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PATIENTS' RESPONSES TO THEIR OWN CASE REPORTS

ROBERT J. STOLLER, M.D.

We would do better ethically and scientifically if throughout the process of writing and publication, we let our patients review our reports of them.

A PROBLEM PRETTY MUCH UNTOUCHED in our literature—that our version of the clinical moment is the official one—is important for us regarding both confidentiality and psychoanalysis as science. I shall discuss patients' responses to their participating in the process of writing, and also their responses, as the years pass, to now-published writings.

When first reporting descriptions of patients, I did not attend to the above problem (i.e., avoided paying attention to, explained away the need to pay attention to, denied the need to pay attention to, accepted that no big problems were involved, etc.). That was a mistake.

Serving more as answers than as questions, few—too few—analytic case reports are long or rich enough for issues of confidentiality to come up. Most of us have probably been untroubled if published narratives were undetailed. Not yet responsive to the philosophers of science, we accepted each other's skimpy, undocumented accounts as reliable evidence. We had—still have—much at stake: pride, including our scientific pretensions, as against humbling candor. But now we know we must try harder, which puts the need to protect patients at odds with our trying to be objective and possibly scientific. The lesson is directed toward psychoanalysts, though

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the examples are not from analyses. Despite this thinness, I think colleagues will see a good fit with analytic patients.

Confidentiality

To orient this discussion, let me review how I record and store clinical material. I have audiotaped most evaluation interviews for more than 30 years, first getting the patient's permission.[1] Most treatment hours in the past 25 years were also taped, except for analyses. I tape and have typed up, in addition, the work with several patients seen individually in a congenial, not-quite-treatment relationship in which, over periods of 10, 20, or more years, they teach me about themselves (I shall not take up the pros and cons of introducing taping into the delicate relationship doctor and patient share [Zinberg, 1985]).

When I do not tape, I explain to patients that, whether taking notes during the interview or not, I later dictate process notes onto tape; the untranscribed tapes are then locked away, not in the office.[2] Both my office and the room where records are kept (neither shared by anyone else) are off the master key for the hospital. If interviews or dictated notes need to be typed, I ask patients' permission to do so, explaining the reason—for my studies, not for the treatment—and stating who will be typing. Patients always have the right to refuse these techniques, including the right, at any time until publication, to withdraw permission.[3] When raw data reach the point of transfer into

[1]For teaching purposes, with a few patients, I also made movies, and in later years, videotapes.

[2]More and more, these notes are filled with what went on in me. Otherwise, besides leaving out a crucial element, they risk turning dead cold if I review them years later.

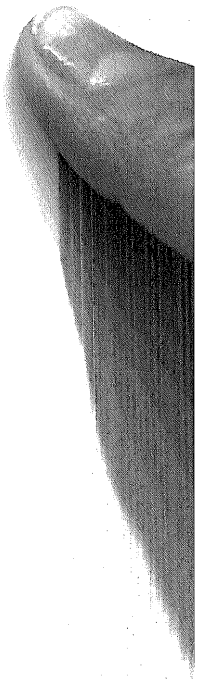
[3]Professor Winslade comments: "You say that patients have the right to withdraw consent until publication. You imply that their authority ends at that point. I disagree. Even after consent and publication, a patient may come to realize that the publication is harmful (*Doe v. Roe*, 1977). I would say that even if patients have read drafts, they have a moral right and should have a legal right to withdraw consent—including to withdraw publication or prevent further publication or limit circulation, etc. Of course the more you have permitted them to participate in monitoring your research, the weaker is their

drafts moving toward publication, patients know they will see each version and can modify and delete, even on galleys. This collaboration starts with most patients only when treatment has finished.

Exceptions to the above techniques of sharing the writing are cases presented in briefest summary, a paragraph or so in length, in which the descriptions are so meager that the bones cannot be identified with the living person; patients reported before I had the sense to worry over these issues; and, more recently, patients written up as I began thinking about, but had not better developed, these techniques. More than ever, I find the advantages outweigh the inconveniences and obstacles.

Free from the commitments of a full practice, I need not choose patients whose identity requires so much protection that the publishable details would be too meager for my purposes. Moreover, I do not treat psychoanalytic candidates. The patients have come mostly from well-removed parts of the community; they are rarely part of a network of acquaintances who can speculate on and perhaps detect whom I describe. Even so, to the extent that people know the areas of my interest, a patient who says I am his or her doctor can induce speculations not imagined with a nonspecializing analyst.

