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Disguise or Consent: Problems and Recommendations Concerning the Publication and Presentation of Clinical Material[1]

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The author argues that the use of clinical material for educational purposes or for publication presents the analyst with a conflict of interest between the protection of the patient's privacy and the educational and scientific needs of the field, and also that it places analysts in the position of using confidential patient material in the service of their own professional advancement. The strategies of dealing with this dilemma can be classified as follows: (1) thick disguise, (2) patient consent, (3) the process approach, (4) the use of composites and (5) the use of a colleague as author. Some of these options may, of course, be used in combination with one another. All of these methods have a place, and the author argues against a uniform approach. Each of these strategies is discussed in terms of its advantages and disadvantages. While no choice is without various risks, some guidelines are offered to assist analysts who wish to present or write about clinical cases.

In the second year of my analytic training, I arrived at the first meeting of my continuous case seminar. The advanced candidate who was going to present her case to the seminar participants sat at the front of the room with her supervisor. At the beginning of the seminar she announced that she and her supervisor had discussed the problem of confidentiality extensively because the patient who was being presented was personally acquainted with a number of analysts in the local community. They had decided that the best strategy was to reveal the patient's name so that those candidates who knew the patient could excuse themselves from the seminar. The name of the patient was then announced. No one moved towards the door. No one gave any non-verbal signs of recognition. The case presentation then began.

As a naïve beginning candidate, I pondered what had just happened. For the sake of preserving the patient's privacy, his name had been revealed. What was more important to keep confidential: his name or the details of his private life? The irony of this strategy did not seem to warrant further discussion by the seminar participants, so I dismissed it by assuming that I was the only one disturbed by it. After all, if the presenter had *not* mentioned the name, one of us who might have known the patient might well have reacted with alarm several weeks down the line when it became apparent that the personal details of the patient being described belonged to a personal friend of ours. What had not been contemplated was that one of us might later become acquainted with the patient and be in the awkward situation of knowing extraordinarily private and personal information about him. In fact, this exact scenario unfolded when I subsequently became acquainted with the patient.

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1 This paper has been selected to appear for discussion on the *Journal's* World Wide Web pages and Bulletin Board (see http://www.ijpa.org).

Since that disturbing moment many years ago, I have continued to struggle with the countervailing duties we embrace as analysts who present material to colleagues and publish case reports in the psychoanalytic literature. As **Goldberg (1997)** has noted, we must safeguard the privacy inherent in privileged communications, but we must also have free exchange of information for psychoanalysis to develop as a science. Goldberg emphasises, and I agree, that no solution is without some undesirable results.

In recent years in my capacity as chair of the American Psychoanalytic Association Joint Committee on Confidentiality and a member of the same organisation's Ethics Subcommitee charged with rewriting the ethics code, I have had continuing concerns. Arguments about this dual

responsibility generally revolve around a choice: the use of thick disguise for identifying information versus the request for informed consent from the patient. When the Committee on Scientific Activities of the American Psychoanalytic Association attempted to reach consensus on issues of confidentiality and disguise, they finally agreed to disagree and went on to otherissues (**Klumpner & Frank, 1991**). The members of the Ethics Subcommittee on Revision similarly had difficulty reaching consensus and came up with an 'either/or' solution:

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).

While this principle is helpful in guiding the analyst to act ethically, it leaves many questions unanswered, which I will pursue in depth in this communication. 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.

Publishing houses and psychoanalytic journals also address the problem in different ways. Some publishers of psychoanalytic books are now asking the author to obtain written consent from patients who are described in the book. The *Journal of the American Psychoanalytic Association* and the *International Journal of Psychoanalysis* ask their reviewers to identify potential problems of confidentiality in papers that are being evaluated, but both journals leave it to the discretion of the authors to deal with the problem in ways that they see fit.

In an informal survey of fifteen analytic colleagues, **Lipton (1991)** noted that the group was about evenly divided between those who did seek the patient's permission and those who did not. Twenty analytically trained psychotherapists in the Baltimore-Washington area polled by Wallwork (1998, personal communication), in most cases, used only modest disguises. Another disconcerting finding from that survey was that 70% of respondents knew about patients who had complained about another therapist's breach of confidentiality. In fact, the average number of violations known per therapist was 3.45. Hence the issue is not simply idle ivory-tower discourse. The protection of patient privacy in educational presentations and scientific publication is an everyday concern within analytic communities.

Among our medical colleagues the controversy about privacy and patient protection has been heightened in recent years by a statement issued by the International Committee of Medical Journal Editors (ICMJE) that was published in the *British Medical Journal* in

November 1995. After years of emphasising the protection of patient anonymity, the group shifted to an emphasis on obtaining informed consent (**R. Smith, 1995**). The statement of that esteemed organisation reads as follows:

Patients have a right to privacy that should not be infringed without informed consent. Identifying information should not be published in written descriptions, photographs, and pedigrees unless the information is essential for scientific purposes and the patient (or parent or guardian) gives written informed consent for publication. Informed consent for this purpose requires that the patient be shown the manuscript to be published.

