

# THE CONUNDRUM OF CONFIDENTIALITY<sup>1</sup>

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*Of what would an analysis consist if one of its essential elements were compromised? How does the need to protect our patients' confidentiality deform our communications and, conversely, how does the need to discuss patients deform their treatment relationships? Could we ever be sure that we would recognize the difference between analysis and fiction? What is this thing we easily label "confidentiality," yet about which we have an uneasy consensus? And can we be sure of the answers we give ourselves?*

*Keywords: confidentiality, ethics, consent, disguise*

*De quoi serait faite une analyse si l'un des éléments essentiels en était compromis? Comment la nécessité de protéger la confidentialité de nos patients déforme-t-elle nos communications et, inversement, comment la nécessité de discuter des cas de nos patients déforme-t-elle la relation thérapeutique? Peut-on jamais être sûr de pouvoir cerner la différence entre analyse et fiction? Quelle est cette réalité que nous désignons aisément sous l'étiquette de la « confidentialité », et sur laquelle nous ne parvenons pas encore à nous entendre? Et pouvons-nous être sûrs de nos propres réponses?*

*Mots-clés: confidentialité, éthique, consentement, artifice*

Analysts as authors was a pressing interest of Freud's and has maintained an important place in psychoanalytic discourse. Stein (1988a, 1988b) wrote several seminal papers about analysts who write. A sophisticated and growing body of literature discussing the challenges that accompany writing and presenting clinical material has followed. This paper joins the con-

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1. An earlier version of this paper was read at the Scientific Conference of the International Psychoanalytic Association, August 2011, Mexico City.

versation on the ethical conundrum inherent in moving parts of an analysis from within the consulting room to the wider world. Although the paper focuses on writing and presenting, it is important when considering abstract issues embedded in maintaining confidentiality to give careful thought to these issues central in every act of “presenting” our patients. We know this is of special concern in the education of next generations of psychoanalysts. Solutions are not offered—rather, questions are raised.

Whereas before I was accused of giving no information about my patients, now shall I be accused of giving information about my patients which ought not to be given? I can only hope that in both cases the critics will be the same, and that they will merely have shifted the pretext for their reproaches; if so, I can resign in advance any possibility of ever removing their objections. (Freud, 1905, p. 7)

Patients’ rights and expectations of confidentiality vs. the analysts’ desire to learn and teach is the primary opposition at the heart of one’s decision to present her patient to an “other,” no matter the setting: written papers, professional meetings, supervision, process classes, consultations, private conversation. Discussion of the issues and concepts intrinsic to this dialectic has evolved into a growing body of literature and debate. The issues are provocative, complex, and vexing; primary among them are authorship, ownership, and privacy.<sup>2</sup>

I believe it is important for us all to enter the debate, the fulcrum of which is poised on the contradiction between putting our patients’ interests first when presenting them in order to learn, teach, and strengthen psychoanalysis—which recursively is also in the best interests of our patients. Solutions to this paradox are fraught with confusion and rationalizations.

As we will see, confidentiality is differently defined among psychoanalysts, even if contextually rather than explicitly. I am using the term to mean straightforwardly maintaining patient identity private and unknown to others.<sup>3</sup> Specific to sharing psychoanalytic clinical material is the caveat that writing and reading, presenting and listening, depends on all participants being ensconced in an analytic mind space.<sup>4</sup>

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2. *Confidentiality* and *privacy* are used interchangeably in the text because they are used interchangeably in ordinary discourse. It is interesting to think of the philosophical distinctions one can make between these two concepts, but in a way that can become a resistance to the necessity for our vigilance in maintaining both.

3. This includes the unacceptability of veiled references, innuendoes, gossip, and joking/playing as part of the discourse involving a patient.

4. This perspective on the responsibility of analysts on both sides of any clinical

It is important to remember that we are always in tension between the “spirit and the law” of confidentiality. While I lean towards the law, I recognize that the spirit will sometimes have to do. Given that we must discuss patients, at least some of the time and in some places, we will be forced to break the underlying promise (even if only tacit) of confidentiality. Even as we embed that fact in rationalizations and elisions, we cannot ignore the insistent reality of this contradiction. And here is the rub. Teaching, supervising, presenting cases personally and in print<sup>5</sup> all hinge on the interface between confidentiality and communication. There is no disputing that how one maintains and manages patient confidentiality within the demands of her various professional roles as well as its integration into her identity is engraved in her stamp as an analyst.

My hope is that in contextualizing controversy and providing perspective, this paper will provide another inroad in the ongoing discussion of the central, and centrally touchy, issues embedded in this core responsibility. This paper is not intended as a review of the important and extensive literature. Rather it is an invitation to the reader to join in thinking through, perhaps for the first time, the vexing problems inherent in keeping our profession vital, relevant, and meaningful in the lives of those who ask for our help while at the same time earning and maintaining their trust.<sup>6</sup> One can say that the roles of the former are antithetical to the goals of the latter. But when blind, concrete obedience to preserving patient privacy (some would say secrecy, see later) rules, then students, colleagues, and analytic self-development suffer. However, when unanalytic, concrete use of patient material (in all situations) characterizes its appearance, then the patient and the analyst suffer.

An admonitory tale is found in Kleinschmidt’s (1967)<sup>7</sup> paper about his thinly disguised patient, Philip Roth. It is worth considering what Roth’s analyst, some journal editors, essentially the profession, did to him and itself in the guise of scientific advancement. When Kleinschmidt asserted that his patient’s creative genius was the result of sublimation of aggressive fantasies in which women were exploited as masturbatory sexual objects

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exchange is interlaced throughout the paper.