No one has yet refused me permission to tape, to take notes during the hour, or to dictate process notes. No one has asked that the tape be turned off during an interview, refused to let me proceed with drafts of papers or books, or stopped publi-



claim that they later felt harmed by the publication. But the *thought* of publication may seem a great idea, and the *fact* of publication may cause a patient to feel very differently—like your humiliated patient [see below]. So in principle I would say that patient consent can *always* be withdrawn . . . as the price *we* pay for the patient's willingness to share thoughts and feelings with us. I think the patient you write about while in treatment *may* later claim that he/she couldn't really appreciate how painful and harmful publication would be. You may just be lucky or intimidating or a very good therapist. But what about those therapists—even psychoanalysts—who write outrageous things about their patients. A person who used to type case reports told me that she was outraged—with probable cause—at what some analysts and candidates put in their reports on patients. I recall with dismay the jargon and potentially misleading information submitted in my own case reports during psychoanalytic training. Leakage and gossip know no distinct boundaries."

cation. No patient expressed concern that my secretary might breach the confidentiality. Most patients ask for changes; these are made. One asked that two chapters be removed from a book so that people other than the patient could be spared; this was done. I would be naive to think that this record of cooperation proves unambivalent compliance.

The present opinions and techniques did not spring full-blown; they developed slowly and are still unfinished. In the following examples there is only enough information to orient the reader to this paper's issues; the reports are not meant to describe the patients well. In fact, I must edit even these present reports and patients' quotes to keep protecting patients' privacy and confidentiality.

Here is how awareness surfaced. Before the case to be sketched now, protected by quiet rationalization and the silence in the analytic literature, "I never thought about these issues." (The quotation marks measure the odd border between conscious and unconscious awareness that insight finally shifts.)

For years before deciding to write a book about her, I had taped the treatment of a young woman with whom I continue to talk now, almost 30 years later. She asked, from the start, to have copies of the transcripts made for her, a library she still rereads. I had each hour transcribed during the years of treatment—not analytic; she was too scrambled for that. She received the copies. They protected her from her memory disturbances, especially those from intermittent psychotic confusions; the transcripts were her hold on the best reality she had: the treatment. (I have never again had a patient's every treatment hour transcribed.) After some seven years, when the heaviest burdens were lifted, I suddenly felt that what she and I had learned about her was a tale worth telling. The paper describing it would have to be book-length. So I now read the thousands of transcript pages, editing out the greater amount. Anticipating the discussion below on psychoanalysis as science, let me underline that the editing process that produces anyone's case presentation is so much the product of the author's intentions and can

be for the reader so invisible a process that we are euphemistic to refer to our written reports as containing "data," "observations," "facts."

This patient spoiled me: she made the problem of preserving confidentiality too easy, for she was enthralled with the idea that her wasted, dangerous, meaningless life and her terrifying struggle could become worthy if it taught others. Beyond that, she felt that the audience would be witness to her agonies and her rescue of herself. Though sharing the anticipation of these dividends, I knew they endangered her. Would they blind her to the risks of the massive revelations and bizarre living style that had to be revealed or no story could be told? We turned this problem over continuously as the writing took shape. I also had to decide if the psychotic texture of her personality[4] made her unable to foresee the dangers of publication—and did her feelings for me also distort judgment? For whatever it is worth, she and I have kept those questions in front of us from the time the book was published until today—fifteen years—and her answer has never changed. She is happy the book is published and feels that its version of her still stands. The many questions I raised about risks to her or to others *have* materialized as we expected during the writing. Some friends, acquaintances, and relatives know she is the person described. Yet she feels, as she had thought before publication, that her transparence is a priceless state, not a self-destructive act.

As with other patients, I asked her to write whatever she wished about her responses to the writing process, then and now (the following is abridged for reasons of space):

> The first time I noticed those black notebooks that contained the transcripts I was, first, surprised. Surprised by the information that I never truly believed you, or anyone else, had any interest in—surprised by the actual con-

[4]She slipped into psychosis whenever reality got too awful. She was not schizophrenic, not deteriorated, often easily and almost always quickly restored from psychosis by interpretations in a safe ambience.

tent—stuff forgotten, crazy talk, even Charlie [hallucinated male voice] was between those black covers. Surprise and suspicion—why would you allow me to see these transcripts? No one ever let me read anything about me. Certainly no doctor, never a policeman. And your transcripts often included remarks that you had made after I had left your office or had called on the phone. What could your motive be: how would these "words" be used against me, what new punishment could result, who else had access to this information? I waited, I tested, I questioned the nursing staff and various residents, but I couldn't "bust" you for any infraction of our rules.

Later, when you began to put together what would become the book and always made the material available to me, I again experienced suspicions and doubts. What could there be about me that anyone would write about, who could care or be interested, and why? What was your real motive? I dismissed the idea, finally, as a ludicrous attempt on your part to manipulate me for some unknown reason. The idea made no sense to me. There would be no book.

