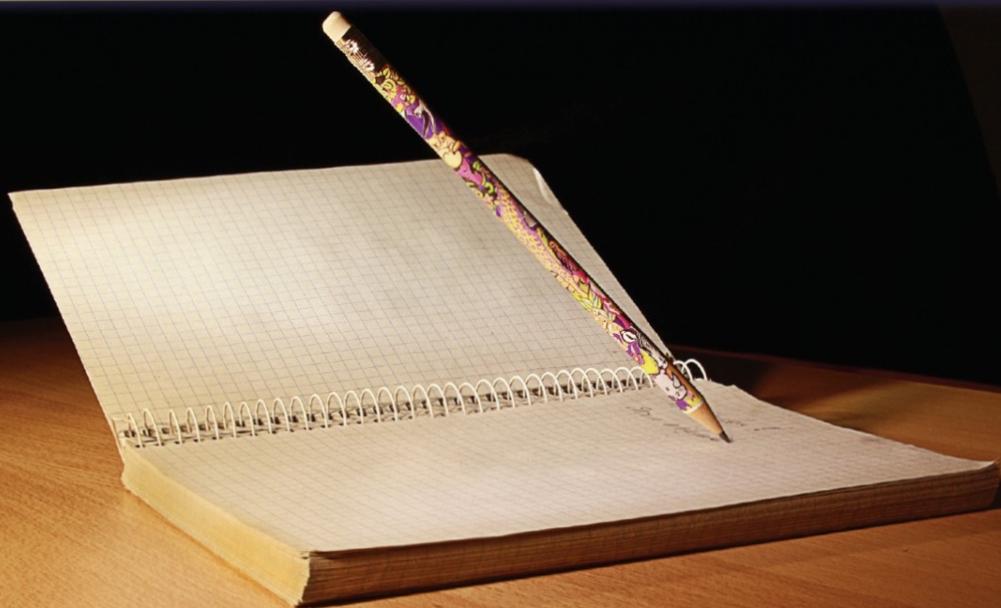


Thinking about Publishing?

On Seeking Patient Consent
to Publish Case Material



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Thinking about Publishing?

On Seeking Patient Consent to Publish Case Material [1](#)

Christopher Clulow, Ernest Wallwork, and Caroline Sehon

Abstract

The onus on therapists to seek the consent of their patients before publishing clinical material may be one reason why so few decide to write about their experience. There are inevitable and unavoidable tensions in balancing the duty of care to patients with other ethical responsibilities, including the needs of the professional community for education and scientific advancement. In this paper, we explore the context and dynamics of seeking consent from couples and families to publish material relating to their therapy and propose a way to manage some of the ethical dilemmas involved in writing about patients that is in keeping with the contemporary analytic literature on the interpersonal unconscious between patient and therapist, and the interpsychic/interpersonal dimensions of therapeutic action. Throughout this paper, the term “patient” is used to designate couples and families as well as individuals.

Key words: psychoanalysis, interpersonal unconscious, ethics, consent to publish, disguise, confidentiality, couple and family therapy.

INTRODUCTION

Most therapists avoid publishing about the part of their work that interests them most: clinical practice. There are many reasons for this—lack of time or inclination, the sheer hard work of putting pen to paper (or its digital equivalent), a fear of failing to capture adequately the complex nuances of clinical process, the need to hide suboptimal clinical outcomes for fear of professional reprisal (despite potential scientific advances, if published), and so on. Other therapists manage to publish, but only after weathering substantial duress, constrained by anxiety and conflict about how to proceed in an ethically competent manner that does not jeopardise the safety and well-being of patients.

We include ourselves among our colleagues who struggle with these dilemmas, sometimes managing them well, sometimes less well. Indeed, our shared awareness of the complex challenges facing authors and clinicians when thinking about publishing clinical material provided the common ground that motivated us to get together as co-authors to write this paper. Our aim is to address a hurdle that can seem insuperable to many clinicians: seeking the consent of their patients to publish. We surprised ourselves by

coming up with a proposal that, we believe, goes some way towards integrating seeking consent with the process of analytic psychotherapy with couples and families.

