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(HOW) CAN WE WRITE ABOUT OUR PATIENTS?

The ethical underpinnings of writing about patients are explored, the question of how best to undertake the writing of case reports being subordinated to a more general question about the ethics of choosing how or whether to write. An unsolvable paradox is encountered here: that we need to write or speak about our clinical work in order to conceptualize and understand the work we are doing, but that in the very gesture of doing so, we are breaking a fundamental bond with the patient. This conundrum is viewed from a number of vantage points. The controversy about *how* best to go about writing clinical accounts is first addressed, after which the literature is reviewed to draw out the ethical conflicts that writing about patients engenders in the patient. Next attention is given to undercurrents in the analyst's motivation to write, again drawing on current literature. Finally, a consideration is provided of how, based on what we might learn from this review, these problems can be addressed.

Keywords: ethics, clinical writing, case reports

From the beginning, Freud made it clear that we can inform each other about the practice of psychoanalysis only by talking about our work with individual patients. Because each analysis is uniquely adapted to the specific patient-analyst pair, this work cannot be assessed using empirical research with large samples. Each analysis follows the free associations of the patient, traveling to the places the analysand is

Training and Supervising Analyst, Boston Psychoanalytic Society and Institute; Co-Chair, Psychoanalysis Study Group, Leslie Center for the Humanities at Dartmouth College; adjunct faculty, Department of Psychiatry, Geisel School of Medicine at Dartmouth College.

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bound to go by virtue of her history. Only by looking at these journeys can we compare notes and theories, aiming to understand the framework we place around this highly unique and rather extraordinary process. Further, by sharing our work and the choices we are making along these idiosyncratic paths, we are able to develop our understanding and work through our countertransferences.

I will endeavor here to step back from the need to write about our cases, in order to consider, on a more theoretical level, *how* we can write about our patients. Following from this, we can ask what it means for both analyst and patient for a case to be written up. What implications does writing for a public forum have for the outcome of an analysis? How does the writing process affect the treatment relationship and the analyst's theoretical understanding? Most important, what does it do to our patients?

My conviction is that writing about and/or presenting our clinical work is necessary for achieving a distance from our practices in order to appraise it. Only through writing about our work can we demonstrate our ideas about clinical conflict and technique. In so doing, we better articulate and understand our own practices. Further, the utter privacy and isolation of clinical practice makes writing just about the only way that psychoanalysts can compare notes. However, though many have considered the best approach to writing about patients, few have fully addressed the specific impingements and ethical conflicts that breaking the bond of confidentiality through writing entails. I will use the existing literature to flesh out the intrapsychic issues at play in writing about patients and then go on to consider the options for navigating this complex terrain.

I will also raise an ethical question that has been largely overlooked in our field: Can we in good conscience write about our patients? Kantrowitz (2005b) has pointed out that just thinking that writing has an effect on our clinical work is a relatively new idea:

> Oddly, . . . until recently the effect of analysts' writing about patients was not included in most analysts' reflections. This extraanalytic activity was thought of primarily as a scientific activity separate from the analytic work itself. And in respect to patients' reactions, it could be separated, provided patients never knew that their analyst had written about them [p. 103].

Yet Kantrowitz's exhaustive research (2004a,b,c, 2005a,b,c, 2006) makes clear that the effect of writing is very much felt by patients, if in a variety of ways. Perhaps because the problems that emerge are so thorny, analysts

have avoided acknowledging to themselves that the act of writing about patients intrudes on the analytic space. Gabbard (2000) comments:

> Crastnopol (1999) has pointed out that our illusion that the patient-analyst dyad is in a completely private cocoon, insulated from other influences, is shattered when we write. The analyst's writing is inevitably part of the dyad's intersubjective experience, and analysts who think of their writing as completely external to the treatment itself are engaging in a form of denial [p. 1075].

Others have pointed to the reassuring role that writing about our clinical work might have for our patients. While writing may break a bond of confidentiality, it may also signify the analyst's commitment to excellence, and her allegiance to obtaining feedback and insight from colleagues.

> The promise to maintain confidentiality may extend to a belief in secrecy that can become ominous and smack of a lack of accountability. The lack of transparent professional standards of audit and peer review of clinical work may threaten a patient's sense of freedom to talk or it may reassure. . . . To create the framework for a transparently accountable discipline taking account of patients' rights and seeking to encourage peer review publication and establishment of best practice, it is possible that the community of psychoanalysts and psychoanalytical psychotherapists should build into its ethical codes and other such guidelines a number of duties to be seen as necessary for achieving good practice: these might be to keep notes, to talk regularly to colleagues about cases, to conduct audits of one's work and, where relevant, to seek to publish and debate the results [Tuckett 2000b, p. 1066].

Tuckett's intention is to break down the black-or-white thinking that considers writing harmful and privacy sacred:

> The issue is too often discussed in fundamentalist terms. In my view, the negative effects of a profession that cannot learn from clinical experience by sharing it in full and frank detail has become alarmingly obvious. The risk that an individual patient may be harmed by disclosure is there, but it must be considered in this wider ethical framework [2000a, p. 409].