5. While there is little conceptual difference to the educational purpose inherent in each of these functions, this paper focuses on writing for publication and presenting in public forums. Some of the elements necessary to dissect obtain though in all areas of professional exchange.

6. There are many dimensions to the trust upon which our therapeutic relationships rest; the focus here is solely on that of privacy.

7. Gabbard (2000) has reviewed this publication from a slightly different perspective.

(p. 125), he unleashed a literary firestorm. Kleinschmidt's formulations about the creativity and inner life of his patient were sufficiently familiar to Philip Roth, who recognized himself immediately. He retaliated against his analyst's transgression with his own words in print, *My Life as a Man*. In the novel, Roth inverts Kleinschmidt's highly inappropriate use of his patient's work/words/associations by creating his famous, foolish(?) character—the analyst, Spielvogel. The patient qua author magically turned fury into farce, and psychoanalysis was the loser.

As one would expect, several significant problems inhere in Kleinschmidt's paper. He runs off with the analytic process and along the way uses Roth's creative output as additional scaffolding for his formulations of Roth's inner life. In turn he presumes to use analytic uncovering and understanding to explain his creativity. As Roth himself has written, time and again, it is unfair to consider an author's fiction his autobiography.

Even if it were, we would agree that an autobiography is neither a psychoanalytic process nor a clinical document. Art is not a symptom, it is a sublimation, and deconstructing it to reach the artist's psychic particulars is ultimately defeating, possibly defamatory. Perhaps most important is that the psychology of the artist is intrinsic to, not separable from, the work—if this were not so, the creative outcome would be forged in a vacuum.

The most significant assault, though, in the publication of Kleinschmidt's paper had to have been on the analysis itself. As one anonymous reviewer put it, "The analytic work was sidetracked." I would add that it was transformed into a caricature of itself and in this way destroyed. This danger looms whenever employing our patients' narratives, emerging as they do from artifacts of personal history in combination with psychic reality. Certainly the patient works with his analyst in constructing this constantly changing narrative, blended of unconscious derivatives, transference/counter-transference elements, and conflict. As with the publication of aspects of Roth's analysis, the analyst may find himself transforming such partial "autobiography" into specious and intrusive psycho-biography.<sup>8</sup>

I focus on this conversion because of the all-too-familiar scene in which we may find ourselves when confronting extra-analytic patient material. We recognize and respect the unconscious as we work diligently in our offices to unearth its derivatives in our patients' psychic lives. Our greatest asset in this effort is the informed and integrated relationship between pri-

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8. Rudnytsky (2007) attempted a similarly problematic translation with Roth's writing, as most likely have others.

mary and secondary process thought, mediated through both the patient's and the analyst's preconscious. In this regard, psychoanalytic therapy is primarily vertical in nature, as distinct from the horizontal nature of case presentations, in all its forms.

Too often, and too easily, cases are discussed as though a "real" person were in the room or on the page. If we are to listen, think, and speak as analysts, then we must remain vigilant to the significant differences between the consulting space and the written page. If the author/presenter keeps in mind that her patient is there to serve the discussion of *principles* of psychoanalysis, then the patient as a *principal* in psychoanalysis is less likely to be misused. If the reader/listener holds the line between the real world and the consulting room, he will be less likely to speak of the person and more likely to conceptualize the psychoanalytic process. When he does, he goes some distance in not intruding on the reality of the patient by speaking as though he knows "him."<sup>9</sup>

From the earliest days, analysts have worried about these matters. While much attention has been paid to his famous cases, Freud actually published very little of his clinical work, given his vast experience: only four cases in *Studies on Hysteria* and five longer case reports, two of which were not his patients. And though Freud claimed to take especial care in protecting the identities of his patients, as Michels (2000) reminds us, we are quite familiar with their names. The pairings of Emma Eckstein / Irma, Anna von Lieben / Frau Cecile, Fanny Moser / Frau Emmy, Aurella Kronich / Katharina, Ilona Weiss / Elisabeth von R, Ida Bauer / Dora, Herbert Graff / Little Hans, Ernst Lanzer / the Rat Man, and the two most well-known, Pankejeff / the Wolf Man and the Child / Anna Freud, have long been unmasked. The most famous cases in psychoanalysis are famously known.

Freud's other well-known patient was Freud; he wrote frequently about his own dreams, parapraxes, jokes, fantasies, symptoms, and illusions. The use of disguise, which Freud considered ineffective and problematic, was undermined by the sometimes anonymous, yet voluminous and often explicit patient information conveyed throughout the minutes of the Wednesday night meetings; also in the letters between Freud and Jung, Adler, Ferenczi, and Fliess, among others.

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9. A gentle analogy can be drawn between the role of the literary critic, as understood by Gombrowicz, and that of the analyst reading/listening to clinical material. "Therefore: do not judge. Simply describe your reactions. Never write about the author or the work, only about yourself in confrontation with the work or the author" (in Franklin, 2012).

There are other indications that Freud shared patient information indiscriminately with a wide swath of individuals (Lynn & Vaillant, 1998). These included patients' family members, partners, and lovers, analysts of his own, colleagues of analyst-patients, even his own children. The last, of course, includes Freud's analysis of Anna and his use of her dreams and masturbatory fantasies as the bases of published treatises. Melanie Klein followed suit with the analysis of her son, publishing papers about his treatment, and battling publicly with her daughter, Melitta Schmideberg, at the British Psychoanalytic. It is in the cauldron of these transgressions, staggering in their indiscretion and impropriety, that our discipline was founded and flourished.

