germany. According to Hitler, the Aryans were the good and superior race, while the Jews represented all that was evil in the world. Hitler disavowed and externalized his own destructive impulses that ultimately led to genocide. This kind of splitting has been repeated throughout history, always with tragic results.

Splitting can also be seen in everyday situations where one person is seen as all good or all bad. I was recently made aware of an example of splitting that occurred in a supervision setting where a student, being supervised by two people, made one of the supervisors "good" and the other "bad," whom she then fired.

Projective identification is related to splitting but goes one step further. In this process, the bad part is projected into the object and the object then holds and experiences the disowned feelings. In psychotherapy, the therapist receives the patient's projections and becomes the container for the feeling that the patient cannot tolerate. The therapist must try to understand and metabolize these feelings.

In real life situations, projective identification can have serious consequences. A case in point might be how homosexuals in our society are treated. Not only are society's negative feelings projected onto them, but they can internalize the projections and develop their own homophobic feelings.

An example of projective identification occurred during a consultation with a colleague. In discussing one of her cases, she experienced a feeling of rage towards her client that she found baffling. The patient had been molested as a child, which led to a series of deeply entrenched symptoms. It became clearer as we talked about it that the therapist had become the container for the patient's murderous rage, which he was not able to tolerate. Once this was understood, the therapist was able to hold this rage until it could be transformed and eventually returned through interpretation to the patient in a less virulent form.

Envy is defined as "the angry feeling that another person possesses and enjoys something desirable" (Klein, 1977, p. 181). Olinick (1980) believes that envy is the sine qua non of gossip. By talking about one's patients, the analyst indirectly brings the patient down to his (the analyst's) level, thus avoiding his own envious feelings.

Olinick (1980) states that there are three conditions that create the need to gossip within the context of psychotherapy. The first is isolation. As practitioners we work alone. We are not supposed to share the information and interventions we make outside of formal consultation. Ours is a lonely profession and our needs for approval or affirmation can be more powerful than our ability to contain them. The

second condition is curiosity. The gossiper and the listener come together in their mutual interest in the subject.

The third and last condition is voyeurism and exhibitionism. Olinick (1980) likens gossip to Freud's analysis of jokes. Freud claimed that jokes are "a social process involving the role of a third party" (Olinick, 1980, p. 442). The person making the joke derives gratification through exhibitionism, i.e. presenting the joke. The receiver of the joke becomes the voyeur who is libidinally gratified through the passive act of listening. Through this process, the joke teller and the joke listener are united against the object of the joke. Freud (1900) believed that the purpose of the joke was for the "satisfaction of instincts, (hostile and lustful) in the face of an obstacle" (p. 100). The obstacle in this case is societal disapproval. Joking becomes a way of undoing repression and disapproval that society imposes (Olinick, 1980). An example of this is the kind of gallows humor that sometimes follows a tragedy.

Not only does Olinick (1980) compare jokes to gossip, but dreams as well. As in dreams, the gossiper experiences something that "excites his repressed impulses and affects" (p. 443). Internal pressures are reduced through disguise (the symbolic dream language) via collusion with another person. The super-ego is bypassed in this process and the ego is gratified through the hearing and telling of the information.

Even the language of gossip, according to Olinick (1982), reflects the "oral and phallic exhibitionism inherent in gossip" (p. 444). Popular representations of gossiping such as lip smacking, tongue wagging, and large-eared listeners certainly reflect what he is talking about.

Olinick (1980) offers an interesting analysis of why we gossip. Using drive theory, he concludes that gossip usually involves the discharge of impulses related to both sexual and aggressive needs. The therapist, uncomfortable with the tension that he experiences, acts it out instead of reflecting on it and using it in the service of the work. Like Langs (1973), Olinick agrees that leaks are the result of the therapist's own neurosis.

In addition to seeing instincts as the engine that drives gossip, Olinick (1980) also discusses how gossip harkens back to the original mother/infant dyad in that it serves as a kind of transitional phenomenon. He draws on Winnicott's (1965) concept of transitional objects in that gossiping provides a sense of security and warmth for the agitated therapist. Much like the child's blankie, the act of gossiping soothes the gossiper's anxiety.

Like Olinick (1980), Medini and Rosenberg (1976) agree that envy is a major factor in gossip. By speaking about the patient to someone else, the analyst's envy is relieved, but, the authors claim, at a cost to the analysis. It is the job of the analyst to reflect on his feelings as opposed to acting on them. By gossiping, the opportunity to understand what these reflections might reveal is lost. The analyst has missed the boat, so to speak, in understanding his patient and himself.

Caruth (1986) defines therapeutic leaks as "impulsive, unplanned, informal communications to a third party including other professionals about information from a patient within the context of a professional relationship" (p. 548). As with the previous authors, she feels that the act of gossiping has to do with ego and libidinal functions such as intimacy, projections, introjections, drive discharge,

splitting, wish fulfillment, envy, and vicarious gratification. She refers to transitional phenomena as well, which are used to soothe the therapist's anxiety. She emphasizes, however, that gossip is a form of acting out and runs contrary to the original therapeutic contract.

Part of gossip's mystique is the secret nature of it. On the one hand when one gossips, a bond develops between the gossiper and the gossipee as a result of the shared secret. This creates a feeling of intimacy between them. On the other hand, gossip weakens the prior bond between the gossiper and the one being gossiped about because the secret exclusiveness they once shared no longer exists. This provides the gossiper a way of distancing himself from the original dyad. Thus, sharing a secret can function as a way of bonding and it can function to weaken a bond.

Caruth (1986) elaborates on the role of secrecy, first by identifying the ability to keep secrets as a developmental achievement. Once the child realizes that the mother cannot read his mind, he understands he has a private world, and with that comes a beginning awareness that he is a separate entity. With this knowledge comes a conflict of wanting to merge (returning to the infant state where all needs were understood and anticipated), along with an equally compelling wish to individuate. These two feelings, merging and individuation, vie with one another throughout life.

With patients who are more primitively organized, there is a deeper need for merger. This can put an enormous strain on the therapist. The therapist may experience the strain as a threat to his own self. Fear of annihilation from the

patient's aggressive or erotic feelings might undermine the therapist's "working ego." When this happens, the therapist may try to weaken the bond with the patient by sharing information from an analytic hour with someone else. In other words, when the therapist feels engulfed by the patient's needs, he may seek to escape the intensity of the dyad by creating a more diluted triad. In sharing the secrets of the analytic hour, the therapist creates a new bond outside of the analytic frame, while at the same time weakening the "secret" therapeutic bond with the patient.

Caruth (1986) suggests that the difficulty experienced in trying to separate from a particularly intense patient can lead to archaic regressive wishes in the therapist. In the same way that the patient struggles with separating and merging, so does the therapist. To counteract these primitive yearnings, the therapist uses gossip to soothe his/her own anxieties. Caruth regards this as a type of transitional phenomenon like the teddy bear. Nevertheless, she believes that gossip can undermine the empathic functioning in the treatment. The therapist, in this case, puts his/her own needs first at the expense of the patient's due to his/her inability to contain uncomfortable feelings.

When there is a failure in empathy, the therapist loses the capacity to be attuned to the patient's inner world. Caruth (1986) posits that gossip is the result of a disturbance in empathic functioning due to counter-transference feelings. If counter-transference feelings are overly negative, the therapist cannot enter the patient's subjective world because either the therapist or the patient is too walled off. If counter-transference feelings are too positive, the therapist is in danger of becoming overly involved and losing the observing ego. This can then lead to

feelings of engulfment. In this context, gossip becomes a way of retrieving the lost part of the self. The therapist/gossiper is able to recapture the lost part of self through an introjective identification with the experiences of the listener. Thus, the gossiper/analyst becomes the patient and the listener becomes the therapist. Through the listener's empathy, the analyst is then able to understand what Is happening in the analytic dyad in a more therapeutic way.

For Caruth (1986), at the very heart of gossip is the wish for intimacy. She points out that the therapist and patient experience intimacy in different ways. For the patient, the intimacy resembles the breast/baby dyad, with the patient's experience like that of the baby, while for the therapist the role of the nurturing mother is evoked. Both parties are equally but differently engaged. The needs are more often met for the baby/patient, but not necessarily vice-versa. Caruth believes that the therapist's needs for intimacy may be met through gossiping since, unlike the patient, the therapist's needs cannot be met in the analytic encounter.

According to Lander (2002), during the analytic process the therapist may find him/herself in symmetry with the patient, which can lead to increased anxiety. By symmetry, he means an over-identification with the patient, putting the therapist at risk of losing the therapeutic stance and inserting the therapist's own values. In a condition of asymmetry, the therapist does not over-identify with the patient, which allows for "free floating attention." The analyst can remain separate. When symmetry occurs, however, the analyst unconsciously seeks to rescue him/herself. This is much like what Caruth (1986) suggested about fears of being engulfed. In this context gossip serves to dilute the intensity of dyad.

Lander (2002) believes that moments of symmetry and asymmetry occur regularly throughout the analytic work. He emphasizes the importance of rigorous training and personal analysis. Only then can the therapist maintain an asymmetric attitude that is so essential for good treatment.

To be able to hold all the feelings, hour after hour, is indeed an arduous task. Lander (2002) suggests that this creates the need to seek a confidante to mitigate some of the anxiety. By presenting to the listener the distressing information, the analyst relieves himself, but then the listener might need to pass the information on as a way of dealing with his anxiety. It becomes like a game of "hot potato" in which the information becomes too "hot" to comfortably hold and must be passed on as quickly as possible to prevent negative consequences.

The psychoanalytic literature describes many of the same reasons for gossiping as did the anthropological, sociological, and literary studies reviewed earlier in this chapter. Longing for intimacy, aggressive and sexual impulses, power, curiosity, voyeurism, and transitional phenomena are all underlying motives for gossip. The analytic authors also add isolation as a potential motive since the context in which therapists work can feel lonely. From an analytic perspective, these categories would, for the most part, fall under the rubric of transference and counter-transference phenomena, referring to the feelings that are stimulated in the analyst and the patient during the course of the therapy.

The counter-transference reactions associated with therapists' need to gossip, as described in the psychoanalytic literature, are envy, anxiety (which gives

rise to transitional phenomena), sexual and aggressive impulses, the need for intimacy, exhibitionism and voyeurism, and isolation.

These transference and counter-transference concepts are very important for understanding the motivation behind the phenomenon of therapists' gossiping. In the following sections I will elaborate on several of these terms because they will help me analyze and discuss my findings. I provided a basic definition of envy earlier, but what follows will be a more in-depth explanation including its theoretical underpinnings. I will provide this expanded definition because, for some, envy is an essential part of gossip.

Envy

Klein (1977) believed that envy is an outgrowth of the earliest infant/mother relationship and is characteristic of the primitive paranoid-schizoid developmental position. In her language, envy's aim is to steal the goodness from the breast and replace it with badness (excrement). Ultimately it aims to destroy the mother's ability to create. Klein felt that the infant's bond with the mother was innate. The baby is already hard-wired for it. The breast is seen as the "source of life." When the infant experiences the breast as satisfying, the prenatal unity he experienced in the womb is restored. The experience in the womb contributes to the feeling of mother as a source of nurturance.

When the breast is a source of frustration, the infant is left in a state of perpetual longing for the experience of prenatal unity and for the breast that satisfies and prevents destructive impulses and persecutory anxiety. Because the experience of the womb can never be fully recreated, a conflict between love and

hate develops. The infant sees the "good breast" and the "bad breast" as two separate objects. Klein believed that the infant is born with both destructive impulses and the capacity to love. The environment plays a part in the further development of these feelings. She gives the example of a difficult birth enhancing destructive impulses such as greed and envy (J. Mitchell, 1987).

Klein (1977) believed that the breast is the first thing to be envied. When the infant experiences the breast as withholding, then feelings of hatred are constellated. When envy is extreme, the mother/infant dyad becomes disturbed.

Envy is very important in understanding negative transference. The impulse to destroy the "good" overrides everything and the patient simply cannot take in what is being offered. Klein states, "It is the nature of envy that it spoils the primal good object and gives added impetus to sadistic attacks on the breast" (Klein, 1977). An excess of envy impedes the development of an internalized good object, which creates difficulties in future relationships.

Klein (1977) saw the "good breast" as the cornerstone of ego development. Without it, there is less possibility for the development of generosity and creativity. She believed that if there were consistency and enjoyment in the feeding experience the infant would eventually be able to internalize the good and loving parts of the mother.

Stephen Mitchell and Margaret Black [1995), commenting on Klein's concept of envy, put it this way,

> The infant cannot tolerate the very existence of something so powerful and important, able to make such an enormous difference in his experience, yet

outside his control. The infant would rather destroy the good than remain helplessly dependent on it. The very existence of goodness arouses intolerable envy, the only escape from which is the fantasied destruction of goodness itself.

