

WRITING ABOUT PATIENTS: I. WAYS OF PROTECTING CONFIDENTIALITY AND ANALYSTS' CONFLICTS OVER CHOICE OF METHOD

Thirty American psychoanalysts who have published articles using clinical material from their patients were interviewed about their method for ensuring confidentiality. Almost twice as many analysts chose to disguise material (15) as regularly requested permission for the use of patients' material (8). The other analysts in the sample varied their approach, depending on circumstances, between using disguise alone and using disguise but also requesting consent. Methods of disguise, the timing of request for permission in relation to the phase of analysis, and changes in analysts' ideas about the benefits and detrimental effects of these choices are discussed and illustrated. Each decision is reconsidered in light of its potential effect on patients and their analysis. The dilemma posed by the importance of writing about patients for the health and growth of psychoanalysis as a field and the potential negative consequences for patients and their analyses is considered.

*Psychoanalysis is a theory of mind and a method
of research as well as a clinical intervention.*

—FREUD (1905, p. 8)

Research requires data. For that reason, Freud maintained that analysts have a duty to publish what they learn from treating patients. This knowledge advances psychoanalysis as a field; it also may help future patients. Most analysts identify themselves primarily as clinicians, not as researchers or theorists. Most analysts do not write.

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Supervision, peer groups, and other mutual sharing of clinical work with colleagues provide opportunities for continued professional growth; however, only a relatively small number of analysts participate in such activities, and the majority of these are likely to have been trained in the same places, often at the same time. Analytic literature, by contrast, exposes analysts to diverse ideas and experiences and stimulates them to reflect on these strange and even “dangerous” ideas. Because clinical material published in psychoanalytic journals has been peer-reviewed, readers are assured that the ideas presented have been evaluated in terms of their merit for consideration.

Analysts who contribute to the literature may be said to have dual careers. Like their colleagues, their first allegiance is to their patients; but they are also, in Freud’s sense, researchers studying the nature and process of analytic work and the phenomena they discover in this process (Freud 1905; Goldberg 1997; Michels 2000; Reiser 2000; Szecsody 2000; Tuckett 2000a,b).

Psychoanalysis is not a hard science; nonetheless, its method, while shaped by the art of individual clinicians, has a structure and certain shared principles. When analysts write, they are often developing variations on themes, but sometimes they are also challenging, even disproving, previously held beliefs; note, for example, our gradually coming to discard the value, or even the possibility, of the analyst’s being a “blank screen.” Such challenges may change long-held assumptions or redress imbalances in emphasis; at times these new ideas are of passing interest and are ultimately discarded. Everyone agrees that it is essential to the development of psychoanalytic ideas and clinical work that at least some analysts engage in the enterprise of writing. But analysts who write about their patients are inevitably placed in a conflict of allegiances. They must protect the confidentiality of their patients while simultaneously providing clinical data accurate enough to support their ideas.

Debate about how best to ensure patient privacy is not new, but recently, as concerns about patients’ rights have become prominent, the issue has drawn increased attention. Should analysts simply disguise clinical material, or should they ask patients’ consent as well? (Gabbard 2000; Arons 2000). What are the consequences of either choice? Authors who have written about analytic writing have often noted how few examples there are in the literature of the effect these choices have on individual patients or analytic work in general.

This paper is the first of a series that will report what analysts actually do to ensure their patients' confidentiality when they write, how they think about the choices they make, and, when data are available, what effect these decisions have had on their patients and the treatment. A second paper (to follow in this issue of *JAPA*) examines the effect on patients when they read what their analysts have written about them. Subsequent papers will include a comparison of the practices and ideas of contemporary American psychoanalysts with those of analysts writing in the early 1980s and with those of contemporary analysts from outside the U.S. who have published articles using clinical illustrations.

The problems posed in writing articles that include clinical illustrations from patient material are manifold. Freud (1905) believed that no patients would have spoken freely had they thought the material would be published, nor would they ever have granted permission had they been asked. In discussing the case of Dora, Freud enumerated the precautions he took to ensure her confidentiality. The patient he wrote about was not from Vienna; no one knew he was treating her; he waited four years from the end of her treatment to write and learned of changes in her that led him to think she would no longer be interested in the events he reported; he used no names that would be recognizable; and he published the case in a scientific journal, which made it highly unlikely that nonmedical readers would come across it. If Dora herself were to see the publication, she would learn nothing she did not already know and would realize that no one besides herself could recognize her. Contemporary analysts cannot feel as confident as Freud that these methods for preserving confidentiality will be effective (even when feasible), but their concerns are very similar.

Recent articles (Arons 2000; Gabbard 2000) have summarized and commented on current debates about how best to maintain confidentiality. I will review the highlights. There is no disagreement among analysts that patient confidentiality needs to be protected; what is debated is how to do this with the fewest possible negative consequences for the patient. Should analysts disguise material and count on no one (including the patient) recognizing the patient, or should the analyst also ask the patient's consent? Many analysts believe that changing identifying features, but not the dynamics or content of the process, preserves both the integrity of the presentation and the patient's confidentiality (Arons 2000; Freud 1905; Furlong 1998; Gabbard 1997, 2000; Goldberg 1997; Shapiro 1994; Stein 1988; Renik 1994).

Nonetheless, they express concern that disguise may mislead or distort, as an account becomes distant from the actual facts (Klumpner and Frank 1991; Lipton 1991). Other analysts propose removing material deemed in-essential to the understanding of the case or illustration (Clift 1986). Composites are another solution, but they may seem too much like fiction (Goldberg 1997). Having another analyst write the examples is proposed as an alternative (Gabbard 2000), but not many analysts are offered this opportunity and analysts often want to express their own ideas regarding their patients.

Still other analysts argue that it is wrong not to obtain the patient's consent (Michels 2000; Reiser 2000; Smith 1995; Stoller 1988). And even when consent is obtained, it may be asked whether *informed* consent can ever be a meaningful concept in relation to clinical material; unconscious factors stemming from the transference inevitably influence the patient's decision (Arons 2000; Gabbard 2000; Goldberg 1997; Stoller 1988; Tuckett 2000a,b).

Granting consent may or may not be preceded by the patient's reading what the analyst has written. When patients read material about themselves there is a danger that the process may become intellectualized (Arons 2000; Lafarge 2000); extraanalytic information about the analyst contained in papers may inhibit associations because of guilt over to knowing "secrets" about the analyst (Berman 1995); the patient may become aware of the analyst's professional self and the professional community and experience the latter as intruders on the analysis (Crastnopol 1999); or the very act of writing may itself serve as a transference-countertransference enactment that ruptures the analytic frame (Feiner 1996). In addition, the patient's feelings about the publication of personal material may change over time (Crastnopol 1999; Stoller 1988).

