Ethical Considerations in the Writing of Psychoanalytic Case Histories

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An essential principle of psychoanalytic practice is the maintenance of strict confidentiality, and yet the presentation and publication of psychoanalytic case histories necessitates considerable public disclosure of the lives of our patients. Inasmuch as psychoanalysis is a particularly frequent, intensive, and lengthy process, a report of the unfolding of an analysis necessarily entails considerable revelation concerning patients, their inner worlds, and their life circumstances. This use of confidential material raises innumerable ethical concerns, and psychoanalysis, with its unique emphasis on unconscious mental processes, also adds to the complexity of ethical considerations by demanding that we take unconscious factors into account. When we speak, for example, of "informed consent" as an ethical principle, we as psychoanalytic clinicians must grapple with the problem of whether to take a patient's manifest acquiescence at face value. This article explores such ethical considerations along with other ethical and clinical complications in the presentation of analytic material for professional purposes.

"W"hatsoever things I see or hear concerning the life of
men, in my attendance on the sick or even apart there-
from, which ought not to be noised abroad, I will keep
silence thereon, counting such things to be as sacred
secrets."

This passage from the Hippocratic oath gives testimony to the age-
old ethical concern with the protection of patient confidentiality. This
symposium is witness to the fact that as psychoanalysts we continue

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to honor our ethical obligations by struggling deeply with the issues raised when we write about our patients.

I believe that the ethical concerns of writing case histories are similar for all clinicians, whether they practice psychoanalysis or other forms of psychotherapy. Psychoanalysis, however, presents unique problems while offering its own valuable contribution on these matters. Inasmuch as psychoanalysis is a particularly frequent and intensive process, a case presentation involves a great deal of detail concerning the patient's private life and circumstances, and, as the treatment is quite lengthy, a report of the unfolding of the process covers a considerable span of the patient's life. All of this means that a psychoanalytic case report, in comparison to case reports of brief therapy or of treatments aimed at resolving specific focused symptoms, necessarily entails considerably more detailed revelation concerning patients, their inner worlds, and their life circumstances.

Psychoanalysis, however, with its unique emphasis on unconscious mental processes, also adds to the complexity of ethical considerations by demanding that we take unconscious factors into account. When we speak, for example, of "informed consent" as an ethical principle, we as psychoanalytic clinicians must grapple with the problem of whether to take a patient's manifest acquiescence at face value. How does one analyze a patient's compliance with the analyst's request to use personal, private, and often shame- and guilt-laden material in a public forum for academic, scientific, or didactic purposes and in the service of the analyst's interests? What are the transference and countertransference implications of making such a request of a patient? Is there a time, either early in an analysis or after the termination of an analysis, when we would consider the patient capable of giving permission "outside the transference," to use a traditional conceptualization or, to put it differently, outside the skewed power structure of the patient-analyst relationship? In short, psychoanalysis calls on us to take unconscious considerations into account—unconscious internal conflicts as well as unconscious interpersonal dynamics—and it is in this realm that psychoanalysis makes its unique contribution to ethical concerns and moral practices. And yet, although analysts have been presenting case material for a century, and while Freud, as we shall see, was alert to these considerations, still, psychoanalysts have written practically nothing about these problems.

In a recent collection of papers regarding writing in psychoanalysis (Piccioli, Rossi, and Semi, 1996), ethical concerns regarding confidentiality and informed consent are barely mentioned. Even worse, they seem to be dismissed. Consider that one contributor wrote, "The problems concerning discretion are greater for the author than for the analysand, whose identity can be disguised. But any case history worth reading tells us quite a lot about the analyst, whether he wishes it or not; that is a price we have to pay" (Paikin, 1996). Stein (1988) published outstanding work on the topic of writing about patients, and yet, even with his intensive focus on the impact of analysts' writing on their patients, his contributions do not address the ethical concerns that we are taking up here.