The ethical underpinnings of writing about patients can be explored from a variety of vantage points. First I will address a controversy about *how* best to go about writing clinical accounts. Then I will examine the literature to draw out the ethical conflicts that writing about a case engenders in the patient. I will then turn my attention to undercurrents in the

analyst's motivation to write, again drawing on the literature. Finally, I will consider what we might learn from this review in terms of how these problems can be addressed.

HOW TO WRITE ABOUT PATIENTS

There is ongoing debate over how to proceed in writing about our patients. Freud established one norm that many hold to. He wrote in some detail in his case study of Dora (Freud 1905) about the careful steps he took to ensure that what he wrote about her would be unrecognizable to anyone trying to discern this young woman's identity and that he waited until a time when he felt that the patient herself was unlikely to hear of the publication, which was printed in a clinical journal not intended for general audiences. Many have followed this standard, relying on disguise of the patient's identity, publication not aimed at the general public, and a reluctance to write about patients who are mental health professionals. However, a competing protocol has come into being that may be far safer in the internet age, when even the most arcane materials are just a Google search away. This path involves telling the patient of one's intention to write about her and obtaining her consent to do so. Some go further and show the write-up to the patient; among these, some actually collaborate with the patient in writing up the case. It is interesting to recognize that Freud too used this method of obtaining patients' consent. Deutsch (1957) cites a footnote which must have been included in a volume of Freud's case studies, but which is not fully cited:

> In a footnote to the Postscript of Fragment of an Analysis of a Case of Hysteria (1923), Freud wrote: "The problem of medical discretion which I have discussed in this preface does not touch the remaining case histories contained in this volume; for three of them were published with the express assent of the patients (or rather, as regards little Hans, with that of his father), while in the fourth case (that of Schreber) the subject of the analysis was not actually a person but a book produced by him" [p. 160].

Gabbard (2000) cites and comments on a rule established by the American Psychoanalytic Association:

> "If the psychoanalyst uses confidential case material in clinical presentations or in scientific or educational exchanges with colleagues, either the case material must be disguised sufficiently to prevent identification of the patient, or the patient's

> informed consent must first be obtained. If the latter, the psychoanalyst should discuss the purpose(s) of such presentations, the possible risks and benefits to the patient's treatment, and the patient's right to withhold or withdraw consent" (American Psychoanalytic Association, 1999, p. 6). . . . Aron (2000) points out that discussions about the ethical considerations in writing up clinical accounts is really at a preliminary stage in our discipline, and we have only begun to fathom the unconscious issues brought into play by these problems. He also stresses that despite some ambiguity, the Ethical Principles of Psychologists and Code of Conduct (American Psychological Association, 1992) suggest that psychologists are required to enforce a "both/and" rather than an "either/or" approach. In other words, they must obtain written consent, but they also must disguise confidential information. Disguise without consent is not acceptable [p. 1072].

Furlong (1998) reports that in the U.S. publishers recommend obtaining patient authorization before publication of clinical accounts in a book; *The British Journal of Psychiatry* requires that patients give consent and read the accounts in advance of publication. Tuckett (2000b) reports that the International Committee of Medical Journal Editors requires that all case presentations be consented to by the patient and that disguise is unacceptable, in that it diminishes the value of the data presented.

The trend seems to be that obtaining patients' consent to be written about is essential. Many analysts are now arguing that obtaining consent and sharing their writing with patients is a part of the analytic process and as such can be useful to the patient. Others (e.g., Kantrowitz 2005a) note that we must assume that our patients can learn of our writing, even if we haven't informed them. Stoller (1988) and Lipton (1991) raise questions about the ethics of publishing about patients *without* their consent (see Kantrowitz 2005a). Others argue that analysts need to work through with their patients the patients' feelings regarding being written about (Pizer 1992). When consent is obtained, the rule is that the patient must be permitted to read and approve the account; failing this, it cannot be published.

While the trend may lean toward informed consent, a large group of analysts argue that informed consent by a patient does not resolve the problem, and indeed creates new ones, given the effect of the transference (Aron 2000; Gabbard 2000; Goldberg 1997; Kantrowitz 2004a; Stoller 1988; Tuckett 2000a,b; Furlong 1998, 2006). Lear (2003) makes a forceful philosophical argument that the moment of requesting a patient's permission to be written about is a rupture of the very essence of the psychoanalytic endeavor. "In psychoanalysis," Lear puts it, "confidentiality is *constitutive* of the process" (p. 4). Psychoanalysis can only unfold

within the safety of an utterly confidential environment. The moment in which an analyst requests a patient's permission to be written about interrupts a process driven by the patient with an agenda centered upon and for the analyst. As Lear (2003) states, once a patient is asked for consent to publish her case, "the analysis would no longer unfold according to the patient's needs; it would unfold according to the analyst's desires" (p. 6). This is an enactment on the analyst's part., As Kantrowitz (2005a) puts it, "By involving the patient in reading very personal material about the analyst, an interpretation stimulated in the countertransference is bypassed and replaced by an action" (p. 379). The implicit power dynamic in this relationship is now in full play, and though the patient may opt to refuse to be written about, such a decision will no doubt shape the evolution of this delicate relationship. If the patient does agree, how does she navigate her concerns about maintaining her confidentiality? How can she engage with the range of reactions she might have to reading what her analyst has said about her? How free is she to disagree? How will knowing that she is a subject for the analyst's research, or even that her analyst holds that wish, shape the content and openness of her free associations?