Identifying details should be omitted if they are not essential, but patient data should never be altered or falsified in an attempt to attain anonymity. Completeanonymity is difficult to achieve, and informed consent should be obtained if there is any doubt. For example, masking the eye region in photographs of patients is inadequate protection of anonymity.

The requirement for informed consent should be included in the journal's instructions for authors. When informed consent has been obtained, it should be indicated in the published article (**R. Smith, 1995**, p. 1272).

This statement clearly gives the nod to scientific accuracy over protection of patient privacy. A moment's reflection leads one to the recognition that even with informed consent, potential harm can

come to the patient if the description of the patient is recognised by others. Indeed, critiques of this proposal (**Vollmann & Helmschen, 1996**; **Snider, 1997**) have stressed that obtaining consent for publication may in fact be harmful in some cases. Moreover, there is no question that in many cases psychoanalytic data on patients is of a more sensitive nature than the personal information revealed in medical evaluations and requires a higher level of protection against breaches in confidentiality.

In this communication I would like to consider in depth some of the issues that analysts must face when contemplating presentation of clinical material or publication of clinical data in scientific journals or books. After surveying the various problems, I will introduce several guidelines to be considered in the hope of further advancing our dialogue on a highly complex, but not quite impossible, area of our impossible profession.

Thick disguise

Disguise is probably the most common method of dealing with confidentiality in case reports. In **Lipton's (1991)** small survey, he reported that the majority of the colleagues he polled did not request permission from their patients when those patients were outside the field and not likely to read psychoanalytic journals. **Goldberg (1997)** has raised questions about disguise because of the risk that accuracy is sacrificed and that alterations in the case may reflect the analyst's unconsciousdistortions of the actual treatment. The Committee on Scientific Activities of the American Psychoanalytic Association (**Klumpner & Frank, 1991**) has also stressed the compromise of the scientific status of psychoanalysis when extensive disguise is used. They present an example of a child analysis describing a patient with gastric ulcer. At the end of the discussion the presenter casually noted that the patient was actually a juvenile diabetic. Such distortions could lead to literature reviews on the psychology of ulcers that erroneously include the psychodynamics of this particular case, not knowing that the case was actually an example of juvenile diabetes.

It is my belief (**1997**) that when disguise is judiciously used, one can preserve scientific integrity while also protecting patient confidentiality. Certain external features can be falsified to mislead readers who might try to identify the patient while maintaining intact the psychodynamic features and the analytic process. While the ICMJE statement affirms that the patient data should *never* be falsified in the service of anonymity, this point of view is not absolute and can certainly be challenged on ethical grounds. Isn't prevention of harm to the patient and preservation of confidentiality a higher value than the accuracy of relatively trivial external details about the patient that do

not materially affect the psychoanalytic points being made in the paper? Clearly, from a scientific perspective, each author has to make a judgement call regarding when a line is crossed and the disguise substantially changes the clinical situation in a way that is potentially damaging to the scientific credibility. Can a man be described as a woman? If a paper revolves around gender as a pivotal issue, changing the gender is out of the question. Can a Korean patient be described as an Iranian? If an author of a cross-cultural paper wishes to make a point about Korean culture, then that author cannot alter the ethnic identity of the patient. On the other hand, if the paper is presenting a point of view about technique, and the author is wishing to illustrate it with process data, the gender or cultural origins of the patient may be of far less importance. Hence the issue of ‘thinness’ or ‘thickness’ of the disguise should be determined based on the theme of the paper and the particular clinical situation described.

From whom does the author wish to conceal the patient's identity? The patient's family? The analyst's colleagues? The patient's friends? Probably all of the above. Trying to conceal the identity from the patient himself or herself is perhaps carrying disguise to an extreme. An unspoken standard for many years in the psychoanalytic literature has been that a case should be disguised sufficiently so that only the analyst and the patient would recognise who it is.

If authors are using the standard described by the respondents in **Lipton's (1991)** survey, namely, that they don't get consent if the patient is unlikely ever to read the psychoanalytic literature, then they must also take into account that patient's family. Certainly if a child analyst is writing about children, that analyst must take into consideration that the parents or other family members may read the article, and serious thought should be given to getting consent from parents. One must also face the fact that the accessibility of even relatively obscure psychoanalytic journals has markedly changed with the cyber-revolution that has gone on in the last decade. Patients can now sit at their home computers and access their analyst's writings with relative ease. Authors must also take into account that patients who may currently have no interest in psychoanalytic publications may develop such interests after termination and years after they have had contact with their analyst.

