WRITING ABOUT PATIENTS: II. PATIENTS' READING ABOUT THEMSELVES AND THEIR ANALYSTS' PERCEPTIONS OF ITS EFFECT

Thirty American analysts who have published articles that include clinical material were interviewed about their methods for ensuring patient confidentiality. Eight of these analysts had patients who had read about themselves or heard their cases presented, though their analyst had not requested permission to use this material. Eighteen patients had been asked and gave their consent to have their material used. Twelve of these patients were shown the material written about them. The analysts' thoughts and reactions to their experiences of obtaining consent and having their patients read material about themselves, and of disguising material without asking consent and then having it inadvertently discovered and read by their patients, are discussed. Their views of the effect on their patients of reading written material about themselves are elaborated with case illustrations.

Part I of "Writing about Patients" described a project in which thirty analysts discussed their views about ensuring patient confidentiality when publishing clinical material. The analysts debated the advantages and limitations of employing only disguise alone or disguise coupled with patient consent. Part II reports the experiences of these same thirty analysts when their patients read clinical material taken from their analyses. Some of these patients had been asked for permission to use their material and were shown what was written. Other patients had been written about in disguise without having been asked for consent and then discovered and read the material.

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Since analysts must write about their patients to keep psychoanalysis from stagnating, it is important that knowledge of the consequences of doing so become part of the psychoanalytic literature. The literature on the ramifications of patients' reading material about themselves, though meager, has in recent years begun to increase (Person 1983; Casement 1985; Stoller 1988; Lipton 1991; Ringstrom 1998; Crastnopol 1999; LaFarge 2000; Gabbard 2000). The current project is a continuation of these enterprises.

METHOD

Thirty psychoanalysts who published articles that include clinical case material in this journal between 1995 and 2000 were selected in a random systematized fashion to be the subjects of this study. These analysts were interviewed by telephone for thirty minutes to an hour. They reported the ways in which they worked to ensure patient confidentiality. They were asked to recount their experiences when patients were asked for permission and about the ramifications of patients' reading material about themselves. Patients' reactions to two different situations were described: when they had not known their analysts had written about them and when patients had given permission for their material to be used.

FINDINGS

Responses to Analysts' Writings by Patients Not Asked Permission

Eight patients read articles about themselves or heard them presented when their analysts had not asked their permission to use the material. All of these analysts were upset that such a mishap had occurred. Their views on the effects on their patients were less uniform.

Patients perceived by their analyst to be untroubled. Three of these analysts did not believe that discovering a paper written about them had caused harm to these patients. Each accepted the patient's unperturbed reaction to this discovery at face value. One analyst had "agonized" over the decision not to ask for permission. He thought his patient would grant it but worried she might not. He thought she would be excited about his writing about her, but also worried she might devalue him if the article was not accepted—this was typical of her. Eventually a friend of the patient read the article and showed it to her.

> The patient recognized herself and was excited by it. It was a narcissistic gratification. She knew it was unlikely that anyone would identify her. She thought that I was special because I had had an article published and that she was special because I wrote about her. At the current time (six years later), the patient is still in treatment. I don't see that this incident has played any particularly important part in our analytic work.

A second analyst who had not asked permission described being "shocked and horrified" when this former patient, who was not in the mental health field, appeared in the audience as he was about to present. He was sure she would recognize herself in the material.

> I called her aside and told her what she was about to hear was about her. She said it was fine. I don't ask permission because I think, why introduce the fact of writing when it may protect against a non-event? Mostly I write to illustrate an idea—e.g., projective identification. Patients wouldn't care if they were used for an example of that; it's not something that has meaning to them. I disguise the examples; the historical data are transformed, as well as the particulars of the exchange that I think could be recognized by the patient. To ask permission would have caused trouble for me, for the patient, for the analysis. I don't want trouble.

The third analyst was giving a paper in another state over five years after termination of the patient's analysis. The patient's sister, who had entered the mental health field but had not been in it at the time of the treatment, was in the audience. After the presentation, she came up to the analyst and said that she knew her sister had been in analysis with her, and that from the history she thought the analyst was describing her. The analyst told her she could share this with her sister and that if her sister wanted to, she could be in touch with her. Her former patient then contacted her. This analyst described exploring the patient's reaction.

