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# Should We or Shouldn't We? Some Aspects of the Confidentiality of Clinical Reporting and Dossier Access

*Allannah Furlong*

In this paper, reservations are expressed about two deviations from analytic neutrality: when the analyst seeks the patient's permission for publication or presentation of clinical material and when the analyst allows the patient access to the dossier under access-of-information legislation. In the first case, concern centres mainly on the entanglement of the patient in the therapist's sanctioned version of their work, an entanglement that might inhibit future revisions of the patient's self-understanding. In the second case, the analytic mental space, symbolised by the dossier, is viewed as neither uniquely the analyst's nor the patient's, a complex dialectical chamber the privacy of which must be respected, even by the patient whose discourse contributes to it, in order for it to function effectively. Transparency and accountability in the analytic context reveal a paradox that is not exclusive to it: the possibility of full disclosure runs counter to the expression of subjective truth. In a clinical example, curiosity about the dossier is seen to have been a new version of an earlier thwarted questioning about origins and identity. A specific deficiency in the therapist's understanding may have contributed to the patient's enactment.

## Introduction

The confidentiality of a psychoanalyst's clinical dossiers, at least as a general principle, is readily endorsed by the psychoanalyst. We are accustomed to firmly opposing the access of third parties to the clinical record, although modern technology has made our safeguards increasingly flimsy, and certain court judgements, at least in the United States, offering new interpretations as to where our duty lies (for example, Ramona versus Ramona, 1993;[1] Tarasoff versus University of California, 1976)[2] have vitiated, or divided, our resolve. Yet there are two occasions on which the dossier is encroached upon from within the therapeutic couple, as it were, rather than from the exterior, and where the ethic of confidentiality risks implosion. In the first instance, it is the psychoanalyst, or psychotherapist, who seeks his or her patient's approval before presentation or publication of clinical material. In the second instance, it is the patient who initiates the request to view the dossier, which is within his or her legal right under present access-to-information legislation (**Doray, 1996**).[3]

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1 In 1991, Gary Ramona won a civil suit for damages against both his daughter's therapist and psychiatrist for their active and 'negligent' role in encouraging her to accuse him of child abuse based upon unsubstantiated memories emerging in therapy.

2 Tarasoff, a student at the University of California, Berkeley, was killed by another student who had been dating her and who had also been in psychotherapy at the student health centre. Tarasoff's parents successfully sued the university and her therapist, alleging negligence in the failure to warn their daughter.

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The premise of the patient's right to know has encouraged these practices, which now have broad social and legal legitimacy. For example, some American publishers recommend patient authorisation before allowing clinical material to be included in book form. In its 'Instructions to authors', the *British Journal of Psychiatry* states that if an individual patient is described, his or her consent should be obtained, and that the patient should read the report before submission (**Wilkinson et al., 1995**). Similar considerations have been applied to supervision. There are professional associations who deem that their members should gain patient permission before discussing cases with colleagues. Yet, setting aside the strictly legal considerations, many analysts, and I am one, remain profoundly sceptical that such transparency is advisable without seriously altering the nature of our work. My understanding of the intersubjective dialectic of the treatment setting inclines me to tug the traditional veil of analytic neutrality and anonymity back into place.

## Patients' Permission for Clinical Reporting

Freud discussed the conflict between clinical reporting and confidentiality on more than one occasion. But whereas he quickly dismissed the possibility of consulting the patient in his preface to the Dora case (**1905**), more recent reflection is less categorical. Winnicott (**1977**) broached the subject of publication with the parents of the little Piggle, and included extracts from their letters to him along with their postface commentary. Some contemporary writers consider it more respectful of patient rights to seek permission for scientific use of case material. Klumpner & Galatzer-Levy point out that analysts committed to 'arriv[ing] at truths collaboratively with patients' (**1991p. 735**) would find it inconsistent to publish analytic findings unilaterally. It is known that disguise has not prevented patients, or their relatives, from recognising their case histories (**Stoller, 1988**; **Lipton, 1991**; **Roth, 1974**), though on occasion erroneously (Stein, 1988b), with potentially calamitous repercussions for the therapeutic relationship. When the patient is permitted to see a draft of the proposed publication, with the liberty to reject, accept or correct it, the resultant dialogue can be seen as both precluding these untoward effects and as affording therapeutic work in its own right. Pizer (**1992**) exemplifies the position that patient involvement in the scientific project produces a therapeutic benefit by way of a narcissistic confirmation or validation. The analyst's willingness to share 'ownership' of the analysis; the opportunity to clarify what may have been misunderstood in either direction; a piece of working through in de-idealisation of the analyst and the analysis: these are other persuasive points that have been adduced in favour of discussion with the patient.