Envy is the most destructive of all primitive mental processes. All the other hatred and destructiveness that characterize life in the paranoid schizoid position are contained in the relation to the bad breast; through splitting, the good breast is protected as a refuge and source of solace. . . . The extraordinary and unique feature of envy is that it is a reaction not to frustration or pain, but to gratification and pleasure. Envy is not an attack on the bad breast, but on the good breast. Thus envy undoes splitting, crosses the divide separating good from bad, and contaminates the purest sources of love and refuge. Envy destroys hope. (p. 100)

Anxiety/Transitional Phenomena

Winnicott (1951) was the first to use the term transitional object/phenomenon. Between absolute dependence and growing independence, there is a transition. This occurs when the infant can distinguish between what Winnicott calls the "me" and the "not me." In his paper entitled "Transitional Objects and Transitional Phenomena," (1951), he states:

I have introduced the terms "transitional object and transitional phenomena" for designation of the intermediate area of experience between the thumb and the teddy bear, between oral egotism and true object relationship,

> between primary unawareness and indebtedness and the acknowledgement of indebtedness. (p. 231)

He further states:

> I am here staking a claim for an intermediate space. Transitional phenomena (e.g., singing oneself to sleep), and transitional objects (e.g., blanket or teddy bear), enable the child to manage his anxiety. The function of the transitional object helps the infant accept the growing awareness that he no longer has omnipotent control. The transitional object is the overlap of illusion and reality, which is accepted by mother and child. . . . The mother's eventual task is to gradually disillusion the infant, but she has no hope of success unless at first she had been able to give sufficient opportunity for illusion. (p. 238)

Transitional phenomena and objects represent the gap between illusion and reality, total dependence and independence, and merging and separateness. These are lifelong processes and according to Winnicott, (1951) never fully completed.

Drive Theory/Aggressive and Sexual Instincts

Freud (1905) believed that human nature was essentially instinctually driven, the two instincts being libidinal and aggressive. When social convention impedes these drives, the end result can be neurosis. Initially Freud saw the sexual instinct as the only source of conflict, but later added aggressive drives as well. Voyeurism and exhibitionism would be included in this category because they both have to do with sexual instincts. Voyeurism is the result of the child's curiosity about the "primal scene" and exhibitionism is the wish to display one's sexual potency and power. Freud wrote,

> What we describe as a person's "character" is built up to a considerable extent from the material of sexual excitations and is composed of instincts that have been fixed since childhood, of constructions achieved by means of sublimation, and other constructions, employed for effectively holding in check perverse impulses which have been recognized as being unutilizable. (pp. 238-239)

These drives become wishes, both conscious and unconscious, which can create strong counter-transference responses in the therapist. For example, in the same way that wishes for intimacy, envy, or a need to be soothed arise, erotic feelings or angry hostile feelings can be evoked in the counter-transference, which might cause a therapist to behave in ways that run counter to his training. If the therapist is unaware of his own counter-transference, it is more likely that he will act on the feelings rather than reflecting on them and thus using them in the service of the work.

Isolation

Although not necessarily considered a counter-transference reaction, isolation is mentioned as another reason for breaching confidentiality. Our work is lonely and the wish to talk to others in our profession, or our spouses and friends can be compelling. Certainly after a difficult day at work, or a particularly difficult hour, a therapist might seek the comfort and companionship of one's partner.

To summarize, the psychoanalytic sources reviewed see psychotherapists' gossip as a form of counter-transference. Envy, anxiety, aggressive and sexual instincts are the major motivations for breaches according to the literature. The

current research study provides an opportunity to explore the relevance of these concepts to anecdotal breaches.

Conclusion

Research studies indicate that the promise of confidentiality or the lack thereof impacts how much a patient will divulge. Despite professional codes of ethics, there is, however, no unifying principle to guide therapists in navigating the complexities of maintaining or breaking confidentiality. Different professional groups have different sets of rules. Although psychotherapists in general agree that confidentiality is important for treatment to be effective, there is no unanimity in the clinical literature as to where to draw the lines. Some of the authors I reviewed recommend ongoing discussion on the topic of confidentiality since it is such an important aspect of psychoanalytic psychotherapy.

Gossip can refer to different types of interactions, and there are many motives for gossiping. Most of the anthropological and sociological authors I reviewed believe that gossip functions to enhance group cohesion, help maintain moral and social order, and create intimate bonds. It also satisfies natural curiosity and enables people to compare their lives to others, which can be very reassuring.

The psychoanalytic authors I reviewed, like the social scientists, recognize some of the potentially positive functions gossip may serve, but they more generally feel that breaches are a destructive form of acting out. There is debate in the literature between those who think it is detrimental to psychoanalytic treatment ever to discuss case material outside the analytic room, and those who advocate for the importance of case consultation. However, if experienced therapists did not talk

about their work using case material, albeit disguised, psychoanalytically oriented psychotherapy would never evolve. Aspiring therapists need to learn how to do the work and learn from the mistakes of others.

Psychotherapists' gossiping is primarily motivated by feelings that are evoked in the counter-transference. Therapists might gossip as a way to self-soothe or express anger. Therapists might unconsciously be seeking intimacy, while at the same time trying to gain control of the feelings evoked by a particular patient. They are particularly vulnerable when they are over-stimulated by the material being discussed in the analytic hour. When this happens, the need to discharge might arise, causing therapists to seek relief outside of the container, despite the "rules" that are expressed in professional codes of ethics, laws and regulations, and clinical training.

The question of why we gossip has not been researched. The psychoanalytic literature suggests that breaches occur as a result of strong counter-transference responses, but a specific study in which therapists are asked to reflect on their own experiences of anecdotal leaks has not been done. My study explores some of the reasons why therapists discuss their patients outside of formal consultation, and casts some light on this phenomenon.

CHAPTER 3: METHODS AND PROCEDURES

The purpose of this qualitative study is to understand how and why psychotherapists gossip about their patients. The term gossip, as used here, refers to the act of talking about or discussing patients outside of formal consultation. The terms "anecdotal therapeutic leaks" and "breach of confidentiality" are also used. The questions explored, as presented in Chapter 1, are the following: How do therapists describe the experience of discussing patients outside of formal consultation? What are the specific contexts? What feelings come up in the aftermath of gossiping? Are there particular types of patients who evoke gossiping behaviors? Does the therapist feel this helps and or hinders the work and if so, how?

Methodological Approach and Research Design

Qualitative research is based on interpretive methods and is appropriate when studying phenomena such as feelings and reflections on the meaning of those feelings. Qualitative approaches allow the researcher to explore specific questions about a participant's subjective experience. I have used a grounded theory qualitative approach, as described by Corbin and Strauss (2008), with data that were collected through in-depth and semi-structured interviews. I took direction from Mishler's (1986) description of the research interview as a dialogue in which researcher and participant together create the context for the participant's subjective experience of the study phenomenon to be explored. Each interview was conducted in a loosely structured and open-ended manner to allow the participant to tell the story in his or her own way.

The method of grounded theory was developed by Glaser and Strauss (1967) "for the purpose of building theory from data" (Corbin & Strauss, 2008, p. 1). By theory, they are referring to a "set of well-developed categories (themes and concepts) that are systemically interrelated through statements of relationship to form a theoretical framework that explains some relevant social, psychological . . . or other phenomenon" (Corbin & Strauss, p. 55).

The constant comparative method of data analysis (Corbin & Strauss, 2008) was used to analyze the data from this study. This type of analysis involved a close study of each participant's responses as well as comparing and contrasting across participants. The process of analysis began when the first interview was completed so that the data collection and analysis could proceed together. Data collected in this way were context sensitive; there were no pre-established categories. Instead categories and concepts that bear relevance to this issue of gossip were expected to emerge from the data. In this way, theoretical concepts that developed were "grounded" in the data.

Participants

The Sample

Qualitative research requires a relatively small sample with an in-depth focus on each participant's perspective. The sample for this study included nine participants. This enabled the researcher to gather in-depth interviews from each person. Corbin and Strauss (2008) believe the concept of saturation to be a main factor in determining sample size. After a certain number of interviews, when no new information is yielded, saturation has occurred. An open and flexible process of

data analysis, beginning with the first interview, shaped how questions and themes in the following interviews were determined. This continued until saturation was accomplished. Saturation is the point at which the concepts are well defined and no further explanation is needed.

Participants were chosen randomly since the subject matter of the research was specific to therapists, but their selection was based on "maximum variation sampling" (Patton, 1990, p. 172) so that there was a range of analytically oriented psychotherapists. Study participants included men and women, as well as therapists from different schools of thought. Patton suggests that with a varied sampling, it is easier to discern patterns of similarity and difference. He states, "Any common patterns that emerge from great variation are of particular interest and value in capturing the core experiences and central shared aspects or impacts" (p. 172).

Criteria for Selection

Participants were psychoanalytically oriented therapists who had at least 15 years of experience. My reason for this criterion was that seasoned therapists had the capacity to reflect on their own reactions in a more considered way. Because men and women tend to "gossip" about different things, it was important that both genders were represented in the study. Each participant was licensed and currently practicing. My hope was that by maximizing differences among the sample, I would have a clearer view of the similarities within it.

Recruitment

Participants were recruited by recommendations from colleagues, and from professional organizations in the Bay Area. Letters were sent out describing the nature of the research (Appendix A) to professionals in the community requesting potential interviewees. Advertisements (Appendix B) were placed in the newsletters of The Psychotherapy Institute in Berkeley, the Northern California Society for Psychoanalytic Psychology, and the American Association for Clinical Social Work with a brief description of the project including my e-mail and telephone number.

A letter (Appendix C) was sent to people who expressed an interest in participating in the research. The letter provided a description of the research along with an Informed Consent form for them to review (Appendix D). A brief questionnaire (Appendix E) was sent out as a way of screening potential participants. Once participants had been accepted, I contacted them by telephone and set up the time and place for the interview. Had there been any potential participants who were not selected I would have sent a brief thank you note, but that was not necessary.

Data Collection: The Interview

I conducted open-ended, semi-structured interviews to collect my data. Mishler (1986) calls semi-structured interviewing a process in which two people share context and meaning in mutual discourse. The interviewer begins by asking open-ended questions and the participant responds. What questions the interviewer asks is guided by the participant's responses as well as the interviewer's research

questions. From this type of interview process, themes and concepts emerge that result in formulations and reformulations of questions and answers. It becomes a circular process in which, according to Mishler (1986) "meaning [is] created in the discourse between the interviewer and respondent as they try to make continuing sense of what they are saying to each other" (p. 53).

Open-ended questions were used to allow the participant to choose exactly the right phrase or words that best described his/her experience. Because my research focused on why therapists tend to discuss patients in casual anecdotal ways, semi-structured and open-ended questions were well-suited to enable both the interviewer and interviewee to understand and construct meanings together.

Procedure

Each interview lasted one to one and a half hours, and was held at the participant's preferred location. I used a tape recorder to record the interviews and later transcribed them. To insure that I covered the essential topics, I referred to an interview guide (Appendix F), which was for my purposes only and did not impinge on the participant's answers.

Before the interview, I discussed with participants the nature of my study, stating that my research concerned why psychotherapists talk about their patients outside of formal consultation. I used the term casual anecdotal leaks as a way to refer to this. I also informed participants that I was not writing about the more egregious breaches, such as those concerning sexual or financial issues, but rather the more casual disclosures that I believe are so common in our field.

Each participant was asked to sign an informed consent form (Appendix D) that was sent prior to the interview. Once the tape recorder was on, I asked the participant to describe his/her experiences of casual anecdotal leaks. Each participant discussed whatever thoughts or experiences s/he has had. I asked questions only if I needed clarification or more information about something discussed.

During the interview, I let the narrative unfold, following the arc of the participant's thoughts and experiences. If I needed more information, I referred to my list of questions in Appendix F. My plan was to allow the participant to reflect on his/her own personal experiences of anecdotal leaks, asking questions only when I needed to clarify or go more deeply into the experience being described.

Topics of the Interview Guide

The Interview Guide (Appendix F) consisted of topics and questions designed to help focus and elaborate on the research questions. As the interviews unfolded, the interview expanded or shifted depending upon what emerged.

My questions did not necessarily reflect the order as listed below but depended on how the interview evolved. The interview guide topics and their rationale are as follows:

1. How did the participant describe his theoretical orientation? Because this study was concerned with anecdotal leaks, it was important to establish if there were differences among clinical orientations regarding this question. Further, it helped the participant to reflect on how his

training and experience as a clinician might have influenced his thoughts on this topic.

2. What were the participant's thoughts or beliefs concerning confidentiality in his own clinical practice? This topic helped determine how the participant thought about confidentiality in clinical practice. Furthermore, it helped to identify the participant's flexibility on this subject. Because there were different opinions in the literature concerning confidentiality, it was important to understand the participant's views on this topic. Is this a topic that the participant had reflected upon?
3. What were the participant's thoughts and feelings about anecdotal leaks? This question helped me understand the participant's judgments or lack of judgments concerning this issue, as well as subjective experiences vis-à-vis the therapist's own leaks. For example, did the participant feel guilty, relieved, or embarrassed by having done so? Did the participant reflect on the experience later on?
4. Could the participant describe an experience where he talked about a patient with a friend or spouse? This question allowed the participant to reflect on a specific incident and helped focus the rest of the interview.
5. What were some of the contexts in which the participant gossiped? For example, was it at a dinner party or with a colleague over lunch, or was it with one's spouse at home after a hard day? The nature of the setting sheds light on what motivated the participant to gossip. For example,

gossiping at a dinner party may be differently motivated than at home with one's partner.

6. With whom was the participant most likely to discuss patients outside of consultation? Were there specific people, such as spouse or friends with whom the therapist is most likely to discuss patients?
7. Were there particular types of patients that the participant discussed? For example, patients who were more challenging, or with whom the therapist more identified? Were there particular types of personality disorders that therapists had more difficulty containing?
8. Did the participant have any thoughts or reflections about why some patients are discussed in this way but not others? Similar to the previous question, did this help focus the participant's attention on why certain patients are never discussed while others are talked about frequently? I suspected that there is a connection between the patient's psychodynamic structure and the frequency and type of anecdotal breaches.
9. How did the participant feel about the interview and was there something he would like to add? I wanted to give the participant the opportunity to add anything that he felt might be missing.