Eventually there was a "first draft." I was absolutely fascinated, first by the size and weight. It seemed like thousands of pages and must surely weigh a ton. I asked if I could take it home, and you said, "Yes." Obviously, to me, it, the so-called book could neither be important nor of any value. Why else would you allow me to take it? How could I be trusted with your work? For two entire days all I did was hold those pages, feel that weight. Finally I began to turn the pages, and was very surprised to discover that it wasn't terribly impressive. There were no secrets that you had kept from me and were now claiming to make available to the world. It contained no threat, no accusations, and nothing of what I had asked you to delete. This so-called "book" was our transcripts, your work and definitions. This was also an incredibly accurate account of my

sexuality, my terrors, my rage—the content of my mind and gut. I managed to get a little crazy. I thought that if I were to burn these pages, this book, this evidence of my insanity, I could begin again with clean pages, a clear life, aware, at the same time, if I were to burn it I would lose the evidence, the proof, that I had worked very hard and suffered a great deal to be well, to acquire some sense or stability in my life and mind.

It was published, and I received a copy. I was excited, pleased and proud. I wanted to share it with everyone I knew and cared about. I wanted my sons and my family to read it, to acknowledge my accomplishments, to recognize what I had suffered, and to congratulate you and me. I don't think I considered what the consequences would be for me if I openly shared my most intimate self with those I loved and cared for. I wish I had, and yet I'm not sure I would have done it differently. My mother, always consistent, denies the existence of the book. One son never read it. The other read parts of it and says he benefited from understanding why I had been missing, either physically or psychologically, from his life for so many years.

There were some, who had been "friends," who never communicated with me again. I was called dirty names; I was called courageous; I was avoided and [was] asked for advice. There were some who wanted more explicit descriptions of my sexual activities; there were some who wanted sexual contact only after reading the book.

Occasionally I still get negative stuff; the book becomes a weapon to be used against me. I can't be hurt by its contents. It's finished, that crazy, criminal and destructive life, but when past behavior is taken and mixed with incidents from now to hurt one of my sons, to manipulate me or to create problems in my life, I resent the book, you, my illness, and find myself wishing I were still capable of that same crazy, criminal and destructive behavior. Wishing, thinking and having destructive fantasies, are as close

as I can or care to get. I'm not 100 percent stable; I'm not always happy; I sometimes entertain suicidal thoughts; I'm sometimes confused by my sexuality. I can't forget the years, and if I do forget, that printed reminder is always available.

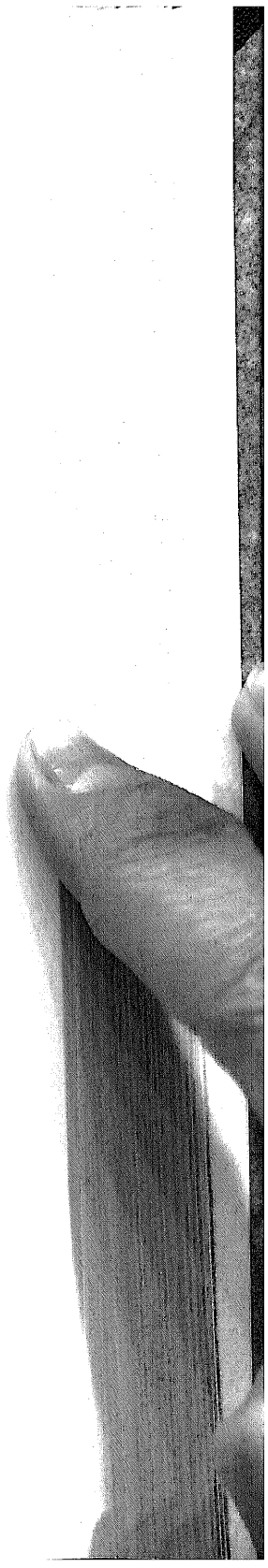
The reader should know that the upbeat, praiseworthy tone of these remarks reflects her having recently worked through a chronic, muffled rage. It had begun (and was never detected by me) when, years ago, I said she was no longer my patient but a friend and collaborator who could, as always, still visit whenever she wanted and talk about whatever she wanted. We can be sure that a patient will respond differently depending on when we ask his or her opinion.

But her situation regarding being in print is—to put it mildly—atypical. Most patients face the risks with smaller expected dividends. She appears first in this paper not to exemplify the main problems and their solutions, but because she was the first patient—because the report was so detailed and long—with whom, as to confidentiality in publication, I began to deal carefully. Yet even before publishing the book about her, I was concerned only about patients' confidentiality, not whether their version would be different from mine or whether, being different, it needed to be considered in writing the report.