A descendant of these dramatic boundary crossings is the reporting on the analyses of candidate-patients within training institutes of the American. In time, enough controversy was generated, and this practice has been all but abandoned. However, before its discontinuation, there were logical rationales for reporting, primary among them the protection of the profession and its future patients. Understandably, the ubiquitous presence of power and politics embedded in this reporting hurt rather than helped psychoanalysis.

Because candidates were aware that what they said in analysis could very well reach others, much of the work had to have been seriously compromised. Unidentified resistances in these training analyses, whether characterized by rebellion or submission, would dominate, with the analytic process most likely often seriously impeded. (This is isomorphic with problems in presenting patients, as we shall later discuss.) And although many analysts went on to have second therapeutic analyses (at least), it is likely that many did not. In addition, the time lag between training and therapeutic analyses had to mean that many patients, and therefore the profession, were seriously ill-served by reporting analyses.

Perhaps the only defence of reporting analyses is that they did not breach confidentiality, since candidates were aware of the ground rules before treatment was undertaken. However, it is difficult to defend conducting analysis in the face of a core value being corrupted. It is a logical, short step from reporting to a progression committee to reporting to the professional community.

Although psychoanalysis is now a broad-based discipline and no longer the province of medicine alone, it has been left an indispensable legacy from that heritage—the Hippocratic Oath. “Whatever, in connection with my professional practice, or not in connection with it, I see or hear, in the life of men, which ought not to be spoken of abroad, I will not divulge, as

reckoning that all such should be kept secret.” The International Code of Medical Ethics, a modernization of the Hippocratic Oath, requires that “a physician shall preserve absolute confidentiality on all he knows about his patient, even after the patient has died.” All mental health professions have codes of ethics replete with nuances and exceptions, yet none exactly represents the particular realities inherent in the patient–analyst relationship.

At a psychoanalytic conference devoted to issues of confidentiality, an interesting observation was presented:

It is as if we have been working with two versions of confidentiality. The first, which might be called “civic confidentiality” is adopted for various kinds of public consumption. The second, ‘psychoanalytic confidentiality’ is privately acknowledged in a wise kind of way but never really developed intellectually in our own literature. We have effectively maneuvered ourselves into a kind of doublethink. (Levin, 2003, p. 63)

For some, confidentiality is absolute, an essential prerequisite for psychoanalysis. John Forrester (2003), a philosopher at Cambridge, makes two related points. First, he warns psychoanalysts not to use trust as the basis of confidentiality because it places too much of the responsibility within the patient and indirectly invokes suggestion as the facilitating instrument of psychoanalysis. (As we know, suggestion and suggestibility are enduring accusations hurled at psychoanalysis.) Second, he asserts that the rule of abstinence is the basis of absolute confidentiality; in other words, the analyst should never act, only speak or communicate within the hour. For Forrester, “professional communication is the analyst’s version of acting out” (p. 25).

It is hard to disagree with the clear, moral meaning in maintaining absolute confidentiality. But beyond its ethical relevance, is there also clinical value to this tenet? Given that confidentiality is “constitutive” of psychoanalysis (Lear, 2003), one might aver that, yes, it is a clinical imperative that we not compromise, otherwise the essence of an analysis is destroyed.

Continuing to think this through, we encounter another element constitutive of analysis—the emergence of the patient’s sense of self. The patient’s private self is unfolding in the shared (public?) domain of the analysis. It is here that her fantasies and relationship with the analyst are imbricated in this emerging self. One pillar upon which this enterprise rests is that of the patient’s capacity to believe that she is in analysis in order to aid in the telling and the transmutation of her secrets into this evolving identity, and that this will remain a private process. In this understanding, the analyst’s

use of the patient's story is not just a breach of confidentiality in the abstract but potentially a violation of the patient's therapeutic development.

Ironically, we also appreciate that trust in the analyst to maintain confidentiality is actually one of the goals of an analysis. In essence, the work is based on what the work is continually in the process of attempting to accomplish. This is not a simple or small point, since in order to help achieve this end, we must turn to our teachers, supervisors, and colleagues. The vexing reality described in the opening of the paper reappears here; the conflict between goals and identity is unavoidable. In order to transmit psychoanalytic knowledge, patient confidentiality must yield, at least a bit. The parameters of the pragmatic basis of disrupting confidentiality in clinical and educational practice then are what need defining and defending.

Levin (2003), continuing his attempt at conceptualizing confidentiality states, "From a point of view internal to psychoanalysis, the idea that confidentiality might ever be 'absolute' makes little practical sense" (p. 61). He goes on to argue that confidentiality is "politicized" and "bureaucratized," having been "transformed into an unrealistic pretense of secrecy." The assumption that the patient is hiding something and that he needs to trust in the confidentiality of the treatment has led "psychoanalysts to have maintained a kind of discrete silence about the fact that this way of picturing the need for confidentiality is profoundly misleading, if not patently false" (p. 56). Nonetheless, Levin too, asserts that confidentiality is constitutive of psychoanalysis.

Furlong (2003) takes the position that the standard definition of confidentiality is one "by which analysts try (impossibly) to measure themselves" (p. 42). She goes on to claim that "psychoanalytic confidentiality is not the equivalent of secrecy, that patient privacy is only part of what is at stake in the . . . treatment, that confidentiality . . . serves treatment integrity rather than the patient's interests . . . and that the boundaries of confidentiality can, and often must, extend beyond the dyad." She also believes that "relational sharing" (confidentiality) rather than "blocked communication" (secrecy) should be our aim; a flexible skin rather than a mechanical lock better defines the correct approach to maintaining patient privacy. For Furlong, a polarity exists between secrecy and confidentiality.