> 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? [Stoller 1988, p. 389].

It is undeniable that unconscious factors, spurred by transferential feelings, are intricately interwoven into a patient's decision to consent to being written about. How, we might wonder, can this be adequately analyzed?

> Lipton (1991) has described how a patient experienced the request for permission not as a reflection of the analyst's ethical concern but rather as a demand from a psychotic parent that had to be accepted without question. Indeed, many patients may feel that to stay within their analyst's good graces, they must acquiesce to the analyst's request. They may feel, with some basis in reality, that the analyst will be hurt or angry if they decline. One confirmation of this hypothesis, and a disconcerting aspect of obtaining consent, is that few patients seem to make the choice of not having their material published [Gabbard 2000, p. 1077].

One conclusion about this controversy has been reached: Kantrowitz (2005c) reports that it is not the method (consent versus disguise) but the meaning that shapes the experience. In interviewing twelve analysts who had read accounts of themselves as patients, Kantrowitz concluded that "from the reports of these twelve analysts, it is clear that whether permission was asked or not was not the determining issue in their reaction to being written about" (p. 136). Among the three analysts who objected to being written about, their issue was with the way in which this was handled, not the choice of disguise or consent.

Before we decide *how* to write about our patients, we need to decide *whether* we can do so in a way that is ethical. I will address the debate about disguise versus consent only with the intention of drawing out the unavoidable problems that writing *in either way* invokes.

TREATMENT DYNAMICS IN WRITING ABOUT PATIENTS

In his first extended clinical presentation, Freud (1905) takes up the problem of writing about patients, admitting that "the presentation of my case histories remains a problem which is hard for me to solve" (p. 7). He goes on:

> If it is true that the causes of hysterical disorders are to be found in the intimacies of the patients' psychosexual life, and that hysterical symptoms are the expression of their most secret and repressed wishes, then the complete elucidation of a case of hysteria is bound to involve the revelation of those intimacies and the betrayal of those secrets. It is certain that the patients would never have spoken if it had occurred to them that their admissions might possibly be put to scientific uses; and it is equally certain that to ask them themselves for leave to publish their case would be quite unavailing. . . . But in my opinion the physician has taken upon himself duties not only towards the individual patient but towards science as well.
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> . . . Thus it becomes the physician's duty to publish what he believes he knows of the causes and structure of hysteria, and it becomes a disgraceful piece of cowardice on his part to neglect doing so, as long as he can avoid causing direct personal injury to the single patient concerned [pp. 7–8].

He goes on to explain the care he has taken in protecting the patient's privacy, waiting four years to publish the case, choosing a patient from a remote town whom no one except Fliess knew was in his care, and

waiting to hear that the patient's life had developed in a way that would make her less inclined to be interested in Freud's publication. He adds,

> I naturally cannot prevent the patient herself from being pained if her own case history should accidentally fall into her hands. But she will learn nothing from it that she does not already know; and she may ask herself who beside her could discover from it that she is the subject of this paper [pp. 8–9].

Writing, Freud shows us, is a potential intrusion into the lives of our patients, but with care, he suggests, we can avert the full extent of the problems it invites. I would suggest that this was not so clear then, and it is less clear today.

The engine or motive force that drives an analysis forward is two-part. On one hand, the analyst invites the analysand to speak her thoughts freely, with the assumption that her words will go no further than the analyst's ears. As the analysand engages in this process, the inevitable outcome is an eruption of questions. *Does my analyst accept me in all my thoughts and feelings? What does my analyst think of the me who speaks these secret thoughts? Does my analyst like me? Judge me? Despise me? Love me?* There is of course a name for these questions: transference. It might be useful to consider Lacan's depiction of the universal transferential position of the analyst as "the Subject who is supposed to know" (1964, p. 232). One thing Lacan makes clear is that the analyst needs to refuse the all-knowing position that the patient cedes to her, so that the impetus of the treatment is returned to the patient. The patient's questions about the analyst's feelings for her, then, are fundamentally unanswerable, bound up in her own thoughts and judgments about her internal life. It is the engagement with these questions that pushes the conversation forward. For the analyst to turn to writing about a patient, and to include in that writing her thoughts or feelings about the patient, is to fundamentally thwart the subtle dynamics of the treatment relationship.