Data Analysis

To analyze my data, I used Corbin and Strauss' (2008) "constant comparative method." The constant comparative method involves comparing pieces of data with other pieces of data within each interview and with other interviews. The idea is

see how they are similar and different from one another. As the interview process proceeds, each new interview affects subsequent interviews, perhaps by adding questions to the interview that can lead to a deeper and more comprehensive understanding of the themes and concepts. By using this method, more information was gleaned and knowledge expanded.

Procedure for Data Analysis

After each interview, I took notes on my own thoughts about what emerged. My aim was to immerse myself in each participant's subjective experience and summarize the themes and concepts. The audiotape of the interview was transcribed and future interviews were analyzed in terms of similarities and differences. I kept collecting data until I felt I had reached saturation in the themes relevant to my research.

Once saturation had been reached, the process of coding began. In order to build theory, pieces of data were fitted together depending on which themes or concepts they described. For example, if several participants described a feeling of anger towards a patient, those excerpts were grouped together and formed a theme. As the coding continued, these themes became more and more refined. Corbin and Strauss (2008) refer to "axial coding" which is the process of grouping concepts and categories. Through axial coding, categories and sub-categories were cross-related so that similarities and differences between them emerged. This allowed for a deeper understanding of the material. Once this had been accomplished, the integration of categories followed. Integration was the final step in identifying and developing a core category that led to theory construction.

Presentation of the Data

The results of the data analysis are presented in Chapters 4 and 5. The fourth chapter consists of a summary and overview of the data analysis as well as the findings. The participants in the study are described, but not identifiable, thus making sure to protect their anonymity. I use examples from the interviews to illustrate common aspects and variations in the categories and subcategories.

Chapter 5 is devoted to discussing the implications of the data through interpretation. The significance and limitations of the study are also discussed. Finally, I indicate how the patterns that emerged related to the literature and the questions originally posed in Chapter 1 of this research study.

Reliability and Validity

Qualitative and quantitative research differ from each other and thus the standards by which validity and reliability are measured are also different.. Reliability and validity are adapted to fit the design and scope of the methodology. In qualitative research, it is the researcher, him/herself, who establishes the "credibility" of the study through the interviewing process. The terms reliability and validity are replaced by "credibility" (Corbin & Strauss, 2008) and "plausibility" (Mishler, 1986). The researcher is the "instrument" in qualitative studies and his objective is to obtain plausible data through the interview process. Through analysis of the data, the researcher interprets the findings, which are grounded in what emerges in the interviews. The subjective nature of the interviews reflects the specific context of each participant's experience; thus more than one interpretation

may exist. Simply put, different meanings and interpretations may be recognized within the same data.

Mishler (1986) believes that, because of the interpretive nature of qualitative research, the researcher is responsible for determining the validity and reliability of the data. A good researcher must have sensitivity, integrity, and skill in the art of interviewing. Mishler states that there is a relationship between validity and the quality of the research process. The researcher must be observant, provide documentation, and be clear about the specific rules used in the analysis. The theoretical framework must be explained, revealing the researcher's stance towards the data. Inferences and interpretations must be shown to be grounded in the actual data. Patton (1990) agrees with Mishler, affirming the need for "methodology skill, sensitivity and integrity of the researcher" (p. 11). Mishler feels that there are no absolute truths, but rather an "assessment of the relative plausibility of an interpretation when compared with other specific and potentially plausible alternative interpretations" (p. 112). The limitations of this study were assessed.

CHAPTER 4: FINDINGS

The question addressed in this research is how do psycho-dynamically oriented therapists describe, experience and think about casual anecdotal leaks. By leaks, I am referring to conversations about patients outside of formal consultation. As a researcher, my interest in this study is focused on the subjective experience of the therapist/participant. What is motivating the therapist, consciously and unconsciously, to speak about a patient outside of formal consultation despite the therapist's sense of ethical responsibility with regard to maintaining confidentiality? My intention is to shed some light on a phenomenon that is very common but shrouded in guilt and embarrassment.

Although some studies have been conducted on how confidentiality or the lack thereof impacts how much a patient might reveal during the course of the work, no research has been done on *why* therapists engage in this practice that violates confidentiality. Egregious leaks, such as sexual or financial improprieties, or revealing identities and actual statements made in the therapeutic hour are not included in this research, though they are certainly worthy of further investigation.

Because I anticipated that this topic might be difficult to discuss openly, participants were asked beforehand to think about times when they have casually breached confidentiality. While this may have impacted the spontaneity of their responses, I felt it would help prepare them for the interview. Otherwise, given the sensitive nature of the topic, I was concerned that the therapist/participants might have had a more difficult time coming up with examples.

By using a qualitative grounded theory approach, I focused on each participant's subjective experience, allowing each one to describe examples of times they had breached confidentiality and to consider the question of how they came to do so. The semi-structured and open-ended interview allowed participants to speak more fully and reflectively on their own experiences of these breaches in confidentiality. However, because the topic involved therapists talking about behavior that might feel "shameful" to them, thus making them feel exposed, I felt the need to gently prompt or re-focus the participants' discussion, using the Interview Guide described in Chapter 3 and included as Appendix F. By "gently prompting," I mean that when necessary, I would occasionally bring the participant's attention back to the subjective experience that had ultimately led to a breach.

The data consist of transcriptions of the audio-recorded interviews. Data analysis followed grounded theory methods as described by Corbin and Strauss (2008). Using their "constant comparative method of analysis" (p. 73) meant that after the first interview was transcribed, the data were analyzed before the second participant was interviewed. In this way, the first interview informed the second, and so on, and so on. This back and forth method allowed me to examine and re-examine the emerging data. New data from each interview were analyzed and compared to previous interviews, which led me to identify similarities and differences among the interviewees. In this way, certain categories and subcategories became apparent. Once that was accomplished, I looked for unifying

themes, which will be presented below and further discussed in Chapter 5, in the context of concepts drawn from relevant psychoanalytic literature.

Participants

To insure the anonymity of the participants, they are described according to their group characteristics. The nine participants were all Caucasian. There were six women and three men. All of them were experienced psycho-dynamic psychotherapists ranging in age from forty-five to seventy-four. All had been in practice for at least fifteen years, the majority of them for more than thirty years. Four of the participants were licensed psychologists, four were licensed marriage and family therapists, and one was a licensed clinical social worker. Only one person worked in an agency but had a small private practice. The eight others were in private practice exclusively.

The recruiting materials (Appendix A and B) specified that the participants must be "psycho-dynamically oriented psychotherapists." Each of the participants in my study met this criterion. All nine of the participants described themselves as relational in their approach. Two participants had been trained as Jungian analysts, although they both felt that while Jung's theories informed their work, they saw themselves as relational. The theoretical orientations did not appear to be a factor in the data that emerged. All of the interviewees were thoughtful and self-reflective, and they expressed a high level of enthusiasm about the topic of casual anecdotal leaks, despite their personal discomfort. Some of the participants had some difficulty in coming up with examples, but eventually everyone was able to recall at

least one experience of leaking. The six women participants were designated F1, F2, F3, F4, F5, and F6. The three men were designated M1, M2, and M3.

One of the criteria for inclusion in this study was that participants had to acknowledge they had engaged in casual anecdotal leaks. I hoped to ease their discomfort so that they could speak more freely by explaining to them that casual anecdotal leaks were extremely common, and that I had engaged in them as well. Despite this, all the participants expressed discomfort or shame during the interview process. Two people misunderstood what I was looking for, saying I had not been clear enough about the question.

Examples of Gossiping

Before presenting the primary findings from this study, I will provide several examples to illustrate what is meant by "casual" as opposed to egregious leaks. I will then look at the differences in participants' stated beliefs about confidentiality. These two sections provide background for examining the themes that emerged as findings and that will be presented in detail.

In the first example of gossiping, F1 describes talking to a friend about one of her patients, but as soon as she had made the comment, her friend wanted more information:

> And you know, I once said, "oh I have a client who's a chef, and you know that's where I learned this, this thing. And she said, "Oh, what restaurant?" And I said, "well, I can't tell you that," and she was very annoyed.

M2's example occurred at a dinner party. The participant expresses a feeling of regret at what he describes as a "gratuitous comment."

> It was part of social conversation, and . . . I don't know exactly what the lead-in to it was, but it was a totally, on my part, I felt gratuitous comment I didn't need to make, where I made a reference to a teenager who has started a blog, um, [clears throat] of all these really unhealthy foods that—and how to prepare them and how to—recipes for them and so forth.

M3's example, like many that came up in the interviews, describes how he sought solace from his wife and his colleague:

> This one person . . . she can get very angry at me and very critical of me. . . . . [I've] certainly talked to my wife about her some, but one colleague in particular I guess was we've, um, spent time together, and, you know, and there's again a consultative quality

In relating this final example F4 said it made her realize that she talked about her patients with her partner in a casual anecdotal way.

> With my partner where . . . I'm trying to remember what we were doing, we might have been listening to a program on NPR, [laughing] and she looked at me and went, 'Oh that's like your client.'

These examples illustrate what is meant by casual anecdotal leaks. No names were used but the participants all recognized that they had spoken about a patient in a way that, upon reflection, made them slightly uncomfortable.

Participants' Stated Beliefs About Confidentiality

Since the central research question concerns participants' reflections on their own and others' breaches of confidentiality, it is important to establish their attitudes on the importance of confidentiality and to compare their stated beliefs to

their actual behaviors. In this section I will give examples of how participants described their beliefs about confidentiality.

There was some variation among the nine participants in this study with regard to how strictly they said they maintained confidentiality. The attitudes ranged from very strict to less strict, with no one at either extreme: no participants believed it was possible or desirable to maintain absolute confidentiality. Nor were there any participants who doubted that confidentiality was a necessary part of the therapeutic contract. On the stricter end, participants used language that conveyed strong feelings about the importance of confidentiality.

F1 related a story in which a friend of her parents, who was considered the "psychiatrist to the stars," talked very freely about his patients in large social situations. She vowed she would never do that herself. She was quite emphatic when asked about her views regarding confidentiality.

> Well, I would say that I have very strong boundaries, and I take the idea of confidentiality very seriously. Um . . . I rarely talk about my clients, you know, to my partner—to really anyone, other than people in my consultation group.

Despite this, she was able to recall a time when she had talked to a friend about a patient who was a chef. She expressed some distress when recalling this.

Similarly, M1 expressed a stricter view of confidentiality. His use of language makes it clear that he means what he says: "Yeah, I mean, I have a fairly—fairly, um—not *fairly*, I have a really strong, um . . . you know, about—like, it—it's, you know very, um . . . needs to be kept, um . . . above all else." Yet he recalled a time that

he talked to his partner when he was dealing with a particular patient, and like F1, he was also discomfited by the recollection.

F3's views on confidentiality were also on the stricter end. When asked about her beliefs with regard to confidentiality, she said, "I think confidentiality is soooo important. It's the cornerstone of, of, I think, sound practice—of really respecting, ah, the primacy of that." Nevertheless, she admitted to talking with her partner frequently about patients. She explained,

> And theoretically, I could be seen by some people as breaking confidentiality in talking with him. And I get that. And I also see that I'm human and I benefit from his ear at times. So there's a leaking that happens.

On the less strict end of the spectrum, some of the participants felt that talking to a colleague in a private setting, or talking with one's partner at home did not constitute a breach, and could be seen as part and parcel of the work. Their language suggested more flexibility about confidentiality.

F2 used phrases like "it depends" and talked about ways it could be useful. She also points out that the context is very important, a point which will be elaborated on in Chapter 5.

> Well some of it depends . . . I mean I . . . I actually think it's kind of okay that it can be actually, um, useful, um, very informative to both parties when there's a shared therapy. When it's just "oh boy, I had a hell of a session today, I mean you know we need to unload as long as there's no um, identifying info." So the other thing that I . . . that's important to me is where the place is . . .

how it's shared. . . . I make it a point to not do that in restaurants . . . or on walks.

F5 thought the context of the breach was an important aspect as well, though speaking with colleagues was understandable for her:

I guess I feel like, it's complex. If I was imagining that it was like a professional collegial conversation, I would understand. I think I'd probably feel judgmental if I just heard people sitting at a restaurant and it was clear that they were talking about a client in that way, I'd probably have some judgment arise?

Additional caveats affecting their attitudes about confidentiality were added when participants described dealing with children or adolescents and collateral contacts were necessary. For example, a participant mentioned how he speaks about patients when he has collateral contacts.

I'm—I'm sort of including in—that when it's broken, through say collateral contact, talking with a psychiatrist or talking with a—another clinician who's working with the couple for example, if it's a couples, individual . . . then I am doing whatever I can do for the patients using whatever I know about the patient for their benefit, as I determine it, subjectively. (M1)

F4 voiced the same sentiment:

I work—I work a lot with, um, with young adolescents, adolescents and young adults, and of course, it's a different confidentiality, um . . . but again, especially with young adolescents, um, needing to have communication with the parents, um . . . I am . . . how I work is, is, it's—being very, um, stingy, if

you will, parsimonious, about what I would talk about. It would be really geared toward what [I] advocate for the child, for the patient.

Variations in stated beliefs about the importance of maintaining confidentiality were not related to the type of licensure, theoretical orientation, or gender; there were differences in the level of strictness among people with the same and/or different licensure, and theoretical orientation. The same held true with regard to gender and age.