Let's begin by examining what "Ethical Principles of Psychologists and Code of Conduct" (American Psychological Association, 1992) has to say relevant to these questions. Ethical Standard 5.08 (Use of Confidential Information for Didactic or Other Purposes) lists two considerations. First, psychologists should not disclose in their writings or lectures personally identifiable information concerning patients "unless the person . . . has consented in writing." Second, in such presentations, psychologists should "disguise confidential information" "so that patients are not individually identifiable to others and so that discussions do not cause harm to subjects who might identify themselves." Although there may be some ambiguity here, my reading of the ethics code is that psychologists must do both—obtain written consent and disguise confidential information. Disguising case material alone is insufficient.

In a recent guest editorial in the International Journal of Psychoanalysis, Goldberg (1997a) raised important questions concerning written case histories. He rightfully argued that "there is a need both to safeguard the privileged communications of patients and to allow psychoanalytic science to progress by way of a free exchange of information" (p. 433). This immediately raises an important problem, for in calling on us to balance the needs of the patient with the needs of science, Goldberg is reminding us of Freud's declaration that psychoanalysis is a theory of mind and a method of research as well as a clinical intervention, and we as psychoanalysts cannot separate out the research aspects from the clinical process. Those who write about their analytic work do not generally do special analyses for research purposes and others for clinical purposes. If we did, then we might well have a separate standard of care for the two procedures, but in fact we have only one, and all our analyses are also research subjects.

Goldberg (1997a) argued contra those who take a firm stand of never writing or presenting case material because he views this stance as neglecting our responsibility as scientific researchers. He also very
cleverly pointed out that these same analysts do not allow their ethical principles to interfere in their reading the case presentations of others. So, in his effort to balance patients' rights of privacy with the research needs of the scientific community, Goldberg considered a variety of compromise solutions. Regarding obtaining patient permission, Goldberg pointed out that what informed consent consists of is most unclear "inasmuch as one can never fully determine the consequences of such a request" (p. 436). Asking patients for authorization to write about them may burden them and may alter the course of their analyses. Goldberg took up the question of how much and in what ways to disguise clinical material; however, he was concerned that a clinical presentation might stray too far from factual reporting. Brief clinical vignettes get around some of these problems, but they do not substitute for an in-depth study of a treatment over a longer period of time. Composites, an account based on bits and pieces of cases, often are not satisfactory, according to Goldberg, because there is the danger of composing a fictional rendition. Although Goldberg acknowledged that all such clinical accounts may be viewed as forms of fiction, he insisted that we must nevertheless be able to rely on the essential factual basis of a case.

This reminds me of a story about a research scientist who did a statistical study of a particular illness and who relied on case histories in the psychoanalytic literature. Later this researcher had an opportunity to discuss the work with the analyst who had written up the case. It turned out that the patient never actually had this illness but rather another disease entirely; the analyst had changed the precise illness in the service of disguise and protecting confidentiality (Lipton, 1991). This is a good example of the tension that may be created between the sometimes opposing values of patient privacy and scientific research.

Gabbard (1997) took issue with Goldberg's portrayal of the complex situation surrounding the writing of case histories. Gabbard claimed that Goldberg had overstated the problem with disguising case material. He suggested that a disguise could change the identifying features of the patient to preserve confidentiality while leaving elements of the process intact. He provided the following guidelines:

1. disguise identifying features of the patient rather than altering the content of the sessions. (2) The goal of disguise is that no one other than the patient and analyst will know whose treatment is being described. (3) Do not write about patients [early] continuing in treatment. [The journal included a misprint, which Gabbard corrected in a personal communication.] (4) If there is a reasonable chance that the former patient may read psychoanalytic journals, meet with the patient and obtain informed consent. (5) Do not write about patients who are candidates or who are in the field without obtaining consent [p. 820].