These justifications, worthy though they may be, are nevertheless dissatisfying. In my estimation, the extension of the epistemological position of collaborative truth-finding in the dyad to the scientific enterprise of sharing data with colleagues is unjustified. Current understanding of the role of countertransference in analytic work acknowledges that the analyst's creative, internal space must prop itself upon, even cannibalise, the patient's subjectivity. But does this mean that clinical reports must be treated as a kind of plagiarism? While agreeing with Balint that the analyst 'must allow his patient to live with him in a sort of harmonious interpenetrating mix-up' (**1968p. 136**), involving the patient in a projected publication does not escape the paradoxical backlash of making this intersubjective fantasy concrete. The tacit accord not to ask the question 'Is it real or imagined?' with respect to the transitional space within the

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3 A law granting private individuals access to information in dossiers concerning them or to the documents of public institutions was passed in the Canadian province of Quebec in 1984.

consulting room is inevitably disrupted by the analyst's introduction of publication/presentation matters. Even where the consequences appear to have been benign, might not the benefits some analysts have seen in disclosure amount to an attempt to find virtue in a necessary evil? Does not the root issue remain damage control of the uncontrolled vicissitudes of the patient's self-recognition? In the limited treatment this question has received in the literature to date, there is unanimity that the analyst's request is 'an intrusion, and will profoundly affect the entire analytic process' (**Lipton, 1991p. 976**).

One strongly held opinion (**Stoller, 1988**) is that the views of patients on the matters about which we write are a valuable and neglected source of scientific data. Stoller contends that case reporting produces a false sense of factuality, where the reader is lulled into accepting the author's version as baseline truth. A panel on the presentation of clinical experience at the annual meeting of the American Psychoanalytic Association in 1989 (reported by **Klumpner & Galatzer-Levy in 1991**) agreed that 'textural richness gives an appearance of truth' (p. 731). Using her own work, Eifermann has illustrated how omissions and disguise 'present a problem inherent to psychoanalytic writing that is to the disadvantage of the development of psychoanalysis' (**1996p. 423**).

The fictionalised incident presented by Roth eloquently expresses the gulf that can exist between the analyst's version of the cure and the patient's. 'How can you, who have done me so much good, have it all so wrong? Now *there* is something to write an article about!' complains Roth's narrator (**1974**p. 243). The asymmetry of understanding between the two members of the therapeutic couple at some or all stages of their work together is certainly a subject worthy of investigation. Yet I am not sure that involving the patient's collaboration in a 'co-construction', aimed at an audience outside of the treatment setting, is the best way to go about it. A compromise that some have settled upon is to petition patient permission only after termination. This solution too is far from perfect, since it begs the question of the dissolution of the transference tie after termination. Moreover, there is no getting around the fact that it continues to introduce a need that is alien to the patient.

Yet another argument one hears in favour of conferring with patients about clinical presentations or publications is that patients and analysts frequently move in small circles and are likely to recognise each other in case histories. In my opinion, this objection forces us to grapple with two interlocking issues that cannot receive adequate elaboration here. At one level, it impinges upon the whole supervisory process, the analyst's freedom to share with some other who would know but never intrude as Bollas & Sundelson (**1995**) have put it. Secondly, the narrow network analysts often work within should perhaps be treated as a symptom both of the enforced intimacy engendered in psychoanalytic institutes where training analyses are subject to didactic approval and interference and of the declining interest in analysis on the part of the public, such that the pool of psychoanalytic patients has become increasingly confined to other mental health-related professionals.

Granted, the issue is a complex one, where no ultimate ethic free of ambiguities and uncertainties is perhaps attainable. Klumpner & Frank reported that confidentiality turned out to be the thorniest problem for the Committee on Scientific Activities of the American Psychoanalytic Association when it studied the reporting of clinical material. Their discussion left them 'with the distinct impression that confidentiality is not simply one issue, but several' (**1991p. 540**). Forgoing with them the goal of a balanced overview at this time, this paper will instead focus on a particular conceptualisation of the intersubjective nature of the human condition from which objections to disclosure can be derived. To my knowledge, this line of reasoning has not been developed elsewhere.

## The Risk of Patient Participation in an 'Official' Case History

Every analysis and every analytically oriented psychotherapy since Anna O's discovery of the talking cure more than a hundred years ago has engaged the therapeutic couple in a historical search through the scattered debris of an individual life. When Freud realised that there was potentially more to Anna O's 'chimney-sweeping' than a purely cathartic process, that therein lay the shattered fragments of an unconscious content, his pursuit of historical meaning made the role of the analyst one of a kind of interpreter-historian. In a steady elaboration over a series of articles and books, Piera Aulagnier (**1975**, **1986**) has proposed that the work of interpreter-historian is also an essential aspect of that part of the psyche under the aegis of secondary processes, the *I*, which Aulagnier treats as a developmental structure in its own right. It is the *I* which founds a personal psychic space, one that can be shared in language. As Aulagnier understands it, it is specifically the *I*'s ability to think about its own origins, and to generate representations of itself that is crucial to the establishment of this psychic space.