Findings: When Participants Breach Confidentiality

Why do therapists gossip about their patients? Study participants were asked to reflect on this question. Their reasons varied according to feelings and needs that were evoked during the clinical hour. In other words, when certain feelings were evoked by a patient, the tendency to leak became more pressing.

None of the participants had ever talked about the meaning of casual anecdotal leaks and they were both intrigued and apprehensive about exploring this topic with regard to themselves. If therapists were very strict about the importance and maintenance of confidentiality, then feelings about therapeutic leaks tended to be more in tune with those values. Nevertheless, even the participants who held the strictest attitudes about confidentiality admitted to having talked about their patients and even the most guarded were able to open up about their own experiences.

Four groups of findings relevant to this study emerged: (a) context of leaks, (b) affective responses to the interview, (c) patients most discussed, and (d) therapist counter-transference feelings and needs.

The first two groups of findings, contexts of leaks and affective responses, while somewhat peripheral to the main research question, provide a backdrop to the other two categories. These themes will be discussed first.

The third and fourth groups of findings specifically examine why casual anecdotal breaches occur. The third group, or category, concerns patients who are most often discussed outside of formal consultation. The results of the interviews reveal that there are certain types of patients who are more apt to stir up conflictual feelings within the therapist and to evoke the therapist's own needs. In seeking to gratify these needs, the therapist is more likely to breach confidentiality as a way of coping with his/her internal experience. Four types of patients emerged as those evoking leaks: (a) most challenging patients, (b) children and adolescents, (c) patients with whom there is a deep connection, and (d) famous patients.

The fourth group, or category of findings focuses on therapists' counter-transference feelings and needs. These findings revealed specific feelings that are associated with a vulnerability in the therapist and provoke an impulse to gossip. These feelings can be described within six themes: (a) dilution of intimacy, (b) need for soothing, (c) exhibitionism, (d) bonding, (e) isolation, and (f) competition and envy. I will begin by giving some specific examples of what I mean by leaks.

Themes Which Served as a Backdrop to the Research Topic

Context of Leaks

One factor that strongly affected participants' attitudes towards the significance of casual breaches of confidentiality was the context in which the breaches occurred, specifically whether it was in a public place or not. All the

participants felt that the context of the leaks was extremely important, and they made comments about their reactions to other people's breaches as well as their own. Talking to friends or colleagues at a restaurant or a party was generally considered inappropriate. Several of them felt it was not only harmful to the patient but to the profession as a whole. Comments about patients that were overheard in elevators, bathrooms, restaurants and the like were harshly judged and condemned. F1 and F3 used words like "horrified" and "freaked out" to express their disapproval. A small minority was less disapproving and felt that if there was no identifying information, then no real harm was done to the patient. Nevertheless, no one in this study felt it was appropriate to talk about patients in public places.

Only a few participants admitted to talking about a client outside of their own homes. Two people said they talked about clients while hiking with a colleague. One admitted that she had discussed a client in a restaurant with a colleague, and one talked about an adolescent patient at a cocktail party. Some others mentioned while riding in the car with a partner or colleague.

The participants who gave examples of leaks in public places expressed more discomfort in revealing this information than those who did not. Interestingly, there was a much stronger reaction to where the gossip occurred than to the gossip itself. Most participants felt that talking about patients in a private context where they could not be overheard was not considered to be a serious breach of confidentiality.

Affective Responses to the Interview

I had expected this topic might be potentially shameful for therapists to talk about and tried to reassure them by referring to my own experiences of leaking and reiterating how common leaks were. As expected, almost all the participants expressed some uneasiness, anxiety, or shame while talking about this topic with regard to themselves. Their responses to the interview took two forms. The first had to do with anxiety about being exposed and judged. Several of them mentioned that not knowing me added to a feeling of vulnerability about revealing this information. F5, for example, said, "Well there was a thread of discomfort. But not an intolerable discomfort. But there's a little bit of discomfort that arises." In a similar fashion, F6 said, "Um, but, I think I did feel—I felt nervous a little, probably exposed, um . . . anxious about being taped?" F1 laughingly said, "Well, I feel uncomfortable telling *you* about it. I didn't feel uncomfortable with *her*."

While still expressing discomfort during the interview, the second type of response, which came up as often as the first, was a sense of curiosity and excitement about discussing therapeutic leaks. For example, M1 said that he had never thought about this topic and that it brought a new awareness about leaks, "Ah, well this was interesting. Yeah, I mean it really gave me, um, ah—things that I hadn't really thought a whole lot about." F3 also felt that she had been made aware of something she hadn't thought about before, "like they illuminated the extremes of how I have leaked, and how I do leak."

Thus, the interview served as a kind of holding environment from which the participants were able to reflect on the question of anecdotal leaks. By doing so,

they had the opportunity to consider the subject in a way they had not before. Consequently, they developed a new awareness about a topic that has been mostly overlooked. That is to say that as a result of being interviewed, they became more conscious of their own experiences with regard to this topic and potentially more thoughtful about leaks in the future.

Reasons for Therapeutic Leaks

The primary findings of this study, which shed light on the reasons for casual breaches of confidentiality, are divided into two groups: patients most talked about, and therapist counter-transference feelings and needs.

Patients Most Talked About

Participants described how they might be more likely to breach confidentiality with certain kinds of patients. Why are some patients discussed and others not? Perhaps the answer is that certain cases elicit more intense feelings and can be more difficult to contain. As noted earlier, four groups emerged as those likely to be discussed: (a) challenging patients, (b) children and adolescents, (c) patients with whom the participant had a particularly deep connection, and (d) famous patients.

Most challenging.

The most challenging patients were generally the ones who evoked feelings of anger, helplessness, anxiety, and inadequacy. In other words, the most challenging patients elicited strong negative feelings in the therapist. These patients were more likely to have characterological issues such as borderline or narcissistic

personality disorders. Such patients seemed to upset the therapist's emotional equilibrium, as illustrated in the following examples.

F1 was working with a couple who fought all the time during the sessions and she had trouble containing them. She told me about an incident when, feeling upset, she talked to her partner about her distress.: "Um . . . so, like I said, high-conflict couples. Where I don't know whether I, you know, disclose details but, you know, disclosing to my partner that . . . I'm, you know, that I'm coming home upset."

F2 talks about a case that is particularly difficult. "I know I've talked with many people about my hardest case, which is a guy I've been seeing for 27 years who is quite schizoid."

The next two examples show how the participants struggle with patients who are suicidal. M1 talks about "management," which I believe has to do with not only his patient, but with his own feelings of discomfort as well. In a similar vein, M2 refers to having "a really hard time." It appears that in trying to work with patients who are so challenging, participants have to deal with anxiety and other feelings that are difficult to contain.

> It was someone who was very, um . . . you know, very, um . . . wounded, [sigh], very, very wounded, um . . . and so, um, profound, you know, major depression and suicidality, and, and of course there was a personality—not of course, but there was also a personality-disordered way in which she, um, perceived our relationship and—and the world, so there's a lot of, of management of all this, (M1)

> I think, in terms of the certain kind of patients, I think—and it—if someone really has, um, thrown me off emotionally, if they're like suicidal, actively suicidal, um, I would be more likely to tell my spouse that I'm really having a hard time. (M2)

Patients who are more demanding generally require more holding from the therapist. This can take a toll on the therapist who must deal with these particular challenges. F5 describes how burdened she can feel with patients who are more disturbed. Like her patients, she seeks relief by creating a holding environment for herself.

> Well I think the patients like, like the people who are like borderline get discussed a lot because they're so demanding. And they're also compelling. I mean I think that's part of it. And I think they actually require more holding than can be provided in an outpatient psychotherapy office.

Children and adolescents.

In working with children and adolescents, some of the rules surrounding confidentiality are different than when working with adults. For one thing, therapists are generally more revealing about themselves when working with younger patients. For another, collateral visits are necessary but can make the boundaries less clear.

In having to deal with the parents of their patients, there is additional pressure on the therapist. It is a bit like walking a tightrope in that both the parents' and the children's needs come into play. This can be difficult to navigate and might create anxiety. Potentially this could lead to breaches of the child patient's

confidentiality to the parents, similar to the casual leaks that occur in other types of cases. F2 states this very clearly when describing her work with younger patients.

> Well—here's one of the areas that I think has been really challenging. There was a period of time where I did a lot of work with adolescents. And . . . the parents, who are paying for the therapy, *need* to know about it, are concerned, and also, sometimes, are sending checks and the kids aren't showing up. In the case of, um, acting-out kids. But then . . . in order to get the confidence of the adolescent, part of my explicit agreement with them would be—this is how I handled it—"I won't tell anybody anything about you without telling you what it's going to be."

M2's example suggests that in talking to his spouse, he alleviates his anxiety through the shared experience of parenting.

> I think that might have something to do with it. Um . . . [long pause] I guess it applies more, I mean I don't really . . . I guess the person who I most often would bring something up that's not in a formal consultation, uh context would be my spouse and we are parents and so we have parenting as a—shared kind of job, [laughs] in a way. Um. So that may also have something to do with it.

F5 talks about how her connection is different with children than with adults and that she tends to be less boundaried. Her words suggest that she can do things with younger patients that she cannot do with adults, and perhaps this lends itself to different rules about confidentiality.

> They're mostly young people, it's that they . . . they touch me in a different way. I think it's . . . I think it's maybe that. Or I . . . I take a different role with them, or I could be . . . do things I can . . . the therapy's a little bit different.

Deep connection.

Some participants mentioned that when they had a particularly deep connection with patients, they were more prone to talk about them. These patients generally evoked feelings of love, compassion, and admiration as compared to challenging patients who evoke negative feelings in the therapist. In the first example, F1 talks about patients with whom she feels especially close. In these circumstances, the therapist may be trying to re-establish a more therapeutic stance.

> People I have more of a connection with. I'd be more likely to. That's what I think. Because I think that, um . . . I think because I have a deeper engagement with them, and . . . so they're more, kind of, in my psyche. You know, they're . . . ah . . . and so therefore maybe I have more counter-transference going on because of that.

M2, talking to his partner about a particularly moving session, wants to share the pleasure he experiences from his sense of connection to his patient.

> I would talk about the fact that I'd had this really moving experience or that someone, I felt like, was, you know, just, in a positive sense, had—had really impressed me or moved me in some way. It's just the pleasure or just—if you have a life experience that really touches you, like if you've been to a great art exhibit or you've been to a play that was really fantastic, or you went out for

a walk and you saw . . . an animal or something that just really was spectacular, you just want to share it with someone who you feel would understand it, and appreciate it, and as long as I feel like I'm still really keeping completely private the identity of the person so that's not at risk,

As an example of quite a different type of deep connection, F6 brought up an interesting case in point of a male client who had an intensely erotic transference to her which made her feel the need to talk about him outside of formal consultation.

So I don't think I'd intended to talk about him, but there it was, and, ah, because so much had been going on the weeks prior to that. And it just felt so uncomfortable for me and so intense and I don't know the lines with him about what's therapeutic and what's not, necessarily, and, um, with some of the transference stuff. With some of the erotic transference stuff.

Famous patients.

Having a patient who is famous or has some notoriety can stimulate the urge to gossip. F3 talked about this experience and how it made her feel special and important. Even if the patient is not "famous" but has some special skill or expertise, the therapist can feel special in being "chosen." The excitement that F3 feels fuels her fantasies about being "therapist to the stars," and how her practice will benefit. By seeing a famous client, she in turn will become famous herself. Her way of coping with this inflation is to talk to her partner who brings her back down to earth.

And—and all kinds of things started happening for me. I started feeling like, what am I going to wear when I go for the session because I want to look, you

know, a particular way. Um . . . if I'm really a good therapist with this couple they're going to refer other rock musicians to me, and I'll be a famous Bay Area therapist dealing with rock musicians. All of these fantasies started happening in my mind in that first session. And . . . I thought, oh God, I'm—I'm just—I'm just the best therapist in the world, and . . . look at me, So, of course I went home and I told my husband about it right away. And it was like, [gasp], you wouldn't believe who came into my office. And, so, I'm telling my husband.

Later on in the interview, F3 revealed the extent to which she felt she had lost her therapeutic stance:

Oh God, yeah. I—I was like practically stalking this client. You know of like, Googling the band's name and figuring out, you know it's like, oh God, they've been here they've done this they've done—you know, they've been at the White House, they've you know, it's like, ohhh my God. Look how special I am by relationship. And, um . . . .and so talking with my husband kind of . . . brought me back down to earth.

In this case, the therapist realized that her reaction was getting in the way of seeing the patients as real people and she sought consultation to help regulate her own feelings. Other participants expressed similar reactions when dealing with people of some notoriety, as in the following selection by M3.

There's a kind of—a gossip part of it? Of seeing somebody who's involved in something political or something financial or something in theater or . . . published a book of poetry or something, I mean, like that, where there's

some notoriety, um . . . just the kind of, the sort of secret pleasure of being able to, ah, to talk about that. Or I might be tempted to but I might not, or at times I might, depending on who the colleague is.

Therapists' Counter-Transference Feelings and Needs

What motivates a therapist to discuss their patients outside of formal consultation? The final group of findings speaks to the needs and wishes that may be activated due to therapists' strong counter-transference feelings. There is an inter-relationship between these needs and the previous group of findings concerning patients most talked about.