This point has been emphasized by clinicians who argue against introducing into an analysis one's intention to write about the process by asking for the patient's consent. Their point is that the intrusion of the analyst's ambition to make the patient a subject of her professional writing alters and affects the treatment relationship permanently. Lear (2003) cogently illustrates that from the moment in which an analyst raises her wish to write about a patient, the treatment is impacted. This generates a wide range of "iatrogenic disturbances of treatment caused by an act that

can significantly modify patients' views of themselves and of their analysts" (Furlong 2006, pp. 757–758). The treatment is fundamentally changed by this request. However, these iatrogenic effects might catch up with a patient either way, given that patients, during their analysis or after its completion, may come across an article in which they are featured.

Another central dynamic in writing about patients is that it is a betrayal for the analyst to articulate feelings about the patient to an audience other than the patient herself. Stoller (1988) quotes from a patient who happened upon a publication in which she had been described.

> "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 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.
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> "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.
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> "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, no one else knew" [pp. 381–382; emphasis added].

This patient captures the feeling that the sacred bond she had forged with her analyst was shattered by his writing; it felt like a violation of her trust in him. Kantrowitz (2004c) found that many analysts fear asking their patients for permission to write about them because they anticipate that the request will be experienced as a betrayal. In the words of one analyst whom Kantrowitz (2004b) interviewed, "What I came to understand was that it was like you took a picture; it stole the patient's soul; that's how she felt it" (p. 111).

Alongside this experience of betrayal, we might add that even were the analyst to let the patient see the paper before publication, the writing would still short-circuit the deep and unanswerable question of who I am to this analyst. In the words of another analyst Kantrowitz (2004a)

interviewed, "My concern is that the analyst's view, my view, might be substituted for the patient's own and lead to a petrification of the patient's insights, a stunting of the posttermination process" (p. 84).

But there are other subtleties at play here too. Every analysand to some degree or other is curious about what is going on in her analyst's mind in this very unusual relationship, in which one is invited to speak her thoughts freely, but the other is relatively quiet about the contents of her mind as she listens. The listener has established her trustworthiness by being intellectually honest and by respecting the solemnity and integrity of the analysand's words. The analysand comes to experience her analytic hours as a safe and solemn space for freely speaking her mind. The assumption is that these utterances will not leave the consulting room. A parallel assumption is that the analyst's careful attention to what to share with her patient about her own thoughts and feelings is also maintained *outside the office*. As the analysand accepts her analyst's reticence to freely associate alongside her own free associations, she trusts that her analyst is equally cautious about sharing her reactions to this patient elsewhere. Certainly some analysands are aware that supervision or consultation may interrupt the privacy of these moments, but they can integrate that these triadic conversations are held in *their* interest. Their analyst is endeavoring to better hear them by speaking about them to others. It is a case of an entirely different order for an analyst to break the bond of confidentiality—to share her patient's words, and her feelings about those words, with a broader audience, in the interest of promoting her ideas about this case. What, we might wonder, is the countertransference significance of an analyst's decision to divulge the intimate moments of an analysis?

The moment in which an analyst elects to write about a patient is a moment of divergence from her clinical stance. Suddenly, the analyst's own needs are being introduced into the treatment whether the patient is informed of this intention or not. The patient's free associations are being interrupted—directly or not—by the analyst's needs.

Of course, authors are attentive to these issues. But again, what about what this means about the analyst/author's relationship to her patient, her willingness to consciously betray a patient, even if she does so carefully and thoughtfully? What about the meanings of which the analyst/author is unaware?

It was Freud who introduced us to the concept of *Nachträglichkeit,* the idea that all past meaning is constantly being reinscribed in the

present, such that every understanding will be reinterpreted, resignified again when we return to it in the future. To assert any kind of finished understanding of a patient, then, is a misunderstanding, or at least an incomplete understanding, of the patient. And writing about a patient invites conveying a finished understanding, a sense of arrival. In Lacan's terms, it risks asserting oneself as the subject who knows.

We have a record of the fact that Ida Bauer's life and identity were changed by her being known as "Dora." With a concern for the well-being of the patient equal to Freud's, Felix Deutsch (1957) waited until the death of the patient known as Freud's Dora before writing of his subsequent treatment of her in her later life.

> I am the physician who told Freud in 1922 of my encounter with Dora. . . . I told Freud how my encounter with Dora took place and how I had *nolens volens* been let into the secret [pp. 160–161].

Dora had come to Deutsch at the age of forty-two, referred by her otolaryngologist after being bedridden with tinnitus, hearing loss, dizziness, and sleeplessness due to the tinnitus—all of which failed to show any organic source—and a general nervous condition.

