Audio-Recordings of the Psychoanalytic Dialogue: Scientific, Clinical and Ethical Problems

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1. Introduction

The tape-recording of psychoanalytic sessions should by now be standard procedure for those who are prepared to undertake serious empirical research on the psychoanalytic process. However, the number of those who expose themselves to this procedure is still small, nearly as small as the number of those willing to engage in the careful scrutinizing of what they do when practicing psychoanalysis. Glover's 1936 (1955) questionnaire investigation into the prevailing techniques among British psychoanalysts has to be looked upon more as an opinion poll than as actual empirical research.

There are many reasons why analysts are so reluctant to use tape-recording in their practice. First of all, since Freud's (1916/17) warnings against the presence of a third person are often extended to the presence of a recorder or of microphones in the consulting room, it is instructive to look at Freud's exact wording. He stated that the patient "would become silent as soon as he observed a single witness to whom he felt indifferent" (p. 18). It is clear that this statement cannot be used as an argument against the tape-recording of sessions.

Freud could not have known in 1916 that human inventiveness would one day produce a very unobtrusive instrument – the tape recorder. As we know, it gives an unmistakably correct account of the verbal exchange that is superior to any recollection by the analyst, including detailed notes written after the session or – as Freud preferred – late in the evening. Since Freud was trained to follow the rules of the natural sciences, we assume that he would have welcomed new ways to assure accurate observation and data collection in the psychoanalytic situation. When he pleaded for training analyses it was in part meant to

reduce analysts' distortions in their understanding of their patients' free associations. Although this was not only an utopian but a misleading ideal for psychoanalysis we believe that it was offered in the same spirit in which we suggest that tape-recording and transcribing the dialogue offers a powerful tool for investigating the exchange between patient and analyst – to the extent that this is expressed in their language. Although much more does indeed happen on an unconscious and emotional level, it is the final aim of the psychoanalytic process to translate or to interpret, that is, to put into words the patient's unconscious wishes and defenses. And these words are the starting point for further investigations.

It is our experience that after a certain time the treating analyst gets accustomed to the tape-recording. And his evenly hovering attention is no longer distracted by his inadvertent attempts to select certain passages for later note taking, to say nothing of the shorthand and seemingly accurate notes that some analysts, e.g. Wurmser (personal communication) have taken. As the first analysts to start, in 1968, tape-recording psychoanalytic sessions in Germany we were very interested in systematically collecting and examining our own clinical experiences with recording. We therefore planned a formal investigation on which we shall report after we first consider certain related problems.

We begin with Freud's warnings against the presence of a third person in the consulting room. Indeed, a great many "third persons" become potential intruders if the dialogue between analyst and patient is recorded and transcribed. The analyst protects the patient in this situation in two main ways: first, by obtaining informed consent, and second, by protecting the patient's anonymity. By now it is a well established fact that only very few patients refuse tape-recording if everything is properly explained. The patient is told that, if he agrees: (1) the sessions will be tape-recorded and made accessible to the patient himself, the treating analyst and the scientific community, (2) it is up to the patient to decide whenever he wants the recording machine turned off and/or if he wishes to stop the recording altogether, and (3) the analyst assumes an active responsibility for protecting the patient's anonymity.

Protecting the patient's identity and his secret, is readily accomplished by such devices as using codes in the transcripts, by systematically limiting access to such transcripts to bona fide clinicians and researchers who themselves assume the treating analyst's responsibility to maintain confidentiality, and by carefully disguising publicly presented and published patient material. Because it is each analyst's

individual professional responsibility to protect the patient's anonymity, St. Nepomuk might be acclaimed as the patron of our profession since he chose drowning in the Moldau river at the hands of a Bohemian king instead of revealing to the king his queen's confessions of her assumed infidelities.