When strong feelings are evoked by particular patients or particular clinical situations, therapists may turn to someone outside of the therapeutic dyad to help them cope. As the participants reflected on why a particular breach had occurred, it became apparent that they were seeking something from the person to whom they had breached. They realized that certain feelings had come up in a clinical hour which were difficult to manage.

In comparing and contrasting the nine different interviews, six categories or themes emerged that identify the therapists' feelings or needs that leave them vulnerable to leaking. As identified earlier, these themes are (a) dilution of intimacy, (b) need for soothing, (c) exhibitionism, (d) bonding, (e) isolation, and (f) competition and envy. I will now discuss them individually.

Dilution of intimacy.

Several of the participants talked about dilution of intimacy as a reason for gossiping. By turning the therapeutic dyad into a triad, the therapist is seeking to

lessen the intensity of the therapeutic relationship, which may feel threatening in some way. M2 addresses this in his example when he feels especially close to a patient.

> Um . . . but I think maybe you're right, that there is a way in which maybe some sort of intimacy between the client and the therapist gets diluted if it's—if it's conveyed to someone else. Um, if it's something that's really said as a secret, then that clearly would be the case . . . possibly one of the motivations is the therapist myself would be having maybe some, ah, ambivalent feelings about the degree of intimacy or about the, ah, closeness that would lead me not to sort of contain it, or . . .

F1 mentioned talking to a friend about a patient when she felt that the sessions had taken on more of a friendly as opposed to a therapeutic tone. Specifically, F1 and her patient, both of whom were very interested in food, talked about this together in some of the sessions. This led F1 to feel that there had been a loosening of the boundaries with her patient that may have resulted in the leak.

> So getting back to why I revealed that, um, well, maybe because it's an aspect of our relationship that feels less clinical. I think that lent itself more to ah, a sort of loosening of the boundaries. I feel uncomfortable telling you about it. I don't feel uncomfortable with her (friend). Because somehow I feel like I revealed something that was, ah, a breach, um, especially for me who is very much a stickler about this.

F4 presented an example in which she talked to her partner about a patient because she really "liked" her. This example is interesting because she may be

diluting the connection to her patient, or she may be bonding with her partner. Perhaps it is both: "Well I think there's the counter-transference of really liking the client, so it's like, you know, I met somebody I really like, you would like them too." Further on in the interview, she reflects on why she talks about some clients, but not others.

> I just don't know what, um . . . because I have other clients that I don't talk about at *all*, and feel no need or desire to, so it's interesting to me that the two that I am aware of are the most difficult, and the one that's the easiest, or the most pleasurable, maybe.

Need for soothing.

The need to be soothed harkens back to the original mother/infant dyad. Gossip may provide a sense of security and warmth when the therapist is feeling anxious. Among participants' subjective reflections on reasons for therapeutic leaks, the theme of soothing was the most common. There were two variations on this theme – venting and discharging, and feelings of inadequacy and helplessness. I have divided the theme of soothing into sub-categories to elucidate those differences.

Venting/discharging.

Several of the participants described times when a session was particularly difficult and the impulse to discuss it with another person became very pressing. In these instances, the capacity to contain the feelings was compromised.

These leaks might be considered as examples of projective identification in which the patient projects the feeling or feelings he cannot tolerate into the

therapist, as reflected in phrases the participants used such as "I needed to get rid of it," or "carrying around a level of trauma that was not my own." The therapist's task is to understand and metabolize the feelings. But if the therapist is also unable to contain the feelings, then the result can be a leak in the therapeutic container.

Three of the participants described times when they felt a strong need to discharge as a result of feelings stirred up in the session. F1, F3, and M3 express this sentiment very directly in their examples,

> Like, I have a –I've had a very difficult session, right before I go home. And ah, you know, I'm very, uh, upset or agitated, and I might say, you know, I just saw a couple and it was really hard, you know. I'm not really revealing anything in particular, but you know, I'm, I need to discharge a little bit, (laughs) . . . to shake it off. You know, to get rid of it.. just saying that allows me to let it go. (F1)
>
> So . . I, you know, therapeutically I see what was happening, but I was still left with carrying around a level of trauma that was not my story, it was her story. And, um, and I couldn't even wait until consultation group, ah, to really, um, discharge it. I needed to get rid of it. (F3)
>
> It's just that we're asked to take in all this psychic material, and ah, it's a lot to carry and when there are people that you can trust because—for various reasons, then it's a relief to be able to, ah, have somebody else know some of what you're dealing with. . . . I think some of it is just being able to—it's almost like venting. You know. Cathartic, kind of. (M3)

The language they use to describe their experiences expresses a pressing need to expel the feelings that are too hard to contain. Words like cathartic, venting, and discharging suggest a certain urgency.

Feelings of inadequacy and helplessness.

Participants also described their need to be reassured when they were confused about how to proceed. Unlike needing to discharge or vent, they are in need of an empathic response to relieve a sense of inadequacy. Kohut's concept of the self-object transference elucidates this dynamic as does Winnicott's concept of transitional phenomena. Their concepts will be discussed more fully in relation to the study findings in Chapter 5.

M1 reported his feeling of helplessness when he reflected on a case with a particularly aggressive and angry patient. He spoke to his wife about it as a way of trying to calm down. "And also, you know, part of it was also this wanting to be helpful, you know? [laughs] Um, and not—and then feeling help*less*. And feeling, um, what can I do, you know, what can I do."

In the same vein, F4's comments also imply a feeling of helplessness when struggling to handle what had been stirred up in the therapy. In the following example, she is very unsure of how to proceed with a particularly difficult patient and is unable to contain her anxiety. She discusses the case with her partner

> I worry that, how am I going to handle this, am I going to do it right, um . . . I tend to want to talk to people? And . . . I know that in *that* instance it was much more about how difficult it was. And how I needed someone to talk about it. The other place I talk about it is in my own therapy. . . . So, I—I

understand that it was difficult, what was up for me. Of just like, feeling like I needed to beat my head against a wall. And really struggling . . . feelings of I'm not doing it right, I'm not good enough, you know. All of that.

F1 talked about how she struggled with feelings of inadequacy but added that she also felt angry and frustrated. When she felt she was not being effective, she turned to her partner to re-establish her equilibrium.

I felt frustrated, maybe a little angry, um, a little angry at myself that I wasn't able to be effective. [Afterwards] I felt relieved. I felt like somebody else was, you know, that he [partner] knew where I was . . . because he was empathic.

M2 and M3 reported that they sometimes turn to their spouses for comfort or even advice when they have had a difficult session. As in the previous examples, their comments demonstrate their wish for a reassuring response. Such needs can occur when the therapist feels deflated and needs reassurance and support to help stabilize his/her sense of self-esteem.

I think that spouses are people who we rely on for reassurance or for comfort or for . . . um, maybe even good advice, I mean not necessarily, like—(clears throat) I wasn't necessarily looking for that, but I think in this case it was more . . . (M2)

I feel met and understood by another person who has some idea of what it's about . . . sometimes, just, again, the comfort of somebody understanding and knowing what it's like, to . . . face situations. it's wanting . . . solace, in a way. Um. (M3)

Exhibitionism.

Another theme that emerged from the interviews and that contributes to understanding what motivates therapists to discuss their patients outside of formal consultation had to do with "showing off." Participants sometimes felt a need to exhibit their "talents" to an audience. The wish to be admired is a basic human need that therapists are as likely to feel as anyone else. For example, F3 talked about the feelings that came up when she began seeing someone very famous. She also talked about her need to "celebrate" her successes with another person.

> I think there are specific kinds of clients or clinical experiences that lead to my desire to talk—um, to leak—to talk outside; one is to celebrate a success, you know of like, um, which kind of is that place of like, look how good I am, you know? . . . I just felt . . . overinflated. And it's like, from that place of over-inflation, it's like, you know, oh my God, my practice is going to be like the best in [my area] because I'm going to be seeing all of these rock stars. so, it tapped into that place of power and, um . . . maybe confidence, you know, even if I'm not feeling confident, somebody else thinks I'm good, and look who's thinking I'm good. You know, so, confidence by association.

For M2, when one of his patients has a "breakthrough" he also has the urge to share it with someone. He refers to the achievement for the client, but he is also proud of own achievement in being able to get his patient to this point.

> I mean that could also be something that gets discussed, is something that was a breakthrough or something that felt like an achievement for the client

or for the therapy. I presented it as sort of an interesting bit of, like, anything one would share at a social gathering that was an interesting little anecdote.

M3 expresses the same sentiment when the work is going particularly well. In this example, he even uses the word "gossip" to get his point across.

> Oh, I mean feeling really pleased about something. Feeling, you know, something really went well, or somebody has achieved something—another thing that came up, I realized as I was thinking about anticipating today, is that sometimes, um, there's a kind of—a gossip part of it?

Bonding.

One function of gossip is to create bonds between people. Gossiping creates a sense of exclusivity, shared values and a feeling of belonging. Thus, the need to bond with another is a frequent theme, not just in psychotherapy but in life. For therapists, the need to connect manifests in talking to others about what happens in the clinical hour.

This next example is interesting because the therapist was both diluting the intimacy with her patient and bonding with her friend at the same time. She mentioned that she had been feeling a little distant from her friend and was trying to create a more intimate connection with her.

> It was a way of connecting with her [friend]. It could be that I was feeling a bit distant from her [friend] and that was my motivation. Well . . . that you know that . . . my client feel that, ah, it's a way of connecting with me and feeling closer to me . . . like a parallel process. (F1)

M1's example reflects a need to bond with others around human suffering. He conveys a wish to join with others, as we all must deal with the human condition. This makes him feel less alone.

> So . . . so I'm taken up with that idea of the human condition, and, um, the meaning of life and those ideas. So . . . so it's all a part of that preoccupation. That—I would talk about this, let's say. we're in the same boat, or there's some collective way.

The themes of bonding and isolation are very much intertwined. The need to bond as a result of feeling isolated was mentioned by several of the participants.

Isolation.

Working in isolation can be stressful and lonely. It is difficult not being able to share one's experiences with a partner or friends, especially when clinical work is so much a part of therapists' lives. Not being able to discuss this aspect of one's life with a partner or close friends can feel very depriving. In the words of participant F4, explaining why she leaked: "I think that private practice is lonely. You know, and . . . [I need] places to talk about things, whether it's positive or negative, in the work, is—is I think what I was after."

Several other participants describe how their feelings of isolation contributed to therapeutic leaks. M1 describes the difficulties of having to hold the feelings that come up in the hour.

> You know because it is—you know, there is that—that um, part of this, that is um—we all are alone with. You know. Facing those energies or those forces

and . . . it's a very, um . . . it's a reality that we can't really, um . . . I mean we could try to avoid it, but—[laughs] but it's, you know, it's there.

M3 and F5 focus more on the need for social contact. M3 refers to his need to "bounce off" his ideas with others, while F5 feels a need for more professional interaction.

> The isolation of doing this work is—is both what makes it possible but it also is, um, limiting, especially—I'm pretty extroverted, so that's—I think that's part of it, that I, ah, feel—it helps me to bounce things off other people. (M3)

> You know, that we're very isolated. You know, we don't—most of us aren't in settings like this, [laughs] you know, where there's a bunch of other people, that you can walk down the hall and talk at the coffee machine, or. You know. So I think that we need more interaction in our profession than we get. I really do think that. (F5)

Competition/envy.

From my review of the literature, I expected to find that feelings of competition and envy would be prevalent. Interestingly, only one participant mentioned competitive and envious feelings as reasons for leaking. However, because the analytic authors I reviewed suggest that envy is the sine qua non of gossip, I have included F2's comments here.

> I was feeling more . . . authoritative. You know, that's the role we fall into. So I was feeling more like—"well, I've seen this and this and this and this, you know, are you aware of those things?" I know what's going on." You know it's like a one-upsmanship kind of a thing? Um . . . so, I think that's in there,

> although . . . I don't like people to feel less than. But it's, I guess it's like, I want to feel big, but I don't want them to feel small [laughs].
>
> I will tell you one thing that I know was a counter transference I had with the couple, was that they were so wealthy, I mean they spent money like they were wealthy. And also that she was so beautiful. (F2)

Summary

As I have mentioned, the reasons for therapeutic leaks are intertwined with the types of patients who elicit intense reactions in the therapist. Feelings such as anxiety can be difficult for the therapist to contain, and in seeking relief, the therapist is more likely to breach confidentiality. Furthermore, the various needs that motivate therapists to breach confidentiality, which form the primary categories of findings in this research study, are fluid. For example, isolation creates feelings of loneliness which creates a need to bond. Dilution of intimacy lessens anxiety by making the therapeutic dyad into a triad. Thus, feelings that are stirred up in the clinical hour can activate strong needs in the therapist which can be met through discussions outside of formal consultation.

In the final chapter, I will discuss the conclusions I have drawn from this study. With self psychology as a theoretical framework, I will use Heinz Kohut's concepts to develop a deeper understanding of the meaning of therapeutic leaks.

CHAPTER 5: DISCUSSION

This study explores how psycho-dynamically oriented psychotherapists describe, experience, and think about casual anecdotal leaks that occur outside of formal consultation. In approaching this topic, I was particularly interested in the subjective experience of the therapist/participant. By subjective experience, I am referring to specific counter-transference feelings that were evoked and, consequently, resulted in breaches of confidentiality. As therapists, we are trained to consider confidentiality an essential part of our work, and yet therapeutic breaches occur with great frequency. Some leaks are very serious breaches of confidentiality, which, if discovered could lead to fines or loss of one's professional license. These more egregious leaks were not the focus of this research.