Publishing without consent can feel damning when we feel guilty about what can seem like appropriating for professional gain an experience that belongs to others, especially when those others have placed their trust and confidence in us to provide help in their hour of need. There can also be a fear of being found out, and facing the sanction of patients and colleagues if the discovery were to lead to a complaint. Publishing with consent can be no less guilt-inducing when there are misgivings about the possible destructive consequences of resurrecting past hurts. We may feel conflicted about asking for something that grateful or generous patients may find hard to refuse despite their having serious misgivings, or may over-willingly surrender to while in the throes of an idealising transference. Seeking consent can unleash latent negative transferences when patients confront material in print that they had not “seen” before, discouraging their therapists from facing such stormy waters in the transference–countertransference field. One member of a couple may exert pressure on the other to acquiesce to their therapist’s request, reviving conflict between them and, insofar as the therapist unconsciously colludes with the acquiescent partner, risking the whole therapeutic enterprise.

In the context of good analytic work, we expect that patients' transferences will become steadily more understood and worked through over time. At earlier phases of the work, therefore, consent is relatively uninformed by understandings that have yet to be unearthed and worked through. As the work goes on, the very process of giving consent may expose patients to the additional risk of complicating transferences, a risk they may take unknowingly. Some of these factors may impose an embargo on clinicians' seeking consent from their patients, and they all warrant careful study. However, this paper will focus primarily on identifying factors that make seeking consent so difficult, and on advancing ways in which the process might be tackled. We will propose a model to complement and even enhance the pact therapists make with their patients to do no harm, be truthful, relieve suffering, protect confidences, promote autonomy, and engender respect, all the while maintaining the bounded, asymmetric roles of patient and therapist that is germane to ethical conduct (Wallwork, 1991, 2012).

DR ELIZABETH'S PUBLISHING DILEMMA

Martha and Jed, both primary school teachers, sought help from an experienced analytic child and couple/family psychotherapist, Dr Elizabeth, in managing the tantrums of their nine-year-old daughter and only child, Maxine. Though seemingly compliant, through her drawings and play Maxine

depicted violent war scenes, sometimes played out around central figures who she indicated were like her parents. At an initial parent guidance session Dr Elizabeth discovered that the couple had each suffered significant losses and trauma in their families of origin. Further, Maxine was conceived after a long period of couple infertility. Dr Elizabeth found that not only did they have difficulty containing their daughter's behaviour but they were also hesitant about asserting themselves with each other.

As the work proceeded, and as the couple slowly developed trust in their psychotherapist, Martha and Jed disclosed how minimal their sexual contact had been since the birth of Maxine, which had been traumatic and involved an emergency C-section procedure. At the parent's request, the guidance work evolved into analytic couple therapy running in parallel with the child therapy.

At the beginning of the couple therapy, Jed and Martha were constrained with each other and then argued incessantly in the sessions, seemingly locked in a paranoid-schizoid mode of relating. Over time considerable progress was made with the couple, both in connection with their roles as parents and potential lovers, and in terms of their developing reflective capacities. As Martha recovered some feelings of sexual desire for her husband, the marriage became less tense and Maxine's behaviour improved. Martha and Jed felt grateful to Dr Elizabeth for helping them to

understand the meanings of their impasse, and the link between their difficulties and Maxine's symptoms. When Dr Elizabeth presented her work to colleagues, she was congratulated on her progress with the family and encouraged by them to write up the experience for publication.

Excited by the work, and motivated by the encouragement of her colleagues, she decided she would publish an account of the therapy. But she was then faced with the difficult dilemma of whether to ask the couple for their consent. At the dynamic core of what she wanted to write about was the partners' shared defence against loss and abandonment, including their fear of expressing anger, accessed by exploring their unconscious phantasies, their intergenerational history of trauma, and the details of their sexual experiences prior to Maxine's birth. After much thought, she decided against seeking consent because the work was ongoing, the detail of the material might be shaming for them, and she felt it would be intrusive, even damaging, for her to make the request. She also thought it was unlikely they would come across the publication since they were not "in the trade". Instead she opted to use a disguise, while also being alive to the risk that by doing so she might compromise the integrity of the dynamic narrative.