But the strongest resistance to tape-recording comes from analysts themselves. It is not easy to expose oneself fully to the critical investigation of colleagues who all too readily infer from the interpretations given to their sources, not in the patient's material, but in the feelings and hidden motives of the analyst. In fact, it is a very sobering experience for every analyst to listen to his own voice and often less than perfect interpretations. Kubie's (1958) description reflects our own experience and the extended quote speaks for itself:

When for the first time a student psychiatrist or an experienced analyst hears himself participate in an interview or a psychotherapeutic session, it is always a surprisingly illuminating experience. He hears himself echo the patient. Or he hears himself outshooting or outwhispering the patient, always louder or always softer. Or he hears himself playing seesaw with his patient – loud when the patient is soft, and soft when the patient is loud. Or with surprise and dismay he hears in his own voice the edge of unintended scorn or sarcasm, or impatience or hostility, or else over tender solicitude and seductive warmth. Or he hears for the first time his own unnoted tic-like noises punctuating and interrupting the patient's stream. From such data as this he and the group as a whole learn a great deal about themselves and about the process of interchange with patients and what this process evokes in them in the form of automatic and therefore indescribable patterns of vocal interplay.

They learn also to watch for and to respect the subtle tricks of forgetting and false recall to which the human mind is prone. In one session a young psychiatrist reported that in a previous interview at one point his patient had asked that the recording machine be turned off while he divulged some material which was particularly painful to him. The group discussed the possible reasons for this, basing our discussion on our knowledge of the patient

from previous seminars. Then to check the accuracy of our speculative reconstruction, the psychiatrist was asked to play to the group about five minutes of the recorded interview which had preceded the interruption, and then about five of the minutes which followed when the recording had been resumed. To the amazement of the young psychiatrist and of the group as a whole, as we listened to the recording we discovered that it had been the psychiatrist and not the patient who had suggested that the recording should be interrupted. Of his role in this, the young psychiatrist had not the slightest memory. Furthermore, as we heard the patient's halting speech, his change of pace and volume, the altered pitch and placing of his voice, it became clear to the whole group that the young psychiatrist's intuitive move had been sound: that he had correctly evaluated the patient's mounting tension and had perceived the need for this gesture of special consideration and privacy. The result was that the patient's rapport was more firmly established than before, to such an extent that the psychiatrist could now recall that it had been the patient who had suggested that the recording be resumed after a relatively brief interruption, and who then, with the machine turned on, had continued to discuss frankly and without embarrassment the material about which he had been so touchy before. The illuminating implications of this episode for the data itself and for the transference and countertransference furnished the group with material for reflection and discussion throughout the remaining course of the seminars. These could not haven been studied without the recording machine (pp. 233-234).

This study of the influence of tape-recording and transcribing on the psychoanalytic process was conducted as a doctoral thesis study by one of us (WR) under supervision (by HK and HT). We wondered if the experiences of a number of analysts over many years still justified Gill's emphatic conclusion: "We doubt that any problem will arise on the patient's part in a research analysis, which is not already known from ordinary analysis" (Gill et al. 1968, p. 236).

In designing this study we were acutely aware of the limitations imposed by the fact that we could not use a controlled design, because one cannot analyze the same patient once with and another time without

a tape-recording! Moreover, we were also still under the influence of the implicit opinions of the majority of analysts against the use of tape-recording. And, to our surprise, it was only very late in our own clinical and scientific work with tape-recorded analyses that we overcame a negative bias against them. Even at the end of this investigation, when Ruberg presented the results at his formal dissertation defense, a colleague, drew our attention to a defensive quality about our undertaking. We believe that he was right and that we did indeed experience guilt-feelings and countertransference responses as part of our biases about the negative effects on the psychoanalytic process.

One source of these negative feelings lay in the high priority we attached to making precise and exact interpretations. Tape-recording and transcribing made it very easy for us to notice that we often failed to live up to our own (and other's) expectations. Nonetheless, we also gave high priority to Freud's insistence that our deepest professional obligations require us to face reality and acknowledge truth. Therefore, increasingly it seemed to us that there must inevitably be beneficial consequences for both individual patients and for the psychoanalytic community when the treating analyst looks straight in the eye what he actually communicates and does in the consulting room. We believe that if the analyst uses transcripts as an opportunity for self-examination as a means for continuous supervision either by self-reflection or by getting supervision based on transcripts, the benefits to the patient are very great indeed. We studied four psychoanalytic treatments and processes, and our own overall evaluation is a positive one: we believe that the introduction of tape-recording has no irremediable negative effects on the psychoanalytic process. On the contrary, it opens new vistas and opportunities for the analyst's work.