> I told her she could read the paper or not—it had not yet been published—and that I would delete her material if that would be her preference. I explained that I hadn't asked her for permission because I thought it was hard for patients to say no; it was a burden to put a patient in that position. She found that interesting and credible. She expressed surprise that I thought her worth writing about. We talked about her reactions to her sister's hearing the material. She wanted to read it. She thought it was fine to publish it. She was someone who I thought would be open to criticize the paper and me. Given that the cat was out of the bag and my thoroughly going over it with her—though my preference would

still be that she not have known—I had already been presented and it would have been me bending over backward not to publish it then. I told her with her giving me the go-ahead that I would publish it. I told her she might over time feel differently about my writing this and publishing it—that she could contact me to talk about it if she did and wanted to. Some years later she returned about a different issue, and she talked about it some more. She felt complimented by it, interested in me and how I focused on my countertransference issues, and that my work with her had helped me. It was a messy situation. I still wouldn't have asked this patient because she had trouble with her aggression and would have had difficulty saying no. My ideas about using disguise, even with this mishap, haven't changed.

Patients perceived by their analyst to be upset. Two analysts reported that their patients were very upset by reading about themselves.

One time a patient read something I wrote. I changed her to a male added from another case and made it a composite. She recognized it and was upset and felt exposed. I asked if she thought anyone could recognize her. She said no, but she had told others that it was in the paper; she'd exposed herself. It was traumatic.

One time a patient read something I'd written about her. She was furious when she found it. It took a very long time to work that out. She thought I was evil, corrupt, that I used her. Some perception that she took what I said as negative about her, though it was actually very admiring of something. But mainly she used it as a pretext to express her sadomasochism.

An analyst upset by a patient's attending a presentation about her. One analyst reported an upsetting surprise encounter in the course of an ongoing treatment.

I had an experience where I gave a paper and a patient in a different field showed up in the front row—spooky. How do you respond in the moment—recognition? friendliness? I felt she was spying on me. The next day in analysis we talked about her not telling me she was coming, the impressions of hearing me, etc. So what goes on when the subject of a paper unexpectedly appears, or someone hears your talk or reads your writing about another patient? This is all current and being explored between us.

Analysts sued by patients. Two analysts reported being sued by former patients for using their material without asking their consent. Neither patient won the suit; in both instances it was judged that the

material was sufficiently disguised and the patient suffered no harm. One of these analysts was too upset by the experience to discuss it further. This analyst has been hesitant to write ever since. The other analyst described the experience:

> One time I wrote a case and a patient read it and wrote to the ethics board and wanted to press charges that I had done this without his permission. He could recognize himself, but no one else could. The incident I wrote about was very specific to him. The ethics board said I'd done nothing wrong. He was someone in the mental health field. One reason I hadn't asked him was that he had moved far away, but actually I don't know if I would have asked him if he were here. I thought his complaint was a reflection of the transference. The situation put me through the wringer, but it didn't change my view that we need to write.

Patients who consented, were not shown material, but read it. A few analysts who requested their patient's permission but did not show them the written material described as unremarkable their patients' reactions when they later read about themselves. One analyst, however, was concerned when he learned that a patient no longer in treatment had read a paper written about him; the analyst worried because he could not explore the patient's reactions.

> I heard that one patient [seen in a clinic setting], who came back to treatment there later, had read a paper of mine and recognized his material. I don't know what his reaction was and that feels uncomfortable. Did he feel I understood? Did he think that he was special to me? That could spoil a later treatment. It could be like idealizing a first love so that nothing later could measure up and that could ruin later relationships with others if not analyzed.

Reports about Patients Shown Written Material

Twelve analysts showed patients the material they wrote about them. Seven of the twelve always asked permission. The majority of analysts who showed papers to their patients had written on process or technique and used verbatim material. When verbatim accounts are reported, it is almost impossible to disguise the material so that patients will not recognize themselves.

Showing written material at the time of the initial request. All analysts in the sample believed that once permission was requested, if a patient asked to read the paper, they needed to accede to this request

or be willing to not use the patient's material if they believed it undesirable for the patient to read it. Several analysts made the point that the things they wrote about had always been shared with their patients; there were no surprises. One analyst emphasized that the writing was done with a conscious "keeping in mind" of how the patient might react to reading it.

Another analyst remarked that material illustrating hate in the countertransference could not be shown to the patient, a point perhaps disputed by analysts who share such countertransference reactions in their work with patients. There are, however, other difficult and potentially untoward consequences of showing patients material written about them. One analyst illustrated with two examples:

> Sometimes patients feel proud, feel special and important to be written about. One time a patient wanted to show others, to boast, and I worried it would lead to exposure but it stopped. We looked at the tug. Another patient read and thought about the paper scientifically.

> Another patient refers back to a piece of countertransference I wrote about in a paper and uses it to get at me. He does it angrily. In some way it points to something which may be helpful to me but there's a lot of anger behind it.

Three analysts considered their showing the patient what they had written a highly unusual occurrence, even though one of them invariably asked for consent. Another of them stated that if a patient was uncomfortable not seeing what he had written, he would suggest that the patient not give consent; however, he granted that there were special circumstances, such as writing about someone connected with the mental health field, when he might show the patient the paper in order to assure him or her that the disguise was adequate.