Discussion

Dr Elizabeth's dilemma in this fictional vignette illustrates many of the

conflicts that therapists face when considering the publication of clinical material. The first of these arises out of the fact that even the best reasons for publishing case material—the advancement of clinical knowledge and continuing development/education of therapists—may fly in the face of the time-honoured Hippocratic obligation to “above all, do no harm”, to benefit patients optimally, to keep private communications confidential, and to respect patient autonomy. It is easy for therapists to downplay the full weight of these moral responsibilities when faced with the heady excitement and potential for enhancing professional recognition afforded by publication. Whatever her personal desires, Dr Elizabeth ultimately cannot escape the fundamental question of whether or not her description of her work with Jed, Martha, and Maxine can be published ethically in a way that minimises the risks of causing harm to this family and to her ongoing therapeutic work with it. It would be essential for her to consider the relative risks and benefits of publication by seeking consent *vs.* the risk/benefit ratio of using a thoroughgoing or thick disguise. It is to be hoped that she is not so misled by her own self-interest as to ignore or minimise the very real risks to her patients that their disguised appearance in a publication entails. For instance, if any family member were to be identified by others this might result in a range of negative impacts. Significant relationships might be disrupted and reputations tarnished; they might even lose their jobs or be passed over for promotion or other opportunities (see, for example, Lipton, 1991; Stoller,

1988). Certainly their confidence about seeking professional help in the future is likely to be dented.

There are also potential costs to Dr Elizabeth if she fails to handle the conflicting ethical issues in her situation successfully. For instance, what would happen if Jed, Martha, or Maxine were to Google their therapist sometime after publication. They might, for example, be shocked by the disclosure of sensitive family details in a public forum if Dr Elizabeth were to have utilised a thin disguise allowing them to identify themselves and, in turn, find themselves unable to tolerate what would likely be unprecedented contact with Dr Elizabeth's countertransference commentary, or with her clinical representation of their hostile or perverse transferences to one another. The affective sequelae of this discovery might well be expected to include a profound sense of betrayal of the trust they placed in her and that they had worked so hard to build together, as well as some combination of shame, disappointment, sadness, depression, and anger, potentially joined with a desire for retaliation and revenge. If the therapy were ongoing, it might be abruptly terminated, at the cost of at least some hard won treatment benefits. In a worst case scenario, Dr Elizabeth might find herself accused before her colleagues, or in court, of breaching professional duties and inflicting any number of specific costs or harms on her former patient.

Although far less severe reactions and consequences are also possible,

and ruptures might eventually be repaired, the point is that any therapist contemplating the publication of case material needs to attend to just how serious and substantive a deviation from the therapeutic frame this is, and why ethical barriers exist against outing patients' private lives, whatever the professional benefits. This especially applies when, as in her case, the therapy is ongoing (Gabbard, 2000). Dr Elizabeth's assumption that her patients will not read her chapter because they are not in the field is disturbing because it implies she is naïve about the implications of information technology as well as blind to the full weight of the ethical tensions that need to be resolved before proceeding to publish.

If Dr Elizabeth were to have consulted the professional codes of leading psychoanalytic associations for help in deciding what to do, she would have found ethical guidelines that give rise to additional tensions around whether to disguise or to seek patient consent.

The Code of Ethics of the British Society of Couple Psychotherapists and Counsellors (BSCPC) advises that:

When considering the publication of clinical material, members should seek the explicit consent for doing so from those whose experience is being described. Where this is not possible, or where obtaining it is felt to be against the patient's interests, care should be taken to ensure that anonymity is ensured by means of appropriate disguise. (British Society of Couple Psychotherapists and Counsellors, 2014, Section 2.5) These guidelines are further elaborated in The American Psychoanalytic Association's "Principles and standards of ethics for psychoanalysts".