2. Method

1. Data

The empirical basis for this investigation rests on four long-term psychoanalytic treatments undertaken by two analysts who, later, were also part of the research team (HT and HK) About 20% of the total number of treatment sessions, 366 out of 1796, were transcribed, not for this specific study, but as part of a general data base for process studies of a variety of questions. The stratified sample covered the entire treatment ranges: out of every block of 25 sessions, 5 consecutive sessions were included (see Table 1).

Table 1

Patient/Analyst	total sessions	sample size	sample in %
A - HT	530	110	21
B - HT	517	113	22
C - HK	408	50	12*
D - HK	341	93	27
total	1796	366	mean 20

*In this treatment the analyst had considerable problems maintaining a regular tape recording plan.

There is a striking difference between the two analysts in the frequency with which sessions were in fact recorded. The junior analyst only actually recorded 12% of the sessions with his male patient compared with 20% for the senior analyst. However, technical circumstances may have contributed to this difference. The senior analyst's secretary regularly set up the tape recorder for him, while the junior analyst had to make these preparations himself. Nonetheless the difference between HK's recording rates with his male and his female patient suggests that other internal, perhaps countertransference, problems may have been present as well.

2. Variables

Since we wanted to assess the impact of tape-recording on the psychoanalytic process our first task was to select what we thought were a set of variables (ways in which the influence would be manifest) and try to operationalize them. We assumed (a) that the impact of the recording could in principle show up anywhere and any time in the material, (b) that it could assume any specific meaning for a particular patient at any given time, and (c) that it could take on different meanings at different stages of a treatment. Our basic strategy was to look at the basic rates of occurrence of these variables compared with a control set of variables that we expected to be important in all analyses.

First, we wanted to find (1) direct, manifest references to the tape-recording procedure by either the patients or the analysts. Second, because we assumed that there would also be indirect, latent or disguised allusions to the recording, we looked for three presumably related themes: (2) remarks about feeling exposed, (3) comments and feelings about being observed, and (4) references to issues of trust and confidentiality, especially in the relationship to the analyst. As control variables we looked for topics that are usually regarded as both common and significant in clinical work: (5) reactions to and feelings about payment, (6) references to the couch, and (7) the reporting of dreams.

3. Measurement - with a Computer Content Dictionary

One might imagine that the straight forward way to search for manifestations of the seven variables that we had decided upon would be to read through the entire 366 transcripts and identify each instance. But this is a big order, surpassing even the motivation of a doctoral candidate. Fortunately we were able to solve our search problem by using a technology called computer assisted content analysis (CACA) which works with the transcripts that are stored in the computer based ULM TEXTBANK (Kächele and Mergenthaler 1983; Mergenthaler 1985; Mergenthaler and Kächele, this volume). The basic method (see Stone et al. 1966) involves designing a specific computer content dictionary as the measuring instrument.

Such a dictionary consists of a set of conceptual categories representing the variables to be measured and each category is in turn defined by a list of words (nouns, adjectives and verbs) thought to exemplify manifestations or instances of the concept. Our seven variables, of course, became our seven categories:

Category No.	Category Name	Description of Word List
1	Tape	All words that refer to tape- recording.
2	Exposure	All words that refer to shame and being exposed in public. Includes positive as well as negative references.

3	Being Observed	All words that refer to the feeling of being observed, looked at, etc.
4	Trust	All words that refer to the feeling of trusting or not trusting somebody.
5	Payment	All words that relate to payment for the treatment.
6	Couch	All words that refer to lying on the couch.
7	Dreams	All words that refer to some aspect of dreams and dreaming.