The next instance is from a still continuing nonanalytic treatment and shows how thoughts on confidentiality entered the main theme of the patient's life. He is a pedophile who uses every moment in his life to suffer—more precisely, to enact—humiliation. The object of fiercely humiliating attacks by his mother, magnified by his father's failure to stand as a shield between boy and mother, and traumatized by an uncle's erotic abuse of him in childhood, he gradually—successfully in late adolescence—conquered the unconquerable by taking into his own hands the machinery of humiliation. At the price of constantly putting himself in painful situations, he became, barring exceptional events, invulnerable to humiliation inflicted by anyone but himself.

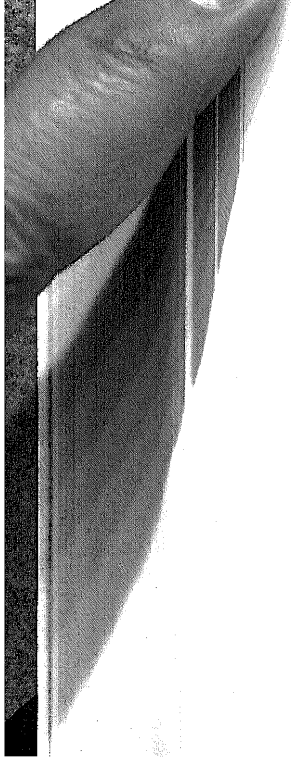
Humiliation was now thrilling, for he believed that no one else in the world was as great, pathetic, or dramatic a fool as he. Here are some of his humiliation devices: being pedophilic although his ideal is to be heterosexual, married, and a father; excessive use of dangerous drugs; an immense collection of pornography; never paying bills until the threats are maximal; being formally educated far below his abilities; not only spending huge amounts of money on prostitutes and nude women dancers, but extravagantly overtipping them; wearing untidy, unclean clothes; never going to the dentist although his teeth are rotting; never washing or keeping up his car; failing his way through many years of therapy with many different therapists of many different schools; interrupting treatment with me whenever he made progress—and one more, the one in which writing and confidentiality merge:

He lived in an apartment, about which I heard from the beginning of treatment. In a draft of a paper that used his case, I described his apartment as "a foul, stinking, rotting, putrescent dump befouled by months of undisposed garbage, unwashed bedding and clothes, newspapers, food wrappings, porno materials, and an aquarium filled with slime and long-dead fish, all sealed behind drawn windows and a locked door." I quote his description: "It stinks in there. There's food that has four months' worth of algae growing outside of it. There's clothes and there's sox and underwear, who knows what's clean or what's dirty, and there's marijuana and pipes and fungus in the bathroom, and old newspapers and old dirty newspapers. The lifestyle in that apartment is so completely contrary to the way I'm capable of living, the way I should be living, the way I want to be living, and yet I continue to keep an apartment I would *never* think of letting anybody see. Staying in that apartment jacking off to my porno. The smell. It's all horrendous." He could talk forever on that subject were he not willing to interrupt to tell of some other disgusting, stupid attribute or experience. Later, I saw how strongly he was motivated by a grandiosity that hid in his humiliations: they are enacted for an imagined audience amazed at his vileness.



Without saying it to him, I began to imagine visiting his apartment, an idea I never have had with other patients. I must have been in tune with him, for he then asked if I might want to do so, something he had never allowed anyone, not even his landlord. He admitted he often daydreamed of dying there from his various excesses. On his being found by the landlord, the world, especially his family, would finally discover how he had suffered. What I saw there confirmed all he had described and more, though despite its horror, the realities were also to be a staging for him—now for me—of its horror.

He enthusiastically showed off each noisome detail and described its development and present significance. Saying goodbye, I gave him a copy of the draft for him to enjoy and correct, pleased to be able to share the work with him. He knew he was to read and make changes as he wished. I was sure he would have a fine time, since here was the living fulfillment of his fantasy that his humiliation was the most foul, the most dramatic, so much so that it would be published. I expected from him only assistance in strengthening the confidentiality.



The next day, I called; he was enraged, frozen. The problem was not that he had a different version from mine. He disagreed with neither the facts nor the protecting of his identity. What shocked him, rather, was that *I had humiliated him.* I had caught him unawares. It was one thing for him to be constantly humiliating himself. That worked well in his unconscious agenda. But I, unwittingly, had slipped past his defense. He was mortified.

Reading the manuscript made real his awareness that he might no longer be in control of his story. His fantasized audience would think as he required of it, but a real audience would see that he truly was a great fool. So he refused to let me proceed with the writing. It even seemed touch-and-go whether he would ever return, but the latter emergency was worked out in telephone discussions. My interpreting this to him, I believe, saved the situation. He returned. He scrubbed the apartment clean, got rid of most of the pornography, and

therewith felt proud. In time, with only a few changes for improving confidentiality, he gave permission to proceed toward publication.