> This story sounded familiar to me. My surmise about the identity of the patient was soon confirmed. In the meantime, the otologist had left the room. The patient then began to chat in a flirtatious manner, inquiring whether I was an analyst and whether I knew Professor Freud. I asked her in turn whether she knew him and whether he had ever treated her. As if having waited for this cue, she quickly replied that she was the 'Dora' case, adding that she had not seen a psychiatrist since her treatment with Freud. My familiarity with Freud's writings evidently created a very favorable transference situation.
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> She forgot to talk about her sickness, displaying great pride in having been written up as a famous case in psychiatric literature. . . . Then she discussed Freud's interpretation of her two dreams, and asked my opinion about it [Deutsch 1957, p. 162].

Deutsch's treatment of Dora was concluded in two sessions. Her auditory symptoms disappeared with his interpretation of their connection to Dora's preoccupation with eavesdropping on her son due to her envious curiosity about his social life. He did, however, research and report on the remaining years of Dora's life. Deutsch's focus was on elaborating the ongoing hysterical symptoms and sufferings that this patient endured after the abrupt

termination of her brief analysis with Freud. We learn of her identification with her obsessional mother, her ongoing disgust with and hostility toward men, and her apparent lack of satisfaction generally. Deutsch sums up with the evocative statement that her death "seemed a blessing to those who were close to her. She had been, as my informant phrased it, 'one of the most repulsive hysterics' he had ever met" (p. 167).

It seems important to consider something that Deutsch left out of his narrative—the effect on Dora of being perhaps Freud's most famous case. We might conclude that the nature of Dora's conflict had already determined her treatment resistance. We could agree with many feminist critics who suggest that the dramatic failure of her analysis with Freud alone sealed her blighted fate. But we also need to consider Deutsch's account of Dora's seeming pride in being a famous case, and her exceedingly positive transference to Deutsch once she learned of his relationship to Freud. Was Dora able to separate herself from the written account of herself? What did *she* think of Freud's ideas about her dreams? Did having Freud's interpretations in writing ready at hand inhibit her in her own ability to think freely about herself, her own feelings, desires, and dreams?

Looking back at Dora, we see that in spite of Freud's careful precautions and confidence that this writing would do no harm, the situation is more complicated than he had foreseen. Dora *did* learn of the publication of her case history. Moreover, the fact that it was published seems to repeat the problem that brought Dora to Freud in the first place: a sense of being manipulated and used by men. In her consultation with Deutsch, Dora conveyed an ongoing feeling of rage at men. She experienced her husband as indifferent to her suffering and her son as disengaged from her as well. She described her "frustrated love life and her frigidity. . . . Tearfully she denounced men in general as selfish, demanding, and ungiving" (Deutsch 1957, p. 161). Deutsch describes how Dora's aversion to men lasted throughout her life: "At the time of her analytic treatment she had stated unequivocally: 'Men are all so detestable that I would rather not marry. This is my revenge'" (p. 166). Perhaps Freud exacted a kind of revenge of his own in writing up this case of a woman who had spurned and rejected him. Unconsciously, in writing up this case Freud played the role of Dora's father, exploiting this young woman, his patient, for his own purposes, just as her father had used her as cover for his affair with Frau K. While Dora presented a highly idealized impression of Freud, and carried that over onto Deutsch, she left Deutsch after just two sessions,

and in spite of a lifetime of hysterical suffering, she never returned to treatment. She may have come to Freud with a tremendous distrust of men, but the unfolding treatment relationship, with the written case history that followed, did nothing to establish a new kind of experience with a man who could be concerned for her well-being.

This case presents in vivo evidence that retroactive reinscription continues eternally, even after the death of both participants. Today we see what neither Freud nor Dora could, the possibility that Freud's writing of this case was itself a repetition of Dora's traumatic misuse by men.

Robertson (2016) documents an analogous dynamic in his experience of asking a patient's permission to publish her case history, and in turn publishing his patient's account of this experience alongside his (Robertson 2013; Anonymous 2013). In his subsequent reflection on this enactment, he claims that all analyses inevitably invite enactments but "that this gains particular relevance when we decide to write about our patients and then publish the reports" (p. 84). Only afterward could Robertson see that he was playing out with his patient the precise sibling dynamic that he intended to write and theorize about.

Feelings about being the subject of someone's writing will evolve over time. We cannot anticipate *how* they will evolve, nor do we know how different our own vantage points may be in hindsight. Even patients who have consented to be written about, or their analysts, can come to regret this decision.

Writing risks solidifying facts, settling matters, and failing to leave room for later interpretations, eventual retranscriptions of earlier experiences. If we could convey that any "interpretation" or conclusion is only the understanding that we have at hand at that moment, that a final conclusion cannot ever be reached, one of the deleterious effects of our writing for our patients might be mitigated. Freud recommended writing up cases only *after* the treatment has been completed, to avoid elaborating theoretical ideas that we might unknowingly impose on our patients. But if patients read our accounts after a treatment and find settled "conclusions" about their character, pathology, or unconscious dynamics, doesn't that intrude on their ongoing self-analytic work? Robertson's patient (Anonymous 2013) presents a very powerful account of the experience of reading one's own case report. She conveys the sense of damage by the concretization of her analyst's version of the story, in which he frames her experience through a diagnosis of trauma.