Just as every race and people known to man has needed to create a myth about its origins, an explanatory legend pertaining to its purpose and destiny, in a similar fashion, Aulagnier considers every child to be driven to explain his or her existence and experience, and especially to interpret the source of his or her affects and relationships. It is the very first paragraph of this 'self-historicisation' that is the most psychologically tricky, and that has the most long-term sequelae. This first paragraph cannot be written by the child alone, who has no choice but to borrow from the parental discourse. Nevertheless, the parent's version of the beginning cannot be adopted unless it 'fits' with the child's primary emotional experiences. The material discourse, though fundamental, is not exclusive: the father is understood to have his part to play in either validating or counterpointing the mother's version. Once the first paragraph is borrowed and identified with, the *I* continues its self-history-making, a lifelong task as 'historian-apprentice'.[4] The psychic work of self-representation and biography will in the optimal case undergo continual revision as the child grows older, integrating new discoveries in its relationship to others.

While freedom to reinterpret its past is essential to its growth, the *I* also needs to preserve some autobiographical constancy. It is Aulagnier's contention that key representations bead the child's autobiography, beads she calls 'upholstery buttons or tuck points'.[5] Each tuck point represents a moment of intense affect where the parents' explanation of what has happened can be compatibly bolted to the child's intuition of his relationship to others. Autobiographically speaking, events, times, dates and places are of interest uniquely in so far as they transmit indications of the desire of significant others as a cause and source of its being.[6]

There can be little doubt, given the regressive pull of the transference neurosis, that the same investment by both poles of the therapeutic relationship is a crucial and necessary aspect of their deconstructive/constructive work together. The revised history that emerges from treatment is a construction to which both patient and analyst have contributed, and, implicitly or explicitly, agreed upon. The analyst's interpretation, in order to be

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[4] By this term, Aulagnier evokes the fragile assumption of mastery proverbialised in the transgression of the sorcerer's apprentice.

[5] I hesitate between these two terms in translating Aulagnier's 'points de capiton'.

[6] In stressing the manner in which the baby unconsciously positions himself with respect to the imagined desire of the parental figures, Aulagnier is following Lacan's (**1977**) lead. However, on the other side of the Atlantic, a very similar idea has emerged wholly independently in the mind of Henry Krystal (**1978**). I am grateful to Dr Guy Da Silva for drawing my attention to Krystal's work.

acceptable to the patient, must offer a change in biography and in self-representation, without endangering the relationships invested so far. How often have we heard patients go mentally blank with the uneasy and guilty notion that they are damaging their parents by talking about them. An episode of intense, incomprehensible, arousal, causing the patient to worry about his or her sanity, can be dissipated if the therapist's words make an effective transference link, thus buttoning down the emotional state to an unconscious movement in relationship to the therapist. The patient in the throes of transference neurosis, like the child, has the need for a legend or fantasy to provide causal explanation for internal upheaval. And of course, the patient in the analytic situation is exposed to the same risks of derailed co-authorship as the emergent *I* of the child, as the catastrophic reaction of some fragile patients to premature interpretations demonstrates.

However, when the issue is to present the history to a third party, as is the case when publishing or presenting to one's scientific community, an additional layer of psychological fallout must be considered. Is it always possible to investigate the transference implications for the patient in the analyst's exhibition to a jury of peers? As a consequence of the intrinsic asymmetry of the analytic couple, the third party's role as witness will inevitably harbour different meaning for patient and analyst. Both egos are involved in a narcissistic temptation, though probably at different levels and for different reasons. In the spirit of scientific endeavour, the analyst is, in principle, submitting to the symbolic castrating power of the peer group. In scientific discourse, there are no 'points de capiton', no agreed-upon anchor points that cannot eventually be challenged. Though psychoanalysis is not an evidence-based science, falsification of hypotheses can occur, not on an experimental level, but on the level of the reader's or listener's internal validation with respect to his or her own practice. That internal verification by the peer group remains relative rather than absolute takes nothing away from its potentially castrating power, and prevents psychoanalysts from 'self-authorising' the scientific value of their work.

Whereas for the analyst, the witness is called upon for scientific validation, and thus might optimally function as an oedipal rival and referent, the same cannot be assumed for the patient.

Enlightening in this context is the valuable extension, added by Jean Laplanche (**1989**, **1992**), to Freud's discovery of the impact of the primal scene on infantile sexual development. The spectacle of coitus is never a purely objective fact: not only does the child struggle to comprehend what he sees, and what he feels, but he has also to cope with the enigmatic unconscious message being communicated to him by the parental couple. 'Freud never suspected this idea: the primal scene only has an impact insofar as it conveys a message, a something-to-be-seen and a something-to-be-heard, on the part of the parents' (**1992**p. 49).