Principle IV on confidentiality states that:

A psychoanalyst must take all measures necessary to not reveal present or former patient confidences without permission. If a psychoanalyst uses case material in exchanges with colleagues for consultative, educational or scientific purposes, the identity of the patient must be disguised sufficiently to prevent identification of the individual, or the patient's authorisation must be obtained after frank discussion of the purpose(s) of the presentation, other options, the probable risks and benefits to the patient, and the patient's right to refuse or withdraw consent. (Dewald & Clark, 2001, p. 5)

The American Psychoanalytic Association (APsaA) leaves the decision whether to disguise or seek consent up to the analyst's best judgment, while the BSCPC prefers consent over disguise, but views disguising as acceptable when obtaining consent is impossible or contrary to the patient's interests. Such ethical codes are drafted to serve as guiding documents rather than as legislative directives. Given the multitude of complex ethical situations that exist even for one couple or family at different phases of the therapy, it would be impossible for a professional association to sanction an ethically superior method of publishing clinical material that would be generalisable to all patients.

Dr Elizabeth's decision to disguise the case material in her publication is in accordance with the BSCPC ethics code, which permits disguise as a second-best alternative when obtaining consent would be contrary, as in this instance, to the patient's interests in continuing to benefit from ongoing

treatment without extraneous interferences and in being protected from disruptive feelings of shame and betrayal that might accompany a request for consent to publish their experiences. By not seeking consent she followed what is probably the practice of the majority of clinicians (Kantrowitz, 2004). What we do not know is how well she succeeded in resolving the tension at the core of the disguising option between thoroughgoing truthfulness in reporting the case material to colleagues, on the one hand, and disguising the case to protect the patient's privacy, on the other. Colleagues differ widely about how thick a disguise is required for anonymity, with those at one end of the continuum imagining that superficial changes in the patient's name and occupation are sufficient and those at the other insisting that patients be unidentifiable even to themselves (the APsaA code of ethics asserts that preserving patient anonymity requires a disguise that strips away all identifiers from the account). The thicker the disguise the better Dr Elizabeth succeeds in protecting her patients from the moral wrongs and harms described above, but this sort of protection comes at a cost of possibly misleading colleagues and undermining the educational goals of the publication.

As we have indicated earlier, the decision about seeking consent, whichever way it goes, is likely to affect and be influenced by unconscious factors. Had Dr Elizabeth sought consent she would have introduced a new set of determinants into the analytic setting that would intermingle with

unconscious factors and phantasies operating within the transference-countertransference field. From object relations and field theory perspectives, these unconscious factors would be expected to influence the internal object relations set of patient and therapist and the interpersonal unconscious operating between them (Scharff & Savege Scharff, 2011). Probably Dr Elizabeth concluded that these risks could be significant. In order to have chosen consent over disguise, she would have needed to be persuaded that consent offered meaningful potential benefits to her patients—for example, by respecting their autonomy to consent or refuse permission for their material to be published and avoiding covert deception that could distort the therapeutic relationship.

There might also be unconscious factors and phantasies affecting her decision not to seek consent arising out of the analytic field of her work with the family. For example, it is conceivable her decision may have been influenced by an unconscious wish to avoid running up against the couple's aggression and destructive phantasies, articulated through Maxine's violent drawings and play narratives. Her decision might then be thought about as an enactment in the therapeutic process, rooted in the therapist's unprocessed countertransference and reflecting her entanglement with the family's defensive system. Or it might be that alliances formed in the triangle of Martha, Jed, and Maxine were unconsciously replicated in her decision to "pair" with her professional community to the exclusion of her patients,

unconsciously living out oedipal dynamics in which, for example, Maxine may have felt shut out by the defensive fusion between her parents. Disguising may have appealed to Dr Elizabeth as a way of defending against, while giving expression to, disavowed desires to harm/punish her patients, for example, through providing a flimsy cover that only superficially complied with the profession's ethics code. Choosing a scanty disguise sets up the possibility of provoking a ferocious fight with these patients that might enact Maxine's destructive play phantasies.

These unconscious factors underline and validate the need for consultation and supervision in helping us think about our experience with patients, protecting them against acting out and optimising the chances of a good outcome to the work. Supervision, consultation, and clinical groups provide the hidden infrastructure that helps maintain and develop the analytic third, and so is understood to be integral to the therapeutic process. This wider audience for psychotherapy is not always acknowledged with patients. Presenting to colleagues through conferences and publications is an extension of this process, although any gain to patients arising from doing so is likely to reduce commensurately with the widening of the professional pool presented to, and disappear altogether if the therapy is no longer ongoing. One might think of an analytic third audience-to-the-therapy continuum on which the duty of care to the patient is prominent at one end and discharged through supervision, and the responsibility for developing the profession

prominent, at the other, and discharged through publishing clinical papers and scientific research.