In highlighting what they consider rigid, even tortured, applications of a "rule," these authors inadvertently point to potential problematics within their formulations. The first is the artificial severing of confidentiality and secrecy, as though the former does not imply the latter. Every textbook definition and every common-sense understanding relies on these concepts,

interchangeably definitive of patient privacy. Therefore, one must carefully tease apart these threads to help distinguish when they are appropriately woven into a coherent, readable tapestry from when they form an entangled and unintelligible set of strictures.

O'Neill (2003) adds another distinction to the discussion: "The challenge consists in distinguishing between what constitutes patient information and what belongs to the analyst, given that there is a permeable boundary between the patient material and the analyst's thinking" (p. 126). This assertion of co-ownership, based to a large extent on the relational model of psychoanalysis, implies that patients do not "own" their analyses, and for that reason it is not they alone who have the right to waive confidentiality. This interweaving of models of treatment and attitudes toward confidentiality is unavoidable, yet troubling as it possibly leads to a loosening of vigilance.

Goldberg (2004), though, reminds us of another imperative—that of ensuring our patients receive our best efforts. For him, cordoning off material that needs to see the light of day can lead the analyst to too readily abandon his analytic stance. When analysts shun talking of patients with colleagues, writing for the literature, and seeking consultations for help with therapeutic impasses, their patients are the losers.

Concern that the analyst is shortchanging himself and his patient intersects with the call for increasing self-disclosure by the analyst. There is a wide range of attitudes towards answering patients' questions, telling them pertinent personal data, and sharing inner thoughts that have led to a true transformation of our professional discourse. It has permeated our literature, with one result being that it is virtually impossible to get a clinical paper published without a discussion of explicit inner experiences of both patient and analyst. This increasing inclusion of detailed analytic process in conjunction with the analyst's private associations and counter-transference reactions is necessarily entwined in any discussion of patient confidentiality. It seems self-evident that the judicious management of self-disclosure is the reciprocal of the judicious use of patient material.

That concepts and contexts encountered when considering these aspects of the debate on confidentiality (forms of therapy, analyst disclosure, co-creation of the material, ownership of that material) also comprise the underlying conceptual differences in treatment paradigms among our different schools of psychoanalysis is an unsurprising discovery. However, differences among colleagues ought not devolve into labelling and diagnosing those with whom we disagree.

For example, we read that some specific attitudes toward maintaining confidentiality are “extreme, rigid, inhibited, and perhaps mask writers’ blocks and other psychological problems” (O’Neill, 2003). Or, “The demonization of the act [the use of clinical material for professional purposes] as something that needs to be excused and apologized for—may also be a form of scapegoating . . . [In relying on abstract rules or the patient’s consent] the analyst may be seeking to rationalize internal conflicts and countertransference problems by displacing them not only on the patient but on the profession as well” (Levin, 2003, p. 70). It has even been averred that some analysts maintain confidentiality due to the projection outward of a dyadic pact of secrecy, “fueled by unconscious anger, paranoia, and guilt” (Caper, 1995)!

This rhetoric may invite, perilously yet understandably, the retaliatory exercise of pathologizing those who choose to present clinical material. We might hear that unanalyzed narcissistic and exhibitionistic gratifications form the basis for presenting oneself through the patient, or that countertransference revenge motivates the analyst to expose his patient. This form of reckless conjecture is limitless. Inferring preconscious or unconscious motivation for any professional choice, using the words and concepts of the consulting room in public debate, often is too easy and always too harmful. The simple truth is that not engaging in these activities is complicated for one set of reasons; participating is complicated for another.

None of this, though, relieves the individual analyst of the need for self-analytic inquiry into his choice to present this patient in this way at this moment; and of course his choice not to.<sup>10</sup> We expect this scrutiny as an integral part of our responsibility to be on guard for counter-transference intrusions into the analysis, into the private space of our patients. That perforce must include trying to ensure (the best any of us can do) that neurotic acting out is at a minimum in the swirl of carrying our patients with us to other parts of our professional lives.

The hardest part of the equation, because the most subtle, is the impact on the analyst’s interior relationship to the patient whom she has brought forward. Pride, guilt, fear of discovery sit on the tip of the iceberg. Less noticeable, though, may be the simple fact of keeping a certain kind of secret from the patient. This is not akin to the private aspects of the analyst’s life, which truly are part of the working through of the transference

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10. In addition to the Stein (1988a, 1988b) papers, an updated paper is waiting to be written regarding all the inhibitions, professional and personal, that limit many authors from presenting cases, especially written and at scientific meetings.

in the form of patient fantasies. Rather, this hidden fact has to do with something the analyst has done “with” and “to” the patient—something actual, recordable, public. This must create a special bond or alter a confident attachment. Simply put, it has an indelible impact.

As stated in the opening of the paper, I believe there is not one way out of the conundrum of competing needs of patient confidentiality with those of exchange, education, and edification within the therapeutic community. My own experience in becoming ensnared in this maze of competing ideals most likely reflects that of many colleagues who present in conferences, classrooms, and consulting rooms; and ultimately, in the literature.