While the ICMJE statement specifically proscribes the falsification of identifying features, thick disguise that protects the patient demands such falsification because general statements provide no protection at all. For example, if an individual's occupation is that of an accountant, and the author says 'a professional man', the description is vague but does not at all mislead the reader. If, on the other hand, the author says the individual is 'an engineer', the reader assumes that the individual is *not* an accountant. Part of the difficulty that we have as a profession with the writer's dilemma is that disguise requires the author to be deliberately deceptive and misleading in the service of a higher ethical standard, namely, protection of the patient's identity. This practice is unsettling to analysts, but it is a part of analytic work that is built in to the high regard in which we hold confidentiality. Information we hear from the couch must be compartmentalised and known but not known in our daily interactions with colleagues. If I hear from the couch personal and sensitive information about a colleague, when I encounter that colleague, I must appear not to know that information, which requires a certain degree of deceptiveness. To do otherwise would be to open a Pandora's box of determining which information we hear from the couch we can use in social intercourse and which we cannot (**Gabbard, 1999**).

A strong argument can be made for not writing about patients who are currently in treatment. When the analyst thinks about the patient in terms of a particular theoretical or technical issue, that analyst is at risk for consciously or unconsciously skewing the patient's material in the direction of that issue. Hence, writing about the patient may intrude on the treatment in a way that is not in the patient's best interest at times. In her discussion of the

influence of the analyst's writing on the treatment itself, **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. Even when the analyst chooses not to obtain consent from the patient, the analyst's professional self intrudes into the dyad as a 'third' with a *different* agenda from the relief and understanding of the patient's suffering. In the case that Crastnopol describes, her patient had a dream in which her analyst was depicted as someone who was available to the patient only on the analyst's own terms and with the analyst's own needs in the foreground. Crastnopol describes how she tactfully analysed the patient's reaction to being the subject of an analytic paper.

To be sure, even when one has chosen to write about former patients, the thought about *the possibility* of including the case material in a future publication can influence the analytic work. H. F. Smith candidly wrote of his own dream about a patient in the course of that treatment:

> *As I was looking at the photograph and facing out through the arches of the building, I was startled to notice that my patient had her hands down the front of my pants. I stepped abruptly away and said, 'no'. As I walked away, I thought with dread, 'how will I ever write this case up?' Even though 'nothing happened', it will surely have an effect on the analysis. I can't pretend it didn't happen (**1997**, p. 19).*

The appearance in the analyst's dream of the analyst's concern about writing up the case reflects the way in which the analyst who writes is always dealing with the inherent conflict between the analyst's needs and the patient's needs (Salvin & Kriegman, 1998).

Another advantage of writing about former patients is that an added element of disguise is present. Current patients are among a relatively small group that others may know about through the grapevine of relatively small psychoanalytic communities. Former patients can be lost among a much larger group of past analysands where the identity is much more difficult to track down, even if one attempted to do so. The analyst can lend further disguise by providing false details of the time frame in which the treatment took place. In today's climate we cannot ignore the fact that there is a cadre of critics who are intensely hostile to psychoanalysis and are eager to track down the identity of analysands and pursue details of published cases that might disparage psychoanalytic treatment.

There is, of course, a significant downside to disguising identifying information instead of getting consent as well. Person (**1983**) described how two of her patients reported feeling 'raped' when they discovered themselves in written accounts by other analysts. Stoller reports on a patient who happened to come across a paragraph he had published about her years after the analysis. The patient noted:

> *My feelings ranged from horror to outrage, from narcissistic pleasure to indignation. Even sadness welled up. I felt used. I felt peculiarly honoured … You said it hadn't hurt me,*

*that you were justified because I couldn't be identified … 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? (**1988**, **p. 382**).*

Perhaps the most celebrated literary instance of this type of discovery occurred in Philip Roth's novel ***My Life as a Man* (1974)**. The protagonist of the novel, Peter Tarnopol, is in treatment with Otto Spielvogel. Tarnopol sees a journal lying on his analyst's desk with an article by Spielvogel entitled 'Creativity: the narcissismof the artist'. He reads the article and discovers that two pages are about him. Spielvogel has disguised Tarnopol as an Italian-American poet in his late forties to mask his real identity as a Jewish-American novelist who is in his late twenties. Tarnopol is outraged at the factual errors, the psychoanalytic understanding,

and his belief that readers will immediately know that he is the patient being described. But what is most disturbing to him is his feeling that his analyst has plagiarised his own material because a childhood trauma described in the article has also been written about in a *New Yorker* article published by Tarnopol.

Psychoanalytic literary critic **Jeffrey Berman (1985)** ingeniously linked this fictional account to a real essay published in *American Imago* (**Kleinschmidt, 1967**). The title of the paper was 'The angry act: the role of aggression in creativity'. Berman noted that Roth gets back at his real-life analyst by creating very close parallels between the fictional Spielvogel's paper and what Kleinschmidt actually wrote. In the Kleinschmidt paper Roth is described as a successful Southern playwright who is in his early forties. Berman observed that the fictional descriptions of the patient's mother and father match perfectly with the descriptions of the father and mother of the patient in Kleinschmidt's published paper. He also noted that Roth provides an almost identical interpretation of the patient's hostility towards women in his fictional account of the Spielvogel essay. In Kleinschmidt's paper in *American Imago*, the author stated, 'The playwright acted out his anger in his relationships with women, reducing all of them to masturbatory sexual objects and by using his hostile masturbatory fantasies in his literary output' (**1967**, **p. 125**). In *My Life as a Man*, Roth creates the following interpretation in Spielvogel's made-up essay: 'The poet acted out his anger in relationships with women, reducing all women to masturbatory sexual objects' (**1974**, p. 242). Berman pointed out that Roth's character Tarnopol felt plagiarised by the analyst's use of his material, and Roth may have stolen back the analyst's words by using them in his own novel.