Some analysts individualize the decision whether to show a patient their examples. They believe that with certain patients a collaborative approach in discussing their clinical write-ups may have therapeutic benefit (Arons 2000; Crastnopol 1999; LaFarge 2000; Scharff 2000; Schwaber 1997). Stoller (1988) believed that patient-analyst collaboration around written material was almost always to the patient's benefit. But many analysts do not agree. Clearly there are diverse and conflicting views about the effect of patients' reading their analyst's account of their material; one view is that it may interfere with or facilitate the analytic process (Scharff 2000).

The timing of requests for permission is another controversial issue. To ask while treatment is under way introduces the analyst's extraanalytic agenda into the process; to ask after termination intrudes on the patient's life and may rekindle issues put to rest, possibly leading to a need for more analysis (Lipton 1991). For these reasons, some analysts believe that to make a general request at the start of treatment is the best option (Lipton 1991; Goldberg 1997; Michels 2000). Others, however, have faulted this solution, since beginning patients do not know the analyst well enough for there to have developed a trust, a working relationship, or a knowledge that therapeutic needs will be met (Arons 2000); asking at the outset, then, risks guarded refusal or uninformed consent. Another concern is that writing about patients still in treatment poses the danger that analysts may begin to fit patients into a theory they have formed about them (Michels 2000). Many analysts join Freud (1905) in maintaining that analysts should neither ask for permission to use patients' material nor write about an analysis before it is over (Gabbard 1997, 2000). But in addition to the drawbacks already cited to this approach, there is the objection that it leaves analysts no chance to get a sense of their patients' reactions and patients no opportunity to analyze them unless after termination they return to their analysts (Arons 2000). But while exploration of these reactions might be beneficial to a former patient, it is problematic if the need must be stimulated by the analyst's request. Finally, regardless of when an analyst chooses to write, the effect of the analyst's subjectivity must be taken into account when reading any presentation of patient material (Tuckett 1993).

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METHOD

The Sample

A systematically random selection of papers (for example, selecting the last article with clinical material in the first issue, the next to last article in the second issue, the third from last in the third issue, etc.) that included clinical illustrations was made using the *Journal of the American Psychoanalytic Association* from 1995 to 2000. At least one article was selected from each issue in the period 1995–1999, including a supplement, and from the first issue of 2000. Thirty-six authors were called and asked to be interviewed. Two indicated that their example was not from their own material, two declined

to participate in the study, and two who were left messages did not return the initial phone call. The sample, then, comprises thirty authors who agreed to be interviewed. All are graduate analysts, twenty-seven of whom have graduated from institutes affiliated with the American Psychoanalytic Association. They range in age from their early forties to their eighties, the majority being in their fifties or sixties. Twenty-three are male. Most of these analyst-authors identify themselves as modern Freudians with an essentially ego psychological orientation, though two spoke of a shift toward relational theory and another of the influence of intersubjectivity.

The Interview

Each analyst-author was interviewed by telephone for thirty minutes to an hour. The interviews were transcribed immediately on completion. The authors were asked how they decided to write about a given patient. Once they decided to write, did they ask for consent? Did they show the patient what they had written? At what time in relation to the analytic work did this conversation occur? What were the ramifications? Had they ever had a patient refuse permission? Give permission and then rescind it? If they disguised the material, how did they do this? When in the course of treatment did they write or begin to write? Did a patient not asked for permission ever discover that he or she had been written about? What were the ramifications? What were their ideas about the benefits and problems of the approach they chose? Did they think differently in regard to writing about patients working in the mental health field? Had their views about using disguise or consent in relation to clinical examples changed? If they had, what factors were responsible? Had they ever written about themselves in disguise?

FINDINGS

Case Selection

Reasons for selection. Why did analysts choose to write about the patients they did? Almost all the analyst-authors stated some variation on the theme that a patient's material stimulated a new idea or illustrated an idea already in focus. Manifestly, the analysts' choices of patients to ask for consent was based a belief that these patients would not be identifiable to readers and that their conflicts would not become inextricably entangled with the request. Latently, no doubt, these choices

were multiply determined. Interdigitation of the psychological issues of patient and analyst may consciously or unconsciously have stimulated the analyst to explore and try to master these shared issues in displacement. The specific meaning of any manifest topic or particular patient, of course, cannot be known without the analyst's associations and exploration, and a majority of the sample did not provide this material.

Three analysts spoke of writing as a kind of self-supervision. They were aware that they used writing, which included intellectualization, as a way of managing countertransference reactions. These analysts seemed conscious of these latent issues, even though they did not explicate them in detail. Here are their remarks:

I usually write about a patient because something in the work is troubling me. I seek a consultation and I work on it in the writing about it.

When I write I'm trying to work out a problem through a kind of self-supervision. I try to understand certain issues that pose transference-countertransference reactions, and writing helps me keep on an even level. I think I write to understand why I did what I did. I wait till an issue is resolved to publish it.

I came to the view that writing about a patient for me is a counter-transference enactment. I could say it's an interesting clinical or theoretical problem. But really I think the papers arose from the treatment rather than some intellectual interest. Writing helps me to shake off an excess amount of stimulation coming off the case and to channel it into the writing. Patients make me interested in something that get stirred up in me—probably not the way it works for many others. They may have intellectual interests and scan for cases. But for me writing gets me to reflect; it gets me to master what is stirring me up. I try to bring intellectual leverage to a puzzling or disconcerting experience.

Reasons for nonselection. All the analysts in this study made it clear that there were certain patients they would never write about. The reasons for this decision were always presented in terms of the patient's welfare. There were some patients who could not be disguised adequately; usually this was because they, or their relatives, were in the mental health field. Some other patients were thought likely to read the psychoanalytic literature and recognize themselves; the analysts of these patients were concerned about negative consequences to the patient or the treatment process if permission were asked. Since for

these patients disguise seemed inadequate, they chose not to write about them.

All the analysts agreed that there were clinical indications in certain patients that mitigated against requesting permission or writing about them without it. These indications related primarily to character structure. Patients with masochistic or paranoid characters and patients eager to please were among those who analysts thought might respond in a manner detrimental to their treatment; they were therefore excluded as subjects for papers.

Confidentiality

Once analysts decided to use a patient's material, their methods for dealing with confidentiality had several variations.

Disguise alone or disguise and consent? Almost twice as many analysts chose to disguise material (15) as regularly asked for permission to use patients' clinical material (8). Seven analysts varied their approaches to confidentiality, at times using disguise alone and at others asking consent as well, depending on circumstances. The small number of authors who wrote about patients in the mental health field (3) always asked the patient's consent. They also obtained the patient's assurance that the material was sufficiently disguised by having the patient read the vignette in question. One analyst described his thinking and the process.