It is not at all clear, everything considered, that Dr Elizabeth made the right decision by opting not to seek consent, and whether the steps she took to disguise her patient was sufficient. If she did not succeed in strip-ping the case of all identifiers, which is harder than most clinicians realise, and if she left the family members vulnerable to being harmed by others and profoundly hurt by discovering her violation of their pact, it might have been better, ethically, if she had chosen to delay writing until much later in the treatment or after the conclusion of therapy and then seek consent. Had she done so what help might she have been given in managing the process? The ethics code of the BSCPC privileges informed consent without saying anything about what this entails. In contrast, the code of the APsaA specifies the information that needs to be available for the consentor to know what he or she is agreeing to. The analyst seeking consent under this code is required to discuss the purpose of the publication, other options, the probable risks and benefits to the patient as well as the patient's right to withdraw consent at any time. But the "why", "what", "when", and "how" of seeking consent are questions that remain largely unanswered. It is to these that we now turn our attention.

INTEGRATING CONSENT-SEEKING AND THERAPEUTIC PROCESSES

Although disguise appears to be favoured by most psychoanalysts as the best way of handling the violations of confidentiality and the risks of harm that publishing case material entails, at least in the current-day US, obtaining consent is considered *prima facie* the ethically superior alternative if strategies can be found to mitigate its chief disadvantages. In contrast with disguise, which is done surreptitiously, obtaining consent honours honesty with patients, respect for their autonomy in asking for their buy-in, and truthfulness in depictions of our work to colleagues. It also leads to superior disguises, because patients are in a better position than we are to know whether unique identifiers remain in our camouflage.

Moreover, an underappreciated and central ethical justification for seeking consent to publish is to be found in the nature of psychoanalysis itself. A feature of contemporary psychoanalysis is the movement towards constructivism, collaboration, and creativity in the quest for meaning and truth in the analytic encounter. Gone are the days in which the analyst was stereotypically depicted as the fount of all wisdom and understanding, whose therapeutic effect was to be understood in terms of the mutative interpretation. Receding, too, is the counterbalancing position, contained in an over-polarised reading of Bowlby's description of therapists as exploratory companions: "Whilst some traditional therapists might be described as adopting the stance of 'I know; I'll tell you', the stance I advocate is one of 'You know, you tell me' " (Bowlby, 1988, p. 151). In their place has

come a more interactive stance that sees psychoanalysis as a shared project in which patient and therapist work together to create something new between them that is by definition idiomatic to that particular therapeutic relationship. Such a stance is not to be confused with the clinician blurring the boundaries of the therapeutic relationship, for example by inappropriate self-disclosure or inviting participation in a shared writing venture, either of which could undermine the therapeutic project.

Despite the logic of seeking consent that follows from an interactive stance on the therapeutic process there is often reluctance to do so because few therapists know how to handle ethically the main hurdles that stand in the way of securing consent with an easy conscience, namely our:

- resistance to intruding into the lives of our patients with requests that arise out of our professional goals rather than those of our patients
- aversion to introducing topics alien to the therapeutic goals of our work that are likely to disrupt already very complex transferences, which could possibly damage the natural flow of a beneficial on-going therapeutic process
- reluctance to putting our interests ahead of the patient's in violation of the time-honoured duty to put the patient's interests first
- distress about hurting patients by asking them to read about their

lives and experiences from the distancing perspective of the therapist writer

- discomfort with assuming a different role-relationship with our patients, one of author and audience rather than therapist with patient.