What is the moral of the story? There are morals on several levels in this case. Certainly at the most superficial level, one can conclude that when an analyst writes about a patient who is a writer, the patient will probably get the last laugh. A second level involves lessons about the so-called 'VIP' patient. When an analysand is well known, analysts should probably forgo the gratification of exhibiting the patient to colleagues through publication. A third and darker level in this provocative tale relates to the analyst's motivations. Unresolved aggression towards the patient may be a significant unconscious factor in the motivations of the analyst who writes. Many of us write in an effort to master complex and difficult countertransference situations in our clinical work. Adverse consequences from publishing case materialmay in some cases reflect our own unanalysed hostility towards the patient we choose to use as a clinical example.

In contemplating the use of disguise without patient consent, the analyst must recognise that there is an irreducible risk, especially in the era of the internet, that the patient or the patient's family may someday discover what has been written and have a host of reactions that may produce some degree of harm. Nevertheless, this risk should not necessarily deter an analyst from using this approach with certain patients. As Tuckett (2000) stresses, in every individual case, the disadvantages to a particular patient must be weighed against the advantage to future patients by creating useful scientific exchanges with colleagues in the pages of our journals. He points out that the potential harm linked to not obtaining patient consent must be taken into account in a broad ethical framework and must not be addressed through the enforcement of narrow or fundamentalist guidelines. Concerns about such harm, however, have led some analysts, such as **Stoller (1988)** to assert that one should always obtain patient permission before publishing case material. Nevertheless, as we shall see, that course of action also entails considerable risk of harming the patient.

Patient consent

The choice of sharing the material to be read with the patient and securing the patient's consent for publication or presentation has the

advantage of being above board, but as Goldberg pointed out: ‘The complications that occur can be enormous, since the patient may feel burdened unnecessarily, and the analyst may feel something similar’ (**1997**, p. 436). Perhaps the central controversy around this approach is whether informed consent is ever possible in such situations because of the influence of transference on the patient's decision. **Lipton (1991)** 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 theirmaterial published. **Stoller (1988)** reported that all of his patients willingly agreed to have their material published. In **Lipton's (1991)** informal survey of fifteen colleagues, among those who had asked patients for permission only one had received a negative response. How does one take into account the patient's ambivalence in such situations? Isn't it a basic premise of psychoanalytic work that the analyst must maintain a certain degree of scepticism about the face value of anycommunication from the patient? It is inherent in analytic work that we are always wondering about multiple meanings, unconscious conflict and a defensive use oftransference feelings. Moreover, the patient's consent at a particular point in time may be viewed differently later in the course of the analysis or after termination. Winslade (quoted in **Stoller, 1988**) noted that some patients may not view publication as harmful until some time after consent has been given. He stressed that thefantasy or thought about the publication of case material may carry a different valence than the actual fact of it, when the patient reads the analyst's comments in an analytic journal. He argues that patient consent can always be withdrawn—in principle—even *after* publication.

My impression from my discussions with colleagues on the subject of consent is that many analysts are quick to accept at face value the patient's agreement to publish because they are feeling guilty about the obvious self-interest inherent in publishing the clinical material. Publications bring acclaim to analysts and advance their careers and reputations. While they attempt to convince themselves that they are being ethical by obtaining patient consent, they are secretly ashamed of exploiting their patient's trust in them by their writing. Certainly a principle that can be universally endorsed is that when consent is obtained in the course of an ongoing treatment, the implications and meanings should be analysed as thoroughly as possible.

I have now seen at least four patients who themselves have introduced the subject of my writing without my asking for permission. These are patients who have asserted early in their analytic work with me that they fervently hoped that I will some day publish an account of our work together. My psychoanalytic work with these individuals has illuminated some of the underlying conflicts and issues that lie behind these requests and have made me wary of accepting patient permission and consent at face value. One example will illustrate some of these concerns.

Ms R was a 23-year-old graduate student who came to psychoanalytic treatment with concerns about her capacity to love and her ability to embrace life in a meaningful way. In the first session of the treatment, she spoke at length about long-standing eating problems. She looked at me and said in a highly provocative way, ‘While I'm sitting here talking to you, I can't help thinking thoughts like how it would feel to eat your knee-caps’. As we explored this somewhat unexpected comment, Ms R acknowledged the shock value of the comment and realised that she was in some way trying to convey to me the desperation that her voraciousness engendered in her.