We used the methods developed by Stone and his colleagues (Stone et al. 1966) to construct our dictionary. From a German thesaurus (Synonymwörterbuch von Textor 1962) – comparable to Roget's Thesaurus – and the DUDEN (a dictionary of written and spoken German) we selected all of the words that might represent or refer to each of the above seven dictionary categories. In this way we obtained a first word list of 1600 words. These words were then compared with our "Basic Vocabulary of Psychotherapeutic Language" – the part of the ULM TEXTBANK containing the vocabulary of an eight million word corpus of text – and we retained only those words that are actually used in psychotherapy sessions. We were left with 735 words distributed over the seven categories. Finally, when we first applied our newly constructed dictionary to the 366 transcripts, we were further able to reduce the list of dictionary entries to 317 because the other words did not occur in these sessions.

With this final version of the Tape-Recording Dictionary (TRD, Ruberg 1982, pp. 139-142) we analyzed the 366 sessions by using a computer text analysis package called EVA-ULM (see Mergenthaler 1985), which yields frequency scores for each of the seven categories for each of the sessions. Although it is clear that the measurement reliability of this method is perfect because the programs do not make mistakes in matching the words of the text to those of the dictionary, nonetheless a real question can be raised about their validity. The dictionary as a measure embodies a simple (if not simple-minded) linguistic hypothesis,

namely that the lists of words which define the seven categories adequately capture the concepts, even while ignoring syntactic and contextual information. Nonetheless those who remain skeptical of these key-word procedures should examine some clinically compelling examples of their ability to measure some rather complex concepts (e.g. Dahl 1972, 1974, 1983).

The practical issue in this validity problem lies in the question: are the text references picked out by the computer program *really* examples of the intended meaning of a given category? To check this, one of us (WR) read all the instances, e.g. all references identified by the text analysis, 14 in the verbatim transcripts and made a commonsense judgment about whether the specific text was indeed an instance of a given category. At the same time this judge was able to identify references to the categories in the text that were not picked up by the content analysis. Table 2 summaries the false positive and false negative identifications.

Table 2 Correctness of Computer-Based Identification (in %)

category	tape 1	exposure 2	observation 3	trust 4	payment 5	couch 6	dream 7
false positive	2.6	48.0	19.8	7.0	6.3	1.0	1.5
false negative	–	3.4	5.1	2.9	2.0	1.9	0.4
total	2.6	51.4	24.9	9.9	8.3	2.9	1.9

In six out of the seven categories there were more false positives than false negatives, in other words, the program "found" instances that were in fact not instances of a category more often than it missed true instances, which is desirable for a scanning procedure. However, more than 50% of the Exposure Category references were misleadingly identified, which certainly highlights the limitations of this kind of diction-ary measure.

4. Results

The misidentified or missed texts were corrected by the judge with the following results for the frequency of direct and indirect references to the tape-recording (Table 3):

Table 3 Frequency of Direct and Indirect Reactions to Tape- Recording and Frequency of Control Variables

	tape	exposure	observation	trust	payment	couch	dream
category	1	2	3	4	5	6	7
n sessions	7	169	44	48	49	36	148
% sessions	1.9	46.2	12	13.1	13.4	9.8	40.4

To our surprise only 7 of the 366 sessions contained direct references to tape-recording. Of course not all initial sessions in which the question of recording was introduced and discussed were included, but one must still consider the possibility of a sampling artifact. The rarer the events in the entire domain the less the chance that these events will appear in the sample. However to adequately study this question in more detail one needs a complete set of recordings of each treatment (see Grünzig 1985 and Grünzig, this volume).

Nonetheless, is it really surprising that analysts and patients so seldom mention the recording? The two analysts in this study had quite different backgrounds and experience. One of them (HT) was a senior analyst with more then 20 years of experience. The other analyst (HK) however, was conducting and recording his first two training analyses. Although it is reasonable to assume that they had quite different motives and reasons for participating, they at least shared enthusiasm for undertaking something as challenging and novel as tape-recording psychoanalyses. In any case, part of the answer to the question lies in the fact that neither analyst forced his patients to talk about the recording. And it is certainly a plausible hypothesis that the analysts failed to encourage

their patients to talk freely about the recordings because of their own anxieties about the procedure. We will return to this matter shortly.