> One time during a termination phase I gave a patient a copy of a paper 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 countertransference in this paper, because I thought it would disrupt the termination for him to read it. 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.

Perhaps it is easier to be more explorative when patients know specifically what material is being used. Aware of the details, patients may not as easily avoid thinking about the request or their reactions to it. Analysts may then in turn feel impelled to more directly explore their patients' reactions.

Only one of the twelve analysts who showed patients written material routinely offered to do so. Apart from the patients' granting permission, however, he did not allow any input from them about what he had written.

> Many people I now see come knowing that I write. I discuss the possibility that I may write about them in the initial interview. When I decide to write, I describe to the patient what I intend to write and offer an opportunity for the patient to read it but not to negotiate about the history, material of the process, or the disguise, though certainly they have the opportunity to have it withdrawn and not published. I've never had anyone ask me not to publish what I wrote. If a patient has a disagreement or correction about a fact I have gotten wrong, such as the age of a sibling or the time some event occurred, I do correct that. But I use patients' material in very limited ways.

Unperceived complications from patients' reading about themselves. Six of these twelve analysts had not found that showing patients the written examples led to any notable complications in the treatment.

> These patients have read the vignettes and it hasn't become a topic for conversation. They have not pursued the issues, though I was open to talking about it if they did. I assume my asking has an influence on the work. But I don't really have evidence of what it is. The patients

are under the influence of transference and might not feel free to say no, so I try to be cautious about who I ask.

I never write about a patient until treatment is over, and then I wait at least a year. I used to tell all my patients at the start of treatment that I did at times write about patients after the treatment. 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've never had a patient refuse. One patient wrote that reading it felt just like being back in analysis.

The patient read it, we met, he liked it, agreed with it. He thought there was a remote chance, even though he thought I'd done a good job of disguise—left out all identifying data—but still he thought someone might sort it out, and given that, he was uncomfortable with a few lines. We went over them and none of them seemed necessary to the flow or arguments. I offered alternative ways of putting the material that he agreed to—there were only a few such changes, and that was the end of it. I said I didn't know if it would be accepted or, if it was, if there would be revision, but I would show him what I'd written if it were and get his permission.

After termination, I contacted one patient and told him I wanted to write about him and wanted him to read it. He gave a written consent and gave some suggestions about what I'd written. He thought I had underplayed certain things about him that he had found hard to face about himself in the analysis. I thought this was a testament to the work. I offered for him to come in and discuss it, but he didn't feel that was necessary. In this instance I was particularly careful because I was describing something which had legal ramifications.

When patients read what I write, their main reactions are narcissistic injury. They feel I've not paid sufficient attention to them. They feel insufficiently important. They think what I've written is accurate, but they thought I would tell their full life story and instead it's about ways of looking at theory or just a paragraph about them. It takes me a long time to write, so usually the material written about is from several years before. I prefer it be from long enough ago that I understand its meaning, since I find it takes time and the understanding changes and develops over time.

One patient had been talking about the topic I had written about. I asked permission. I wondered if we could talk about it; if she wished to read it, that was okay or, if not, that was okay , but [I told her] that I wouldn't publish it without her permission. She was very thankful. She took it home, read it, cried about the things I'd written. The only thing she

> wanted to change was the disguise. So I changed that. We explored what that had meant to her. The repercussions were minor and mostly positive. She didn't feel used. The patient was several years into her treatment then and is still in treatment. I don't see any notable ramifications. She is the only patient I have ever asked for permission and showed an example.

The last analyst quoted wrote about the same patient on a second occasion. In this instance the patient had said something "brilliant and witty" that had hurt him. He was reluctant, though unclear about why this was so, to address this with her directly. Instead he wrote a poem about it that he felt he needed to show her, since it both came directly from his experience with her and included a phrase she had used.

> The patient was flattered but also guilty that I had kept from her that she hurt me. She was grateful that I wove her phrase into my poem. She did not think it was a big deal and wondered why I felt I had to hide it. I expressed in my writing my admiration for her skill, my envy of her ability to express herself so beautifully, and my shame about what she had seen and revealed about me. How did this effect the treatment? Despite the fact that this patient has had considerable suffering, she has an amazing sense of humor and a mobility of cathexis—a real flexibility. I haven't found more in the work of any interference.

In this instance, the analyst was very forthright about his own reactions to the patient, as well as self-revealing in the work. The impact on the patient of reading what her analyst wrote, as well as his self-disclosure, may not have interfered with the analytic work, but it would be unlikely that it did not have some influence on its direction.