About one year into the treatment, I took a summer vacation for two weeks, and the patient struggled to get through my absence. On the first session after my return, she told me that she had missed me terribly and decided that she must be experiencing ‘transference’. I asked her what she meant, and she said, ‘I feel like I'm falling in love with my analyst’. She went on to say that she had gone to a local bookshop and found a book of mine, ***Love and Hate in the Analytic Setting* (1996)**. She said she found it interesting but was intimidated by how much I knew and how scholarly I was. As she read through it, she said she found herself strongly wishing that I would some day write her case up in a book. She commented, ‘I can just imagine the passage: “Ms A, a young woman in her twenties, told

me that she wanted to eat my knee-caps in the first session". You could then call the book *Cannibalism in the Analytic Setting'*. We both laughed heartily at her quip.

As the laughter died down, I wondered with her if there were any other feelings she might have about the prospect of appearing in something I wrote. She said it would be a great honour. She said it would make her feel like she was one of my most special patients, if not *the* most special. I then enquired if she would have any feelings of betrayal at having private aspects of her life appear on the page. She replied that she would have no feelings whatsoever of betrayal because she would know that she was helping others through allowing her own situation to be published. She would actually feel quite good about it. She told me that in reading through my book, she felt that I wrote with respect for patients.

I pointed out to her that she had decided to locate my books and read them while I was away. I asked her if she had any thoughts about the timing. She replied that it was one strategy of trying to maintain contact with me during my absence. She even said that while reading the words I wrote, she felt very much as if I was there with her.

At this point I commented that it seemed difficult for her to elaborate on this feeling that she was developing transference and falling in love with me. She replied, 'Well, I'm not sure that falling in love is the right term for it. I feel emotionally intimate with you, and I have loving feelings for you. They don't seem as sexual or incestuous as they have before'. She went on to say that she had called a former boyfriend while I was gone to 'drain off' some of the feelings towards me.

I asked her about what else had happened while I was gone. She said that she had been a peacemaker in her women's group, and one of the members of that groupsaid she was acting too much like a psychotherapist. I told her I was wondering that if one way she had cannibalised me was to take me inside her and become me byplaying the role of therapist in her women's group. She said that indeed she had even been using my words and my mannerisms. She said that her mother used to tell her she was a great mimic. I suggested to her that taking on my characteristics may have given her the feeling that we were really not so far apart—it was like I was there with her. She said she hadn't thought about it but may be that was one of the reasons she had got through the week as easily as she did. I then said to her, 'I wonder if the fantasy of appearing in a future book that I might write was a way of imagining that I would take you inside of me, and then by being in my book, you and I would be together forever'. Ms R reflected for a moment and said, 'Then I'd never have to go through this feeling of traumatic separation I have when you're gone'.

I fully realise the irony of introducing a case vignette in the context of a paper about methods of protecting patient privacy when publishing clinical material. I would like to clarify for the benefit of the reader that I did obtain this particular patient's permission while also disguising some of the details of the case. (However, I did not choose to disguise the anatomical feature—the knee-cap—that was targeted in Ms R's fantasies.) This vignette compellingly shows how the fantasy of appearing in the analyst's publications is often intimately linked with other transference wishes that require

analysis. After the fantasies are analysed, should the analyst then accept the consent and proceed to publish the patient's material? What if the analysis of thetransference fantasies reveals highly narcissistic and exhibitionistic determinants of the wish to appear in the analyst's publications? Is the analyst colluding with the patient's psychopathology to proceed with the plan to write? In the case of Ms R, the wish to appear in my book was a wish never to terminate, never to separate, and thus avoid the necessary experience of grief and mourning that accompanies the bleak fact that all analyses must end. It may also have contained a sexualised wish to have me inside her or have her inside me. Finally, there was a wish to fuse and have me incorporate her in the act of being 'inside' my book.

A further problem in deciding to obtain consent is that once the analyst has introduced the idea that the patient will appear in a publication, it inevitably affects the subsequent course of the analysis. Aron (2000) courageously disclosed an incident in his own practice when he wrote a paper about a dream he had had in the course of the analysis that he shared with his patient. When he asked the patient to read the paper, the patient was ambivalent but told Aron he felt he could not decline. Reflecting on the incident, Aron noted that his dream was a wish fulfilment because it fulfilled his wish that he would dream about the patient so that he could tell the patient about the dream and write a paper about it. In retrospect he acknowledged that his motives were not predominantly in his patient's best interest but rather more linked to his own professional preoccupation and ambition. Patients who know their analyst is writing about them may feel as though the analyst is shaping the materialto an imaginary audience. Patients may not feel free to explore these fantasies and simply tolerate them as

part of what they see as their duty as an analysand. As noted previously, of course, even if the analyst does not seek consent, the patient may still sense the analyst's intent to write.

To avoid some of these complications, many analysts will seek permission for publication after the termination of the process. While this may prevent some of the difficulties inherent in getting permission during the course of the analysis, it creates a new set of problems. How does recontacting the patient affect the post-termination consolidation? What if the former patient has a negative reaction and needs time to work it through? If a series of sessions are needed, does the analyst charge the patient even though the contact was initiated by the analyst? Is the informed consent any less problematic *after* termination than before? An extensive literature suggests that transference and the power differential accompanying it persists long after termination (see **Gabbard & Lester, 1995**, Chapter 8, for a review of this literature). Aron (2000) has pointed out that we are hard pressed to find any time either at the beginning of the analysis or long after it when the patient would be able to give permission outside of the influence of the transference.