When an analyst requests permission to publish material from a patient's treatment, does his supplication not create a partial role reversal and an offer to exhibit themselves as a fertile couple before others? Unconscious sexual fantasy can be stimulated by the complicity of such a public pairing (Stein, 1988b). What might it mean to the patient to participate in the analyst's quest for recognition elsewhere? To be counted as part of a body of evidence offered to this peer group as a demonstration of the latter's professional competence? Is it ethical to involve the patient in a relationship of latent rivalry and competition with an audience outside of the consulting room? And how might an imagined recognition in the regard of an idealised other play a part in the patient's acceptance? It will be recalled that Little Hans was well aware of the 'Professor's' presence behind his father and begged the latter to relay some of his questions.

The patient cannot be expected to situate himself in the same way as the analyst with respect to the 'proof' or 'verification' of the dyadic construction when it is offered to a third party. While good reconstructive/constructive

work has the effect of increasing the interpretive mobility of the patient, the risk cannot be discounted that the patient who approves of a public version of his history will 'freeze' in an alienated identification with it. Under what conditions would the patient escape the imaginary pull of transference, be indifferent to the immobilising effect of an 'official' history, avoid feeling seduced by the public confirmation by the analyst, or prevent being solicited by its exhibitionistic aspect?

By making explicit his or her wish to write about a particular aspect of the patient's treatment, the analyst is signifying in a particularly forceful way recognition of it. Might the published history act like a pause button, rather than as an anchor point, turning a still from a live sequence into a permanent excessively cathected definitive version? One can wonder whether one of Stoller's patients was expressing a sentiment of this order when in the midst of a pell-mell of positive and negative feelings about having been the subject of a full book case study, she wrote: 'I resent the book, you, my illness, and find myself wishing I were still capable of that same crazy, criminal and destructive behaviour … *I can't forget the years, and if I do forget, that printed reminder is always available*' (**Stoller, 1988p. 377-8**, my italics).

Our sensitivity to the risk of patient compliance, whether it be a consequence of our reading of Winnicott or of Lacan, gives us no alternative but to pose these ethical and technical questions before acquiescing to legal pressures or to well-meaning humanistic concerns. I share with Casement a deep uncertainty as to what is the 'right' thing to do. He has written that asking a patient about possible publication … introduces an intrusive factor into the analytic process. Some patients are unable to cope with this 'rocking the boat' of the analytic experience, and it will always rock it. We cannot always assess correctly when it is right to ask for that permission from a patient. It may never be right' (**1985**p. 224).[7]

## The Dossier as a Piece of the Analyst's Psychic Work

There is another aspect to the confidentiality of clinical work that is problematic in contemporary practice, though it is, in many ways, the obverse of the scenario described above, and that is the patient's right to information in his dossier. As a protection against abusive practices, as an encouragement to accountability, and as support for the dissemination of knowledge, access-to-information legislation has been hailed. Nevertheless, it is clear that, if naïvely applied to the dossiers of the practising psychoanalyst, this legislation can be expected to undermine the capacity for transference and countertransference elaboration and working through.

In a practice bulletin on 'Charting psychoanalysis', a Subcommittee of the American Psychoanalytic Association (**Gray & Cummings, 1995**)[8] has recently made a courageous effort to grapple with this contradiction. Their conclusion is clear: 'We believe a serious dilemma is created for the maintenance of the patient's ability to work in the psychoanalysis when chart records (including progress notes), which are susceptible to external scrutiny, must ultimately be available for review by the patient …' (pp. 5-6).

The Subcommittee goes on to point out how any accountability of psychoanalytic documentation, be it to a third party or to the patient, 'will distort the process of evenly hovering attention that characterises classical psychoanalytic technique … We believe this is an absolute problem apart from that of confidentiality. This topic has only recently begun to receive the intense scrutiny it requires' (p. 6).

It is not just that the notion of an unconscious means the existence of inferences and speculations in the analyst's mind that the patient does not yet recognise as his own, or may never recognise as his own. It is also that analysts cannot claim the same objectivity for

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7 I am grateful to Ronald Aldous for pointing out Casement's treatment of the issue to me.

8 The committee's full title is: Subcommittee on Notes for Federal Programs of the Committee on Peer Review.

facts noted in their dossiers as for those in the standard medical chart; nor would it be scientific to treat them as such. If Laplanche's work (**1989**) on the induction/seduction effect of the classical framework, or Aulagnier's (**1986**) insistence on the prescience of the analytic 'offer' over the patient's 'demand', or the legacy of writings on how countertransference-monitoring can guide the analyst to insight are taken seriously, then the file kept by a psychoanalyst must be looked upon as an amalgam that can no longer be said to 'concern' exclusively or to be 'caused' exclusively by the patient. The psychoanalytic dossier bears witness from a certain countertransference perspective that cannot claim empirical faculity. The analyst's notes, as well as his elaboration of them in theoretical writing, are themselves products of a certain constellation of repressive and instinctual forces. Shibboleth though it is to repeat this premise, it nevertheless forms the first, and most obvious, difference between a psychoanalytic dossier and any other standard psychiatric chart.