One time during a termination phase I gave a patient a copy of a paper [I was writing] about him. The patient returned it, edited with red marks. I gave this patient the paper because while he was not in our profession, members of his family were and knew he was in analysis with me. I was concerned that he would be recognized, though he was not. I wanted to make sure that he knew exactly what he was consenting to. I don't really know if there was any detrimental effect to his reading it. Issues of narcissism and masochism came to the fore. Was it a masochistic submission to my request? These issues of masochism and sadism would likely have come up in termination anyway, but the [prospect of] publication focused it. Did he really want to do it? Or was he submitting to me? It brought back sadomasochistic fantasies from adolescence. This patient had previously been in analysis with someone else, who had been wild and crazy, and the patient went along with it without questioning it. I wanted to be sure he felt he had a right to say no without my being angry with him. The patient was a thoughtful and caring person. He added to the disguise but tried to be careful to do it in a way that didn't distort the material. I didn't write about my counter-

transference in this paper because I thought it would disrupt the termination for him to read it. I thought it would muddy the waters. I think you should maintain anonymity and neutrality as much as you can; the associations should be the patient's, not ours. On the surface the patient responded well, but it stirred up a lot of competition. Whose insights were these? Were the ideas mine or did he give them to me? These competitive feelings and thoughts had been hidden behind masochism. So this was a sign of his growth that he could be openly competitive and not just eat it.

Twelve analysts showed their patients what they had written about them. Six of these twelve stated that they wanted to be certain about the adequacy of the disguise. Other reasons for showing patients the material about themselves included the analysts' wish for reassurance that what they had written, and how they had written it, was acceptable to the patient. Two analysts who showed their patients clinical material did so with the express intention of making it part of the analytic work; in one of these instances, the analyst did not consider the work formally analytic, due to the severity of the patient's pathology.

It might have been anticipated that the older analysts in the sample, trained at a time when analysts were not as sensitized to issues of patients' rights as is the case today, would be more likely to employ disguise alone when writing clinical examples. However, age was not a factor that discriminated among the analysts in terms of their method of preserving confidentiality.

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Methods of Disguise

All these analysts, whether or not they asked consent, disguised the clinical material. They did so in a variety of ways. They changed names and other identifying data such as profession, geographic location, age or number of siblings, religion, and, in a few cases, gender. Most analysts who changed a patient's gender worried that readers might draw incorrect inferences from this alteration, but they did not consider gender relevant to the point they were trying to illustrate and believed that the change ensured the patient's privacy. Some analysts disguised their patients by omitting demographic details. This approach was often used when a paper was illustrating an aspect of technique or analytic process. Other analysts disguised their patients by introducing "red herrings." They altered or added details—e.g., adding extra siblings or making siblings cousins—that bore no relevance to the issues being

illustrated. One analyst elaborated this strategy, giving a nuanced sense of how details can contribute to disguise: “I change locations. I put the patient in a different climate—e.g., Alaska rather than Mexico—and say something about the weather—e.g., snow delayed the patient, whereas the patient was really late but for another external reason.” The analyst-authors were all clear that they would not change the dynamics or alter verbatim material. Some, however, disagreed with the “red herring” solution, believing that such disguises might well affect the depiction of dynamics.

Consent

Eighteen of the thirty analysts had on at least one occasion asked a patient’s permission to use his or her clinical material for publication. All eighteen had at least one patient who consented, and many had several. In this study, only three patients are reported to have denied permission. In most instances in which a request was made, unless the analyst pursued a patient’s reactions or addressed related material in displacements, the discussion was brief and did not lead to questions or exploration. Some analysts reported pursuing the issue; others did not.

The meaning of giving permission. Two analysts focused on the meaning and motives of patients’ consent:

Sometimes a patient may want to be exhibitionistic; sometimes patients may want you to write about them, even as an attack on relatives. It’s complicated because the motive may be self-ridicule or ridicule of their family. So even the patient’s consent is not the whole issue.

I’ve never had a patient refuse permission. I’ve had patients give permission where later it turns out not to be good for them and it could be a masochistic component. Permission plays out characterological orientations. Sometimes there are reverberations, where issues keep coming back, sometimes for years. With one patient the reality negotiation about giving me permission was central; she felt that she had given me something and so had become part of my life outside the office; it felt meaningful to have a role in my life. For others, giving permission doesn’t seem to make a lot of difference one way or the other; they metabolize it and move on.

The latter analyst’s description indicated that he explored the meaning of consent with at least some of his patients. Other analysts may also have done so, but they did not indicate this in their accounts. When analysts accept a patient’s consent without further exploration,

on the surface it can seem pragmatic. Likely the analyst feels relief from the worry that the patient might refuse or that the request might iatrogenically stir conflict; once consent is granted, the analyst should in theory feel relief also that he or she can freely use the patients' material. That none of the analysts in the sample expressed feelings of relief may reflect the latent conflict that analysts experience when using patient material. This issue and some possible reasons that analysts avoid exploring these conflicts will be discussed below.

While some analysts were quite reflective about the meanings and motives of their patients' consent and reactions to written material, neither they nor most other analysts in the sample discussed the analytic meaning of their choice of patient to write about, or their reactions to the patient's response when permission was easily granted. The absence of this self-exploration may be an artifact of the interview's not having specifically included this question. Perhaps, knowing that this study would be published, these analysts showed a preconscious reluctance to expose this more personal dimension even though they knew also that their anonymity would be ensured by virtue of the size of the sample and the absence of identifying details.

There were, however, some notable exceptions to this trend toward nonreflection. Such a counterexample was offered by an analyst who wished it had been possible to withdraw a paper already published:

A patient in the mental health field had said fine, no problem, good for the field, but then there was a problem. The patient felt embarrassed about some of the material. I recognized this in a derivative form. It was not in overt feelings. Looking back on what I wrote, I see that the patient saw himself as quite regressed; this was the patient's view, not mine. In retrospect, I did not feel comfortable with the patient's feeling this. I wished I'd never published it. I feel I should have waited longer for reactions from him. If I had had the full force of the patient's reactions, I probably would not have rushed it. I wouldn't do that again. I don't know about the long-term consequences, because the analysis was interrupted for reality reasons. That left a lot unclear. Part of me would like to talk to the patient about it even now, but I don't want to intrude on his life or interfere with his current treatment.

The fear of intruding on a patient's analysis or life was a factor that influenced many analysts in regard to the timing of their requests for permission.