Analysts' withdrawal of patient material. Two analysts reported withdrawing patients' material because of what followed the request for consent. It is notable that neither of these analysts had at first thought of the request as something that would stir conflict in these patients. Their accounts show how each of them expanded their understanding of the dynamic complexity that was stimulated.

Both of these analysts spontaneously reflected on the effect their patient's reactions had on them and what they learned from the process.

> During treatment a patient, not in the field, read something I'd written—not about this patient—and told me an example that confirmed the point I was making and said I could write about that. I thanked her. But then over the next sessions, I noticed there was difficulty in our working. This was a patient who had been exploited by her family.

I realized that she felt exploited by this, even though she offered it. It was a really compelling example and a temptation to use it. So it was really an issue of whether this treatment was going to be for her or for me. I told her that I revoked her permission and promised I'd never use the example.

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

Reactions to patients who read material and refuse consent. Three analysts reported that a patient had refused to give permission. Two of these three analysts elaborated their reactions and the subsequent process. In the first example, the refusal was accepted matter-of-factly. In the second, the analyst persisted, putting the material aside and then asking again. At one point the patient would give consent and then later rescind it. The analyst was spontaneously reflective about his reactions to his patient's refusal and described gaining insight into its meaning.

I had only one patient who said absolutely no. Her suspicion of me and my motives was about everything and included the idea that I would be using her. Her fantasy was I would use her material for my self-interest, to get promoted, tenure, etc. I asked her only once again and when she again said no then I dropped it. Suspiciousness remained as a general topic, but the specifics of writing didn't. Maybe it will come up again in termination.

> When the patient refused, I had to do a lot of work to stay with the patient's feelings and not get caught up with my own reactions. I was surprised and hurt at the refusal and it took me a while to understand the patient's position. At first the patient was adamant and I pressed it. Then I realized I had to back off and I left it to be understood over time. What I came to understand was that it was like you took a picture; it stole the patient's soul; that's how she felt it. It fit in with so much other stuff of her being fearful of what I'd do to her, but it brought all this to a head prematurely. It touched things she needed to deal with, so I didn't think there were any long-term negative consequences. It made the patient angry, as if I were stealing something from her. It was like reacting to an analyst getting pleasure from interpreting or any other libidinal investment in the work.

The therapeutic use of patients' having read material about themselves. Two analysts used their writing about their patients as part of the therapeutic work.

> I haven't asked permission or shown material in more traditional analyses, but with one patient who had been traumatized, I asked her to read a chapter. I knew this patient would find out. It was six years into treatment, a long treatment that is still going on. This patient had so many fantasies of being special, had been involved in some boundary violations, and had paranoid tendencies. I felt if I was going to write about her I needed to discuss it with her. She felt it was offering something and wanted to do it. Some traumatized patients have felt so useless, worthless, that when they get to a place when they feel helped they want to give something back, to feel a participant in helping others. There's a collaborative mirroring, supportive element, to showing what is written. At the time of publication, I showed it to her and she didn't have much to say about it. She was surprised I chose this aspect of the work to write about. It didn't seem very central to her. I'm sure there's a lot more to it. The analysis of the meaning of my writing to her has not been fully explored.

The other analyst asked permission from two patients and showed them what she had written. This analyst believed that a major advantage in showing a patient material was that it could allow a useful deidealization of the analyst. However, she thought this approach was contraindicated if the patient was a mental health professional.

> I don't think it would be useful to share written material with someone in the field, because it would likely become intellectualized. Having

the analyst's perspective for these patients (who are not in the mental health field) is useful in part because it deidealizes the analyst. When she read the material, my patient thought I understood her but not perfectly, which she would have wished, but then she came to feel that it was okay that it was not perfect. With analysts or candidates, it might serve as a resistance. It also might result in reifying some point of view or analytic technique. Candidates tend to scrutinize my writing. If it were about them, it might be hard to be critical or hard for them to develop different, independent ideas. I worry it might interfere with formation of their own analytic identity.

This analyst thought she was more exposed by the vignettes than her patients were. She worried about the deleterious effect of writing and wanted to be sure her patients could say no if they wanted to. The issues of exposure for her patients and their feeling that she was wanting something for herself, which she had expected to arise, did not come up with either patient. One patient, who was in the termination phase, gave her permission.

When my patient read the vignette, she had a positive reaction. It made her feel special. She was also able to bring in what had not felt good in the analysis. She was happy with her disguise in general but had reactions of wanting to change what I described in some small ways. We were in agreement about what had happened, but she had a need to correct me in a way that was related to the competitive issue. I agreed to the corrections when I agreed with the patient, which I did. A central issue stirred for her by reading what I wrote was her competitiveness. She had the feeling I would achieve fame by writing. This patient wanted fame, but she didn't want to do anything to get it. The other thing was that what I had done wasn't perfect. She had thought of my doing analysis as my way of being special. My willingness to come up with a description of doing an analysis that wasn't perfect, and her own distress that the analysis was not perfect, then led the patient to think of our work somewhat differently. She wanted to get the most she could out of analysis and began to make more of an effort. The issues that I had dreaded coming up of my own self-interest did in a way, but it was in a way that was workable and not at all dreadful.