Our proposal re-envisages consent as an organic part of the therapeutic process rather than something alien imposed upon it. While we understand that this will apply to some and not all patients, we hope to offer a strategy to stimulate thinking as to how to respond to the foregoing hurdles, showing how the consenting process may arise naturally within a certain kind of therapeutic process, in which writing about the couple's core dynamic issue is incorporated into the therapeutic work and considered with the patient before the possibility of sharing it publicly is even entertained. The patient's interests are continually being addressed here, because from the outset the writer's voice remains the therapist's voice, not that of an alien author. The patient is kept informed of what he or she needs to know if her therapist should decide to seek consent for publication, because writing is presented from the outset as a product, co-owned by the therapeutic dyad and aimed at fueling a deeper understanding of the patient, and advancing the therapy.

Key to our re-envisaging of consent is the foundational concepts derived from object relations and link theory, that therapeutic understandings derive from an emphasis on the interpersonal unconscious within the analytic field,

and not simply by an understanding of the patient's mind, separate from an interplay with the analyst's mind. The attendant implication is that no party to the process can adequately represent reality in the absence of the other, and the risk of "discordancy" is high if a unilateral attempt to do so is made (Morley, 2007). There is thus a strong ethical as well as scientific argument for integrating consent-seeking with the therapeutic process.

The truthfulness of a representation of the analytic process no longer rests with the analyst alone. Therapists are human, and when we write about our experience of a therapy we will be describing something that, while being true to our experience, may not be true to that of our patients. Our subjective depictions support our identities as practitioners and the theories that make sense of the work we do. We may focus on aspects of the therapy that have more meaning for us than they have for our patients. The only checks and balances that can be brought to bear on this process (excluding, for the moment, the role of colleagues) come from the patients themselves. By reading how we as therapists are representing our patients, as obtaining consent requires, our patients can provide alternative perspectives that may change the way we write about the experience. While this may not satisfy some objective canons of veracity, it may have a greater chance of corresponding to intersubjective/interpsychic realities than if either therapist or patient represents only their own perspective.

There is a countervailing argument to this position, which is that professional privacy needs respecting every bit as much as patient privacy. Professionally we want to have the freedom to write about all manner of clinical concerns, particularly the most difficult ones, where it may be neither desirable nor possible to secure patient consent. Or, in securing consent, the content of what is written about is watered down or edited into something that is thought to be acceptable to the patient. A different kind of truthfulness is then compromised: the clinician's truthful representation of her or his own experience undiluted by anxiety about how this will be received by the patient.

OUR PROPOSAL

There are five options commonly advanced for managing confidentiality when publishing clinical material (see, for example, Gabbard, 2000): thick disguise, patient consent, focusing on clinical process, using composite illustrations, and colleagues acting as authors (for example, a supervisor writing about a supervisee's patient). Our proposal focuses principally on two of these: *seeking consent* to write about *clinical process*. For the purposes of this paper we are not addressing the other three. Our proposal is offered in the spirit of stimulating thinking and discussion rather than legislating. We suggest a framework in which therapist's engage in the following eight processes:

1. Extending what is communicated about the therapeutic frame.
2. Reflecting on the therapist's intersubjectivity contextualised, unconscious motivation to publish.
3. Considering potential impacts on patients and their social unconscious.
4. Timing the request.
5. Selecting what to write about.
6. Deciding how to write about it.
7. Consulting with the patient.
8. Acknowledging permission.

Extending what is communicated about the therapeutic frame

At the outset of every therapy, clinicians outline the physical, temporal, and financial aspects of a contract that will form part of the therapeutic frame: minimally, a place to meet, a regular and bounded time, a financial arrangement. Some will go further than this, assuring patients of the boundary of confidence surrounding everything disclosed in sessions and the

circumstances when this might be overridden without their consent—as, for example, when there is risk of very serious harm. These parameters may be written down or simply spoken about, but the expectation is that these terms are mutually acceptable before the therapy begins.

There is an opportunity at this pre-therapy stage to extend what is conveyed to patients about the parameters of the therapeutic frame. For example, the therapeutic process might be represented from the outset as a collaborative process in which communicative media of all kinds, including written material, might be drawn upon. Some therapies already do this when introducing video feedback as a means of learning from experience. Various therapy traditions incorporate formulations written by psychotherapists, worked on and revised by patients in the course of the therapy, resulting in something fluid that represents an experience that all the parties concerned can buy into. Written formulations are often used in mentalization based therapies (Allen & Fonagy, 2006), integrated approaches to treating depression through couple therapy (Hewison et al., 2014), and dynamic interpersonal therapy (Lemma et al., 2011).