Requests at the beginning of analysis. Four analyst-authors introduced at the beginning of analysis a request for general permission to use the patient's material. The request was presented in the context of a discussion of other working arrangements, such as fees, vacations, and policies about missed hours. These analysts explained to the patient that they taught and wrote, and that analysts involved in these activities use illustrative patient material, though disguising any identifying data. The analyst would ask the patient to think about how he or she would feel about giving permission to use material from the analysis in this fashion; if this was not acceptable to the patient, the analyst would not do so. One of these analysts added that he had many vignettes from patients over the years, and that a patient might read something he wrote and assume it was about him or her when in fact it was not. This analyst reviewed his arrangements once a year so that patients could reconsider how they felt about them. Two of the four analysts no longer believed that generalized consent was necessary. Here is what one of them said:

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I used to tell all my patients at the start of treatment that I did at times write about patients after the treatment. I never write about a patient until treatment is over and then I wait at least a year. I would send them a copy of what I wrote and ask for their permission. I'd disguise it. The patient would then write back giving me permission. I used to do this because I was a full-time academic and I'd be publishing. It was a clearing the way. There were never any objections or strong reactions, so after a time I just stopped making that initial statement, but I always asked permission afterward.

Requests in the middle phase. The five analysts who requested permission in the middle phase of analysis stated that they encountered no strong reactions and did not believe the request interfered with ongoing work. They chose to ask for permission when clinical material captured their interest, because, in the words of one, "the material [at such points] has a vividness and freshness that it lacks after the fact." This alive, affective engagement with the material was also the reason given by those analyst-authors who used disguises alone and wrote while the treatment was ongoing. For this group of analysts, ongoing material held their interest in a way that was more gripping than when they were no longer treating the patient. One of these analysts, who used disguises but did not request permission, stated that writing even earlier would not feel problematic, but it was unlikely until the middle phase

of analysis that she could know her patient well enough to clearly formulate an understanding. Two other analysts made similar points:

Originally I was swayed by people who said not to write until the treatment is over. It makes sense because you don't know whether your conclusions are true or false. But for me I found . . . that I want only to write during the treatment—because that's when the iron is hot and grabs me. I do bear in mind the scientific limitations of doing it that way. But writing gets you to reflect and read about similar problems that have been reported in the literature. It helps the treatment.

Although many feel that writing during treatment is a problem, I think it gives an opportunity to work with the patient on what has been written about and the reactions. To ask at the start of treatment in a blanket way seems to be asking a lot to negotiate at the start. If I were the patient I'd want to know what the analyst would write about, when it was being written, and I'd want to see it. Initially, it would likely feel invasive—a use of power and control and seems destructive to the initial sense of safety. After a while, you have a whole set of understandings that have created a sense of trust. It's usually in the middle or late phase, and I only do it in a treatment where I think it will be tolerable.

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Requests in the termination phase. The five analyst-authors who chose to ask the patient's permission during the termination phase believed that this allowed the patient's reactions to become part of the treatment process, which was not possible in the same way after termination. One of these analysts offers this view:

I prefer to wait until the patient is in the termination phase to ask about writing. There are pros and cons about any way. If you wait until after termination, they don't have the opportunity to get to the unconscious meaning of giving or not giving consent. If you ask earlier, it's introducing a parameter and the patient may not yet be ready to understand why they are agreeing or not. But by the end the patient is psychologically stronger. It seems like the best compromise.

Requests after termination. Only one analyst in this sample always waited until after termination to request the patient's permission. Two other analysts frequently, but not routinely, waited until after termination to ask patients for consent. Five analysts ask permission during treatment but choose not to write until afterward because of the effect on the analyst's listening. One analyst's explanation follows:

I don't like to write while I do the work. The nature of writing pushes me for closure. I don't mean what I write isn't honest, but the actual writing changes the way I feel about the patient and the analysis. So I don't write while I see a patient. When I write it becomes something I'm invested in. It forecloses an openness to their material in my mind. When I work I want to be open to wherever it may go.

Approaches to Preserving Confidentiality

Analysts committed to a method. The five analyst-authors who have always asked for patient permission have worked in academic settings, where obtaining the consent of human research subjects is a requirement. These analysts extended this rule to their analytic work. Two of these authors are not now directly involved in academic work but have been mentored by those who are. None of these analysts reported negative effects from asking patients their consent.

In contrast, ten analysts who always employ disguise believed that their patients would be affected negatively by a request. These ten analysts never asked permission. Some of their reasons are as follows:

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The point about writing about a patient is never about him or her but that the dynamics described would apply to many patients. I wouldn't want to emphasize the importance the patient has for the analyst in terms of scientific interest. I would not want the patient's satisfaction or dissatisfaction with what I wrote or the fact I was writing to be a factor in the analysis.

I'm not comfortable asking patients for permission. If treatment has been going on for a long time, I worry patients would wonder what I've been interested in all along, whether they think I'm using them, whether it takes away the feeling treatment has for them. Patients are under pressure to say they agree because of the transference, to comply, a lot doesn't get talked about. If the patient doesn't give permission, there's a countertransference response, a tension. The patient's response gets talked about, but I'm not sure it all really gets resolved.

I always disguise. I feel strongly that patients shouldn't be told. I heavily disguise. Patients I can't disguise well enough, I can't write about. I think it's a transgression to ask a patient. I feel a level of betrayal to use a patient for myself, to be writing about them. I don't know when you could ask during the treatment or call someone back. Informed consent is a pseudo notion. I don't think it can be worked through: being special, being used, paying for the time. I hate the whole thing because I love to write. I not only worry about the writing but also it affects the treatment—that I'm doing it—that the idea in the patient's

material becomes what I'm listening for and then the patient may try to deliver it.

I never inform the patient. I try to disguise it, try to choose someone who won't read the literature, and I worry. I don't ask because I think it corrupts everything in the treatment. It's a narcissistic gratification, a seduction, and a gratification. I'd be using them and it couldn't be analyzed.

I don't see it as a free choice. Is it conceivable that someone as a result of analysis and a time lapse could and might be asked? Maybe. It would have to do with my view about the resolution of the transference and the characterological structure of the patient—dependent, masochistic, paranoid would disincite me. Someone quite autonomous, post-analysis, on the healthy end of neurosis might be able to give permission, but even then not pure, but maybe it wouldn't hurt them. The way asking might be harmful is that something necessary to analyze might become less available. If the patient felt special or that I had special regard for them or that I was tied to them, love them, [was] dependent on them in their fantasy . . . this extraanalytic thing could get in the way of bringing that to analysis because it would seem confirmed by my request. Or maybe that they would have to suppress their aggression, their wish to say no, to submit to me, feel it as my dominance. So the hurt would be in the sense of limitation on the work.

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Ambivalent views. Other analysts are more conflicted about how to deal with confidentiality. Regardless of the decision they have made to disguise or ask consent, they worry and view it as a serious dilemma for which they have not found a satisfactory solution. Several analysts described their conflicted feelings about using patient material.