Goldberg and Gabbard have done an important service in bringing these issues to our awareness, and they have provided some worthwhile initial guidelines for us to consider, but it seems that this discussion is only at a preliminary stage and that the discipline has not begun to do justice to the unconscious dynamics that are bound to come into play. Unfortunately, Goldberg (1997a, b) did not refer to Lipton (1991), who began his excellent essay on the topic by citing Freud's (1905) preface to the Dora case. Lipton quoted Freud:

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. In such circumstances persons of delicacy, as well as those who were merely timid, would give first place to the duty of medical discretion and would declare with regret that the matter was one upon which they could offer science no enlightenment. But in my opinion the physician has taken upon himself duties not only towards the individual patient but towards science as well; and his duties towards science mean ultimately nothing else than his duties towards the many other patients who are suffering or will some day suffer from the same disorder. 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 [Freud, 1905, p. 8].

At the risk of extending this quotation, I think it is worth noting the considerations that Freud elucidated in "Fragment of an Analysis of a Case of Hysteria":

I think I have taken every precaution to prevent my patient from suffering any such injury. I have picked out a person the scenes
of whose life were laid not in Vienna but in a remote provincial town, and whose personal circumstances must therefore be practically unknown in Vienna. I have from the very beginning kept the fact of her being under my treatment such a careful secret that only one other physician—and one in whose discretion I have complete confidence—can be aware that the girl was a patient of mine. I have waited for four whole years since the end of the treatment and have postponed publication till hearing that a change has taken place in the patient’s life of such a character as allows me to suppose that her own interest in the occurrences and psychological events which are to be related here may now have grown faint. Needless to say, I have allowed no name to stand which could put a non-medical reader upon the scent; and the publication of the case in a purely scientific and technical periodical should, further, afford a guarantee against unauthorized readers of this sort. I naturally cannot prevent the patient herself from being patroned 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 besides her could discover from it that she is the subject of the paper [Freud, 1905, pp. 8–9].

The very quantity of arguments that Freud mounts here should be enough to alert us that he was nervously aware of remaining difficulties, and, of course, in spite of all these precautions, Dora did later discover that she was the subject of Freud’s case history and that, like Freud’s other patients, from what we know, she was proud of it. Nevertheless, Freud here anxiously anticipated so many of the considerations (and rationalizations) that would be used by analysts over the course of the next century, and he established the tension between the dual loyalties of patient confidentiality and scientific research as fundamental to the ethical dilemmas with which analytic clinicians would have to struggle.

One thing that Freud did not do was to ask Dora for permission to publish her case; instead, he insisted (we now know quite incorrectly) that no patient would agree to such a request. One can only imagine the clinical complications that would have arisen had Freud asked Dora for her consent to publish the case history. As Lipton (1991) pointed out, in our own era of third-party payment and peer review, considerations of privacy have become much more complicated.

How free is the patient, in the midst of an analysis, to decline permission to the analyst to use material from the analysis? Let me make all you readers very anxious for a moment by asking you to perform what philosophers like to call a thought experiment. Imagine that a patient tells her analyst that he may use her clinical material for the purposes of writing a journal article. She specifically encourages her analyst not to overly disguise the material because she wants to make a contribution to society. Consider that, during the next year, the patient goes into a state that analysts have traditionally referred to as a negative transference. She decides to file suit against her therapist for unprofessional conduct or to bring him up on ethics charges on the grounds that he violated her confidentiality. Her attorney makes the argument that the patient’s consent, which she admits having given, was meaningless, as it was obtained while she was a patient, vulnerable to undue influence on the part of the analyst, who should have maintained a fiduciary responsibility toward her. After all, the attorney says, “You are a psychoanalyst, aren’t you? Your patient’s conscious response was to agree to the use of her material, but didn’t you consider that unconsciously she was at least ambivalent? And if she were at all ambivalent, even unconsciously, then how could you, as her analyst, have gone ahead and used the material?” I hope that I have made you all sufficiently anxious! Now, I am not an attorney, and I really do not know what the legal ramifications are, but let us examine this more closely in order to consider the ethical, professional, and psychoanalytic problems that are raised.