My first presentation at the mid-winter meetings was well attended and I was encouraged to submit my paper for publication, but I stopped myself. How could I be sure that the disguise I employed sufficiently would protect my patient’s identity, given that she was a member of our professional community? Nonetheless, I had already played with fire by presenting the case in the first place. More than a few of us have colleagues and friends who have found themselves, whether as presenters or patients, caught in webs of titillation, gossip, and embarrassment when the case material is too close to home for them or someone in the room.<sup>11</sup>

Writing and publishing entail their own specific problems. An early paper on supervision allowed me to talk with those about whom I was writing, but it is the only time I have. When a paper in the *Journal of the Americal Psychoanalytic Association* was nominated for the Journal Prize, I became very troubled upon realizing that if it won, my patient would be more prominently displayed. Pleasurable pride had to make way for painful anxiety. A paper that has great meaning for me, because of its topic, 9/11, has an extended clinical composite<sup>12</sup> as its final section. I allowed it to be published in a lesser-known journal, passing up the invitation to put it in a more prominent journal as well as a chapter in a book; I realize this was a rationalization at best. There are other papers and other dilemmas.

One colleague (Levin, personal communication) rightly perceives my “guilt and regret” in these matters. Yet these states of mind, some among

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11. Another paper is needed to tackle the very serious responsibility we have as listeners and readers of the material of our colleagues. The burden of confidentiality extends to all of us in each instance, and when we are able to discern the identity of the discussed patient, it is incumbent upon us to assume the mantle of the analyst, and not divulge.

12. The case composite, an important confounder in our profession, will be discussed below.

several, do not fully reflect the serious issues we are forced to confront whenever we begin the process of taking our patient out of the consulting room and into a public forum. In respecting the axis of this paper—the clash between the goal of maintaining patient privacy and the need to educate—identifying guilt and regret is not sufficient to soften the tough contours of our dilemma. Obviously, the analyst’s comfort/discomfort is an important barometer of the problem. However, changing parameters to ease the analyst’s conflict goes only a short distance in ameliorating the matter. Ignoring the misuse of clinical language described above, we know that there are good arguments that lead some not to present specific clinical data while allowing others to rely on mechanisms that hopefully safeguard privacy. But neither cohort adequately bridges the divide.

The strongest and most familiar advice when writing about patients includes disguise and informed consent.<sup>13</sup> An important caveat to keep in mind as we proceed is that—in contrast to a research protocol in which the subject, from whom consent is requested, is an anonymous (read disguised) and incidental participant—in analysis the subject (patient) and the researcher (analyst) *are* the research.

Gabbard, a leader in this area, lays out the dilemma in all that is discussed herein (Gabbard, 2000; Gabbard & Lester, 1995). His thinking, explication, and serious study of the issues are at the forefront of the discussion. He has suggested thoughtful guidelines, although he acknowledges that none “can possibly take every individual situation into account. The analyst must make [the] judgement call” (2000, p. 1084).

His thinking is evident in his report of a reverberating experience from early in his training.

Looking back on that continuous case seminar many years ago when I began my candidacy, I am still somewhat dismayed by the revelation of the patient’s name, but I am also more charitable in my judgement of the supervisor and the candidate who chose to make the disclosure. I empathise with the kind of dilemmas such situations present, and the more I have studied the problem, the more I am struck by the irresolvable nature of the challenges posed by presenting and publishing clinical material. (2000, p. 1084)

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13. A set of data and a description of the debate critical to the central concerns in this paper that focuses on informed consent can be found in Rodriguez Quiroga de Pereira, Messina, and Sansalone (2012). Of particular interest is their reference to the Nuremberg Code and its broad application to psychotherapy and psychoanalysis. The paper also offers an invaluable emphasis on training.

Gabbard's memory focuses on the discomfort produced in the listener, akin to that described earlier. Gabbard's sensitive appreciation of the difficulties in presenting helped him tolerate the transgression and also led him to much profitable grappling with the issues stirred up that day, capturing perfectly, as it does, the conundrum. The secondary discovery of the patient, the tension within the listener/reader, the lessons imparted about psychoanalysis while eliding those to be learned about the ethics of presenting, the patient lost in the middle—all these and more are embedded in the “irresoluble nature” of the dilemma.

Additionally, but maybe most importantly, this remains such an important problem in its own right precisely because we have no way of assessing the subtle impact on the treatment stimulated by the presenter's discomfort, which must on some level mirror that of Gabbard, the young candidate in the room. Thinking again of Lear and Forrester and our own inquiry, we know that a boundary has been crossed, and somewhere within the analyst's mind, she knows it. The intertwining of moral and practical considerations is obvious and unalterable, because there can be no forgetting that the analyst has a professional ego ideal, a superego, a sense of right and wrong.<sup>14</sup>

Judy Kantrowitz has contributed a highly regarded and heuristic body of work (2004a, 2004b, 2004c, 2005a, 2005b, 2005c) on the varieties of problems involved in writing about patients and those solutions some analysts develop in response. Included in Kantrowitz's comprehensive study is the impact on patients who discover they have been written about without foreknowledge or permission, patients who have been asked permission, and analysts whose own analysts have written about them. One of the most valuable aspects of this work is its highlighting the continuum among these various contexts. Its most compelling, unsettling really, element is its confirmation of the absence of a clear resolution.

Kantrowitz presents testimony of patients who are horrified (remember Roth), in contrast to those who are gratified at discovering themselves in print. There are some invited to collaborate on papers with their analysts<sup>15</sup>

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14. I include Tuckett (2000, p. 409)—“Psychoanalysts must frequently confront irresoluble conflicts that can only be negotiated on a highly individual and moment-to-moment basis. Such is the case with dilemmas involving disguise and/or consent”—to emphasize that the problem is universally pondered.