I've been writing about clinical work for fifteen to twenty years. I've become more inclined to ask permission, to show patients what I write and at the same time be more protective if I feel I can't show it to them, more concerned that for some it might be harmful. I feel less inclined to write about patients. It takes a toll of anxiety, guilt—it's tiring to have to deal with the self-serving component in it. Yet it's essential to write about treatment in a truthful way—but I'm less optimistic that you can do it. You can learn from how someone thinks and works, but it can also seem exhibitionistic. It happened to me. In [a particular paper] I wrote about things in a very self-exposing way. I wouldn't do that again. Many saw it as exhibitionistic. Is there a way to remove that quality? Virtually impossible to do. If we write with all of our fantasies and feelings, communicating what we show and see, it stimulates voyeurism. One can experience analysis from the couch and one can describe it from the

analyst's perspective, but to try to take on describing the process, that's something else.

The first issue is responsibility to the patient. A patient I wrote about had finished and came back. . . . She was a writer and I wanted to show her I'm a writer too, look what I did, what we did together. There was that feeling of competition. I didn't do it, but I couldn't get over the intensity of the wish. The excitement, pleasure at the idea of sharing it. What do you do with that? Would she have liked it. Probably. It's stimulating, provocative, but unfair. It ties you to the analyst, a narcissistic tie and idealization not worked through since you are chosen and there it is in print forever. It makes it real, concrete forever—saying the patient's words. The patient thinks of the analyst writing about them alone. It's charged; it's a burden. I think people who tell patients are rationalizing other things—it isn't in the patient's interest. There's a deprivation in the work; maybe because the analyst uses the self so minimally, writing helps. It's an expression of the analyst that isn't in the treatment. On the other hand, analysis isn't that fragile. I don't know if it's so different from other issues that have to be worked through. There's no reason patients couldn't come to tolerate and work through all that is stimulated when they know their analysts have written about them.

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I'm not sure it's ever helpful for . . . patient[s] to read about themselves with the full complexity spelled out. If you can get permission without seeing it, it's a different issue. But if the patient is going to read it, it inhibits what you'll want to say. You can't say everything you want to say about your own feelings and everything you think about the patient. The way I write is with a lot of detail that an adult wouldn't want shared, no matter how nice it was about them. I have adult patients who were written up as children who have a distance on it and find it kind of interesting. But you don't know how they'll feel reading it later. But if you don't write, that's not that good either. We have to write because we can't learn if we don't. So we have to weigh it.

I worry that patients' reading about themselves may promote an overly intellectual part of their experience; patients have a more fluid and evolving conception of themselves. I think of it as being a post-termination request. But a lot of work goes on after termination. Reading about themselves from their analyst's perspective might put their ideas into a static form that could be an impediment to further working through. My concern is that the analyst's view, my view, might be substituted for the patient's own and lead to a petrification of the patient's insights, a stunting of the posttermination process. I imagine the longer one waits after termination the better, but old cases are probably not as compelling to write about. But I worry that all my justifications for not asking are covers for cowardice. I wonder if

my concerns are a rationalization of my apprehension, yet I do think there is reason for concern.

One of the concerns of this analyst was that the written words of the analyst could usurp the patient's experience. This subsuming of the patient's experience would occur seemingly because the patient would accept the analyst's view as truer or more valid than the patient's own. Concern about the influence of the analyst, due to the power of the transference, is a theme that occurred repeatedly.

Changes in views. Nine analysts have changed their views, concluding they should now ask for consent; they were divided in their reasons. Four believed they need to ask consent because they have become more worried about patients coming upon their material and feeling betrayed. One analyst described this concern.

With all the easy access to articles on the internet, it's a different world. I'm going to try a new policy and see how it works. In the introduction and arrangements at the beginning of treatment I am going to say that in the course of our work I may find it useful to consult with someone about a particular problem and sometimes I find it useful to convey something in writing, and if I do either of these things with total anonymity, how would they feel about that? I'll bring this up, get their reaction, see how it feels. Would I show the article? Probably not. If the patient asked to see it, I'd say yes—not comfortable entirely but at least it would be out front. I wouldn't offer it. The downside is that to ask suggests I have an interest outside of the patients themselves. They could view me mostly as a scientist. It sets a different agenda. The worst outcome, though, is to find something written about you or someone you know. I found something written about my father and another close relative. I never told them. I know they weren't asked. That's got to be a betrayal. I've taken that risk for thirty years—it's never safe, but now it seems too easy to look up papers.

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Four other analysts, initially hesitant to ask for permission, believed, based on their experience, that asking consent had posed no problems for the treatments when it had been requested. Three of the four did not believe they had seen any derivatives that suggested interference with the analytic work. Their views are expressed in the words of one:

I told one patient in the midphase of a six- or seven-year analysis that I 'd like to write about him. He gave permission. There were some exhibitionistic dreams that related to the homoerotic transference, but

I think that would have come up anyway. This man was obsessive so there wasn't that much affect anyway. He thought it was important for the field to have things written and didn't feel exposed or betrayed. I don't think that had an adverse effect, but that's an inference. I never offered to show him the written material, and he didn't ask. There was nothing in it that the patient didn't know. I didn't see any derivative effects of asking permission to use material with him or others I've asked, but my own defenses may keep me from seeing the effect on the treatment.

Two of these analysts' views about analytic work, as well as about asking consent, have changed.

My views and ways of dealing with writing about patients have changed. In previous papers I did not ask for consent. I concealed heavily. Afterward, I felt I had done the wrong thing, not because I thought the patient would see it, but I became aware that transference continued even after termination. I had gone back to see my own analyst, and patients of mine came back to see me. Transference issues were still active. It made me think that I would be uncomfortable having a secret from a patient if the patient were to come back. Actually, one patient I had disguised in writing and not asked did come back, and I was not so uncomfortable. So I had anticipated an interfering counter-transference that did not occur. But my model of treatment had also changed. Before, I had been constructing what was occurring in words from the patient, but I'd begun to see that what I was constructing also had my own stamp on it, that there was a constructing coming from me that was part of it. This changed my view to more of a two-person model of analysis. So writing a vignette changed. Whatever I thought was not true unless the patient thought part of it, and the patient had to contribute to it. So I decided to try to discuss this with some of my patients [not patients in the mental health profession, with whom she thought it would become intellectualized]. I thought that this would not be such an intrusion into the analysis to ask and to bring the material I was thinking about, since it was the patient's material.

I think more whether to inform patients now. I was trained to maintain anonymity. Initially I was less likely to ask permission. Something that has always bothered me is how contemptuously people wrote about their patients. In principle I'd never do that. I'd never write anything about a patient that I would feel funny about their seeing; even when not asking their permission I had that guideline. I want to write so they would feel okay if they read it, but now I feel a greater sense of wanting them to see it. I feel more comfortable with self-disclosure and the relational impact. Writing about patients has instilled a certain kind of conscience, which means making sure whatever a patient reads

has to not be destructive to them or their treatment. Generally I write about issues that the patient and I have sufficiently analyzed together. There is nothing new or surprising to the patient in what I write.