Should we ever write about a patient before treatment ends? Is the writing process, including the desire to get on with the writing, a mostly negative influence? What fantasies—resolvable or not—are stirred in the patient who helps me? What evidence (beyond mere conviction) do we have on either side of the issue? Those who practice what Freud preached—be like a mirror, be like a surgeon—rather than what he practiced will know that such interference is bad. Those who pride themselves on maximum flexibility and unorthodoxy may see little problem. For myself, the answer is "it depends." The two patients with whom I did this work during treatment both felt it was powerfully helpful. Can we trust their opinion? Will their enthusiasm persist after treatment ends? In later years? The jolt of insight is a rare occurrence in insight treatments. Should that jolt come from seeing oneself written about? When does it improve the power of confrontation and interpretation and when is it harmful? How many interventions (silent or overt) can an analysis stand before it is no longer analysis?[5] What shall we rule as being an intervention?

A patient, still in analysis, chances on a paragraph I published about her. She writes about it at my request, years after ending analysis.

> I scan the article before putting it aside for later, and my eye catches a vignette, which I then read. I felt a kind of panic. I felt my blood turn cold. For there I was, the patient, displayed (circumspectly) on the printed page. Here I was, being written about without knowledge of the fact. Confidentiality was not an issue. But I was stunned. I couldn't—and still can't very well—articulate my feelings. Later, as I read the article, I found myself devouring each

[5]The purest of pure technique for one analyst (e.g., silence) is brute intervention (conscious or unconscious sadism) for another.

word in my paragraph, searching for clues to your writing-about-me experience, probing the psychic space between us, trying to imagine your thoughts and feelings.

My feelings ranged from horror to outrage, from narcissistic pleasure to indignation. Even sadness welled up. I felt used. I felt peculiarly honored. But why such varied emotions? Were they peculiar to me and my histories? Is it akin to what a girl experiences when touched by father in forbidden places, or is it a bit more generalizable, that there was a failure to respect *our* bond.

You said it hadn't hurt me, that you were justified because I couldn't be identified [I recall that slightly differently: I believe I said it need not have hurt her because she could not be identified, thereby ignoring in the comfort of proper ethics, her more complex experience]. Was that it? Was that the limit to your thoughts and feelings? How could you know that by not informing, or warning me, or whatever, that you were transgressing that sacred boundary, the infinite trust I placed in you. Why did it matter so? It was true [and], no one else knew.

I am at present pulling together transcripts of interviews with a pornographer, who is not and will never be my patient. He is in the X-rated industry, he says (and proves), not for sex or money, but for "immortality": in his avowed rebellion against society, he wants his name, his appearance, and his acts to be permanently memorialized.

In the first draft, I altered his name and other specifics, but when he reviewed the material, he insisted all facts, including his name, be restored, saying he had already broadcast what is reported therein. His parents are dead, his wives and other women, children, colleagues in copulation, professional associates, police, lawyers, and others who would identify him not only know his story, but would not be newly exposed should I publish. Does he have the right to tell their parts in his narrative?

His motives for helping me are both generous and private.

He is pleased to be useful, and he also sees a sort of fame as his reward for being identified in professional journals.

Psychoanalysis as Science

Though shorter, this section is as important to me as the one on the ethical issue. Psychoanalysis deals with problems at the center of philosophers' concerns, and so an exciting literature is growing on the question of whether psychoanalysis is a science. Most analysts—not I—think it is, and frequently say so.

I think psychoanalysis is naturalistic observation, a first step toward, a sine qua non of, but not yet an example of, a science (as "science" is used by those whom psychoanalysts, on their way to their medical and doctoral degrees, respected as scientists).

Despite having enthusiastically benefited from discussions by philosophers of science, I believe our concern with their concerns: logical positivism, prediction, logical formalism, enumerative inductivism, the semantics of the concept "true," the correspondence theory of truth, induction and deduction, cross-checking by evidence not psychoanalytically generated, formal experiments to test analytic hypotheses, success or failure of Freud's tally argument, effects of the analyst's power of suggestion on patients' responses, convergence of conclusions, statistical correlations, probability theory, tautologies and syllogisms as pseudo-logic devices, etc. (Edelson, 1984; Grünbaum, 1984; Popper, 1959), should be preceded by a simple-minded, concrete effort. We must cut to the bone on the nature of our evidence. Can we know what was happening in the office as doctor and patient talked? Can the analyst, the patient, a third party? How are the reports on the encounter related to the event being described? Putting aside the question of whose version of an event is accurate—presuming for the moment that mine is and that the patient's is irrelevant—how can I share with you the original event in an analysis? Not only are you not allowed to witness it, but if you did, without having witnessed

every other moment in the treatment, you could not put into perspective all that the patient and I take for granted. Progress notes help (Wallerstein and Sampson, 1971); a transcript can, in different ways (Gill and Hoffman, 1982); hearing the tape from which the transcript was made tells more, a videotape even more; "naturalizing" the text can increase its power to convince (Spence, 1981). But who can say if these improvements in accuracy are accurate enough? Who can say what are the criteria for "accurate enough"? How can the third party know what the participants are thinking and feeling? What can we make of silences? It may be premature, then, to worry about eliminative inductivism and falsifiability when, in contrast to enterprises easily labeled "science," no one but the participants observes the action, and no direct observations can be shared with referees.