A more profound ethical issue raised by asking for consent is that we may have caused a devastating and harmful impact on patients. In a critique of the ICMJE statement, **Snider (1997)** suggested that despite the blanket endorsement of obtaining informed consent, there may be instances when consent should be waived if the reading of the information by the patient is likely to result in harm. I personally know of two cases where patients of colleagues were so devastated by what they read about themselves that they abruptly quite the treatment and refused to discuss it further with their analysts. One was narcissistically wounded by the diagnostic understanding that the analyst had presented about him. The other was enraged because the analyst had promised confidentiality during the initial meetings prior to starting the analysis. **Stoller (1988)** reported on a patient who read what Stoller had written about him and felt that his analyst had humiliated him. **Lipton (1991)**recalled a patient who read the description his analyst had written of him and felt as though he were being presented as ‘crazy’.

Other complications are possible as well. A colleague had shared a case report with his

patient, who was happy to provide permission for publication. However, months after the permission was provided, the patient wished to publish a lengthy letter to the journal where the case report was to appear, as a way of providing her own point of view about what the analyst had described. While the intent was not overtly challenging or hostile, the patient felt that an elaboration from the patient's point of view would greatly enhance the educational value of the author's contribution. This created a complicated analytic problem for the dyad to work out between them. This vignette illustrates an irreducible fact: we can never know in advance when it is appropriate to seek a patient's permission or how that patient will react (**Casement, 1985**).

In an interesting self-reflexive development in the psychoanalytic literature, we are now beginning to read extended analytic case reports about how the analyst deals with the analytic impasses that may develop in the process of obtaining permission for publication. **Ringstrom (1998)** wrote an essay about the applications of the double-bind hypothesis to psychoanalytic treatment, and he added an illuminating epilogue that described how the double-bind style of the patient reported in the article manifested itself in discussions about giving permission for the paper to be published. Like others, Ringstrom's patient felt both honoured and exploited. Although he had long had a secret wish that Ringstrom would write about him, he felt that introducing the writing into the treatment was highly intrusive. The patient recalled as a teenager how his mother had entered a school project of his in a contest without his permission. He also felt that Ringstrom was using their collaborative work for his own professional advancement. Ringstrom then offered to withdraw the clinical material from the paper, and the patient vociferously objected because he felt he would no longer be special. Hence the same type of double-bind transference-countertransference impasse that had been the very heart of the paper was replicated in the difficulty the analyst encountered in trying to obtain permission. He felt ‘damned if he did and damned if he didn't’.

Furlong (1998), in a compelling argument in opposition to asking for patient permission to publish, emphasises that no matter how well-intentioned the analyst may be, the request introduces a need of the analyst that is alien to the patient. She asks:

> *Under what conditions would the patient escape the imaginary pull of transference, be indifferent to the immobilizing effect of an ‘official’ history, avoid feeling seduced by the public confirmation by the analyst, or prevent being solicited by its exhibitionistic aspect? (p. 732).*

One final concern about consent is that it may restrict self-disclosures by the analyst. In the current psychoanalytic *zeitgeist*, it is unfashionable for the analyst to be a cipher in clinical accounts. Indeed, some editorial readers are likely to express concern if the analyst's subjectivity or countertransference is not reported as part of the consideration of the psychoanalytic situation. Consent may interfere with candid disclosure about the analyst's feelings or fantasies regarding the patient. Certain kinds of feelings in particular, such as conscious sexual desire for the patient, may be omitted because the patient must read the account before signing consent. Thick disguise may offer a more candid account of countertransference.

Before moving on from the issue of consent, I wish to clarify that disguise and consent are not 'either/or' alternatives. A patient's permission for publication in no way obviates the analyst's ethical requirement to protect the patient's identity. For this reason, all published cases should be disguised to some extent, even when the patient gives permission.

The process approach

At this point in the consideration of the alternatives, we can see that any solution to the problem of the conflicting demands of patient privacy and scientific advancement involves a

risk of potential harm. The Committee on Scientific Activities of the American Psychoanalytic Association has proposed a model that tries to address both the scientific and the confidentiality concerns (**Klumpner & Frank, 1991**). The members of this committee expressed some distress at how often clinical reports do not provide the actual process material that led to the analyst's psychoanalytic formulations about what was going on with the patient. They felt that enough verbatim data must be provided to enable analytic readers to judge for themselves about the deductive process by which the analyst writing the case report reached his or her conclusions. Out of these concerns they developed an experimental format devised especially for the examination of analyst-analysand interactions. The format is designed to allow readers to judge the data on their own merits. In their suggested model the author first identifies the way the process was recorded (i.e. process notes, tape-recording etc.). The author also reveals how much time elapsed between the session being reported and the notes being derived from that session. In addition, the setting is described so that it is clear whether the process is psychotherapy or analysis, how many sessions per week were involved and the phase of the treatment. The patient's comments are reported in lower case while the analyst's comments are in capital letters. Non-verbal information is reported in parentheses. Private thoughts of the analyst are reported in capital letters in parentheses.