I think that we would all have to agree that most patients would indeed have mixed feelings about being used in this way. Nevertheless, in real life, people do make informed decisions despite their ambivalence. But psychoanalysis is a unique slice of life. Patients are not as free to provide informed consent. That is why, for example, we would not allow ourselves to have sex with them, even if it seemed to be consensual. It is why we have to be quite careful about entering into a business transaction or bartering arrangement with them. And yet, we routinely use clinical material for our own purposes and assume that it is okay because we have disguised the material to our own satisfaction, there is a scientific need for these publications, and perhaps the patient has given informed consent.

How often, I find myself wondering, do we actually get their permission anyway? Some of our journals explicitly require that authors obtain permission from patients. Contemporary Psychoanalysis, for example, in its “Information for Authors,” includes a section called “Confidentiality,” in which it states: “It is the author’s responsibility to disguise the identity of patients when presenting case material and to obtain their written permission to do so.” Most psychoanalytic
journals do not address this concern or state any such expectation in spite of the fact that they often clearly state that authors are required to obtain permissions from original copyright holders and previous publishers.

If so many of us ask patients for permission, then why are there so few illustrations in our literature that describe the impact of this on the ongoing analytic work? I believe that we need more reports concerning requests for patients' consent because the very act of bringing this topic up with the patient is bound to be quite complicated, and, although in some cases it may prove productive and to the patient's benefit, in other cases it may be personally painful to the patient and destructive to the treatment. We need to know more about these consequences, and it would be useful to have the full range of responses documented in our literature.

If so many analysts get their patients' permission to publish, then I would expect that many patients would want to read the case write-ups. If indeed they are reading these professional articles, then why have we heard hardly a word about their reactions in all our literature? (There have been a few exceptions—e.g., McDougall, 1995. Recently, Psychoanalytic Dialogues published Cramopolis's (1999) fascinating case presentation relevant to this topic, also see S. Pizer's article in this issue.) Can it really be that so many analysts let their patients read their papers concerning these ongoing analyses, and yet no one ever thinks to write about how this affects the analyses? Or, do these analysts somehow discourage their patients from reading the papers or even convey an attitude that discourages the patients from even hinting that they might like to read the papers?

Furthermore, if a patient does not actually read a draft of the paper, then it is obviously left to the analyst to decide in what manner and to what extent to disguise the case material. But then how does the analyst ever feel confident that what he believes is appropriate camouflage would really be enough to satisfy the patient? As the patient's life is involved, should not the final say about what constitutes acceptable concealment be left to the patient? One answer to all this is to use case material only from analyses that have been terminated long ago. This poses other problems. First, many analyses go on for a very long time. If I, for instance, had to wait until analyses were over to use clinical material, it would slow down my clinical writing considerably, probably decades. I would be really old before I could publish more clinical material. Furthermore, the analyst/author would then have to contact the patient to ask permission to use the material and would have no opportunity to analyze or get any sense of the former patient's reactions. Also, it is quite common for patients who have terminated to come back into treatment at some point. Moreover, even after the analysis is long finished, there are serious ethical questions about exploiting former patients who continue to relate transferentially to past analysts, which is to say that the former analyst may still be in a position to exert undue influence. For example, I believe that there are significant analytic ramifications and ethical concerns about asking a one-time patient, even well after the termination of an analysis, to contribute money to the analyst's institution.

Furthermore, all of what I am discussing applies not only to publishing analytic case material but to using it in teaching seminars, in training situations, and for other purposes. All of our trainees routinely present clinical material to supervisors, to case seminars, as case write-ups, and so forth. Are patients told that any of this will be done? Often they are, and yet, in supervising numerous postdoctoral analytic trainees, rarely have I heard a patient ask the analyst, "So, what do you say about me in class? What do your classmates think of our work? What do your supervisors think?" How is it that we are so skilled at conveying to our patients that we prefer that they not raise these issues?