The other patient, who had terminated two years earlier, had come back a number of times for a few sessions. The analyst wrote her a letter requesting permission to use her material and invited her to come in to discuss it. She did not charge the patient for this or any session related to the written example.

> This patient had felt really helped by her analysis. The patient was excited about having her analysis written about. She wrote a letter describing her understanding of how her analysis had worked. I felt her to be a real collaborator. These sessions and then the patient's reflecting on them seemed to crystallize aspects of this patient and our analytic work. The patient became more aware of me and my countertransference responses, for better or worse. It made the work feel more intimate to both of us, mostly in a positive way. This patient came two or three times to continue working on what this write-up brought up.

This analyst had approached these patients about writing with "a great deal of anxiety." It seemed to her "a violation of [her] . . . training." She thought her supervisors and colleagues would disapprove. When she presented this material, she found it was quite controversial. However, she was reassured that everything that came up was "workable" and helpful to the patients, in that it stimulated a deeper exploration of problem areas.

Patients' reactions to reading about other patients. Another issue not often addressed is patients' reactions to reading what their analysts write about other patients. Two analysts reported these experiences.

> One patient was deeply upset about reading an article I wrote about another patient. It was a patient I liked so much. I wrote that in the early years of the treatment that I found I looked forward to the patient's hours, felt like a genius with everything I said to him, etc. Later this fell apart. This other patient reacted that she was certain that I was not this fond of her. It stirred up a special injury from the past for her. This patient was not in the field, but she read everything I wrote and I would not have written about her. Writing about patients not only affects the patient written about but other patients who read.

Analysts Written about by Their Own Analyst

Seven analysts had the experience of their own analysts having written about them and reading the material. Three of these analysts had been asked permission; four simply discovered the material.

Permission asked. Two of the three analysts (then patients) who had been asked permission read the material and found it innocuous. However, one of the two emphasized that though confidentiality had been maintained, it had not assured anonymity:

> A former analyst of mine wrote about me and asked permission. He disguised me. I gave permission. I mentioned this to a colleague who

said, "Oh, you must have been John." He was right on. He'd read and remembered the paper. I felt a little embarrassed, but nothing in the paper was that troubling. But it's a cautionary tale. I think we underestimate the perceptiveness of the readership.

The third analyst, prior to analytic training, was asked permission before his analyst submitted a paper for publication. He had been very upset by the analyst's insensitivity about preserving his confidentiality.

> Before I was a candidate, my first analyst, though in other ways abstemious, wrote about me without asking me. He gave me a copy of the article to read while I was in the third year of analysis for me to approve it. It wasn't disguised enough. If it were to appear, my friends in the field could easily recognize me. I refused permission for it to be published at that time. I said I might feel differently later. Ten years later I did feel differently and told him it was fine to publish it. But by that time he had lost interest in it; it was never published. At the time, it shook me. I felt what he did was wrong. It breached analytic confidentiality at a vulnerable time of analysis around material not fully explored and closed off those issues with a conclusion about the material; that was a foreclosure of work that had not yet been explored enough. It was inexplicable to me that he would do this. I got a lot of help from this analysis; I was able to talk about and explore what he did and how I felt about it. He was very open to hearing my complaints, understood, and said he hadn't realized I'd be recognized and felt that having done this was something he needed to explore in himself. He agreed not to publish the paper unless or until I gave permission.

Permission not asked. Four analysts were not asked permission. Two of these analysts seemed unperturbed by discovering material that had been written about them. One of the two said, "It occurred—no big deal." The other offered a somewhat, but not much more, elaborated reaction:

> One of my analysts made a one-sentence description of something between us. I found it. He didn't ask me. It was innocuous and didn't bother me. It was while I was in analysis but didn't identify me at all; he hadn't asked my permission.

In contrast, the other two analysts who were then patients were very upset by their analysts' use of them. Neither was consciously disturbed by the fact that the analyst had not asked permission or had written about the analysis; nonetheless, each experienced a particular kind of injury from the experience. One was hurt by the disguise the

analyst used, believing it revealed the analyst's unflattering view of his patient. The other elaborated the experience of discovery as an intrusion.

> This intrusion happened to me as a patient. I think my analyst used material about me in a classroom situation and may have written about me. It wasn't the issue of my analyst doing it, but my knowing, that was the intrusion. I felt a disappointment and a sense of being misused, being an object. I don't think I really worked it out, but maybe she would have disappointed me in some other way. It was hard to start another treatment. I knew I felt betrayed.