This format requires very little identifying information about the patient. By choosing the material carefully, the analyst can easily find sessions involving an exchange that says very little about the external life of the patient. Proper names can be changed or deleted. Yet the process between analyst and analysand can be described quite accurately for scientific purposes since little disguise is necessary.

This model also addresses a major concern in recent psychoanalytic writing that has been articulated by **Tuckett (1998)** in his role as editor of the *International Journal of Psychoanalysis*. In his effort to create a reasonable standard for peer review of psychoanalytic papers, he has become concerned about the method of argument used in psychoanalytic publications. He has called attention to the tendency of many analytic writers to use a rather specious mode of persuading their readers, such as argument by authority (often Freud) or the construction of a straw man. The advantage of the process model put forth by the Committee on Scientific Activities is that the write-up provides detailed process data that can easily be evaluated by outside readers to determine whether or not the author's thesis is convincingly demonstrated by the clinical material.

Spence (1998) has cautioned that clinical case reports are inevitably infiltrated by the analyst's wishes. We are more inclined to write about what confirms our theories than what disconfirms them. We are probably operating with narratives that extend beyond case material whether or not we ever publish or even write up a case. Hence attention to how analytic material is recorded is critical for the scientific advancement of psychoanalysis. In this regard, the process approach has much to recommend it.

This method is not applicable to all types of analytic writing. While this approach helps to demonstrate a point of technique, it will not be of much use if one is attempting to illustrate, for example, the psychoanalytic understanding of a particular symptom, syndrome or behaviour. In such

case reports, detailed information about the patient's childhood, outside behaviour and relationships may be necessary to support one's thesis.

The use of composites

There are also instances in which a pervasive psychodynamic theme is present in a variety of individuals with the same diagnosis or same behaviour pattern. If serious concerns about confidentiality arise—for example, the patients involved may be mental health professionals—the author can consider the use of composites. Inother words, characteristics of several different

patients can be combined into a single case example to illustrate the overarching themes. **Klumpner & Frank (1991)** have acknowledged that this method may function well for educational usage. However, they also stress that the reader should be alerted that this strategy is being used to illustrate a particular thesis.

In my own writing with Eva Lester (**Gabbard & Lester 1995**), I was faced with a complex problem of confidentiality when I needed to illustrate certain patterns within analysts who had committed sexual boundary violations with their patients. Because some of the individuals involved were well known by analytic readers, I created some composites that illustrated pervasive vulnerabilities, wishes, and conflicts within certain subgroups of these analysts. As **Klumpner and Frank (1991)**suggested, Lester and I also revealed this decision in the introduction to the book. In other instances where composites were not practical, we obtained written permission from the professionals involved, some of whom felt strongly that they wanted to make a contribution to the field by having their situation described. The composites were drawn from over seventy cases of professional boundary violations so that attempts to directly link any element of a composite to a specific individual would be fraught with difficulty, particularly since there were so many similarities among the many cases within a subtype. Hence when considering this mode of disguise, there is safety in numbers.

Colleague as author

One more innovative approach about which very little has been written is for the analyst to ask a colleague to write up the case material. Some countertransferenceexperiences may be extremely difficult for the analyst to discuss in writing. By having a colleague do the writing, the analyst contributes to the profession while preserving anonymity. One such situation happened in my own career when a female colleague approached me for a series of consultations to help her deal with intense erotic feelings towards a male patient. As the consultation proceeded, she encouraged me to write up the process, knowing that her anonymity was assured. At first I was hesitant to do so, but as we continued to discuss it, I felt it was a rare opportunity for readers to hear a ‘no holds barred’ account of eroticcountertransference. The paper was ultimately published (**Gabbard, 1994**), and to this day the analyst has remained anonymous.

While this particular clinical situation involved erotic countertransference material, one can conceive of many other situations in which colleagues might be in a better position to write up certain accounts than the analysts themselves. Particularly sensitive material in the patient might warrant such an approach just as much as difficult countertransference situations. Of course, the immediacy of the analyst's own experience may not be captured in the prose of others as well as it would if the analyst were the author. Hence something is undoubtedly lost in the transfer of authorship.

A specific variant of this approach occurs when supervising analysts write up clinical material from analyses conducted by their supervisees. Two types of consent are potentially involved in this practice. First, supervisor and supervisee must consider whether the patient's consent is needed. In addition, a more complicated issue may be whether or not the supervisee can truly give informed consent. Some supervisees in that situation may feel they have no choice but to accept their supervisor's wish to use the clinical material for publication. After all, they are being evaluated by the supervisor, and their progress in analytic training may depend on the supervisor's positive opinion of their work. At the very least, supervisors in this situation must thoroughly explore the decision to publish and try to create a climate in which the supervisee can decline the supervisor's request.