I had one talented supervisee who was tape-recording her sessions for use in supervision and in a case seminar. One of her patients said to her, "You know, it's fine for you to tape and present me in class, but I'd really like it if in turn you tape-recorded the class discussion and supervision and let me hear it. After all, maybe it would be valuable for me to be let in on the discussion." I asked myself and my supervisee, would this reflect aspects of mutuality or symmetry? (For an elaboration of this distinction, see Aron, 1996.) What might be gained and what lost in such a practice? Would it deepen the analytic investigation or foreclose it? How could we know? But, regardless of how to proceed clinically, I think that my supervisee must have been doing something right that her patient was able to bring this up so directly, because in my experience, it so rarely emerges.

I agree with Lipton's (1991) suggestion that, if the illustrative material that we are using from an analysis is rather brief and might apply to many patients, asking for permission seems superfluous, but that, if we are planning to use extensive material, then we should certainly ask the patient for permission. Lipton assures his patients that he will disguise the material and that they will have the opportunity to review the write-up and provide their thoughts. But in
my view, even Lipcon, whose article is among the best in the literature, continues to underemphasize just how powerful the analyst's influence is and how intimidating it may be for a patient to refuse permission. Lipcon raised the possibility that it would be better to ask all patients for permission at the beginning of treatment, but he argued that, at the beginning of treatment, some patients may have an even stronger transference to the analyst, others may hold back material knowing that it may be published, and still others may simply refuse to go along with such an arrangement.

For a brief time, I attempted, in the interest of honesty and full disclosure, to tell new patients that I did a lot of writing and that it was possible that I would want to use material from their treatment for presentation and publication. I quickly learned that this approach did not work very well, at least not for me. These people, my new patients, did not know me yet and had no reason to trust me; furthermore, it raised the question in their minds as to whether I was there predominantly to meet their needs or to meet my own. Now, as we all know, this is indeed a legitimate question. There are inherently diverging interests that lead to inner and interactive conflicts between patient and analyst. These genuine conflicts of interests are often deceptively hidden within analytic technique, and a complex process of negotiation is required to deal with these diverging interests. The analyst's theoretical, academic, and research interests are one set of factors that often constitute a conflict of interest. Although this ultimately needs to be addressed and negotiated, in my experience it is a clinical mistake to raise this with patients before some working relationship has been established and patients have had at least some experience having their therapeutic needs met with the analyst.

One solution, problematic in its own way, includes introducing various forms of fictionalization and deception into clinical narratives. We know, of course, that many of the greatest names in the history of psychoanalysis relied on autobiographical material to construct their most famous case histories. From Freud's thinly disguised autobiographical paper on screen memories to Anna Freud's paper on beating fantasies, presented to qualify her for membership in the Vienna Psychoanalytic Society, and derived from her own analysis conducted by her father, from Melanie Klein's earliest contributions on child analysis, which were secretly based on her analyses of her own children, to Kohut's two analyses of Mr. Z, which, we have learned, were based on his own analysis and self-analysis, there is an illustrious though some might consider notorious tradition of fictionalization and fabrication of supposedly scientific data. These classic cases reflect compromises between our scientific aspirations and our need to protect personal privacy, although here the privacy that was being protected was the writer's own. The history of these cases raises the question of what kind of science psychoanalysis may be and leads us to consider all case presentations, unless otherwise specified, as semi-fictional illustrations rather than as research data. It is easy enough for some to criticize psychoanalysis on these grounds as unscientific, but this critique, so often made by nonclinicians, does not take into account the psychoanalyst's need to struggle with and uphold both sets of values, the values of scientific research and the responsibilities of clinical practice.