In contrast, one analyst expressed increased concern about asking consent because of the effect he believed it had on the treatment:

It complicates things to ask. The two experiences I had when I asked I didn't feel good about. . . . I feel it was an interference to bring things in. I think I wouldn't write about a patient in the field again. The way I like to do treatment, and think is best for the patient, is for the patient to unfold his story at his own pace and let it remain the patient's treatment. I think I work best when I have no purpose other than understanding the patient. Things inadvertently break through the frame, like countertransference. But this is a preventable intrusion. It introduces something you want.

Other Issues

Negative consequences. Other complications in relation to writing about patients include the countertransference stirred when patients refuse permission, which three patients did. But more devastating are lawsuits filed by patients who feel betrayed and seek redress. Two analysts reported having been sued by former patients who discovered they had been written about. Neither patient won the suit, but the analysts experienced considerable distress in the process.

Three analysts withdrew clinical material based on their patients' responses. They did so despite the fact that the patients had in fact given them permission. In each instance, the analyst did not believe it was in the interest of the patient's treatment to have the material published.

Using oneself as an example. One solution to the problem of using clinical material without struggling with issues of patient confidentiality is for analysts to write about themselves in disguise. Most analysts rejected this solution. They thought it could not be objective or valid. In this sample, no analyst wrote an entire case about him- or herself. The nine analysts who did employ this method used some material, most often from their own analysis, to illustrate a particular point; they did so on only a few occasions, in two instances as part of composites. Five of these analysts had presented themselves in disguise in papers written early in their writing careers, and had not repeated this use of themselves.

DISCUSSION

If the views of the thirty analysts in this study are representative of American analysts who write using clinical material, then contemporary ideas about how best to maintain patient confidentiality seem divided between disguise alone and disguise with consent. Lipton (1991) reports a similar finding from his informal survey of analysts. Another finding similar to Lipton's is that the majority of analysts in this project did not request permission from patients who they assumed were unlikely to read the psychoanalytic literature; these patients most often did not work in the mental health field.

Writing about Mental Health Professionals

Almost all of the analysts expressed considerable concerns about the risk of loss of confidentiality for patients who work in the mental health field or whose relatives are mental health professionals. Most analysts in the sample made a point of requesting permission from patients in the mental health field. But a few viewed such patients as no different from others and when writing about them did not alter their disguise-only policy. While some analysts are strongly committed to each position, the greater number, whichever method they chose, view neither strategy as being without some hazard, especially when writing about patients in the mental health field.

Informed Consent

Analysts today are sensitized to the potential for abusing power. They are more aware that the power of the transference may make it impossible for patients to freely grant permission. This change in attitude accompanies the analytic community's increased sensitivity to the role and influence of authority in general, as well as its specific relevance in analytic work. Concomitantly, patients are more aware of their rights and the potential for having them violated.

Another change in attitude has come from a new understanding of the nature of transference. Since transference is no longer thought to end with the termination of treatment, but rather to persist over time, though in diminished form, it no longer seems a solution to the problem of influence to request permission after termination. This change in thinking about the persistence of transference may be one of the reasons why only one analyst in this study routinely waited until after termination to request permission.

Patients' Gratifications: Enacted and Therapeutic

Although they value having patients' conscious consent, most analysts indicated an awareness of many characterological traits that might have led patients to grant permission as an enactment of their problems. Exhibitionism, masochism, compliance, and the wish to please or to be special are some of the factors identified by analysts as motivating their patients to give consent. A few analysts believed that for some patients, reading the analyst's account of their work together can validate the work that was done, or the relationship with the analyst, or be a confirmation that the analyst shares the patient's understanding of his or her difficulties and the process of their work. When patients experience reading the material in any of these ways, it can also be therapeutically beneficial, in addition to being gratifying.

Analysts' Gratifications: Professional and Personal

Most analysts do not believe that patients benefit from being written about. The benefit they see from publishing clinical material accrues to their colleagues, to the psychoanalytic community, and to the science of psychoanalysis. All of the analysts in the sample know that they get something for themselves from writing.

Some are clear that they use writing to work out countertransference issues. In that respect, their writing may also be of benefit to their patients. Most analysts, however, think of their writing as a primarily an intellectual endeavor. This would seem a manifest and, at best, partial explanation of their motives, as choice of topic, patient, and time of writing are undoubtedly overdetermined, with intellectual interest only the conscious, surface layer. But certainly most analysts know themselves and their complexity better than to stop here. Possibly these analysts just did not want to reveal more in the interview.

Many analysts write out of the belief that authorship brings professional advancement or at least greater recognition or even regard among their colleagues. Recognition of having a self-interest may be a major reason for analysts' reluctance and ambivalence about asking a patient's permission; it introduces the analyst's agenda into a situation that is meant, apart from payment, to be solely for the patient.

Analysts, of course, are likely to derive other satisfactions from the work, but these benefits remain a private matter; they are not usually something about which the patient has direct information. Analysts have their personal and characterological reasons for having chosen

their profession, often a wish to master their own psychological issues.¹ Doing analysis may provide analysts a way to continue learning about themselves (Kantrowitz 1996). Whether these private benefits to the analyst adversely affect patients is not an either/or matter. It depends on how the analyst's gratifications and frustrations interdigitate with those of the patient. Analysts try to monitor themselves, keeping these potential interferences in mind. Every analyst interviewed was clear that if a piece of writing could be perceived as interfering with the patient's treatment, even if consent was given, the material would not be used. But this, of course, meant that the analyst had to be aware that writing about the patient posed a problem for the patient.

Disguise

The greatest drawback in choosing to disguise clinical material and publish it without obtaining permission is that a patients may come across it, recognize themselves, and feel betrayed.² The worst outcome is seen when such a discovery negatively affects a patient's feelings and changes what was otherwise a positive analytic experience (Person 1983; Stoller 1988). The discovery may adversely affect the patient's feelings not only about the analyst but about the treatment itself; it may then erode psychological gains. In the current litigious climate, some patients may even sue for what they believe is a breach of confidentiality. Although they are not likely to win the suit if the analyst has taken sufficient care to disguise the material, the experience for both parties is likely to be painful, or even traumatic.

Not all patients who discover they have been written about express this sense of violation; some seem to take it for granted that publishing clinical illustrations is an accepted part of the work.

The likelihood that patients may read what is written about them has greatly increased (Gabbard 2000). A number of the analysts interviewed pointed out how the internet has made psychoanalytic articles easily accessible. Curious patients, looking up an analyst on the internet, might well stumble on an article that includes material about

¹There are, of course, less sublimated reasons for becoming an analyst, such as voyeurism, wishes for power, and wishes to be idealized—which, if not sufficiently analyzed and resolved, can be detrimental to patients.