DISCUSSION

The examples given by these analyst-authors reveal a wide range of reactions by patients as perceived by their analysts. It must be kept in mind that except for the reports of the seven analysts with personal experience of reading what was written about them, these accounts are all reports of how analysts processed their patients' experiences. We cannot assume that these patients would give similar accounts of their reactions. In addition, while accounts that report patients' distress and the process of exploring its vicissitudes are likely to approximate at least a part of patients' reactions, the long-term ramifications of reading about themselves still remain unknown.

When analysts report that patients seem to have had little reaction to reading material about themselves, this may or may not accurately reflect the patients' actual reactions. Sometimes patients tell their analysts or former analysts their reactions, but sometimes they do not. Sometimes they do not know themselves what they feel until a much later time. And sometimes what they say may be just how it is.

When patients do not continue to talk about their reactions to their analyst's request to use clinical material from their work, it may be that they are accepting that analysts need such illustrations for the field. They may not pursue the issue further because they accept, and wish to accept, this request as something separate from the analytic work. But when patients actually read material about themselves, the separation between the scientific and the personal would seem much harder to maintain.

Analysts themselves would like to maintain this distinction between scientific and clinical work. The wish to maintain this distinction may be why most analysts in the sample stated that their reason for writing was to develop and illustrate ideas. Only a few gave the more

personal or more clinical reason that writing provides a supervisory function or, more specifically, helps them deal with countertransference reactions.

The Analyst's Wish to Accept Manifest Consent

Most analysts are thoughtful about which patients they ask for use of their material, but once they ask, they want to the patient's consent. They want to believe that there are no untoward ramifications to patients' reading about themselves that play out in analysis or that adversely affect patients' feelings about their analyst or the analysis. If analysts thought the effect of patients' reading about themselves or their treatment would be detrimental, they could not make these requests. Analysts who believe asking for consent is detrimental use only disguise or do not write about patients at all.

Some analysts in the sample, who have never asked permission and whose patients have read or heard papers about themselves, tried to maintain that not asking was still the best policy. Though their patients had recognized themselves or someone else had, these analysts continued to believe that it was not likely that such recognition would occur. These incompatible ideas—that patients would not likely recognize themselves, even though at least one had done so—were presented simultaneously and without recognition of the contradiction. Patients' discovering material written about them is disconcerting to analysts; when thinking about it, the analyst's usual logic becomes disrupted. Analysts need to not see these contradictions. They want neither to hurt their patient nor to give up writing. This kind of denial appeared nowhere else in these interviews. But many of these analysts rationalized their ways of dealing with confidentiality.

The reports of the analysts in this study illustrate a wide range of behaviors in terms of how extensively and intensively patients' reactions were pursued. Some analysts maintained there were no reactions. Some analysts accepted whatever manifest reaction the patient reported and pursued it no further; others offered opportunities to explore it; still others looked for reactions in displacement and continued to follow the ramifications over time.

Once again, since requests for permission are the analyst's agenda, continued pursuit of their meaning to the patient is a Janus-faced issue. On one side, the tracing and searching of a patient's reactions reflect the analyst's efforts to ensure that the meaning to the patient is under-

stood and analyzed. On the other side, however, the analyst's continued focus on this question can be experienced by the patient as a further intrusion, a distraction from the patient's agenda. Once the request for consent is made, there has been an enactment by the analyst. Only a few analysts in the sample openly worried that the request for consent and the patient's reading of the paper might submerge issues through their enactment.

Patients' Reactions

Patients' reactions to reading about themselves varied considerably. Some were much more forthcoming about their reactions than others, though for some this may have been influenced by the extent to which their analysts inquired. When patients openly expressed their responses, and the meaning to them of being written about was explicated, their analysts often seemed able to analyze the material in a way that was productive. Analysts who had themselves been written about as patients often stated that issues similar to those stirred up by their own experience came up for patients in other ways. But only one analyst in this sample openly asked what added impact might have been created by the analyst's having concretized the meaning through the request for consent, or through reading the example. The one analyst who did raise this concern had himself been written about when a patient.

Another unexplored area is the fantasies that may have been stimulated by the analyst's request, and the patient's reaction to discrepancies between the fantasy and what the analyst might actually have written. If fantasies of importance were stimulated and the analyst's account of the patient turned out to be a brief vignette used to illustrate an idea, some analysts report that their patients were disappointed. Though these analysts may then have attempted to analyze this disappointment, these interventions were not described in the interviews. Such iatrogenically generated experiences of disappointment are likely to have echoes in the transference and can create complications for the analytic work.