Given all the complex clinical and ethical dilemmas in writing about patients, my own inclination is to favor the liberal use of disguise and even fictionalization and to value the educational and communicative value of a good story over the scientific effort to record factual, undistorted evidence.

Another approach to case histories is based on inviting our patients to participate more fully as collaborators and even coauthors in the writing enterprise. Stoller (1988) took a strong and radical stand by asserting that we should involve patients in our writing by encouraging them to review and comment on our case reports throughout the process. He described his own clinical experiences in which patients largely responded positively to being included in the process. He issued the challenge, "Show your patients your descriptions of them" (p. 385). He also argued that we should include our patient's views regarding the matters about which we are writing—while remaining free to describe our own independent perspective on the treatment.

When Freud wrote that patients would never consent to having their case histories published, he neglected one critical factor. He underestimated the narcissistic gratification to the patient of being the subject of the analyst's case presentation, and it may be even more fulfilling to the patient to work as a collaborator with the analyst reading and commenting on drafts or even writing their own versions of the treatment. That it is gratifying to the patient may make it easier for us to get patients' authorization, but it raises even more troubling ethical and clinical concerns. After all, we have an obligation to protect patients, even if the gratification of a collaborative role leads them to encourage the analysts to publish. One male analyst was involved, for example, in publishing a lengthy article based on analytic work with a female patient. This patient had been sexually abused as a child and
had been sexually involved with two prior psychotherapists. The analyst included the patient, who had been reading quite a bit of the analytic literature, in the writing process by showing her drafts of the paper and asking for her feedback. The patient was happy to cooperate and claimed that being involved with the analyst in this way was good for her personal growth. Whose needs were being met? The analyst’s sophisticated view was that he understood that he was using his patient for his own ends, but he believed that this patient could not participate in an analytic process conducted with greater objectivity. He rationalized that he was adhering to a contemporary psychoanalytic model of neutrality (Greenberg, 1991), being an old object in once again using the patient to meet his own needs while being a new object in the sense that his use of her was far more benign, not apparently destructive to her, and seemingly even helpful to her treatment. This analyst may be right in this case—I cannot know or judge—but one can see in this example not only the ways in which conflicts of interests are inherent in the analytic situation but also the many complex and subtle ways that we can rationalize and justify our own clinical choices. It is certainly conceivable that more will be gained analytically by getting patients’ feedback regarding our clinical reports than by proceeding with anonymity. To return to my supervisee and her patient who asked for feedback about the supervision, might my supervisee learn a tremendous amount by listening to her patient’s reaction to a supervisory session or a case seminar? Yet, might it intellectualize the entire process? Might it divert attention away from the patient’s concerns to the preoccupations of the analyst? Might it be upsetting to hear the reactions of outsiders? Might it inhibit the supervisor and classmates from speaking freely, knowing that the patient would be listening to the tapes? Might it overly concretize “the Third” (see Aron, 1999) by bringing them into the analysis as concrete real presences rather than by keeping them in the realm of the symbolic or at least the imaginary?

All these are serious and meaningful objections, but are we so certain that analytic practice has reached full maturity that it is no longer worthwhile for individual analysts to experiment with more innovative forms of practice? I find myself very much in agreement with Berman’s (1997) neo-Freudian challenge to analytic conservatism: “To keep psychoanalytic treatment alive, and to render it more effective, we need innovative experiments. Such experiments may require attempts to reassess our conception of boundaries. Defining innovative approaches as boundary violations may delegitimize them and support barren conservatism” (p. 570). Nevertheless, once again, our attention is directed to the problem that we inevitably use patients for our own research purposes. There are important ethical considerations involved in experimenting with patients—particularly in innovations regarding therapeutic boundaries. Here is another illustration. Once, I had a dream about a patient and decided to report the dream to the patient and ask him if it might not be productive to collaborate on exploring what it meant to him and what it might reveal about our relationship and the analytic work. This is the dream:

I was here in the office sitting behind the couch as I usually do with you. I remember that I was fumbling around with a pencil. It was a short pencil, the kind that people give out when you are asked to fill out a form of some kind. You got annoyed that I was making noise, and you complained. I felt annoyed that you were complaining about this, like, oh there you go again, things here are not perfect enough for you. Everything has to be just so. We were annoyed with each other.