The main findings of the content analysis are shown in Table 4.

Table 4 Frequency of Direct and Indirect Reactions to Tape- Recording for Four Patients in % of Sessions

category	tape 1	exposure 2	observation 3	trust 4	payment 5	couch 6	dream 7
Pat. A (N=110)	–	49.1	–	15.5	3.6	5.5	25.5
Pat. B (N=113)	2.7	35.4	18.6	3.5	22.1	19.5	60.2
Pat. C (N=50)	–	58.0	2.0	18.0	18.0	4.0	8.0
Pat. D (N=93)	4.3	49.5	23.7	19.4	11.8	6.5	51.6

One of the puzzling findings is that in this sample of the four patients only the two female patients, one from each analyst, referred to the tape-recording (Patient B, 2.7%; Patient D, 4.3%). Moreover these same female patients much more frequently talked about "being observed" than did the male patients. In fact the results indicate that patients of the same sex (A and C were male, B and D female) were more alike than patients of the same analyst (HT: A and B; HK: C and D).

5. Clinical Illustrations

Let us return now to the hypothesis that the low frequency of references to tape-recording was at least in part due to the analysts' failure to encourage the patients to talk about their responses and associations to the procedure. In an informal attempt to throw light on this question we shall provide some examples from the two treatments where

we found direct references to the recording in the sample of this investigation.

Patient B

Session 101: The patient asks, after a discussion of details of her sexual problems, if the recording machine is still on. The analyst replies, "Yes." She wonders if Mrs. X, the analyst's secretary, will transcribe the session, but before the analyst answers she adds, "You need not answer. I don't care anymore." When the analyst wonders why she retreats so quickly she focuses on the fact that the secretary is female and thus might have a more truthful and stricter attitude towards sexual perversity than the analyst seems to have. Thus the topic shifts from the recording and transcribing to the patient's conflictual material.

Session 202: The patient understands one of the analyst's statements to be an explanation of his analytic technique. She highly appreciates this and wonders if there is no tape-recording during this session since the analyst seems much freer and less restricted than usual. She experiences the audio-recording as a kind of higher moral pressure under which the analyst suffers just as she suffers under the strict authority of her headmaster.

Session 352: The patient recalls that from time to time while waiting for the hour to begin she has heard funny and sometimes derogatory remarks coming from the secretary's office. She believes that these are references to typing the tapes of the patient's sessions. She has recently read an article by her analyst and had the impression that, just as the secretary must despise her, he despised the patient whom he described in the article. She is very critical of the analyst for this, feels rejected, and imagines that after the session the analyst sits down at his desk, writes an essay about her and gets excited about the session that just finished because of its scientific implications. She is reduced to a mere object of science.

Three examples were found in which the reference to the tape was not manifestly connected to the treatment. *Session 129*: The patient reports on tapes with stories from her grandmother. *Session 213*: The patient uses a tape recorder herself to conduct an opinion poll in her office. *Session 279*: The patient mentions the use of tape-recording in her own profession. Obviously all three of these incidents might be indirect references to the treatment, but the analyst did not so interpret them at the time.

In summary it appears that Patient B's reactions to the tape-recording indicated a central concern that the function of the recorder was that of a moral censor. In her third session she reported childhood memories of going to confession and compared these with the analytic situation. She said that, even today she still had trouble participating in "open confession ceremonies" as they were practiced in Catholic church services. In hour 242 (not in the sample) she told a dream in which her analysis was being conducted publicly. The analyst pointed out the connection between confession, being treated publicly and the tape-recording.

Patient D

In the introductory session this patient of the junior analyst had reacted very positively to the idea of recording, saying that her brother, who was a psychologist, could make use of the tapes himself.

Session 3: The patient talks about what the relationship with the analyst means to her. She wants to exclude any personal, emotional relations, saying, "Yeah, if one could achieve that, that would make it much easier to convey to you what comes to my mind – if I could switch you off, if I would be all on my own in this room and could talk to the tape alone." The analyst points out that this expresses her ambivalence between wishing for closeness and wishing for protective distance.