The right to, and necessity of, a secret mental space as part of the individuation/separation process is beautifully conceptualised in another article of Aulagnier in 1976. She pointed out that an excessively zealous injunction to free-associate may have a paradoxically alienating effect on the psychotic patient, for whom an 'I' capable of claiming possession of, and authorship of, a private psychic space cannot be taken for granted. To be able to enjoy a thought, felt to be engendered by onself and not to feel obliged to share it, is for some patients an unusual accomplishment that should be respected.

It is probably equally true that the analyst's own psychic work must preserve its intimacy and secrecy so as to avoid hampering reverie. For a significant category of analysts, process notes are part of the ongoing metabolisation of patient material. There are analysts who are not given to note-taking, who do not seem to need to review process notes, who do not require the external prop of writing to carry their patients inside them. These analysts might presumably be less perturbed by a ruling that would allow patients to see their dossiers, since these latter are not real working documents in their case. But for many analysts, their process notes, recorded to a greater or lesser degree, trace their inner pondering of the mutual narcissistic mirroring of the relationship, with the analyst's ego emerging as an additional site of examination. Whether explicitly or implicitly, the written record of psychotherapy or analysis is equally the record of part of the therapist's/psychoanalyst's self-analysis.

In the practice bulletin of the Subcommittee of the American Psychoanalytic Association referred to earlier (**Gray & Cummings, 1995**), distinctions between progress *notes, process notes* and *working notes* are proposed for analytic files. Progress notes constitute documentation for third parties, a documentation the subcommittee finds inimical to the psychoanalytic treatment process. On the other hand, process notes that are created for educational purposes, or the more sketchy and informal working notes kept by some psychoanalysts, do not have the same disruptive effect. Their value in psychoanalytic work is 'a very individualized matter, derived from the analyst's education, experience, and preference … They are a reflection of the mental life of an analyst engaged in psychoanalytic work' (p. 8). Nevertheless, the existence of process and working notes poses a medical-legal dilemma, one acknowledged by the committee. Even if these notes are kept separate from the patient's 'health care records', and care is taken that they contain no material that might be used to identify the patient, the court may still consider them to be part of the clinical record and subpoena them. The same right to consult could presumably be granted to the patient. This risk will not change, in my estimation, until the courts and the public are sensitised to the detrimental impact of transparency.

The interest of third-party payers in the dossier, or of the legal instances involved in civil or criminal proceedings against the patient or analyst, is a separate issue, outside of the scope of this paper, which is focusing on the ethics

and dynamics of the dossier as a point of contention within the therapeutic couple. However, it is relevant to point out how third-party access has altered the way in which charting is done by mental health professionals, making notes simpler, less detailed, and more impersonal. Institutional charts now attest to a certain minimum standard of care and no longer document the psychodynamic process as such. In Bollas & Sundelson's acerbic comment: 'The analyst is now writing for the state and to the state' (**1995**p. 96).

A separate, private, file has been advocated by some, but since, as mentioned above, any note made in the course of rendering a service is considered part of the record, this clearly does not solve the problem. If the issue behind the patient's request to see the dossier touches upon an example of presumed incompetence or professional misconduct, it should not be the patient who peruses the analyst's notes, but only the latter's peers, disciplinary committee or equivalent.

The paradox may be that the truth, at least in the intrapsychic sense, cannot come into being except in a situation of non-transparency. Or, perhaps it would be more accurate to affirm, borrowing the expression of Lacan, that the 'time for understanding' must be at first a non-accountable one, before a second 'time for concluding'.

## The Enigma of the Analytic Setting and of the Analyst's Own Unconscious

At the risk of stating the obvious, a patient who requests to review his or her dossier is looking for something. Putting aside instances in which the patient is hunting for 'proof' in a contention about the treatment, might he or she be seeking some intelligence about his inner life or identity that has not been forthcoming from the therapist? Might there be a kinship, in certain clinical situations, between the child's sexual curiosity and the patient's pursuit of enlightenment via the dossier? Freud was the first to point out that obstacles parents put in the way of sexual enlightenment can hinder the child's intellectual development in other spheres by a ricochet effect of repression. Klein (**1931**) corroborated Freud's intuition though she added that anxiety about learning is stirred up much earlier than Freud had assumed. The inside of the mother's body is the earliest object of the impulse to know. Dread of the mother's body as a 'place full of destruction' (p. 240), whether a consequence of guilt over the sadistic overtones of penetrating her secrets or because of early traumas associated with maternal deprivation, can suppress the child's investigation.