Review of the Findings

Four categories surfaced from the interviews: (a) the contexts in which leaks occur, (b) the affective responses of the participants to the interview, (c) the kinds of patients most likely to be discussed, and (d) the therapists' counter-transference feelings and needs, The first two – context of leaks and affective responses – I consider to be secondary categories that served as a backdrop to the last two – kinds of patients discussed and counter-transference needs. I consider these last two to be the primary categories because they address why therapists gossip about their patients, as well as the conditions that make these casual breaches more likely. The two primary categories were broken down into sub-categories and will be individually discussed.

The ideal of confidentiality is rarely attainable in reality. My findings indicate that all the therapists in my study, regardless of their specific training, gender, age, or values about confidentiality have needed to discuss what happens in certain clinical hours with someone to whom they look for support. Is this pathological, as some of the analytic writers suggest? In general, I would say no. As discussed in Chapter 2, particularly when reviewing literature from the social sciences, gossip serves many important functions within any given community, such as bonding, maintaining social order, and creating a sense of belonging. This also holds true with regard to the psychotherapeutic community. My findings suggest, however, that there is an additional element when it comes to gossip within the psychotherapeutic community, namely, that it is an expression of needing to re-establish one's therapeutic perspective, which has been temporarily impacted by strong counter-transference reactions.

Discussion of Secondary Categories

Before I begin discussing the two primary categories and sub-categories of findings, I would like to briefly review the two secondary themes of contexts of leaks and participants' affective responses to the interview as discussed in Chapter 4.

Without exception, every participant mentioned that context in which the anecdotal leak took place was of utmost importance. Each one had a story to relate about overhearing therapists discuss patients in public places and how that felt disturbing, intrusive, and disrespectful. Several mentioned that it tarnished the reputation of both the therapist and the profession as a whole. They tended to

emphasize how their examples had taken place in private, with trusted colleagues, friends, or intimate partners.

Regarding the affective responses of the participants , they all confessed to some discomfort in revealing to me incidences when they had engaged in casual anecdotal breaches. These feelings, however, were coupled with curiosity and enthusiasm. Several of them felt that they had learned something as a result of the interview and that they would be more conscious with regard to this topic in the future.

In the following sections, I will summarize the results of the research using the primary categories and sub-categories that emerged. Next I will summarize the results with references to the literature that was reviewed in Chapter 2. After describing how the primary themes inter-relate, I will discuss the findings from a self-psychology perspective using the work of Heinz Kohut. I will also include some theoretical concepts from both an object relations and attachment theory perspective. Finally, I will discuss the limitations of this study with recommendations for future research.

Discussion of the Primary Categories

The underlying question of this research project was not about *if* therapists breached confidentiality, but *why*. Given the frequency of breaches, my focus has been on trying to discern what purpose they serve. Findings from this study can contribute to understanding a phenomenon that has not been previously examined. In addition, they show that breaches do serve a purpose in helping therapists maintain their emotional equilibrium as well as addressing other therapist needs.

The findings were grouped into two interrelated categories. The first category discusses which patients are more likely to be the focus of gossip. The second category concerns the reasons why therapists talk about patients outside of formal consultation.

Patients most discussed.

The category of Patients most discussed broke down into four sub-categories: (a) most challenging, (b) children and adolescents, (c) deep connection and (d) famous patients.

The most frequent response among the participants had to do with their most challenging patients, who tended to exhibit more characterological disturbances. These patients might be diagnosed as having borderline or narcissistic personality disorders, and were more likely to arouse negative feelings in the therapist.

With regard to the other three groups of patients – children and adolescents, those with whom the therapist felt a deep connection, and famous clients – the participants were more likely to have positive feelings that led them to leak. These positive counter-transference feelings were uncomfortable in some way, which resulted in an urge to discuss them with another person.

Anxiety, helplessness, inadequacy, anger, as well as love, admiration, and feelings of deep connection were all part of the emotional repertoire that led to breaches in confidentiality. In other words, when a participant had intense feelings, be they negative or positive, the tendency was to discuss them with someone. This is what Olinick (1980) was suggesting when he stated that therapists, unable to

contain the tension stemming from a clinical hour, act it out instead by gossiping. The participants in my study most frequently turned to a partner or a close colleague or friend.

Therapists counter-transference feelings and needs.

This category, which is at the heart of my research study, is a direct outgrowth of the previous category. The patients who arouse the strongest counter-transference feelings are the ones most associated with therapeutic leaks. The reasons for these breaches fell into six themes that related to underlying motivation: (a) dilution of intimacy, (b) need for soothing, (c) exhibitionism, (d) bonding, (e) isolation, and (f) competition and envy.

There were times when participants described how talking about their clients served to dilute the sense of intimacy in the therapy relationship. In several examples the therapist felt the boundaries had become blurred and talking to a third party helped the therapist re-establish a more neutral stance.

The need for soothing was the most frequent reason given for therapeutic leaks. Almost all the participants eventually realized that they were looking for some kind of reassurance, support, and empathy when they breached confidentiality. Two types of subjective experiences emerged around the need to be soothed. The first had to do with a need to discharge. When the therapist was overwhelmed, either with anxiety, anger, or even sadness, the urge to get rid of the feelings resulted in a breach. The second experience had to do with feelings of inadequacy and helplessness, which arise often in the course of depth-oriented

psychotherapy. The participant/therapists in my study felt that talking to someone they were close to made them feel better able to handle the situation.

Exhibitionism was only mentioned in passing in the literature as a reason for therapists' breaches of confidentiality. In the interviews, however, it turned out to be a frequent response. The examples of exhibitionism that emerged from the interviews were connected to intense wishes to be "seen."

Bonding as a reason for therapeutic leaks came up for two different participants. Ben-Ze'ev (1994) talks about gossip as a way of satisfying tribal needs. Working in isolation and suffering along with patients creates a longing to feel support from one's community. Being with other therapists who understand what it is like to sit with people who are sometimes very troubled can ease some of what a therapist must carry. Three participants specifically mentioned isolation as a reason for therapeutic leaks. This category is very closely linked with bonding. Isolation creates a longing for others who are in the same boat.

Competition/envy came up only once, which was unexpected. Since several of the analytic writers felt that envy was the sine qua non for gossiping, I expected to find more examples of it.

While every participant expressed some discomfort and anxiety in admitting that they discussed patients outside of formal consultation, the majority of them said that talking to a partner, friend or colleague was helpful. As long as the patient's identity was protected, (no names or other identifying information) then the general feeling was that no harm was done.

Relevance of Findings to the Literature

In my review of the literature, I found that while there were many similarities among the two perspectives, that of psychoanalysis and social science, with regard to how gossip functions, their attitudes towards gossiping differed. The three perspectives shed light on the nature and function of gossip and casual therapeutic leaks.

The psychoanalysts believe that breaches are not beneficial and are damaging to both the work and the profession as a whole. The non-psychoanalytic writers regard gossip in a more neutral, even positive light. While they agree that gossip has its detrimental side, they also see how it serves the needs of the community in crucial ways as well.

According to the psychoanalytic literature on gossip (Caruth, 1986; Lander, 2002; Medini & Rosenberg, 1976; Olinick, 1980; Rosenbaum & Subrin, 1963), breaches in confidentiality are always a result of strong counter-transference reactions in the therapist. Most of these authors agree with Freud (1905) that gossip has a hostile intent, and suggest that it is tied to aggressive or sexual instincts. They regard leaks, regardless of the reasons, as a form of acting out, which ultimately hinders the work. Caruth (1986) for example states that leaks are a result of the therapist putting his/her own needs first. Both Caruth (1986) and Lander (2002) suggest that leaks function to create some distance for the therapist when feelings of being engulfed are evoked.

The analytic writers, in general, believe that by containing all the feelings that come up in the therapeutic hour, the therapist's reflections will lead to more

thorough insights into the patient's psyche. This would potentially deepen the work and lead to a fuller understanding of unconscious material.

Both the psychoanalysts and the social scientists agree that among the reasons why gossip occurs are the need for soothing, intimacy, and bonding, as well as the influence of envy, competition, and grandiosity. These categories were also present in my findings. Although competition and envy were considered to be one of the primary reasons for breaches in the analytic literature, my findings produced only one example of each, from only one of the participants.

Olinick (1980) mentions power as a reason for leaks in the sense that the gossiper, through the act of gossiping, derives a feeling of moral superiority to the patient. While none of the participants mentioned power or moral superiority as a reason, breaches as a result of anger, as presented within the sub-category of venting might be interpreted in this light.

The non-psychoanalytic authors express a more optimistic attitude when it comes to gossip. They observe that gossip serves the community in many important ways. Ben-Ze'ev (1994), Emler (1994), Goodman (1994), Schein (1994), Besnier (1989), and Gluckman (1963) believe that gossip helps maintain group cohesion, moral and social order, and bonding and intimacy among members of a specific group. It also provides information with regard to how other people experience the world. Emler (1994) believes that gossip helps the human collective to function. Although this was not specifically stated in the findings, therapists who talk with other therapists about their work, might also be seeking information about how their colleagues handle clinical situations. While the social scientists consider

gossip in the context of group dynamics, many of their observations apply to therapists. The findings from this study confirm that the reason members of a particular community gossip are the same reasons that people in the therapist community gossip. Reasons such as bonding, intimacy, power, and information gathering within the community of therapists are a part of why therapists seek out others with whom to share their experiences.

The psychoanalytic authors focus on the subjective experience of the therapist as opposed to the social scientists who see gossip through the lens of group dynamics. Nevertheless, the same motivations for gossip are present regardless of the particular orientation. The participants in my study described the same motivations for therapeutic breaches as did the analytic and social science authors.

My findings concur with the analytic authors in that counter-transference reactions are the impetus for therapeutic leaks. What these authors do not take into account, however, and which the current study demonstrates, is that therapists are also human beings whose needs may be addressed in relatively harmless breaches, like the gossip described by anthropologists and sociologists. If a therapist is flooded with feelings and loses the therapeutic attitude necessary for the work, then turning to a trusted colleague, friend, or partner can help re-establish the appropriate stance.

Reflections on Therapeutic Leaks

Reflecting on the question of why therapists engage in casual anecdotal leaks, what became apparent was how the various reasons were inter-related. For

example, the theme of dilution of intimacy could be seen as a need for soothing due to anxiety constellated by feeling "too close" to a patient. Isolation, which can feel depriving, creates a need to bond, and both isolation and the need to bond stem from an internal longing to be connected.

In reviewing the sub-categories, the most common need was for participants' uncomfortable feelings to be understood and soothed. With the exception of exhibitionism, the five remaining sub-categories all stem from the therapist's internal agitation brought on by intense counter-transference feelings.

Exhibitionism differed somewhat in that the underlying need was more about being seen and admired. Reasons for therapeutic leaks can be consolidated into the themes of soothing, being part of a larger community, and exhibitionism. Thinking about the findings in this way, I began to consider how self psychology offered a framework in which to understand these needs.

Theoretical Frameworks for Discussion

The primary frame for this discussion of the findings is Heinz Kohut's (1971) self-psychology model. In addition, attachment theory (Schore, 2003) and Winnicott's (1951) concept of the transitional object also offer insights with regard to casual anecdotal leaks, and I will briefly discuss them as well.

Kohut's Self-Psychology Model

Several ideas from Kohut's (1971) self-psychological theories are particularly helpful in understanding the phenomenon of therapeutic leaks. They are the concept of self-object functions of mirroring, idealizing, and twinship and the self-

object transferences that address these functions, along with the concept of empathy.

Self-object and self-object transference.

The self-object and self-object transference are at the heart of Kohut's (1971) theory of therapy. Kohut states that the self-object is neither a self nor an object but rather a relationship that refers to an intra-psychic experience. Through the primary caretaker's attunement to the infant's needs, both parties experience themselves as part of a unit that imparts strength through merging (Kohut & Wolf, 1978). Atwood and Stolorow (1984) agree with Kohut that the self-object concept provides a psychological framework from which to understand the development of self structures.

Mirroring and the mirroring transference.

Kohut (1977) describes one pole of the self-object functions as the mirroring function. Mirroring is an essential ingredient in normal human development. The mother's attunement and approval of her infant's experiences are a precursor to its ability to internalize a sense of expansiveness and enthusiasm about itself. The mother who coos and smiles at her baby is actually performing a very important function that helps in the development of self esteem later on. In a mirroring transference, the analyst provides the mirroring so that the patient can eventually internalize this function. The word mirroring is very apt because that is in fact what happens in the facial expressions, tone of voice, and general meshing with the infant's expressions and vocalizations.

The participants in this study were more likely to seek some form of mirroring from a primary self-object when their self-esteem had been wounded. The goal in doing so, was to re-establish their emotional equilibrium which, due to intense counter-transference feelings, was temporarily thrown off balance.

Idealizing and the idealizing transference.

According to Kohut (1977), the infant experiences the parent as the embodiment of perfection through which contentment and omnipotence are possible. He refers to this as the idealizing self-object experience, and in the therapy context as the idealizing transference. Without this perfect self-object, the infant can feel powerless and enfeebled. Kohut believes both mirroring and idealizing self-object experiences are essential for healthy emotional development. The infant comes to rely on the primary care giver, (the idealized self-object) for calming, soothing, and a general sense of well being, without which he could not manage his anxiety and affect (McLean, 2007).

For the most part, participants in this study attributed their leaks to being temporarily unable to manage their affects. The idealizing self-object function of their primary relationship(s) enabled them to get the relief they needed.