Therapists might also include in their discussion with patients the need to confer with colleagues about their practice in order to maintain and develop the services they offer. Patients would be assured of anonymity in these circumstances (for example, supervision, case conferencing, or

presenting to colleagues in other forums bounded by confidentiality), although the circumstances themselves may not need to be made explicit. What might be added is that, in some instances, conferring might take the form of writing for publication in a way that would protect the patient's privacy interests. If introduced in the context of a general discussion of the patient's thoughts about confidentiality and the therapists usual practices, both parties may come to understand the others views on confidentiality from the beginning. The point of including the possibility of publication into the terms of the therapeutic relationship at the outset is not to ask for consent—that would be meaningless, as there is no way any consent given could be informed at this early stage—but to prepare the ground for a request at some later stage, if it were to become appropriate to do so. The request for consent, should it be made, may then come as less of a shock and be seen as part of the therapy because this possibility was included in the initial understanding about the bounds of the therapeutic frame.

Of course there are countervailing reasons for not front-loading therapy with too much information. Patients are preoccupied with their own concerns when seeking help, and are often not receptive to information about the therapeutic frame, and there is the risk of implying that the therapist's needs takes precedence over those of the patient. Clearly, a workable balance between orienting the patient adequately without derailing the formation of a solid therapeutic relationship has to be found—not an easy task. We give

priority to keeping the analytic space open at the beginning of the therapy for an exploratory dialogue between therapist and patient.

Reflecting on the therapist's intersubjectively contextualised, unconscious motivation

Reflecting on why we as therapists might want to write about our work with an individual, couple, or family, may be the most important part of the whole consent-seeking process. The answers we come up with are going to be important not only in terms of clarifying our own minds, but also in conveying and justifying to patients why we are making the request at all. At some point we shall have to answer to patients about the purpose of any proposed publication, and the risks and benefits of going down that path.

This can be a complex process. It is one thing for therapist and patient to arrive at a shared understanding of the latter's problems and to celebrate how this has helped to move things on. But what if there is no shared understanding, or no change has been achieved, despite arriving at a mutually acceptable formulation of the problem and its causes? Therapists are still likely to want to describe defensive processes and the challenges they pose, even when the therapy has had little discernible effect. We need case examples that illustrate current knowledge for teaching purposes, as well as those that carve out new areas of understanding and break new ground. True, what may constitute existing knowledge for one party may be new for

another, but asking for and giving consent may be very difficult when problems are entrenched and unchanging. Even though we know as therapists that much can be learned from “failed” therapies, the gains arising from writing about these may be much less clear to patients.

It is in these circumstances that conferring with colleagues is likely to be especially useful. We will receive feedback about whether what we propose to write about is likely to be of interest and value to the field, and how our ideas relate to other knowledge that is out there in the professional community. This may help us in justifying writing about an experience to patients. Some argue that unless we have something new to say that cannot be said without using case material we should not be considering publication at all (Halpern, 2003). But if what we write sheds new light on psychological phenomena or therapeutic technique then a justification will have been provided.

It is important to highlight the role supervisors and colleagues can play in helping us think about whether our wish to write about a particular patient might constitute an enactment, an unwitting repetition of a dynamic pattern that has been problematic for the patient and in which we may have become caught up through entering an unprocessed part of the intersubjective field of the therapy. Once we are awakened to such blind spots, we might decide never to publish such case material. On the other hand, we may opt to delay the decision about publishing to a more mature phase of the therapy when we

would have a deeper understanding of the transference-countertransference dynamics at play. Deferring publication may give us time to consider more thoroughly whether publication would represent an acting out of the dynamics within the analytic field, potentially to the detriment of the patient and the therapeutic project, or a parallel endeavour that would ultimately enrich the forward momentum of the therapy.