The very existence of a dossier, and note-taking during sessions, if that is the case, can be a stimulant to the patient's curiosity. Following Freud and Klein's lead, we might wonder if the analyst's notes assume for the patient the connotation of a veiled maternal body or primal scene. However, I would suggest that there is more to it, or at least potentially. More broadly still, does not the benevolent neutrality of the analyst itself constitute the equivalent of an enigmatic message (**Laplanche, 1989**), which mobilises and props up a passionate questioning on the part of the patient? Comprehension of the seductive and enigmatic effect of the analytic setting may further illuminate a patient's request to view his dossier. This request may be both a displacement from and a by-product of the destabilising impact of the analyst's dispassionate curiosity. If 'the truth about the subject emerges only in the mirror of his witness' (**David, 1966**), the analyst/witness cannot dissociate this truth from the inductive power of his/her presence.[9]

To the patient's lack of mastery over the situation, we must add that of the analyst, whose ongoing self-scrutiny can never foresee all the blind-spots and enactments his or her own unconscious can perpetrate. This admission applies to the presentation and publication of clinical material, which can contain an incompletely understood portion of the analyst's own psyche. One can only conjecture as to the impact on the patient who may obscurely intuit this countertransference undercurrent. In a

recent article discussing the analyst's 'right to privacy', Bromberg (**1997**) placed an intersubjective dialectic at the heart of impasses in which the analyst's privacy becomes resented by the patient. In Bromberg's opinion, what has occurred is a

> transference-countertransference enactment in which the analyst has been refusing *to recognize and reveal his own dissociated experience of the patient*, who then, often desperately, tries to find a way to penetrate and devour the contents of the analyst's mind in order to find himself within it (p. 32).

Something of this dynamic may be at work when the patient seeks access to the dossier, as the clinical example presented below suggests.

## A Clinical Example of a Request to See the Dossier

The example that follows, drawn from the author's work, suffers from certain limitations. It occurred in the non-analytic setting of intensive psychotherapy, first in institutional outpatient work and then in private practice. Moreover, the patient was allowed to see the dossier. The account of the incident and its après-coup elaboration will endeavour to show how the request to view the dossier might have been symptomatic of an intersubjective dialectic repeated in, *but equally mobilised by*, the therapeutic relationship. In particular, my sense is that a certain inhibition or deficiency on my part prevented the request from being properly interpreted at the time.

The treatment of Sally, the young woman in question, had been in progress for about two years. During that time, my preoccupation had focused on helping Sally to make the step from a troubled adolescence, in which she had toyed with drug abuse and near-delinquency, to the young adult tasks of moving away from home and finding satisfaction in work. Her solution to the impossible ego ideals inherited from an idealised, then fallen, and finally, prematurely dead, father was a tough, counter-phobic cynical attitude. Any emotional display was deprecated as weak and feminine. Much of the early work had converged on her attacks on structure, on limits, and on her own intellectual potential. She refused to explain her curiosity about the dossier other than to voice a vague suspiciousness about confidentiality.

A dossier kept in the institutional setting is not under the exclusive custodianship of a single staff member, and access to it has to follow an administrative protocol. With the symbolically triangulating function of the father figure in mind, I decided not to stand in the way of the patient's application. It was only later that I realised that an imperfect grasp of the transference-countertransference field had obstructed an adequate interpretation of Sally's curiosity about the file. Arrangements were made for her to meet with the team psychiatrist, who agreed to her request, and allowed her to sit alone for an hour to peruse the chart. Unbeknown to the psychiatrist, she even retained a part of it, which she took home for a few days before returning. It was evident that she was dissatisfied with her search, though she continued to baulk at disclosing why. I did not look into the possible significance of the part of the file that she had temporarily removed.

Sally's treatment at the clinic ended eventually with my departure from the institution. She had no wish, at that time, to be referred to anyone else. Nevertheless, after an interval of a few years, Sally decided to consult me in private practice. Coming out of the closet in the meantime had not lessened her self-hatred. A

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9 De Carufel (**1994**) has theorised that the analyst's aim-inhibited, detached containment of the analytic or intensive psychotherapeutic setting has the unsettling consequence of provoking the release of a primary process unconscious sexuality characterised by a break-up of links, by a zero principle discharge of all energy, and by a part-object eroticism. Laplanche (**1986**) refers to this as a 'death-instinct sexuality'. The deconstructive fragmentation of the ego's defensive organisation is a necessary prelude to new insights into unconscious factors, and to a new integration of them.

few serious relationships with women had withered, in part, she supposed, because of her tyrannical emotional demands.