Twinship and the twinship transference.

The twinship function is about being part of a community of similar others. This is the function that eventually leads to the development of talents and skills. In this study, this function addresses the need to combat isolation and bond with others who understand or have similar skills, such as the participant who wanted to unite with the parenting skills of his wife.

Empathy.

> Kohut's (1984) concept of empathy is also relevant to my findings. He states:
>
> The best definition of empathy—the analogue to my terse scientific definition of empathy as "vicarious introspection." . . . is that it is the capacity to think and feel oneself into the inner life of another person. It is our lifelong ability to experience what another person experiences, though usually, and appropriately, to an attenuated degree. (p. 82)

The therapist's "evenly hovering attention" enables empathic responses to the patient's associations. The continuous participation of the therapist is necessary for work to continue.

Just as patients turn to therapists for their ability to understand what it is like to "be in their shoes," therapists look to their self-objects for the same reasons. Because our work as psychotherapists can at times feel overwhelming, the wish for an empathic response from our own self-objects becomes more pressing.

Relevance of Kohut's concepts to the findings.

The self-object functions of mirroring, idealizing, and twinship, along with the attainment of empathy, enable us to establish a sense of self that navigates relatively well in the real world.

If something happens so that the parent is unable to perform these essential psychological functions, the likelihood is that future problems will be present later on in life. However, even if things have gone relatively well, there are times when one needs to rely on others for these functions. Kohut (1977) maintains that these needs are normal and not pathological. As psychotherapists, we are asked to take in

and hold very difficult feelings at times, which can leave us vulnerable and in need of admiration, soothing, and understanding by others like ourselves.

Based on the responses from the interviews, almost all the participants expressed the need for soothing because of the feelings stirred up from a difficult clinical hour. To whom do they most turn? The majority turn to either a partner or a trusted friend or colleague. These significant others are used as self-objects to calm anxiety, provide reassurance and offer empathic understanding. Much as a mother provides a soothing presence – an idealizing self-object experience – so do partners and colleagues. Self-object needs are life-long and do not end with childhood. They continue throughout the life cycle.

Kohut (1978) believed that all children go through a period of healthy exhibitionism, or narcissism, in the maturational process. If the primary caretaker cannot respond empathically to the child's sense of omnipotence, then the child cannot fully resolve the issues and internalize the more adult version, which is a feeling of self-esteem. Behavior that appears grandiose or exhibitionistic in adulthood may be an indication of early developmental deficits, or it may be a normal response to being over-stimulated, as when participants wanted to "show off" or tell stories about famous clients. Being met by an empathic self-object's attuned response helped participants handle their own feelings of narcissistic arousal.

One of Kohut's (1978) major contributions was to explain narcissism as having a place in normal, healthy development, not just as a sign of pathology. As with self-object needs, which continue throughout life, the wish to be seen and

admired is something that never disappears. Therapists are no exception. As human beings, we all need a certain amount of recognition. Only if the wish to be admired is excessive is it a problem. In the normal course of events, however, this is not the case.

Isolation, one of the themes of my findings that helped to explain certain leaks, means that therapists' work goes largely unseen. In self psychological terms, mirroring and twinship self-object needs are not met. Unlike other professions, therapists do not have the benefit of receiving supportive and validating comments except in formal consultation. Often this does not suffice. Most therapists are more likely to discuss a pressing problem rather than a gratifying success. This creates a fertile field for leaks to occur.

It is important to reiterate that the needs for mirroring, idealizing, twinship, and empathy are basic to human nature and should not be considered pathological. Only in extreme cases does it become problematic.

Kohut's concepts are helpful in understanding why therapists casually breach confidentiality about their patients. Three major themes that underlie findings from the current study – the need for soothing, understanding and exhibitionism – are explained developmentally through Kohut's concepts of the mirroring , idealizing ,and twinship self-object functions.

Attachment Theory and Winnicott

Although I chose self psychology as a model for understanding the results of the research, other models may also offer ways to think about the data. For

example, the need for soothing might be seen through the lens of attachment theory. Allan Schore, (2003) states:

> Attachment theory . . . is fundamentally a regulatory theory. . . . Attachment can be conceptualized as the interactive regulation of synchrony between psycho-biologically attuned organisms. The attachment dynamic which operates at levels beneath awareness, underlies the dyadic regulation of emotion. (p. 64)

Schore's work, (2003) draws from a psycho-biological orientation in which the primary caretaker and the infant share a "commutual" psycho-biological environment. He states that "the right-brain to right-brain psycho-biological transactions that underlie attachment processes are bodily-based, and critical to the adaptive capacities and growth of the infant" (p. 67).

Schore (2003) highlights the fact that from the moment of birth, the infant is dependent on the primary caretaker for regulation of its affective states and that this occurs on a psycho-biological level. If, for example, an infant becomes overly agitated, it is the caretaker's responsibility to bring the baby back to emotional stasis. He further states, "The primary caregiver's interactive regulation is therefore critical to the infant's maintaining positively charged as well as coping with stressful negatively charged affects. These affect regulating events are particularly impacting the organization of the early developing right hemisphere" (p. 65).

The need for affect regulation does not end in infancy or early childhood, but continues on throughout life. Schore's theory provides a psycho-biological explanation for Kohut's (1977) developmental theory. Both Kohut and Schore

emphasize the mother's role in regulating affect and providing a calm presence that is essential for normal development to occur.

Other ideas I found useful in interpreting the findings were D. W. Winnicott's (1951) concepts of the transitional object (i.e. blanket or teddy bear), transitional phenomena, (i.e. singing oneself to sleep), and his concept of play. Olinick (1980) discusses how gossip harkens back to the original mother/infant dyad in that it serves as a kind of transitional phenomenon. He draws on Winnicott's (1965) concept of transitional objects/phenomena in that gossiping provides a sense of security and warmth for the agitated therapist. Much like the child's blankie, the act of gossiping soothes the gossiper's anxiety.

With regard to Winnicott's concept of play, Spacks (1985) points out that gossip can be a form of playing which enables us to access our authentic selves and connect to our creativity and spontaneity. In this way, "therapeutic gossip" can serve as an enlivening experience which makes life meaningful.

Limitations of the Study and Implications for Future Research

Participants in this study were four psychologists, four marriage and family therapists, and one social worker. The sample did not include psychoanalysts who might have provided another dimension with regard to casual anecdotal leaks. It might be useful to conduct a study of casual leaks using psychoanalysts exclusively to see how they compare to other professional clinicians.

Another limitation of this study is that all the participants came from the San Francisco Bay area. It would be interesting to explore whether regional differences make a difference in thoughts about therapeutic leaks.

A third limitation is that the participants were asked to remember specific times when they had leaked and some of them had difficulty recalling exact details. These gaps in recollection may have influenced the data. Although this is a common issue in qualitative research, it may have affected the interpretation of the results.

Finally, the fact that I had only one interview with each participant may have limited the amount of information that was revealed. Because of the sensitive nature of this topic, participants may have been more guarded than if we had been able to spend more time together.

Future research on the topic of therapeutic leaks might focus on how therapists were able to implement the therapeutic leak in the service of the work. In other words, how the therapist subsequently used the breach to further understand what was happening in the clinical setting. In that way, the breach could help to inform the unconscious of both therapist and patient.

Concluding Thoughts

All of the participants in this study, regardless of age, gender, or years in practice or licensure, were able to remember times when they had talked about a patient or patients with someone other than their consultant. None of them felt that any harm was done to the patient/s as a result. Mostly they felt that being able to talk to a partner, friend, or colleague was, in fact, quite useful in helping them to re-establish emotional equilibrium.

The one major caveat was where the leak occurred. All of them had stories about hearing patients discussed in public places, such as restaurants or at dinner parties, and felt uncomfortable overhearing these discussions. Not only did they feel

it was disrespectful to the patient, but that it besmirched the practice of psychotherapy as a whole.

The findings suggest that talking about patients fulfills some needs that are not completely satisfied in formal consultation. Formal consultation usually occurs on a weekly or bi-weekly basis. The expectation that therapists can always contain their uncomfortable feelings until speaking with a consultant seems unrealistic. In addition, there is a difference in the relationship one has with a consultant in contrast to that of a close colleague or partner. People who serve as self-objects have greater familiarity with our particular vulnerabilities and can therefore provide a different perspective than a formal consultant.

Therapists are asked to take in and hold the emotions that come up in the clinical hour. Some of these emotions are very difficult to tolerate without some form of empathy or emotional support, so turning to a partner or someone with whom there is an empathic connection can become a pressing need. Self-object needs are basic to human nature. We all occasionally need holding in order to hold our patients in their suffering.

In conclusion, the findings of this study indicate that casual anecdotal leaks are very common among therapists and do serve a purpose. Because the work of psychotherapy can be very intense, therapists must absorb and contain difficult emotional content that inevitably stirs up their own feelings. These feelings, often thought of as counter-transference, are extremely important and help us to understand our patients' conflicts better. At the same time they can also throw us off

balance in the process. Often, we turn to others to help us get understanding and relief.

The more the subject of casual anecdotal leaks comes out of the closet, the more therapists will be able to reflect on their own behavior, be more accepting of their own needs and more circumspect about how they discuss patients outside of formal consultation. Being able to talk about leaks in an open and thoughtful way can lead to awareness that has been hidden under a shroud of shame and secrecy. As psychotherapists, our work is about uncovering and bringing new awareness to our patients. This is a standard we must hold for ourselves as well.

APPENDIX A: RECRUITMENT LETTER

Lonnie Prince, LCSW
2903 Shattuck Avenue
Berkeley, CA 94705
Telephone (510) 845-8179
e-mail: lprince9@yahoo.com

Date:_____

Dear_____,

I am in the process of writing my dissertation for my doctorate at the Sanville Institute in Berkeley, CA, and am asking your help in recruiting participants to interview for my research.

I am doing a qualitative research study on the meaning of anecdotal therapeutic leaks among psychotherapists. My intention is to explore how therapists think about, experience and reflect on these leaks.

Much has been written about egregious breaches but little has been written about these types of casual anecdotal leaks which occur quite frequently. For this reason, my study will attempt to expand on this topic and increase understanding of this relatively unexamined phenomenon.

I am looking for a small number of psycho-dynamically oriented therapists who have been practicing for at least fifteen years. The participants must be able to talk about and reflect on their own experiences of anecdotal leaks.

The interviews will last for sixty to ninety minutes and be relatively unstructured. The session will be recorded at a time and place convenient for the participant.

Do you know of anyone who might be appropriate and interested in this study? If so, could you either tell them about it and suggest they contact me, or give me their names so that I might contact them directly?

My contact information is at the top of this letter. Please let me know if you have any questions which I'd be happy to answer.

Sincerely,

Lonnie Prince, LCSW

APPENDIX B: RECRUITMENT AD FOR NEWSLETTERS

Lonnie Prince, LCSW
2903 Shattuck Avenue
Berkeley, CA 94705
Telephone (510) 845-8179
e-mail: lprince9@yahoo.com

Ad to be submitted to professional newsletters:

SEEKING PARTICIPANTS FOR RESEARCH STUDY. I will interview experienced psycho-dynamically oriented therapists concerning the nature of anecdotal therapeutic leaks. They will be asked for specific instances from their own practices and reflect on the nature of this experience. If you are interested, or would like to learn more about this study, please contact me at the above address. I am a doctoral student at The Sanville Institute in Berkeley, CA. Thank you.

APPENDIX C: LETTER TO PROSPECTIVE PARTICIPANTS

Lonnie Prince, LCSW
2903 Shattuck Avenue
Berkeley, CA 94705
Telephone (510) 845-8179
e-mail: lprince9@yahoo.com

Date: _____,

Dear _____,

Thank you for your interest in my research project. The purpose of my study is to explore the meaning of therapist's casual anecdotal leaks. Since therapeutic leaks are so frequent, I am hoping to shed light on how they may help or hinder our work. By casual anecdotal leaks, I am referring to the phenomenon of discussing patients outside of formal consultation. There has been very little written about these casual breaches and my aim is to bring more awareness to this topic which has been relatively unexplored.

The interview, which will be tape recorded, will take sixty to ninety minutes. You may choose the time and location which is most convenient. I may also follow up with a brief phone call if I need clarification about something we discussed. If you choose to participate, my hope is that you'll find the process helpful in understanding this phenomenon.

The interviews are confidential. Your anonymity and that of any clients you would discuss during the interview will be completely protected.

Please take a few minutes to review the enclosed Informed Consent Form, a copy of which you will be asked to sign at the time of the interview. If you wish to proceed, please fill out the brief screening questionnaire and return it to me in the pre-addressed stamped envelope as soon as possible. If you meet the criteria for this study, I will call to set up an appointment.

Thank you for your participation. Please feel free to contact me at the above phone number or e-mail address, or if you have any questions.

Sincerely,

Lonnie Prince, LCSW
Doctoral Candidate, The Sanville Institute

APPENDIX D: INFORMED CONSENT FORM

THE SANVILLE INSTITUTE

Lonnie Prince, LCSW
2903 Shattuck Avenue
Berkeley, CA 94705
Telephone (510) 845-8179
e-mail: lprince9@yahoo.com

I, _____, hereby willingly consent to participate in an exploratory study of how and why psychotherapists gossip about their patients. How do therapists describe discussing patients outside of normal consultation. This doctoral research project is to be conducted by Lonnie Prince, LCSW, under the direction of Whitney van Nouhuys, PhD, principal investigator and research faculty member, and Samoan Barish, PhD, faculty member at The Sanville Institute.