Have patients explored their fantasies and interpretations of their analyst's motivations and countertransferences, either in general or specifically in relation to the issue of their having been written about? If the analytic work has not included such a focus, will the discovery of a paper that includes their clinical material stimulate this kind of inquiry?

What are the reactions of patients to their analyst's perception of them as glimpsed through the analyst's writing? What do patients think they have learned about their analyst's feelings about them? Does the analyst raise these questions with them? Should the analyst? Would raising them be intrusive, as these thoughts might never have come up were it not for the article the patient read? When are analysts conscientiously pursuing the effects of introducing their writing, and when are they simply pursuing their own agenda? When is such a pursuit beneficial, and when may it be harmful? The answers to these questions depend on both the patient's issues and the nature of the patient-analyst pair. Analysts must consider these questions in relation to each individual patient.

The Effect on Writing of Knowing Patients Will Read

When analysts write about patients with the thought that their patients may read what they are writing, this must have some effect on what they write. A number of analysts in the sample emphasized that they would never write anything that they and the patient had not already discussed. Analysts who write about diagnostic issues, perhaps using patient material to describe some syndrome, strongly preferred to use disguises without asking consent; they were concerned that patients would find some view about them that had not been processed in analysis and might experience it as narcissistically injurious. Particularly when writing about syndromes, analysts had concerns about the impact of their tone.

Consciousness of tone seems a desirable consequence of analysts' awareness that patients may read their papers. Analysts in this sample all seemed respectful and caring about their patients. While this may partly be an artifact of the sample, it may also reflect a sociological trend. Perhaps the shift in ideas about authority and the view of the analyst as a participant in a process has resulted in analysts' increased humility—a recognition of the commonality of human vulnerability and ensuant difficulties.

In the past, when articles communicated a view of the patient as if the analyst were merely a silent filter for the material, the primary concern was often the analyst's tone or the worry that patients might feel misunderstood or objectified if they were to read the analyst's account. Now that the analyst is apt to include countertransference material, there is an additional concern about the meaning this disclosure may have for the patient (see Gabbard 2000).

A number of analysts in the sample stated explicitly that knowing that their patients would read the papers they wrote meant that there were issues they would not include. Reporting negative countertransference reactions, unless they had been explored with the patient, is an example of a topic they would not include in papers. But this sacrifice of material might include any areas that they believed might hurt or humiliate patients. Of course, the analysts did not always accurately assess which issues might stir their patients' sensitivities.

It is clear that an awareness that the patient may read what is written influences, and may at times even shape, what is communicated; at the least, this means that certain kinds of data will be omitted. The implication of restrictions on what analysts feel free to write about patients means that there is likely to be some skewing of what is presented in the psychoanalytic literature. Although it seems reasonable that cautions be employed, analysts should be aware that in accounts of patients, all may not be told.

Selection of Patients

All of the analysts in the sample stated that they were highly selectively both about which patients they would ask for permission and about patients they would show what they had written. Most analysts cited compliant, masochistic, and paranoid patients as ones they would never ask. Patients who had been used or abused were generally excluded, though there was one notable exception in which just such a patient was thought to believe there would be a therapeutic benefit from allowing her material to be used. Most analysts would not write about people in the mental health field; even fewer would consider writing about them without asking their consent and showing them what was written. Other reasons for not requesting permission included concerns that the analyst's request might stimulate shame, fear of exposure, exhibitionistic wishes, excitement or inhibition, narcissistic injury or gratification, or a revival of childhood experiences of betrayal. However, since being written about will have a meaning for any patient, it would seem that the particularity of the meaning may not always be the crucial element in an analyst's decision. What seems crucial is the extent to which the analyst believes these meanings can be analyzed with a particular patient.

Informed Consent

For the most part, these analysts knew their patients quite well before asking permission and so were not likely to ask someone unamenable to granting it. This likely explains why almost all patients who were asked gave their permission. To what extent consent was influenced by the transference cannot be assessed, though analysts are increasingly aware of the role it plays in skewing patients' responses. Many analysts debate whether a therapeutic alliance can meaningfully be distinguished from a positive transference; both are likely to lead patients to comply with their analyst's requests. Again, analysts need to remain aware that cases presented may not be representative of most cases in analysis, since patients who give consent or about whom analysts believe they can safely write may differ in various ways from other analysands.