What I was then slowly able to realise was that the first treatment had bypassed a significant sector of Sally's suffering: namely, the desperate humiliation she felt about being a woman. Also overlooked had been the sexual longing behind her macho posturing and mistrustful attitudes. Though I had been aware of the lack of sexual pleasure in her relationships to men, I had not connected her idealised expectations of me with homosexual conflicts.

Sally had been an adopted child, finding stability and consistent nurturing only after an early history of neglect. The adoption itself had been problematic, with the natural mother's ambivalence creating protracted uncertainty for all involved. In retrospect, two main themes can be discerned in her request to see her dossier. On one level, her psychiatric dossier represented an avatar of the mysterious adoption dossier, about which her adopted parents were secretive and conflicted. Her earliest enquiries into the circumstances of her adoption were greeted with tears by her adopted mother and evasive replies. What she did learn about her natural mother was so uniformly bleak that she was faced with a painful dilemma. How was she to reconcile a view of herself as the desirable adopted child, with a representation of herself as the progeny of such grotesquely inadequate parents, neither of whom had ever wished to take care of her? As Aulagnier has indicated, a quandary confronts the subject when the parental biography offers such an unpalatable identification. The adoptive couple's lugubrious portrayal of the ‘first paragraph’ of Sally's life story was probably coloured by the fact that each of them had been a victim of episodes of parental abandonment in their own childhoods. In reproaching Sally's birth mother for her neglect and immaturity, had they not at the same time been addressing a personal grievance to their own mothers?

On another level, what was missed in the first treatment was an unspoken question addressed through the transference that concerned Sally's femininity and sexuality. Did the female therapist recognise and value that femininity, and did the therapist believe she was homosexual? The answer to the latter query, which she was secretly hoping to find in her chart, appears, in hindsight, to have been a counterpoint to my failure, in the first two years of therapy, to have shown concern about her development as a sensual, sexual being. The belated attention to these interlocking issues of sexuality and identity is reminiscent of Freud's chagrined insight after the stunning departure of Dora. However, whereas Freud had difficulty positioning himself in a maternal transference, I may have underestimated the paternal transference. It was Sally's father's conflicts about women that were key to her childhood feeling that she should have been a boy. His perfectionism and pride had made him a hero to his little daughter, but his hatred of his own promiscuous and demented mother infiltrated his perception both of the failings of Sally's natural mother and the emergent sexuality of Sally's teenage years. He encouraged her to tomboy pursuits and teased her when she wore dresses.

This perspective on Sally's conflicts is consonant with the study Lacan (**1951**) has made of Dora, for whom the same ‘mystery of her own femininity … of her bodily femininity’ emerged in what Lacan has called the ‘third dialectical reversal’ of her analytic relationship with Freud brought about by her quitting treatment. The shock of this reversal was what led Freud to a reconsideration of his interpretation of Dora's transference. In Sally's case, the question from childhood, keenly reactivated in the here-and-now of the therapeutic connection, had to do with the mystery of being seen, and valued, in having a little girl's body, a body vulnerable and dependent, but powerful in its own way as a source of pleasure and of seduction. This unconscious interrogation, because the analyst/therapist had not as yet learned to put it into the symbolic register of words, was constrained into being displaced into a concrete act with paranoid and delinquent overtones. Sally's demand to see her dossier and the therapist's

obtuseness to her sexuality were complementary halves of an enactment.

The astonishing intuitions penned by Winnicott in his article, 'The antisocial tendency', can be transposed to the therapeutic relationship I have tried to transcribe here. Where he spoke about the mother's reaction to her child's antisocial behaviour, we could substitute the analyst/therapist:

> It should be said, however, that whatever the mother does [to help her now delinquent child], this does not annul the fact that the mother first failed in her adaptation to her infant's ego needs. The mother is usually able to … do a successful therapy … because she enables the infant's hate to be expressed while she, the therapist, is in fact the depriving mother (**1956p. 312**).

The environmental failure haunting Sally from her childhood, repeated in the course of treatment, that her request to view her dossier symbolically aimed to redress, was the father's, and subsequently the therapist's, missed recognition and symbolisation of a valued femininity. This incident would also seem to fit the dialectic described above by Bromberg (**1997**), in which the analyst's dissociated experience of the patient triggered a hunger to penetrate the analyst's mind/dossier *in order to find herself within it*.

## Closing Remarks

Although requests for dossier access and patient approval of publications do not as yet appear to be common occurrences, they can provide a useful vantage point for a discussion of the implications of an intersubjective theory of the treatment setting. Moreover, the frequency with which these issues come up in analytic and psychotherapeutic practice can be expected to increase under the impact of the themes of empowerment and accountability in contemporary Western culture. Baudrillard has already warned us about these cultural changes and their psychological sequelae:

> Certainly … [the] private universe was alienating to the extent that it separated you from others—or from the world, where it was invested as a protective enclosure, an imaginary protector, a defense system. But … as long as there is alienation, there is spectacle, action, scene … [On the contrary] when all becomes transparency and immediate visibility, when everything is exposed to the harsh and inexorable light of information and communication. We are no longer a part of the drama of alienation; we live in the ecstasy of communication (**1983**p. 130).