The main issue, however, is which participant's version is correct. Most everyone outside the analytic orbit says there is no way to know; no version is correct (not even when patient and doctor agree—when they *really* agree, not simply decide to agree to agree).

Patients' sense of what happens in treatment (for instance, an interpretation's value) is our constant concern, but our literature has not dealt head-on with the idea that patients' opinions can be as much or more right than ours. We have settled this latter issue silently, and perhaps cruelly, with presentations whose foregone conclusions support us. Pick up any issue of a psychoanalytic journal—50 years old or today's—and read at random a clinical description. The report is so much the analyst's version and the writing style applied to the clinical story so free of uncertainty, whether the writer's version of the story is the right one or not, that we automatically accept the description as reality. Try this exercise: read each word as if you were skeptical, and see if the description cures your skepticism. Do you find evidence for the author's saying that the patient was "extremely" this or "hardly" that; that such-and-such was a pathologic defense while something else was a healthy sub-

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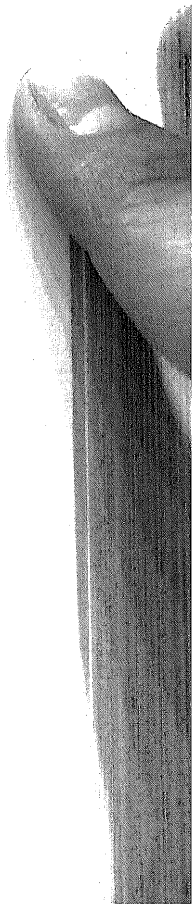
limation; that the analysis revealed that . . . ; that, as the author declares, it was unquestionably the case that . . . ; that the patient's response to the described interpretation was the response the author reports to us? You will sense, beyond the innumerable declarative statements that produce a sense of factuality, an ambience—a rhetoric—in which the author's position is the fixed point in the universe, serving as baseline truth. If you doubt this, then accept my challenge: show your patients your descriptions of them. The failure to do so contributes to the defensively authoritarian tone sensed by people—not all enemies—outside analysis.

I do not think, however, that if my version does not agree with my patient's, the two of us must publish a communiqué on our deliberations. I still have a right to my opinion. But psychoanalysis should develop a new rhetoric in which our patients' positions are visible. Doing so may also help us develop more rigorous, as well as more readable, less jargon-soaked argument.

The issue is probably no more than an ethical and scientific one, as long as confidentiality is preserved, for we are under no legal obligation to be accurate or even-handed.

What do candidates or other professionals feel when they turn up in a paper? What would parents think on seeing themselves described? Siblings? Spouses? Lovers? Friends? How many reports do you recall in which the authors tell us they were wrong and the patient right? Those few I know of served, even in their confessing the analyst's mistake, to show the author's wisdom. Whose story is to be believed? If we cannot be sure, or—more likely—if no version is, then why worry whether psychoanalysis is a science?

Psychoanalysts can appreciate these problems on remembering how they confronted possible breaches of trust in their training (more, perhaps in the past when, as candidates, training analyses and control work were scrutinized by committees, with weakened concern for gossip *in* or *ex camera*). An example of the lasting pain thus produced is documented (Wallerstein



1981). The American Psychoanalytic Association, in 1965, created "an official Study Group on Supervision" to study the supervision process. The candidate chosen for the study kept extensive progress notes on each hour of the analysis, giving the notes to the supervisor as well as reporting to him. The supervisor then presented his own notes and experience to the Study Group—but the candidate was not told he had been chosen.