Guidelines and conclusions

This overview of the analyst's dilemmas regarding writing and presenting clinical data suggests that the patient's right to privacy, the profession's requirement to publish advances and new knowledge in the field, and the analyst's need for recognition are inevitably in conflict. No solution to the dilemmas posed in this paper is perfect. Any decision regarding disguise, consent and disguise, the process method, or the use of composites or colleagues carries with it a host of potential problems for privacy and for scientific reporting. Nevertheless, I wish to close this communication by offering several guidelines based on extensive discussions with colleagues, consultations on instances where breach of confidentiality was alleged, the careful reading of the literature, and my own struggles with all of these considerations.

The approach the author chooses should be tailored to the setting of the case report. For example, when an analyst is presenting clinical material in a distant city or another country, thick disguise may well be sufficient without obtaining consent (unless the patient is well-known or in the field). On the other hand, presenting to a continuous case seminar of candidates in a local setting may be more compromising of confidentiality, and the analyst may wish to seek the patient's consent. If the point being illustrated is one of analyst-analysand interaction, or a specific technical intervention, the process method may be the most desirable strategy. Of course, regardless of the setting, other considerations may override these generalisations.

From the standpoint of protecting patient privacy, vignettes rather than extended case histories are preferable (**Lipton, 1991**). Analysts are at times guilty of speaking in paragraphs when a sentence will do. The analytic writer must be judicious in determining how much clinical material is really necessary to support the thesis of the paper.

If the analyst chooses thick disguise without obtaining consent, he or she should carefully consider the consequences of the alteration to the field (**Clifft, 1986**). Will the change substantively affect the future psychoanalytic understanding of a particular condition in a way that misleads the field? Also, the use of false specifics is far better than vague statements for purposes of disguise. Finally, authors should probably omit unnecessary identifying details while focusing on *internal* wishes, fantasies and conflicts.

Writing about patients *after* termination has many advantages. Disguise is more challenging to penetrate when the patient is not currently in treatment because it may be difficult to place the patient in time based on the vignette reported. While some who object to this approach suggest that analysts' memories of their own feelings, the patient's affective states, and the details of process are far from perfect, careful annotations made after the sessions may preserve that memory so that a vignette can be written with the immediacy necessary for vivid clinical reporting. If one chooses to seek consent from a former patient, the interference with the treatment itself is much less than if sought during the process. Nevertheless, as noted previously, there are other problems entailed in trying to process the patient's reaction after the analysis is over. The other advantage of waiting is that the patient's analysis may have been reflected on for a good deal of time so that the analyst has a more comprehensive understanding of what transpired in the analytic process.

If consent is obtained, the impact of the discussion should be thoroughly and unflinchingly analysed. A corollary of this point is that apparently non-conflictual acceptance of the analyst's wish to publish should be regarded with some degree of scepticism.

For analysands who are in the mental health field, such as candidates, consent is necessary. **Goldberg (1997)** has argued that the special situation of training analysis should not be exempted from scientific discourse because of confidentiality concerns. A special set of difficulties accompanies such publication, but certainly candidates who are the subject of articles

must be consulted prior to publication or presentation. Unfortunately, I am personally aware of situations where candidates discovered themselves in their traininganalyst's publications and were dismayed that they were not asked for permission. In some of these instances the candidate's trust and even the progress made through the training analysis were substantially damaged.

Every decision about the method of protecting patient privacy must be based on a clinical judgement that is unique to the patient and the situation. Absolutes in ethics guidelines, such as those proposed by ICMJE, cannot possibly take every individual situation into account. The analyst must make a judgement call based on his or her best assessment of the patient's likelihood of reading the report, the viability of thick disguise, the impact of consent and the potential harm to the patient that might accrue from any decision made. When there is considerable doubt, consultation with a

colleague may be of great assistance. In fact, it is highly useful to share papers routinely with colleagues for their feedback.

Ethical concerns about the protection of the patient's privacy must take precedence over the analyst's need to publish for his or her own needs or for the profession's advancement. Some patients who have begun treatment knowing that I write have conveyed to me that they do not wish to appear in any publication I might write. I have always respected that wish and told the patient that I would honour the request.

Looking back on that continuous case seminar many years ago when I began my candidacy, I am still somewhat dismayed by the revelation of the patient's name, but I am also more charitable in my judgement of the supervisor and the candidate who chose to make the disclosure. I empathise with the kind of dilemmas such situations present, and the more I have studied the problem, the more I am struck by the irresoluble nature of the challenges posed by presenting and publishing clinicalmaterial. Tuckett (2000) emphasises that psychoanalysts must frequently confront irresoluble conflicts that can only be negotiated on a highly individual and moment-to-moment basis. Such is the case with dilemmas involving disguise and/or consent. The guidelines I am here proposing are undoubtedly imperfect as well, and I hope that they will simply contribute to an ongoing dialogue with my colleagues about ways in which we can improve our mastery of the difficulties we face in reporting our work.

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