15. Suggesting that patients writing papers with their analysts about their own treatment is somehow therapeutic seems to be based on a (sometimes wilful) misunderstanding of the analytic method. This way of thinking would have us stretch the

and others who are presented with published products. Patients may be variously asked for consent to be written about in the beginning of treatment, later in treatment, during the termination phase, or even years after analysis has ended. And analysts write about candidates as well as analyst/patients. The poignant comments made by analysts who struggle with maintaining their patients' privacy while gratifying their own need to write help one feel less alone. But patients' confusion, complaints, concerns at having being written about undo this comfort, leaving one more conflicted.

Patient consent is a slippery concept. The basic reality is that neither a patient nor his analyst can possibly anticipate the fate of the myriad meanings that being written about will evoke; that they will transmute over the course of an analysis is certain.

We got excited about it as a process . . . he said he knew people would say it was not a good idea to do this while I was in analysis, but this situation was an exception. Well, why did I need to be an exception? But it was very gratifying for both of us. . . . But the exhibitionism and the feeling I was a colleague—I couldn't see all that then, but I wish I could have. (Kantrowitz, 2004b, p. 117)

Some suggest that by including a general request for permission to write about the patient in early consultations there will be somehow less disruption to the process. This potentially ignores several critical variables. First, the prospective patient may make the understandable inference that treatment is contingent upon agreement, which only adds to the persuasive power of the request. Second, a patient cannot be expected to give blanket approval without knowing which aspect of his treatment will be described in print.

Presumably one might not mind one thing being written about but would hate another aspect of her analysis being recorded.

I said it was all right with me as long as the research was not on father and daughter relationships, my particular area of conflict. He said if at any time I decided that I didn't want my sessions taped, we'd have to do it differently . . . he didn't do a great job helping with father-daughter issues. He just became like my father, not inappropriately, but he was as pleased about my deciding to go into a field related to his as my father had been earlier when I started out in his as a graduate student. That didn't get analyzed. (Kantrowitz, 2004b, p. 109)

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concept of co-construction to a clinical breaking point.

Some analysts seek permission to write about patients after termination; given that transference never ends, our concerns linger. Additionally, it seems reasonable to worry that post-analytic contact initiated by the analyst is itself a powerful seducer, perhaps pulling the patient back into treatment. Including the patient in the writing of a paper, as is often the case when post-termination agreement is reached, has enduring problems of its own. But this occurs also in ongoing analyses.

Some authors have argued that submitting clinical reports to the patient for editorial review prior to publication actually enhances the value of the finished product by [liberating] the analyst from theoretical prejudices and thus deepens understanding . . . The question, however, of the greater or lesser subjective accuracy of any given clinical report is secondary to the problem of introducing a systematic, patient-derived slant into most or all clinical reports, producing a massive cumulative effect of distortion. (Levin, 2003, p. 65)

Finally, how easily can the patient say no when approached by her analyst at any point in the relationship with such an overt request/implicit demand? In fact, the small database indicates that few do. We surely know that the larger universe of transference/counter-transference issues can arise with equal power in the face of the patient's refusal as well as her compliance. We might expect that denying one's analyst produces covert repercussions damaging to the treatment within both partners in the relationship. The potent additive of the analyst's desire being thwarted cannot be overestimated. Whether the analyst is gratified or frustrated by her patient's response to a request for permission to write of or present the treatment, the tapestry of trust upon which the analysis is woven becomes frayed.

A colleague, when a candidate, allowed his analyst to audiotape several sessions, given the very interesting work they were doing on some aspects of his sibling rivalry. The analyst asked also for permission to present these tapes in a class he was teaching on psychosexual development in a different institute. Although the material contained primitive homicidal wishes and incestuous fantasies, neither patient nor analyst considered the obvious connection between them and his excitement about "working" with his analyst outside the consulting room. It was with some surprise that the patient later realized he had been severely misused. It became impossible to analyze his anger and humiliation in the face of this iatrogenic intrusion. Some things can never be undone, done over, or analyzed. It is impossible to suggest that we can ever be too careful in these matters.

Disguise is another familiar device for protecting patient confidentiality. Yet we wonder if disguise is not ultimately disingenuous, teetering on dishonesty. Once the author tampers with the material by changing say the profession, age, birth order, ethnicity, or even the sex of the patient, she is imposing an editorial imprint. Although all data presented are passed through the subjective filter of the analyst, restructuring reality is a particular form of manipulation. The reader/listener, influenced by inaccuracies, can be led blindly, but definitely down the wrong path.

Years ago, I attended a conference at the British Psychoanalytic at which a revered analyst presented a case that had key biographical material omitted to help preserve confidentiality in that small analytic community. Something was incongruous. In private conversation, the analyst described having excised the father's violent, physical abuse of the patient. This of course changed one's understanding completely of the patient's dynamics, transference, and the analyst's counter-transference. What then had we been listening to?<sup>16</sup>

This is not a new phenomenon. In 1924, we have Freud confessing that Katharina had been abused by her father and not her uncle, as he had written in 1895. In contrasting this with changing the name of a mountain in a case report, Freud described the former a grievous disguise, the latter an insignificant one. As Michels (2000) put it, "The identity of the owner of the phallus was important; the name of the mountain on which he lived was not" (p. 368). But for all I might know, as an American living thousands of miles away and more than a hundred years later, the choice of the mountain might have been importantly misleading. Who knows what else it stands for—phallic imagery and all!

Finally, the composite case, which is but one form of disguise, presents the same challenges, the same deception, the same shortchanging of the audience. However, it also allows for such confusion of character and conflict that it is a pretty perfect mechanism of obfuscation. But just ask the reader/listener how she feels when discovering that the case is really cases, that the individual is a group, that her own thinking has been entrained in a winding subterfuge. Deception in the abstract must always be corrosive, but when linked to the need to protect an other we move from the abstract and philosophical to the real and moral.