Years later, on the way to preparing the monograph for publication, the Study Group contacted the former candidate:

> I first learned of the research when I received a package in the mail whose contents surprised me. I learned from the enclosed manuscript that I had been the subject of a study on the nature of psychoanalytic supervision. . . . I had before me a considerable number of pages of manuscript written by him [the supervisor] on my case. The question, "Why was I not told?" leaped into my thoughts. How could *they* (whoever *they* were was not yet known to me) undertake this study without notifying me, without me notifying my patient? How could *he* (my erstwhile supervisor) do this to me? This first outburst of anger dissipated and was then replaced by a sense of hurt. I came to appreciate why the word *grievance* contains within it the word *grief*—for a grievance is based on loss, a loss of esteem for oneself and for others who have arbitrarily inflicted this loss [Shevrin, 1981, pp. 312–313].
>
> In my estimate there was more than a coincidence in the fact that the research was undertaken without informing the candidate or the patient of their roles in it, on the one hand, and the narrow focus of the study, on the other. As a researcher I am myself quite aware of the inclination to simplify and avoid complications. The charge is most often leveled by the clinician at the experimenter. But, in my experience, anyone doing research who becomes aware of the inherent difficulty and complexity of the phenomena he is studying is ready to simplify whenever possible.

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> Sympathetically, we can understand this as an act of denial in the face of considerable challenge and complexity. The researchers were also concerned about not affecting the candidate's training and the patient's treatment, which they judged might be adversely influenced by knowledge of the research. It is ironic that analysts would take the position that knowledge withheld is knowledge without adverse effects; or that knowledge freely shared and mutually understood is likely to prove harmful. . . . I would conclude that the Study Group made its initial decision to keep both analyst and patient uninformed on the basis of the institutional model for decision-making, not the educational or psychoanalytic models. It was mainly based on the exercise of administrative power rather than on the basis of shared responsibility [Shevrin, 1981, pp. 264–265].

This excerpt suggests the outrage, controlled but deep, expressed by the former candidate-analyst, an example of the first issue I am raising. The monograph (Wallerstein, 1981) also serves to exemplify my second point: the supervisor's and the candidate's versions of the supervision are powerfully different. There are then, in this natural experiment, the experience of the patient; the analyst; his supervisor; the Study Group reported to, a continuous, hidden presence in the supervisor as he did the supervision; the chapter authors (some of whom were participants in the original drama, now transformed into writers and editors); the editor of the volume; changes introduced by the publishing process; and each of us who judges (interprets) what he or she reads. The pain on both sides persists to the present, to be seen in Wallerstein's (1985) reply to Slap's (1985) book review.

Among many important clarifying points Wallerstein makes is one that relates to a purpose of mine in this paper: to change matters. Ethics are not eternal. "The supervisory process note material was prepared and transmitted . . . in a manner fully in accord with the prevailing research ethic of the time. The material submitted gave no clue to the identities of the super-

visor, the candidate, the setting, or the Institute" (Wallerstein, 1985).

When we read the cries of pain and disbelief published by authors of books given a negative review—"Dr. X. cannot even have read my book or he would not claim that I said. . . ." we again watch these forces at work.

Then there is the question of our plucking, from the mass of perceptions that make up a clinical instant, the issue we choose to focus on. Our skill is made up of innumerable such judgments each moment. And how often do we leave out of progress notes a point that, now forgotten, was nonetheless recognized during the hour as important; or, remembered, was considered too unimportant for mention but, we learn the next day, was for the patient the focus of the last hour (or one the week before, a year before)? And in remembering, long after, what happened, how much distortion do we put on memories?

The point, of course, is not that patients are more likely to be correct than we are. If we analysts cannot usually be more objective than our patients, more in touch with our patients' unconscious ideas and feelings, more skilled in handling transference and countertransference—empathic enough so that patients know they are being heard—then psychoanalysis has real trouble. To believe in insight is to presume that a more accurate version exists. But an outsider cannot experience these factors, certainly not from our descriptions (although the better the writer, the more believable his narrative). Even more complex: for each of us—patient or doctor—there is no *one* version. What I finally, consciously conclude is made up of innumerable part conclusions, along a continuum into unconsciousness, some of which contradict each other or carry more or less weight at different times. Our responses change over time. What does the play of the transference—positive and negative—do to the patient's reading of the clinical moment?

Beyond all that is the reader, moving in a dialogue with the text, often convinced his interpretation of the published interpretations is correct. Were you not judging, as you read

their quotes above, what the patients "really" believed when they wrote of their experiences with my writing process? If you are as suspicious of colleagues as I, you wondered if the patients are telling me the truth (their truth), whether they can know that truth, to what extent they are still under the influence of transference, what they imagine are my reasons and desires in asking their help, how much more accurately (freely, truthfully, uncomplicatedly, yet richly, reliably) they would answer if *you*—benign stranger—could ask them what they make of this project. These multiple, shifting opinions do not have the smell of science.

Conclusion

Colleagues similar to me will be tempted to evade the responsibilities sketched in above. Admitting them certainly causes trouble: jeopardized theory, flawed hypotheses, admitted uncertain treatment techniques, deflated belief that psychoanalysis is a science, undermined hero worship, awakened dissatisfactions. Just as the failure to do followup studies weakens analysis but spares us inconvenience, so does our not letting patients work over what we plan to say publicly about them. But, in the long run, all we suffer by sharing our plans is inconvenience and a few unreportable cases.