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## Translations of Summary

Dans cet article, l'auteur exprime un doute en ce qui concerne deux déviations de la neutralité analytique: quand l'analyste recherche la permission du patient pour publier ou présenter un matériel clinique, et lorsqu'il permet au patient d'accéder au dossier sous la législation de l'accès à l'information. Dans le premier cas le problème est centré principalement sur l'implication du patient dans la version que donne le thérapeute de leur travail, une implication qui a la possibilité d'inhiber les révisions futures de la compréhension qu'a le patient de lui même. Dans le second cas, l'espace analytique mental qui est symbolisé par le dossier est perçu comme n'étant pas uniquement celui de l'analyste ni celui du patient, une chambre de dialectique complexe dont le caractère privé doit être respecté afin que cela fonctionne vraiment. Dans le contexte analytique, la transparence et la responsabilité laissent apparaître un paradoxe qui ne lui est pas exclusif: la possibilité d'une divulgation complète va à l'encontre de l'expression d'une vérité subjective. Dans un exemple clinique, la curiosité concernant un dossier fut perçue comme étant une nouvelle version d'un questionnement antérieur contrarié se rapportant aux thèmes de l'origine et de l'identité. Une déficience spécifique dans la compréhension du thérapeute a pu contribuer à l'agissement du patient.

In dieser Arbeit werden Vorbehalte gegenüber zwei Abweichungen von der analytischen Neutralität geäußert: wenn der Analytiker den Patienten um Erlaubnis fragt, klinisches

Material zu veröffentlichen oder vorzustellen, und wenn der Analytiker aufgrund der Gesetzgebung über den Zugang zu Informationen dem

Patienten Zugang zu seinen Fallnotizen gewährt. Im ersten Fall drehen sich die Bedenken vor allem darum, daß der Patient verstrickt wird in der vom Therapeuten sanktionierten Sicht der gemeinsamen Arbeit; dies kann zukünftige Überarbeitungen des Verständnisses des Patienten von sich selbst behindern. Im zweiten Fall wird der analytische seelische Raum, symbolisiert durch die Notizen, als weder ganz dem Analytiker noch ganz dem Patienten gehörend angesehen. Stattdessen wird er als ein komplexer dialektischer Privatbereich gesehen, dessen privater Charakter, damit er effektiv funktionieren kann, respektiert werden muß, und zwar selbst vom Patienten, der durch seinen Diskurs dazu beiträgt. Im analytischen Kontext zeigt sich in Transparenz und Verantwortlichkeit ein Paradox, das nicht ausschließlich in diesem Bereich vorkommt: die Möglichkeit voller Offenlegung läuft dem Ausdrücken subjektiver Wahrheit zuwider. In einem klinischen Beispiel wurde die Neugier an den Fallnotizen verstanden als eine Neuauflage eines vormals vereitelten Hinterfragens von Ursprüngen und Identität. Ein besonderer Mangel in Verständnis des Therapeuten kann zu der Inszenierung des Patienten beigetragen haben.

En este artículo se toma postura contra dos desviaciones de la neutralidad analítica: cuando el analista solicita el permiso de los pacientes para publicar o presentar material clínico; y cuando el analista permite que el paciente tenga acceso a su expediente, en virtud de la legislación sobre acceso a la información. En el primer caso, la cuestión se centra, sobre todo, en la confusión del paciente ante la versión autorizada del terapeuta acerca del trabajo que están haciendo juntos, complicación que podría inhibir revisiones futuras de la auto-comprensión del paciente. En el segundo caso, el espacio mental analítico, simbolizado por el expediente, es vivenciado, no sólo por parte del analista sino también del paciente, como un espacio dialéctico complejo cuya privacidad debe ser respetada, incluso por el paciente, quien contribuye con su discurso a que tenga lugar, con la finalidad de que todo funcione de modo eficiente. La transparencia y la responsabilidad en el contexto analítico da lugar a una paradoja que no es exclusiva de este campo: la posibilidad de que todo llegue a saberse, se opone a la expresión de la verdad subjetiva. En un ejemplo clínico, la curiosidad por el expediente, fue considerada como una nueva re-edición de un cuestionamiento que había sido impedido antes, acerca de los orígenes y de la identidad. Una dificultad para comprender algunos aspectos concretos por parte de la terapeuta, pudo haber contribuido a una puesta en escena [enactment] del paciente.

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