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16. Martin Stein (personal communication) told of a colleague who taught one of his classic papers each year in a seminar at the institute. In each class at least one candidate wondered about the not-so-latent homosexuality of the male patient described. Stein had "changed" the sex of his female patient, but did he really?

When a patient discovers himself in the literature, there is no telling or controlling the outcome.<sup>17</sup> From anguish to outrage, from glee to pride, patients may experience betrayals that cannot be undone easily, or at all.<sup>18</sup>

This intrusion happened to me as a patient. I think my analyst used material about me in a classroom situation and may have written about me. It wasn't the issue of my analyst doing it, by my knowing, that was the intrusion. I felt a disappointment and a sense of being misused, being an object. I don't think I really worked it out, but maybe she would have disappointed me in some other way. It was hard to start another treatment. I knew I felt betrayed. (Kantrowitz, 2005c, p. 136)

Galatzer-Levy (2003) earlier published a significant review of the literature, reporting on attitudes and approaches to the issue of writing about patients. He quotes colleagues arguing that research demands are more important than claims for confidentiality, that analysts can be trusted to provide just enough data to fortify their clinical and theoretical positions, and even that "what they [patients] don't know won't hurt them." And when the patient discovers herself in her analyst's paper? Galatzer-Levy reports a remarkable solution offered by some. That is, when patients' exhibitionistic, masochistic, and narcissistic trends intersect with fantasies about their importance in their analyst's practice as demonstrated by being written about, they should simply be treated as grist for the mill. Unfortunately, that shallow and overused concept too often covers a multitude of analysts' errors. It is particularly disturbing when misused as consolation for analyst-induced provocations of patients' conflicts. Why would we do in print to a patient what we would presumably, and hopefully, not do in a session?

I would think that none of us has ever participated in a clinical presentation that does not include a long string of reactions from the audience: laughter, disapproval, admiration, excitement, sympathy, empathy, dis-

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17. A pernicious aspect of disguise not mentioned as a problem in its own right is that the analyst as author provides an inducement for patients and their friends/colleagues to parse the paper looking for clues as to the presence of the patient(s). The results are equally troubling, whether the guesses are right or wrong. Additionally, the author/analyst tells patients about other patients, even if disguised and indirect—a clear boundary violation in any other context; think of the analytic "pioneers" and their violations described above. For example, "Winnicott held Margaret Little's hands through many hours as she lay on the couch, and on at least one occasion broke confidentiality by telling her about another patient he was treating and about his countertransference reactions toward that patient" (Gabbard, 1995, p. 1131).

18. A particularly evocative example of this is found in Crastnopol (1999).

dain, among so many others. Imagine the individual being spoken of, let's say you, walking into the room. Think of your embarrassment or shame or excitement, certainly your astonishment. Grist for the mill?

Serious complications produced by changing mores regarding what analysts are willing to share of their personal associations, reveries, memories, personal histories, and counter-transference reactions belong here as well. Although not a breach of confidentiality per se, it is the corollary piercing of a barrier. In this instance it is of the stimulus barrier the patient erects that is so instrumental in allowing the transference to flourish. When this barrier is lowered and the patient unwittingly confronts his analyst's inner life in conjunction with his own, overwhelming emotional havoc may ensue.<sup>19</sup>

It told me too much of what my analyst's thoughts and feelings were . . . I thought what he said about me presented me in a way that was not very sympathetic. The sessions he picked were ones where he was put off, frustrated. He didn't think I was thinking in a useful way. He was irritated and bugged by me. After I read this I became more anxious and was trying to please him. (Kantrowitz, 2005c, p. 139)

An unmentioned but significant extenuation of patient material in one publication or presentation, regardless of the patient's permission, disguise, etc., is its appearance in other analysts' papers. Given that the treating author has absolutely no control over the fate of his patients' publicized clinical material, the patient is open to being "used" again and again. A cascade of criticism and reinterpretation is unloosed, and the patient stands to suffer. Would it be radical to suggest that editors disallow this practice, asking authors to rely only on their own clinical data?

As Kantrowitz (2004b) reminds us, more than once, "The . . . interviews reported . . . reflect only conscious responses; the unconscious ones were not probed for" (p. 103). Her work, as with that of Galatzer-Levy, is a survey and as such remains on the surface of things, an important place to start. Nonetheless, this level of discourse reminds us that we have no way of predicting what a presentation will do to both participants in the therapy. Keeping in mind that transferences of both patient and analyst define the therapy, we know that although reaction range is limitless, the ability to

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19. This is in contradistinction to the analyst having a public persona, a different topic altogether. It is a different order of magnitude for a patient to discover her analyst's political views, say, in a letter to the editor than his anger or sexual interest in response to her in the hour.

work things through is limited. It cannot be otherwise, because the analyst's actions are both real and ineradicable.

It is necessary that we acknowledge the obvious differences between presenting a patient in order to learn how to better help her in the moment (in supervision or a process class) and in presenting process material (in the literature, on the stage) to make a larger clinical or theoretical point. In the first instance, the interests of the patient are more manifest, in the second the analyst's are. Conversely, asking permission of patients in order to teach, write, and present may be easier than asking in order to learn, such as for consultations and supervision. The exception is with candidate-analysts whose educational aims are transparent and who are ethically required to explain at the outset of therapy the convergence of the therapist's education and the patient's treatment.