I understand the procedure to be as follows:

1) One sixty to ninety minute audiotaped interview will take place in a private confidential setting to be arranged by myself and the researcher. I will be talking about my thoughts and feelings with regard to anecdotal therapeutic leaks. This will involve discussing clinical vignettes. I am aware that some of these audio tapes will be sent to an outside transcribing service. The researcher will make every effort to avoid saying my name or other identifying information about myself or my clients on the audiotape. If such information accidentally recorded, it will be omitted from the transcription. I am aware that the audiotape will have a number rather than my name.
2) I am aware that talking about casual anecdotal leaks may cause some emotional discomfort. Should that happen during the interview, I understand that I may terminate the interview at my discretion. Should I so

request, the researcher will provide crisis counseling at this time. Should I experience discomfort after the interview, I understand that I may contact the researcher who will make provisions for me to receive professional help for a reasonable and limited time.

3) I understand that I may withdraw from this study at any time. I also understand that this study may be published and that my anonymity and the confidentiality of my material will be protected unless I give written consent to such disclosure. Otherwise, no names or individual identifying information will be used in any oral or written materials. The audiotape will be erased at the completion of the data analysis.
4) I understand that I have the option to receive feedback from the results of the study. Please send me a summary of the results at the address below.

Yes_____No_____

Signature:_____ Date:_____

Address:_____

If you wish to receive a copy of this study, please provide your name and address:

Name:_____

Address:_____

APPENDIX E: SCREENING FORM

Lonnie Prince, LCSW
2903 Shattuck Avenue
Berkeley, CA 94705
Telephone (510) 845-8179
e-mail: lprince9@yahoo.com

NAME: _____ AGE: _____

ADDRESS: _____

_____

TELEPHONE:
(Days)_____**(Evenings)**_____

EMAIL: _____

DEGREE: _____**LICENSURE:**_____

THEORETICAL ORIENTATION:_____

YEARS IN PRACTICE: _____

APPENDIX F: INTERVIEW GUIDE

Thank you for agreeing to this interview and helping me with my research project. This will be an audiotaped interview lasting about sixty to ninety minutes. I am interested in hearing your thoughts and feelings concerning your own experience with what I call "casual anecdotal breaches." By anecdotal breaches I am referring to situations in which therapists discuss patients outside of formal consultation. This is a very common phenomena and something that almost everyone does.

The topic of casual anecdotal breaches has not been explored and I am hoping to shed some light on something that has been outside of conscious examination. I am hoping that in opening up this topic, you might help me better understand how you think and deal with this issue in your own practice. As we talk, I would like you to reflect on examples from your own experience. Let's begin by talking about your own theoretical orientation.

I. How does the participant describe his theoretical orientation?
II. What are the participant's thoughts or beliefs concerning confidentiality in his clinical practice?
III. What are the participant's thoughts and feelings about anecdotal leaks
IV. Can the participant describe an experience where he talked about a patient with a friend or a spouse?
V. What are some of the contexts in which the participant gossiped?
VI. With whom is the participant most likely to discuss patients outside of consultation?
VII. Are there particular types of patients that are discussed?

VIII. What are the thoughts or reflections about why some patients are discussed in this but not others?

IX. How did the participant feel about this interview and is there something he would like to add?

APPENDIX G: PROTECTION OF RESEARCH PARTICIPANTS APPROVAL

THE SANVILLE INSTITUTE
PROTECTION OF RESEARCH PARTICIPANTS APPLICATION

Title of Research Project The Meaning of Therapeutic Resolution in Psychotherapy: Why Therapists Disagree

Principal Investigator: Whitney van Nouhuys, PhD
(print name and degree)

Investigator: Connie Prince
(print name)

I have read the *Guidelines, Ethics, & Standards Governing Participation & Protection of Research Participants* in research projects of this Institute (in Appendix D of the Student and Faculty Handbook), and I will comply with their letter and spirit in execution of the enclosed research proposal. In accordance with these standards and my best professional judgment, the participants in this study (check one)

_____ Are not "at risk."

__x__ May be considered to be "at risk," and all proper and prudent precautions will be taken in accordance with the Institute protocols to protect their civil and human rights.

I further agree to report any changes in the procedure and to obtain written approval before making such procedural changes.

Whitney van Nouhuys 3/2/11
(signature of principal investigator/date)

Connie Prince
(signature of investigator/date)

Action by the Committee on the Protection of Research Participants:

Approved ___x___ Approved with Modifications _____ Rejected _____

_____ Date 3/8/11
Signature of representative of the Committee on the Protection of Research Participants/date

_____ 3/26/11
(signature of dean & date)

REFERENCES

Abrahms, R. (1970). A performance-centered approach to gossip. *Man: The Journal of The Royal Anthropological Institute, 5*, 291-294.

Albers, D., & Morris, R. (1990). Conceptual problems in studying social workers' management of confidentiality. *Social Work, 35*, 361-362.

Allphin, C. (2005). An ethical attitude in the analytic relationship. *Journal of Analytic Psychology, 50*, 451-468.

American Heritage Dictionary (3rd ed.). (1992). *s.v.* gossip. Houghton Mifflin.

Atwood, G., & Stolorow, R. (1984). *Structures of subjectivity*. Hillsdale, NJ: Analytic Press.

Ben-Ze'ev, A. (1994). The vindication of gossip. In R. Goodman & A. Ben-Ze'ev (Eds.), *Good gossip* (pp. 11-24). Lawrence: University Press of Kansas.

Besnier, N. (1989). Information withholding as a manipulative and collusive strategy in Nukulaelae gossip. *Language in Society, 18*, 315-341.

Berry-Harris, T. (2007). *Examining therapists' perceptions of confidentiality* (Doctoral dissertation). Available from ProQuest Dissertations and Theses database. (UMI No. 3298541)

Bollas, C., & Sundelson D. (1995). *The new informants*. North Vale, NJ: Jason Aronson.

Burka, J. (2008). Psychic fall out from a breach of confidentiality. *Contemporary Psychoanalysis* 21 (1) 54861

Caruth, E. 1986). Secret bearer and secret barer. *Contemporary Psychoanalysis, 21*(1), 548-561.

Chase, D. (Creator), & Van Patten, T. (Director). (1999). *The Sopranos* [Television series]. New York, NY: Home Box Office.

Clinical Social Work Federation. (1997). *Clinical Social Work Association code of ethics*. Retrieved from http://www.clinicalsocialworkassociation.org/about-us/ethics-code

Collins, L. (1994). Gossip: A feminine defense. In R. Goodman & A. Ben-Ze'ev (Eds.), *Good gossip* (pp. 106-116). Lawrence: University Press of Kansas.

Corbin, J., & Strauss, A. (2008). *Basics of qualitative research.* Newbury Park, CA: Sage.

de Sousa, R. (1994). In praise of gossip: Indiscretion as a saintly virtue. In R. Goodman & A. Ben-Ze'ev (Eds.), *Good gossip* (pp. 25-33). Lawrence: University Press of Kansas.

Ellman, S. (1991). *Freud's technique papers: A contemporary perspective.* Northvale, NJ: Jason Aronson.

Emler, N. (1994). Gossip, reputation and social adaptation. In R. Goodman & A. Ben-Ze'ev (Eds.), *Good gossip* (pp. 117-138). Lawrence: University Press of Kansas.

Fonseca, C. (1982). The gossiping analyst: *The International Review of Psycho-analysis, 9,* 355-357.

Foster, E. (2003). Research on gossip: Taxonomy, methods, and future directions. *Review of General Psychology, 8*(2), 78-90.

Freud, S. (1900). The interpretation of dreams. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vols. 4 & 5, pp.1-626). London, England: Hogarth Press.

Freud, S. (1905). *Three essays on the theory of sexuality.* New York, NY: Basic Books.

Freud, S. (1988). On beginning the treatment. In P. Gay *Freud, a life for our time* (pp. 363-378). New York, NY: W. W. Norton. (Original work published 1913)

Furlong, A. (2003). The why of sharing and not the what: Confidentiality and analytic purpose. In C. Levin, A. Furlong, & M. O'Neil (Eds.), *Confidentiality, ethical perspectives and clinical dilemmas* (pp. 40-50). Hillsdale, NJ. Analytic Press.

Gay, P. (1988). *Freud, a life for our time.* New York, NY: W. W. Norton.

Glaser, B., & Strauss, A. (1967). *The discovery of grounded theory.* Chicago, IL: Aldine.

Gluckman, M. (1963). Gossip and scandal. *Current Anthropology, 4,* 307-315.

Goodman, R. (1994). Introduction. In R. Goodman & A. Ben-Ze'ev (Eds.), *Good gossip* (pp. 1-8). Lawrence: University Press of Kansas.

Klein, M. (1977). *Envy gratitude and other works.* New York, NY: Dell.

Koggel, C., Furlong, A., & Levin, C. (Eds.). (1994). *Confidential relationships: Psychoanalytic, ethical and legal contexts.* Amsterdam, The Netherlands: Rodopi.

Kohut, H. (1971). *The analysis of the self.* New York, NY. International Universities Press.

Kohut, H. (1977) *The restoration of the self.* New York, NY: International Universities Press.

Kohut, H. (1978). The psychoanalytic treatment of narcissistic personality disorders. In P. Ornstein (Ed.), *The search for the self: Selected writing of Heinz Kohut: 1950-1978* (Vol. 1, pp. 205-232). New York, NY: International University Press.

Kohut, H. (1984). *How does analysis cure?* Chicago: University of Chicago Press.

Kohut, H., & Wolf, E. (1978). The disorders of the self and their treatment: An outline. *International Journal of psychoanalysis, 59,* 413-425.

Lander, R. (2002). The incontinent analyst. *International Journal of Psychoanalysis, 84,* 891-895.

Langs, R. (1973). *The technique of psychoanalytic psychotherapy.* New York, NY: Jason Aronson.

Lear, J. (2003). Confidentiality as a virtue. In C. Levin, A. Furlong, & M. O'Neil (Eds.), *Confidentiality, ethical perspectives and clinical dilemmas* (pp. 3-18). Hillsdale, NJ: Analytic Press.

Lindenthal, J. I., Jordan, T. J., Lentz, J. D., & Thomas, C. S. (1988). Social workers management of confidentiality. *Social Work, 33,* 157-158.

Lynn, D., & Vaillant, G. (1998). Anonymity, neutrality, confidentiality in the actual methods of Sigmund Freud: A review of 43 cases, 1907-1939. *American Journal of Psychiatry, 155*(2), 163-171.

McLean, J. (2007). Psychotherapy with a narcissistic patient using Kohut's self-psychology model. *Psychiatry, 4*(10), 40-47.

Medini, G., & Rosenberg, E. (1976). Gossip and psychotherapy. *American Journal of Psychotherapy, 30*(3), 452-458.

Mishler, E. (1986). *Research interviewing: Context and narrative.* Cambridge, MA: Harvard University Press.

Mitchell, J. (1986). *The selected works of Melanie Klein.* New York, NY: Free Press.

Mitchell, S., & Black, M. (1995). *Freud and beyond.* New York, NY: Basic Books.

National Association of Social Workers. (2008). *Code of ethics,* Retrieved from http://www.socialworkers.org/pubs/code/default.asp

Nowell, D., & Spruill, J. (1993). If it's not absolutely confidential, will information be disclosed? *Professional Psychology: Research and Practice, 24*(4), 367-369.

Olinick, S. (1980). The gossiping analyst. *International Review of Psychoanalysis, 7, 439-444.*

O'Neil, M. (2007). Confidentiality, privacy, and the facilitating role of psychoanalytic organizations. *International Journal of Psychoanalysis, 88,* 691-711.

Paine, R. (1967). What is gossip about? An alternative hypothesis. *Man, 2*(2), 278-285.

Patton, M. (1990) *Qualitative evaluation and research methods.* Newbury Park, CA: Sage.

Rosenbaum, J., & Subrin, M. (1963). The psychology of gossip. *Journal of the American Psychoanalytic Association, 11,* 817-829.

Schein, S. (1994). Used and abused: Gossip in medieval society. In R. Goodman & A. Ben-Ze'ev (Eds.), *Good gossip* (pp. 140-153). Lawrence: The University Press of Kansas.

Schore, A. N. (2003). *Affective dysregulation and disorders of the self.* New York, NY: W. W. Norton.

Spacks, P. (1985). *Gossip.* Chicago, IL: University of Chicago Press.

Strauss, A., & Corbin, J. (1998). *Basics of qualitative research.* Thousand Oaks, CA: Sage.

Tannon, D. (1990). *You just don't understand.* New York, NY: Ballantine Books.

Tarasoff v. Regents of University of California, 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (Cal. 1976).

Tomlinson, C. (2003). The early history of the concept of confidentiality in psychoanalysis. In C. Levin, A. Furlong, & M. O'Neil (Eds.), *Confidentiality, ethical perspectives and clinical dilemmas* (pp. 139-150). Hillsdale, NJ: Analytic Press.

Winnicott, W. (1951). Transitional objects and transitional phenomena: A study of the first not-me possession. *International Journal of Psychoanalysis, 34*, 89-97.

Winnicott, W. (1965). *Maturational process and the facilitating environment.* New York, NY: International Universities Press.

Zungu, C. (2008). *A study of views of intern psychologists and registered psychologists on the concept of confidentiality.* ResearchGate.net. doi:10530/359