The Impact on Patients of Being Written About

Even if there can be no truly meaningful informed consent because of the influence of the transference, does this mean that giving permission must be harmful to the patient? Four of the seven analysts who were written about by their own analysts when they were patients do not feel this was harmful to them. A fifth objected only to the timing of publication, and the sixth only to the disguise. A seventh did not object to the material being used but wished her confidentiality had been better preserved and that she had never learned of the publication. This analyst describes a longer-term untoward consequence: the sense of betrayal engendered by the experience made it hard for her to enter another treatment. Her experience is perhaps an argument against actively pursuing information about a patient's reaction to the analyst's writing. It is noteworthy that a relatively large number of analysts in the sample had themselves been the subject of papers by their analysts. It may well be wondered whether other analysts who discovered they had been written about felt more troubled by the experience and in consequence have chosen not to write about patients.

If patients are gratified or feel special, is it likely to harm them? If feeling special is central to a patient's character, it seems likely that it would become a subject of analysis in any event. If compliance is an issue, this can be analyzed as it emerges in other areas and, at a timely moment, be related to a "too easy" acceptance of a request for consent. One analyst pointed to the detrimental consequences if a sense of spe-

cialness was not analyzed—namely, the continuance of a fantasized, idealized relationship that might spoil future relationships. If the meaning of feeling special or gratified had not been explored, the analyst's request might have stimulated an issue in need of analysis.

The gratification, sense of specialness, or any other meaning that being written about by one's analyst has for a patient will to some extent be concretized for patients who know that their analyst has written about them. The long-term consequences of an experience that cannot be fully analyzed are not known. There are, of course, many areas in every analysis which are not fully analyzed. The limits placed on analysis of this particular enacted area are set by the analyst's request—an action the analyst can choose to take or not. No generalized assumptions may be made about how patients will experience being written about or what the long-term effect of this experience will be. Undoubtedly, reactions depend both on the particular issues for each patient and the nature of each specific analytic relationship.

The reactions of the patients described in this study are various and differ over time. Patients' seemingly casual acceptance of analysts' intent to write about them, or of their actually having done so, does not necessarily mean that on a deep level it is fine with them; but neither does it mean that these patients are defending against an awareness they find unacceptable. Patients' initial negative feelings about being written about, when their material is well disguised and tactfully presented, cannot automatically be equated with "harm" to the patient. Patients may work through their initial reactions and no longer feel hurt, and they may gain useful insights about themselves through analyzing their reactions. Of course, this may never happen. In the latter instance, patients may experience the disruption of a sense of well-being based on an analytic experience in which they had felt known and understood. But what constitutes harm, just as what constitutes therapeutic benefit, is very complex and not easily defined. Only further exploration of these reactions can provide clarification in this area.

To return to the question raised at the beginning of this discussion, What do patients do to make it all right with them that their analysts write about them? Many of the patients selected by their analysts not only tend to be "reasonable," manifesting "unobjectionable positive transferences" (Stein 1981), but also use compartmentalizaton as a defense. Patients who are not disturbed by their analyst's writing about them may be able to separate the writing from the analysis itself. They

may also be able to hold in their minds the complexity and "doubleness" of experience. If patients are able to view what their analyst has written about them as being both about them and not about them, just as they have come to understand transference feelings as both about and not about the analyst, then perhaps they have been able to attain a distance that makes it acceptable to them that the analyst has used their material. Analysts have to hope that such a solution is possible.

Colleagues Who Read Material about Themselves

Similar concerns exist in relation to the material in this current project. In every instance, permission was granted to use examples from the interviews. Confidentiality was ensured simply by removing all identifying data except the pool from which the sample was drawn. Both the sample and the pool were large enough to preserve anonymity.

Nonetheless, each of the analyst-authors in the sample might react to the use of the interview material he or she provided. Respect and appreciation for those contributing their thoughts is an essential part of this process. A patient once said, "You can tell me anything you want, provided you put it in a proper envelope." Generally, this is true. Most of what one wants to say can be said with tact. But there are limits, and sometimes thoughts must be sacrificed to avoid causing feelings of disrespect or other forms of hurt. Just as analysts agree that some patients should not be written about, there may be some material that is too potentially hurtful, too personal, or too elusive to be put into words.

At the same time, readers must be assured that issues are not sidestepped. In this paper, the most salient issue that might upset the analysts who volunteered to be interviewed is their tendency to want to make it "all right" that they are writing, a temptation to ignore the negative reactions their patients may have and to minimize and so avoid struggling with their own conflicts over using their patients' material.

CONCLUDING REMARKS

Analysts need to write for the benefit of the field, their patients, and often themselves. At the same, they must continue to struggle with concerns about potential harm accruing to their patients from being written about. There are patients for whom this is indeed damaging. The examples in this paper show that analysts are not always aware

which patients will feel injured or what aspect of the writing they will experience as injurious. Patients do not always tell their analyst, or even know themselves until later, that they have felt hurt or have experienced other adverse consequences from having their analyst write about them. There is no perfect solution. All analysts can do is to try to be sensitive in their requests and writings, and to be alert to the ramifications of their decisions.

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