> But a person who has experienced trauma is a kind of person, isn't she? Am I that kind? "What kind is me?" asks a famous philosopher of science, sensitive to our interactions with such kinds. . . . The labels take on lives of their own, when we take them on, as does the larger world around us. I won't of course, let this happen, since I have read my philosophy. Or won't I? Just how deeply or permanently has all of this unpleasant stuff taken up residence in my "psychic structure"? I spend the next couple of weeks after reading this paper behaving very much like a traumatized person. I feel terribly alone. Who on earth can I talk to about any of this? Briefly with my husband, but we both decide this is not healthy. He doesn't need to know everything. That is why I see an analyst in the first place! I am distressed, my skin feels paper thin, this doesn't feel like a liberating revelation. For awhile, everything seems just a little bit poisoned. Little room left for mysteries, grace, no spaces left for shaking off this weight. So much time lost, frozen pain locked in, apparently by "defences" of which one is hardly aware [p. 49].

Lear (2003) articulates the underlying issues that this patient has captured:

> Who is this story *for* and, more important, *whose* story it is?
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> The answer might be that it is the analysand's story and it is for the analysand. But to what extent is this answer compromised by the analyst telling his or her story of the analysand's story? Isn't the analysis ideally supposed to be a place where the analysand works out his *own* story? [p. 9].

It is clear that writing about a patient intrudes on her own process of telling, and understanding, her story. Whether she consents or not, the analyst's version of the story is out there, and the meaning and effects of that alters things permanently. This underscores that it is no small choice to decide to write about a patient in the public arena. There is a wide range of impacts—some unknowable—to consider.

WHY WE WRITE

We have to consider here *why* we write about our patients and *for whom* we are writing. One could say that we write in order to understand, but this can manifest in a variety of ways. Sometimes we write to work though problematic experiences that we are still trying to understand. At other times, we write to share—to admit to our difficult moments in the hope of finding common ground with others who have struggled in similar waters. Or we write to separate, to break out of a treatment that has us in its grips.

We might also write out of revenge—we share our formulation of a patient as a way of pushing back against a sense of mistreatment by the patient. At still other times, we may write to educate, to convince others of some new aspect of technique that we feel we have identified and to seek confirmation from others that our idea has merit. We seek reassurance, support, and even admiration through our writing.

While all these dynamics and more may be in play, I do think, in contrast to Lear (2003), that writing about patients may be necessary. It allows us to work though countertransference, providing an adequate distance from the intensity of this exquisitely private conversation, and it promotes ongoing learning about out work. Even our patients might be happy to know that we are checking ourselves against colleagues in order to become aware of what we might be missing. As Furlong (2003) puts it,

> The confidentiality of the process is there to unfetter the patient's discourse and the analyst's reverie. The circulation of information outside the dyad need not be toxic, may or may not disrupt the analytic couple's openness to new meaning. Key to contamination and inhibition of analytic work is whether or not disclosure continues to serve an analytic end [p. 45].

Why we write, then, is always overdetermined, and though we may know in the present moment what our conscious intention is in writing about a case, we may discover, after the fact, other latent motives, some of which may be hostile or untoward. Gabbard (2000) notes that writing may commonly be spurred by unresolved aggression. We may know we are writing to address complex or painful countertransference dynamics, but overlook the way in which publication of this material brings harm, expressing our unconscious anger at the patient. As Furlong points out, many of Kantrowitz's interviews with analysts who write about patients support Gabbard's claim. Furlong (2006) raises the question of whether

> "the darker sides" of the analyst's conscious and unconscious motives are given enough consideration and—in minimizing the effect on patients of confrontation with parts of their personality and attitude as revealed in the writing—whether these analysts are not giving short shrift to the difference between implicit intuition on the part of the patient and explicit knowledge gained through reading [p. 758].

The other side of this aggression is that the act of writing, and perhaps especially getting our patients' permission, may also be an act of seduction. Furlong (1998, 2006) has best conveyed the way in which this

intrusion into the analytic space may send an enigmatic message. Quoting Laplanche (1993), she claims that when patients encounter our writing about them, they are forced into an awareness of erotic signals that need to be decoded. From the moment a patient reads our writing about her, she gains access to our minds in a way that runs counter to our habitual practice in the consulting room. She hears concretely about our thoughts and feelings about her, the understanding of her that we hold in our minds. This access can be experienced in a range of ways. The patient is gaining access to her analyst's internal life, but may also be perceiving her analyst's energetic relationship with colleagues with whom she hopes to share her writing. The analysand is meanwhile seeing herself in a new role, as an object of the analyst's desire. All of this can take on an eroticized feel.

Some point to the patient's experience of witnessing a kind of primal scene between her analyst and these colleagues, putting the patient at the keyhole, witnessing her analyst's engagement in the professional world (Furlong 2006). Patients may not want to think or know about their analyst's status and involvement with colleagues.