²Gabbard (2000), Arons (2000), Tuckett (1998, 2000), and Goldberg (1997) have provided excellent summaries of the issues and dilemmas in deciding between disguise alone or disguise with consent as a method of preserving confidentiality. The following discussion builds on their ideas and extends them based on the interviews with these thirty analyst-authors.

them. If they are still in treatment, likely they will talk about it. If they are not, they might contact their former analyst and discuss it. If they don't, however, there will be no opportunity to explore, understand, and, if necessary, repair what may have felt injurious.

Another negative consequence to using disguise that has often been cited is the introduction of misleading information into the literature; the danger is that others may take a piece of disguised information as a fact and make extrapolations from it that are erroneous. An example cited by Klumpner and Frank (1991) illustrates this point. In this instance, a patient described as having a gastric ulcer in fact suffered from juvenile diabetes. Another analyst might use this case to formulate a theory about the psychodynamics of people with gastric ulcers and so be led astray.

This objection to the use of disguise seems based on a misunderstanding of the nature and purpose of psychoanalytic case examples. The data they provide are not comparable to the data of basic science, or even social science, since they are taken from a single case. Analysts can only illustrate the points they want to make; they cannot prove them. As is so commonly pointed out these days, what analysts report is colored by their subjectivity. If the analyst makes points clearly and provides relevant clinical material in support of an argument, the reader may be persuaded to take the author's position seriously. It may stimulate clinicians to compare their own experience and find examples from their practice that may be rethought in the light of what they have read. But what has won the reader's serious attention is the author's ability to convey a new understanding and the reasoning behind it.

Clinical observations may be the stimulus for theoretical discoveries, but they can never be the proof of them. Human complexity is too great to be reduced in this fashion. The multiplicity of meanings and functions in any behavior, symptom, or interaction needs to be respected. This is a uniquely psychoanalytic perspective. It must be stressed, then, that details that might be disguised—profession, geographic location, number of siblings, place in sibling order, religion, disease, accident, particular trauma, or even gender—should not be used by another author to support a thesis, unless it relates to the same topic the clinical example was originally intended to illustrate.

Reed (1993) suggests that there should be an unspoken clinical convention among analysts. The reader should recognize the analyst's specific purpose in selecting the example and not try to draw other

conclusions from the identifying details or use them for other purposes. No details given should be assumed to be factually accurate. To accept Reed's proposal requires that analyst-readers trust the integrity of analyst-writers. Analysts need to trust that the clinical material reported is not fiction, that the dynamics related to the theoretical point the author is making are represented as the analyst believes they in fact operated. Since analysts cannot be objective scientists, readers are simply being asked to judge how well an author has made a point. However, unless this convention is accepted, many analysts, and others reading the psychoanalytic literature, are likely to assume that factual details are represented accurately and so may use them erroneously. To prevent this, some analysts suggest that when disguise is achieved by misinformation, a footnote or endnote be provided alerting the reader not to take all the details of the description as fact. The problem with this suggestion is that it tends to undo the disguise. In this regard, it is better to omit information than to alter it.

92 *Composites.* Composites, as a vehicle for disguise, were used by only a few of the analysts in the sample. Perhaps this is because most of these analysts were not writing about syndromes, where such a method can be useful. Gabbard (2000) emphasizes, quite correctly, that when an analyst uses this method it should be made explicit. An example of the method is Gabbard and Lester's illustration of the kinds of analysts who might commit sexual boundary violations (1995). In such instances, it is possible to describe personality types and then provide brief fragmentary examples omitting all identifying data.

Writing up a colleague's clinical material. Having other analysts provide case examples for one's published work is one way to get clinical material into the literature while ensuring confidentiality. An analyst who contributed clinical material to the study reported in *The Patient's Impact on the Analyst* (Kantrowitz 1996) uses for teaching purposes an example he provided. Thus, he uses the voice of another, but his own material, to convey ideas. Obviously, this solution will work for only certain material and for certain analysts. For the analyst who wants to write, it is no solution at all.

Consent

Regarding the hazards of asking consent, the analyst-authors in this sample all pointed to the various ways in which requesting permis-

sion may interfere with material in an ongoing treatment and be an intrusion in the life of someone who has terminated. In this they agree with the psychoanalytic literature on the topic (Gabbard 2000; Arons 2000; Goldberg 1998). A major problem, already noted, is that truly informed consent can never be given, since it is always granted under the sway of the transference, even when treatment is over.

Requests at the beginning of analysis. Granting that consent can never be truly informed does not lead inevitably to the conclusion that patients will be adversely affected by giving permission. Although patients whose characters are organized around pleasing are unlikely to say no, their transference issues around the wish to please will certainly be stimulated and become manifest around other topics. Once understood, their granting of permission can be reevaluated in this light.

While a number of analysts in the sample found no difficulty in making the request for permission in the initial hours, Arons (2000) has reported doing this for a short period of time, after which he concluded that neither he nor his patients knew each other well enough to feel comfortable with his introducing a request for permission early on.

Since most analysts report having some patients of whom they would never ask permission, because of particular conflicts or character structures, it is hard to see how one could routinely ask at the outset, when conflicts and character structure are known only sketchily. Nonetheless, this study shows that some analysts do just that, and seemingly with no ill effects, at least none of which they are aware. It is not clear whether this conclusion is a matter of the analysts' comfort or a "blindness" to the effects of their behavior.

Arnold Goldberg (personal communication) recommends that all analysts make this request at the beginning of treatment. His argument is that if that were done the burden of this problem would be shared by everyone in the field. He archly states that those who object to the practices analysts employ around confidentiality should not read articles containing clinical material. His point is that the burden that comes with trying to advance psychoanalytic knowledge should not be the responsibility solely of those who choose to write. Still, most analysts prefer to wait until they feel comfortable that a given patient will not be burdened by the request, and they can still find they have been mistaken once they ask.

Requests during the course of treatment. Making the request to use a patient's material during the course of treatment poses other risks.

The meaning for the patient of both the request and the content of the writing may become interwoven with the current material of the analysis. The reverberations ensuing from stimulation or inhibition in reaction to the request may then be played out in the analytic process before they have been well enough understood to be recognized. Potentially the meaning can then remain unanalyzed. However, analysts today are sufficiently aware of the impact of their contributions to the process that they would likely note changes in a patient that follow a request. Connecting these matters in the analyst's mind and then bringing them to the patient's attention would likely be part of the analytic work.

Asking patients for permission to write about them during the termination phase has the advantage that most of the patient's issues have by then been explored and are understood. A disadvantage is that the request itself may interfere with the process of facing and analyzing the issue of separation. In writing about the patient, the analyst links the two of them together on the printed page; the connection is preserved in perpetuity. Although a request for consent may be flattering to the patient, it has the potential, as one analyst in the sample suggested, for creating a specialness that can interfere with other relationships in the future. It might also inhibit patients from bringing up negative feelings in the termination phase, out of a wish to maintain this positive, special connection. But positive feelings toward the analyst or the analysis are interferences only if they restrict the expression and exploration of negative ones, and this is not invariably the case.