But what of those with varying degrees of seniority? It is difficult to imagine telling a patient of a counter-transference dilemma for which we need a consultation; of an interesting aspect of the transference that we would like to present in a peer group; of a personal reaction we might share with a colleague over lunch. We again find the same suggestions as with writing—make a blanket statement at the beginning of treatment of the need to discuss the case at various points in the treatment so as to help the patient, disguise the patient's identity, or ask for consent in the moment of the presentation. But as with publication, it is easy to slide down a quite slippery slope.

What to do? While guidance, example, and apprenticeship are the hallmarks of psychoanalytic pedagogy, presenting clinical material creates a special challenge. "Stated bluntly, anonymous disclosures of clinical material in supervision, teaching, or scientific presentations are not breaches of confidentiality at all" (Levin, 2003, p. 73) is a trenchant recognition of that which I would term a significant category error. This confusion arises when the inherent distinctions between the realm of individual rights and the principles of constitutive confidentiality are not kept in mind. Levin makes it clear that if it were possible to transcend the conceptual differences between the two, we might arrive at some resolution of the ethical tensions in our work. Unfortunately, we cannot elide the inconsistency of holding the patient's privacy safe in mind while at the same time using her most private inner experiences to teach others. But what we can do is acknowledge the inescapable challenges and their attendant ambiguities, which is the surest path to better judgment.

The issues that refer back to the analyst's character, as adumbrated above, include the following. In some instances, the analyst's self-awareness goes

a long way in safeguarding the work, and in others, it fails. Also, the analyst's aim in helping patients stabilize boundaries among parts of the mind, between body and mind, and between wish and adaptation are inevitably undermined when she herself crosses particular boundaries. Consent and disguise, which seem a way around this knot, are a kind of trick that obfuscates the partial rescinding of one's responsibility to a patient. The use of a patient to further the analyst's aims or, more benevolently, the well-being of her patient and her profession, will always have an impact on the analytic relationship. We can never escape the risk that the use of clinical material in one context will produce contradictory detrimental results in another.

And in order to do that, we must bring these issues to the seminar table, to the supervision hour, to the junior colleague asking for help on a first paper. In other words, let us talk about the problem and teach the tools of critical thinking that allow one to make the most mature and considered decisions. One's analysis is a *sine qua non* in this effort, but one's education is the context in which we can as a profession help ensure our ethical north.

Without "ethicizing" away the case presentation, the basic building block of our curriculums, we must carefully scrutinize our choices. Analysts often inadvertently add to corrosive complacency by handling the "hot potatoes" of our work with claims of exceptionalism. And although it is true that we collect unique data, that we are especially educated and trained in understanding those data, and that the data themselves are the work, we are also caretakers of extraordinarily precious information. We ask our patients to entrust us with the privilege of using that information in order to help them in their lives.

Therefore, the question still nags at us: what is deformed when a promise, even if unspoken or undetected, is broken? Whether embracing the language of absolute, constitutive, or relative value, keeping our patients' confidences is a psychoanalytic professional ideal and essential to the analytic contract. It is not just the telling of a patient's narrative, diagnosis, psychic conflicts, and compromise solutions that is at the heart of the matter. It is the application of a gloss on this behaviour; philosophizing, arguing, and wishing it away threatens to subvert standards of professional behaviour and decency.

The inevitable falling short of an ideal does little to injure its value, but ignoring the descent degrades it. As we have seen, there are different ways to handle the confusion and the conflict produced by the unbending fact that the creativity, health, and longevity of psychoanalysis depend on the disruption of this ideal. Since psychoanalysis has something special to say

about the human condition, we will continue, for all sorts of reasons, to turn to the world beyond the quiet, private interior of our work. An ethical person follows rules that exist whether determined by professional committees, legal fiat, the culture of her institute, or her own moral compass; how, when, and where she does is part of the measure of her capacity as a psychoanalyst and her integrity as a professional.

These are the imperatives that must be taught and remembered. Early in the paper, I referred to the “stamp” of the analyst, not the “rules” of the profession. Being an analyst is impossible in some ways. One works in isolation, as she is continually bombarded by words and actions that threaten to destabilize her sublimated character defences. It is her main task to provide an arena of safety for her patient and herself within which reside several mainstays of stability. Self-awareness, open listening, and protection of the patient’s privacy are chief among them, reflecting as they do the skills of an accomplished clinician—one who is honest, has all “ears” attuned in all directions, and keeps paramount her patient’s legitimate expectation of confidentiality.

Ironically, these capacities are best accomplished with the careful use of case histories. In other words, analogous to analysis itself, the process is the cure. Producing case histories (fragments as well), discussing them, building on them, essentially learning from them are skills learned slowly. And they are taught best as a “reflection” of an analytic setting, not as the “reality” of an individual, whether the presentation occurs close in the room or at a distance in the hall, or on the written page.

Ethics, what always reflects the moral balance between competing needs, is the name of the game. It’s hard work I know, but perhaps every editor, each program organizer, and all classroom teachers, supervisors, and analysts must first speak with the writer or presenter, whether self or other, to decide when confidentiality is being breached rather than observed. A simple question is inadequate; rather, a conversation is required. Though this is arduous work, it could also serve as the basis of continuing dialogue about this abiding aspect of our patients’ need of us and ours of them. In other words, as we chip away at the constructs of conflict, let us keep our minds and ears open to when presenting clinical material can erode the trust required for the work to continue, and to be effective. This offers us the best chance of strengthening our collective and psychoanalytic ego ideal of ethical professionals. Thus, we end where we began: with the insuperable predicament posed by the mutually exclusive imperatives of protecting patient privacy and educating the next generation, as well as

ourselves. Remembering that ego ideals are only approximations is our most effective balm.

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