The patient and I spent the next few weeks of the analysis discussing this dream. How free, I wonder, was the patient to decline my invitation to discuss the dream, or even to stop me from narrating it in the first place? We discussed both the content of the dream and the feelings stirred up by the fact that I told it to him. It seemed to me that the incident proved of limited value, but it did not actually seem to be very dramatic. Frankly, from my point of view, not much happened, but I was pleased that it had been an unusual occurrence, and I was glad to be able to view myself as innovative and daring. So, after a few weeks of analytic investigation of this complex interaction, I wrote a paper about it and asked the patient if he would like to read it. He was ambivalent but told me that he felt he could not decline. I should have stopped there and investigated this further, but in my own eagerness and anxiety I went on to give him the paper to read.

The weeks following his reading of the paper were difficult and painful for me and yet powerful and enlightening. One of the most important things that I learned was that the dream was a wish fulfillment. One of the images in the dream was of my fumbling with a pencil, in response to which both the patient and I had associated to some phallic and homosexual concerns, which certainly were relevant. Sometimes, however, a pencil is just a pencil, something that one uses for writing. When I say that the dream was a wish fulfillment, I am
referring specifically to the idea that it fulfilled a wish that I dream about a patient, precisely so that I could tell the patient the dream and write a paper about the resulting interaction. I knew at the time that I had an interest in the issue of the analyst's self-disclosure, and specifically I had read with great interest the work of Tauber (1954) who had discussed sharing his dreams with patients with reportedly good results. I did not recognize at the time, however, just how much I was determined to pursue these interests. I now acknowledge, in retrospect, that my motives were not predominantly in the patient's interest but in my professional preoccupation and ambition. My point, however, is that I was able to realize this in an experientially meaningful way only when I was able to get analytic feedback from my patient, who was both angry at my intruding on his analytic process with my own needs and gratified that he was able to point this out to me and have me be responsive to his feedback. Ultimately, telling the patient my dream was neither destructive to the analysis nor particularly helpful to the patient, but sharing the write-up with the patient and encouraging his feedback served to clarify my own blind spot and advance the analysis.

The dream, I came to understand, symbolized my very conscious conflicts concerning the risk that the patient would become angry with my writing about his treatment. In the dream, you see, all I am doing is fumbling around with a pencil, a small one at that. His anger over this is all his fault, nothing that I have to feel guilty or apologetic about. My fumbling around is precisely how I felt I was behaving in regard to the issues that I have raised in this paper: Do I tell him that I am writing about him? Do I just disguise the material? Do I let him read a draft of the paper? Do I ask him to give written consent? How will this all affect our ongoing work? Or do I wait until after he terminates? What is the correct form (remember that the pencil is the kind that one uses to fill out forms), and am I following proper form in writing about my patient?

In the years that he was conducting his self-analysis and inventing psychoanalysis, Freud told Fliess that he could have dreams made to order. Perhaps my dream too was made to order, and hence my subjectivity, including my dreams, disclosures, desires, and writings, influences my analytic work and at times raises complex clinical as well as ethical challenges. But why should these ethical concerns disturb only my own sleep when psychoanalysis, Freud believed, is supposed to disturb the sleep of the world. Freud bequeathed to us all a psychology with moral and ethical implications—his was "the mind

of the moralist," as Rieff (1959) called it—and Freud's moral philosophy demanded that we accept the inherent conflicts of the human condition. An examination of the ethical considerations in writing about our patients demands no less than that we unflinchingly face these contradictions and live with the moral struggle created by the tension of their opposing forces.

REFERENCES