The effect on the patient when analysts search extensively for derivatives related to requests and then intensively analyze this material needs to be considered. Concern, or even guilt, about having made a request may cause the analyst to intrude further into the analysis. On the positive side, when the request stimulates aspects of the patient's character or conflicts that are either already known or newly discovered, a focus on the meaning of the request can be usefully folded into these broader issues. Under these circumstances, the request may have serve to highlight or unearth areas that require analytic attention. Finally, once an analyst has made a request, whenever this occurs and however much it stirs in the patient, something has been enacted by the analyst that may place limits on its exploration by the patient. While in most cases the primary motive in the analyst's request for use of clinical material is to make intellectual advances in psychoanalysis as a field, unconscious motives stemming from unconscious conflicts that overlap with

the patient's are likely to contribute. If the analyst's action concretizes a meaning for the patient, whether he or she feels special, exhibited, or in some other way gratified, then this meaning may never be fully analyzable. There always remains a meaning beyond its meaning to the patient.

Request after termination. During treatment, a request for consent may be disruptive but can be processed; after treatment, the process is not interfered with, but the feelings stirred may disrupt what has been consolidated and may require further treatment lest they remain unmetabolized or worse. If the former patient does not return to discuss his or her reactions to the request, its meaning and its effects on the patient will not likely be pursued. As a result, whatever negative sequelae occur may go unanalyzed.

Some patients may consciously accept a posttermination request as reasonable for the sake of the profession, or may feel narcissistically gratified by being chosen. The latter reaction might suggest that certain narcissistic issues were not sufficiently explored in the analysis. But neither reaction would likely prove disruptive to the former patient's experience of the analyst or the analysis. As such, neither response would seem particularly detrimental. But other patients might feel narcissistically injured by the analyst's greater interest in the profession than in themselves, or might perceive the request as revealing the analyst's self-interest, and in either case feel used.

If issues of shame, trust, or fear of exposure (real or imagined) or revived experiences of childhood betrayals were stimulated by the request, the analyst may have selected a former patient unwisely or failed to have appreciated the degree to which these issues had not been resolved. Patients may react to what they perceive (correctly or incorrectly) as the analyst's view of them or the treatment (positive or negative). As noted earlier, several analysts expressed concern that the analyst's account of the treatment might usurp the patient's view of the process. Failure to explore any of these potential reactions might disturb the patient's previous satisfaction with the analysis.

An analyst can remain totally unaware of this disruption unless the former patient chooses to return and explore it. When written material is given to patients after termination, an invitation to come in and discuss their reactions may lessen the hazards of this approach, but the relative brevity of this contact does not ensure that reactions of distress will not occur, at the time or later, that cannot be discussed and explored with the analyst. Patients may, of course, go back into

analysis or psychotherapy with someone else and explore these reactions. Indeed, the impact of the discovery that their former analyst wrote about them may lead some patients to seek further treatment.

Sometimes former patients are aware of something untoward having been stirred and return to explore it. In such instances, the analyst's request may have unsettled a previously "good enough" resolution; but, it may also have provided an opportunity to more satisfactorily rework residual issues. Nonetheless, this work will have come about because of the analyst's initiative, not that of the patient.

Conflicts over Writing about Patients

It should be emphasized again that all of the analysts interviewed were concerned about their patients' welfare. The interviews show that many of them were often consciously conflicted about requesting permission to write about their patients. Nonetheless, once the decision to ask permission was made, analysts at times minimized their conflicts or avoided struggling with them. While this was certainly not true of the majority of analysts interviewed, the tendency to rationalize decisions was notable in the sample.

This disinclination to be more self-reflective raises the question whether analysts unconsciously fear that a request for consent might be more harmful than less obvious impositions. Certainly all analysts introduce into treatments personal artifacts of which they remain unaware, unless these are brought to their attention or come to be considered. But the request to use a patient's material occurs because, however ambivalently, the analyst has decided to introduce it; it is a conscious decision to take this action.

The likelihood is that when analysts avoid struggling with their conflicts over using patient material, conscious or unconscious guilt over the personal gain is implicated. As stated earlier, the financial gain from working with patients is open, acknowledged, and accepted. However, to benefit in some other way from working with patients—though undoubtedly it occurs in various psychological ways for all analysts—may feel suspect and unacceptable. While most often analytic writing brings neither monetary gain nor academic advancement, it is likely to provide some prestige and the opportunity to advance in professional associations. This personal gain comes because these analysts have made contributions that have earned their colleagues' respect; the papers or books they have published have informed and

stimulated other analysts. In most instances, personal ambition is not the primary reason analysts write, but it may create a secondary gain that many analysts would prefer not to think about.

Of course, not all publications use patient material, but when they do, analysts may be indebted to their patients in ways that may make them uncomfortable. While guilt about using patient material in ways that serve personal ambition is likely to be at least preconscious, other potential sources of guilt may be less consciously accessible and experienced as more shameful when recognized. Gratifications that are narcissistic or exhibitionistic might fall into in this category. On a deeper level, analysts may feel guilty about appropriating something that belongs to the patient—their history, a life—and using it for their own purposes. In this respect, analysts may feel guilty that they want the patient to give something to them—to feed them, so to speak—or that they want to be united with the patient forever, and that they have enacted such wishes by the very act of writing.

The writing analyst has to be willing to tolerate the intrapsychic conflicts that using patient material stirs. But there are interpersonal as well as intrapsychic consequences. The benefit from publishing papers may be experienced as especially suspect because not all analysts avail themselves of this opportunity. Not every analyst wishes to write, though some who wish to may not be able to because of personal constraints. Many analysts can not afford the time for this unremunerative activity, or they may have other priorities for the hours they do not see patients. Other analysts who wish to write but do not may be limited by more personal inhibitions. The writing analyst has to be willing to tolerate the envy and competitive feelings—at times manifested in behavior—stirred in colleagues whose ambitions have not been actualized. Perhaps guilt (conscious or unconscious) over professional competition and the use of patient material to further ambition, in combination with other needs, makes some analyst-writers avoid exploring their conflicts over this aspect of their motivation.

CONCLUDING REMARKS

Patients' rights are emphasized more today than in previous times, and this is as it should be. But the need to communicate clinical material, as well as ideas, for the benefit of the field may consequently have become undervalued. Papers that include clinical material are vehicles

for the transmission of new ideas and stimulate the growth of psychoanalysis as a discipline. Writing about patients is like walking in a mine-field. There are no good solutions. It is natural to want to avoid the conflict that thinking about the use of patient material stirs, but analysts are committed professionally and personally to facing internal struggles. The solution is not to stop writing about patients but to face and struggle with the conflict it creates as directly and honestly as possible.

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