Others highlight the more direct seduction of the patient that the writing process engages. The publication may function as a kind of exhibition of the intimate and erotic bonds of the treatment relationship, an assertion on the analyst's part of her love for and interest in the patient. Once an analyst introduces a request to write about a patient, the power dynamic is upended. The analyst is expressing a need or desire vis-à-vis the patient. Agreeing to be written about may feel equivalent to accepting the position of a favorite, even beloved patient. While patients may harbor fantasies of this sort within the frame of an analysis, that is a far cry from seeing these experiences enacted *by the analyst.*

Regardless of the erotic or aggressive undertones, what may be most troubling is the more primal experience—our writing sheds light on our unconscious as it is at play in our work. We inevitably disclose ourselves to our patients in our writing in ways they may never feel ready for. As Furlong (2005) puts it,

> We cannot, naturally, know in advance that which in the unconscious has escaped our control and remains misunderstood in our effort to theorize. Yet, it is precisely the movement to include and understand our participation in the relationship, with its risk of revealing an incompletely apprehended kernel of ourselves, which marks the originality of psychoanalytic communications oral and written. . . . I do not think we have thought deeply enough about the ethical consequences that derive from this specific fact about clinical writing in our

> discipline (this fact may not be unique to analytic writing but it certainly is a specific byproduct of any serious consideration of the unconscious). There will always be a subjective quotient in analytic "fact" sharing, a sharing that reveals something of the analyst as well as of the patient.

No matter why we write, we cannot deny that in writing we are seeking some level of recognition, some gratification of our narcissistic needs. Assuming that we are talking here about writing with an aspiration of publication, we are expecting a line on our C.V., or recognition from both an editorial board and a broader audience. We are hoping to make a mark in the psychoanalytic literature. This is a libidinal gesture on our part. And if we are doing this through writing about a patient, then we are using our patient for self-satisfying purposes. Is it overstating the facts to consider such a shift of clinical focus toward our personal satisfaction or gratification to be a subtle type of boundary violation?

To be sure, other aspects of our work are bound more to self-satisfaction than to our patients' needs. We collect fees. We enjoy vacations that are paid for by the profits of our work with patients. We present cases as part of our analytic education and certification process to advance in our profession. To maintain our capacity to practice, it can be argued, it is necessary that the needs of our analysands be balanced by attention to our own needs. I think we could also argue that we *need* to write about our clinical work, because we need the presence of a third to stabilize the dyadic bond of analyst and analysand. As Furlong (2003) says, writing helps us think and work analytically. That does not mean, however, that we need to *publish* our writing to a broader audience, and this is a question that I think bears attention, with no expectation of coming to a resolution. There are many less public ways to share our thoughts about our clinical work, from supervision to study groups. When one is committed to the idea that her clinical account needs a broader audience, that might be a moment to pause for reflection. There are, of course, a variety of ways in which we write about our patients, and that is what I would like to consider next.

WAYS FORWARD

It may seem that I have presented an impossible bind. Writing about our work is essential for the furthering of clinical practice. Process notes are the essential material for communicating the totally unique and individual

texture of this conversation between this analyst and this patient. No technique manual or theory can anticipate the choices an analyst will make in hearing and responding to a patient. Even the words of the process notes alone miss important, guiding aspects, including the tone and tempo of the patient's voice, alongside her shiftings and movements on the couch. Analysis is founded on words, and we need to share words with each other in order to ensure that we are striving toward a common, and a meaningful, goal. And yet doing so seems to violate the essential trust of the analytic commitment and to rupture the analytic bond, disabling the very structure we aim to study.

This, however, is where I think we could step back and establish some norms. Many analysts write up cases as part of their training process at institutes or for certification. At some institutes, control case patients are informed in advance of their role in their analyst's training and are asked to sign a release allowing use of the analytic material for educational purposes. Perhaps this practice should be adopted universally. Clinical write-ups in the context of training are presented to a circumscribed audience and the patient is not privy to the account. While this undoubtedly bleeds into the treatment in unnameable ways, the harm it might cause seems limited. Analysts who are beyond training might be able to find analogous ways of writing, such as sharing written accounts with small consultation groups.

The next level of clinical reporting is writing presented orally to a confined audience. Again, with adequate attention to confidentiality in the presentation, and the assurance that the meeting will not be reported in a publication or online, the harm or intrusion to patients seems circumscribed.

The real challenge is when cases are written to be published in print, rendering them a Google search away from patients. In this case, I think, analysts must give serious thought to what they need to say. Some write to illustrate aspects of technique. For that purpose, brief vignettes are often possible and the extent of countertransference addressed can be limited to feelings that arise in a specific encounter. This seems like a digestible disclosure for a patient to happen upon. Other writers are able to group patients and present an imagined encounter to illustrate a point, keeping specifics of particular patients' identities out of the picture. Lear (2003) provides an excellent example of making use of a very limited but rich clinical vignette that illustrates and brings alive his point

without saying much at all about the person he was treating. Stimmel (2013) suggests that maintaining a focus on presenting *process,* over the *person* of the patient, might better serve the interests of confidentiality. "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" (p. 88). Case histories, Stimmel (2013) says, "are taught best as a 'reflection' of an analytic setting, not as the 'reality' of an individual" (p. 104).