Session 4: The patient begins by asking whether the tape machine is turned off, because the dust cover is still on. She says that last night she was out and consumed quite a few glasses of wine. The analyst interjects, "So you may not want to record your present state," to which she replies with a certain irony, "No, that doesn't bother me at all. Maybe I'm concerned that you'll miss my precious utterances. But maybe the machine is running. Who knows?" The analyst suggests that perhaps the importance of the tape-recordings is what happens to them. She then reports having felt deserted over the weekend (between sessions 3 and 4) just as she had often felt during empty weekends at her school. She then reports a dream in which a girl exhibited herself in a police station to a man who got sexually aroused. In the next scene during a medical examination a physician took an x-ray and then looked only at her bare skeleton. She wanted a more satisfying examination and was disappointed. The analyst tells her that she is feeling insecure about her own attractiveness and connects this to her feelings about the tape-recording.

Session 88: The patient complains that she has nothing to talk about. She says that if she could feel that somebody likes her then she would be able to talk a lot – sometimes even too much – and "when I have the feeling that you are cool, this doesn't work at all." The analyst says that she feels an obligation to feed him. And she refers back to the previous session where she said that in every session at least one sentence from her must be useful. She feels all of these tapes are full of empty, worthless stuff. They should contain at least one precious word or else they could be thrown away. The analyst points out that she feels she has to report something special in order to be appreciated. She then recalls feeling humiliated during her initial interview with the head of the clinic; she had the feeling that she could not show him any of her positive assets and hoped that he would also listen to these tapes. Then he would learn more about her difficulties, but also have a chance to see her accomplishments, because she perceived being offered an analysis in his clinic as an act of mercy.

In summary, the tape-recording seemed to have several different but related meanings for this patient. In one instance the recordings were connected with her obligations to a powerful father figure, the chief of the clinic, to whom she felt obligated, but whom she wanted to impress. In another it represented a means of giving gifts to her client-centered therapist brother. And it confronted her with her own feelings of emptiness, unattractiveness and worthlessness, and the wish to give precious words to the analyst lest the tapes too be worthless.

6. Ethical Aspects

When a psychoanalyst asks a patient for informed consent o make audio recordings of the analysis he explicitly or implicitly informs the patient that the boundaries of the privacy of the consulting room are extended to involve other people, known or unknown to the patient. These include those who transcribe the tapes and professional colleagues who either listen to them or read and study the transcripts. Moreover, the analyst assumes the obligation to maintain the patient's confidentiality within these limits. In contrast, patients undergoing supervised analyses are rarely if ever informed of that fact and the implicit extension of the boundaries of privacy that it entails. It is curious that analysts who might be very uncomfortable with the first extension, which the patient knows about, are likely to be quite comfortable with the other extension of which the patient is typically ignorant.

We believe that the openness of the analyst's attitude, as embodied in obtaining informed consent, can contribute significantly to a therapeutic alliance based in part on the fact that both patient and analyst know that the analyst, as well as the patient, will be observed by others, that in that respect they are both "in the same boat." While it is undoubtedly true that some patients and analysts view this as an unbearable intrusion on their privacy, it is also true that others find it not only tolerable, but liberating.

We believe that an analyst not only has the negative ethical obligation to not harm his patients, but that he also has a positive ethical obligation to take any reasonable steps that promise a better and deeper understanding of his patients and thereby enhance his effectiveness as an analyst. The beneficial effects of recording may occur quite directly, as when the analyst replays all or a portion of a session during ongoing treatment, or they may occur more indirectly as a result of studying transcripts at leisure after an analysis is ended. We believe that it is healthy for an analyst to be confronted with what he *in fact* has said, with his actual interpretations, rather than be satisfied with his own fallible memory. It is healthy to relisten or reread and discover, or have one's colleagues point out that one missed some important material, just as it is healthy to note when one seems to have understood and made a useful intervention. These considerations alone would constitute sufficient reason for introducing tape-recording as a regular procedure, to say nothing of the value of the potential knowledge to be gained from systematic research.