Have I sufficiently indicated that the ethical problems of getting patients' permission to publish may be insoluble? The old riddle: when someone says "yes" to a powerful figure, what parts of the "yes" come from love, fear, insight, possession of the facts, the state of one's digestive tract, the season of the year, the phase of the moon? Exhibitionism, vindication, revenge, desire to help humanity, desire to help me, fear of reprisal from me, to solidify things learned during treatment? All could play a part. Is informed consent possible?

An unpleasant thought: confidentiality in medicine, including psychiatry and psychoanalysis, does not exist except in rare cases. Hospital and clinic records are unprotected from

third-party payers, professional personnel, record-room staff, anyone who wants badly enough to get into a chart, and still others. Patients are presented in person or in absentia at all sorts of teaching sessions, from one-to-one supervision to referrals from one doctor to the next for a second opinion or for treatment, to seminars, to classrooms with 150 and more students. Professionals discuss patients privately and publicly, at home and abroad. Gossip frequently is ordinary behavior.

Confidentiality is not a high commitment even among analysts. Rooms are more soundproofed than mouths. Is there such a state as relative confidentiality? Can confidentiality be practiced here and ignored there?

Perhaps we should stop pretending that we can change reality, and admit we cannot. Perhaps reality indicates that we practice a different ethic from the one we profess, that we are closer to the ethic of the political system that protects itself more than it does the individual. It is easier to change ethics than reality. Which is the higher principle—leads to the greater good—freedom of research or freedom of the individual?

Another problem. On our dying, how can we protect our patients? To the extent that our writings were backed up by progress notes or tapes, how can confidentiality be preserved and these materials still be available to colleagues? (Has the rape of Freud's privacy and of his patients' yielded enough to justify the plundering?) Who owns the tapes of interviews—patient or doctor?

These conflicting issues—confidentiality and accuracy of report—are complex, perhaps in some ways insoluble. I have noted here how inconvenient they are for us and must admit a lingering uneasiness for having made myself face these issues, even more for trying to discomfort others. But think of our colleagues in related disciplines who, to justify labeling themselves as scientists—"social scientists"—feel they maintain the purity of their data, their theories, their thought, by willfully excluding the kinds of reports we, even when being skimpy, feel to be the core of our work. What can we say to these

colleagues about their pride in not reporting the settings, the nature of the individuals—"observer" and "informant"—who were there, and the unedited experiences—words, feelings, nuances—that are the raw material we need for evaluating their theoretical positions? How can we accept—we cannot even reject—a judgment on human behavior made in the absence of detailed report? What is consensual validation when individuals do not share observations, but only convictions?

I have not tried to deal definitively with the questions raised herein, but would be happy should this airing lead to further discussion. However, though tentative and working more with questions than declarations, I end with one strongly held opinion. We should not write about our patients without their permission to do so and without their view of the matters about which we write. Though being scrupulous may blur the sureness of our beliefs, psychoanalysis will be the better for it.

REFERENCES

DOE V. ROE (1977). 93 Misc. 2d 201, at 210,400 N.Y.S. 2d 668, 674 (Supp. Ct.).

EDELSON, M. (1984). *Hypothesis and Evidence in Psychoanalysis.* Chicago: Univ. Chicago Press.

GILL, M. M. & HOFFMAN, I. Z. (1982). *Analysis of Transference. Psychol. Issues,* Monogr. 54. New York: Int. Univ. Press.

GRÜNBAUM, A. (1984). *The Foundations of Psychoanalysis.* Berkeley: Univ. Calif. Press.

POPPER, K. R. (1959). *The Logic of Scientific Discovery.* London: Hutchinson.

SHEVRIN, H. (1981). In *Becoming a Psychoanalyst,* ed. R. S. Wallerstein. New York: Int. Univ. Press, pp. 227–268, 311–329.

SLAP, J. W. (1985). Book Review: *Becoming a Psychoanalyst. Int. J. Psychoanal.,* 66:383–388.

SPENCE, D. P. (1981). Psychoanalytic competence. *Int. J. Psychoanal.,* 62:113–124.

WALLERSTEIN, R. S., Ed. (1981). *Becoming a Psychoanalyst.* New York: Int. Univ. Press.

——— (1985). Letter to the Editor. *Int. J. Psychoanal.,* 66:499–502.

——— & SAMPSON, H. (1971). Issues in research in the psycho-analytic process. *Int. J. Psychoanal.,* 52:11–50.

ZINBERG, N. E. (1985). The private versus the public psychiatric interview. *Amer. J. Psychiat.,* 142:889–894.

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