The most troubling issues emerge when an analyst wishes to present an entire case, with process, exploration of transference/countertransference, and background. Here again, the rationale for such a complete breach of confidentiality needs to be made clear. It is no longer true that, as Freud (1905) said, we need case histories to show the "causes and structure" of a particular disorder (p. 78), but case histories do serve new purposes today. Each time the intention to publish a full case report is felt, I would argue, an analyst should stop herself first and consider what is getting repeated, what is being enacted, and whether the originality and utility of this material is worth the harm it may cause. Further, she should try to imagine the negative effects it may yield, and to seriously consider how adequately these effects can be analyzed. She should ask herself if it is fair to the patient to impose this enactment on her, and should be ready to drop the project if she sees too much potential damage. If she finds herself in this position, she might entertain Gabbard's suggestion (2000) that we publish our case histories anonymously, to protect our patients from finding them by searching their analyst's writings. I'm thinking of an article I reviewed for a journal that was the third paper its author had written about the same patient, a patient who was a narcissistic extension of her parents. I'm not confident that such cases should be written about for publication. Couldn't this analyst have chosen a more private venue in which to work through her ideas? Analysts need to exercise restraint as part of the writing process. Journal editors and reviewers need to encourage this discipline, pushing authors about what they might leave out and bringing into question case descriptions that appear to truly compromise the essential bond of confidentiality. Stimmel (2013) describes an instance in which she elected not to accept an invitation to publish a case she had presented at the meetings of the American Psychoanalytic Association, as well as other occasions on which she held back publications that felt

worrisome in relation to her patients. Kantrowitz too provides an example of an analyst's restraint (2004b):

> The first paper I ever wrote, I asked the patient's permission. It was a lengthy analysis and this was about a year or two from the end. The paper had been accepted, with a need for revisions, at the time I asked her permission and gave it to her to read. The patient gave me permission, but I ended up feeling she was not free to say no and [that] it would harm the treatment if I published it. I felt she had reservations she couldn't directly express. For example, she was resentful that I would advance myself at her expense. She had a younger, very successful brother whom she'd like to have cut down, whom she felt really vengeful toward. She said it was fine to publish it and suggested some minor changes, but I realized for the health of her treatment I couldn't publish the paper. So I withdrew her permission. The treatment prospered, but I was very unhappy. It was my first analytic paper; I had put a tremendous amount of work into to it, hundreds of hours, and to feel I couldn't publish it! I was surprised what a huge role this had in the analysis. I was very naive. I just assumed analysts wrote about patients. I thought it was just accepted that it was done to advance the science. I didn't give a thought about how it would be a transference-countertransference issue. What a hot potato! I put in a lot of work, and then I realized that this material didn't just belong to me. It cost me a lot, but I learned a lot [p. 110].

Perhaps the only solution to the problem is one as totally individualized as psychoanalysis is as a practice. One essential step might be the open acknowledgment that these problems are inescapable, and that every moment of articulating our impressions of our clinical work is fraught with multiple meanings, some of which are problematic. I would think that every analyst writing about a patient should be in a state of conflict and doubt as she writes, aware of the risks. She should question any tendency to assert her knowledge or sense of closure about a case. She should write in order to open up questions, not to answer them. She should imagine her patient's responses to each word, and ask herself again and again what she might leave out. Attention needs to be given to the likely unfolding of meanings that could accrue in the future, as well as the known meanings that are already in the mix. These words from Robertson's patient might help hold future writers accountable:

> Where is the oxygen, where is the life in this life? What was our initial bargain, anyway? Am I really a client? A *patient?* Does all this make me mentally *ill?* Or am I someone working out the logic of her soul in dialogue with an experienced other? . . . Is it really an unmitigated pleasure to see one's traumas and defences front and centre with all the rest left out? Do actual analysts perform this thought

> experiment as they write? Would it make a difference if they did? Should it? [Anonymous 2013, p. 48].

Furlong (2006) cites Goldberg on the "'essential, irreducible undecidability' (2004, p. 521)" (p. 763) of ethical decisions such as the acceptability of writing about our patients. The idea is that each situation is unique, and that in each situation there are dynamics that can be grasped only partially by either analyst or analysand. My best recommendation is that every analyst who engages in clinical writing embrace this undecidability, and keep it in mind in guiding her process. This undecidability is the rudder that steers the ethics of this encounter, pushing the analyst to resist writing in every aspect as she moves forward in writing, considering at every step the possibility of abandoning the project or limiting its scope or audience, pushing her to hold herself accountable to her inviolable bond with her patient.

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53 South Main Street, Suite 311
Hanover, NH 03755
E-mail: ackerman@post.harvard.edu