Considering potential impacts on patients and their social unconscious

The fear that involving patients in the decision to publish will damage the therapeutic relationship and the patient themselves goes, for many therapists, to the heart of their reluctance to seek consent. As we have already indicated, there is concern about the therapist's agenda intruding on the therapy and the influence of transference on how a request will be received, especially when any benefit for the patient resulting from publication is hard to identify. Transference factors, it is argued from this perspective, make it very hard to ensure that any consent given or withheld is informed, the subjectivity of the transference interfering in the process of making an objective decision. Putting aside any critique about the possibility of ever being in an objective state of mind, this fear conceals the considerable pain and distress that can result from a patient discovering that they have been written about behind their back, so to speak, and the potential damage this can do both to them and any gains that may have accrued from the therapy.

We suggest that the therapeutic space is never as hermetically sealed as we sometimes like to imagine, and that therapeutic work is constantly challenged by so-called intrusions affecting the frame—overheard voices in the corridor, the therapist’s lateness or unplanned absence, fire drills, and so on. We also know that, when thought about with patients, these intrusions can move the work forward and are not inevitably at odds with the therapeutic process. Asking permission to write about an aspect of the therapy is of a different order to asking for a change in appointment time, but as a request emanating from the therapist it is not a difference in kind. If the various meanings of the request are addressed and worked with they, too, might have unexpected benefits for the therapy.

In couple and family work thought must be given to the implications of there being more than one individual comprising the patient. How do we cope with differences between intimate partners over giving consent, or include the child’s perspective in an age-appropriate way? Questions of consent may easily be hijacked by dynamics within the couple and family system that might indicate appropriate differences over respecting boundaries or ongoing problems in the couple or family concerned. How any publication might be used inside or outside the family also needs consideration. Divorce makes private troubles very public, and the possibility of papers being used destructively in court proceedings is something that therapists need constantly to keep in mind.

Clearly there are patients who will react adversely to any request, who may be particularly vulnerable, or for whom raising the matter may be experienced as an abuse rather than a request. The therapist must then judge if or when to make the request, and whether it is appropriate to be writing about such patients at all. The key decider is whether seeking consent can be brought into the work and thought about with patients as part of the therapeutic process. Here we might learn from therapies that actively use questionnaires in the course of therapy to evaluate how patients are feeling and their levels of distress on a range of indicators. Or we might draw on the experience of therapies referred to earlier that use written formulations, which are developed and revised in collaboration with patients, to articulate the nature of the problems being addressed and how they might be understood.

Timing the request

It is one thing to write a formulation that only therapist and patient will see; quite another to share this with a wider audience. At what point will the therapist ask for consent to “go public” about something that is essentially private? To ask for consent prior to the therapy, as researchers do, will inevitably by-pass the consent being informed, because no-one knows how the therapy will unfold and what will emerge as the focus of the publication. To ask during a therapy risks introducing an alien object—the readership—

into the therapeutic relationship, intruding on the therapy relationship and process. To ask after a therapy is ended is to invite patients to re-enter the therapeutic space without providing the containment of an ongoing therapeutic relationship, and so risk disturbing them and destabilising the balance they have established.

In order for there to be trust and confidence in the therapist's intent in seeking consent, it is likely that the timing of a request will come later rather than sooner in a therapy, and certainly after a therapeutic alliance has been established. If the intent is to write about the therapy as a whole then the request might come in the ending phase, and perhaps in the context of reviewing the experience of the therapy with patients. In these circumstances it may be appropriate to work on a written evaluation of the therapy, or a closing summary, as a collaborative process that might then form the basis of a publication.

However, we think that the most valuable accounts of therapy focus on the fine-grained detail of a sequence of interactions between therapist and patient that illustrate, for example, a pattern of interaction triggered by an emotive event, or a sequence that triggers or contains the expression of affect. These accounts invite readers to consider the process data for themselves and form their own judgements about what is happening, and have the virtue of including rather than removing the therapist from the process being

described. Moreover, it is not hard to see how valuable such accounts might be to patients, who have the opportunity to revisit a sequence in a session and learn from observing what is happening when this had not been possible at the time because of their emotional involvement. The written account then functions as a kind of third position, allowing space to think about what happened for both therapist and patient. In that sense it works rather like the use of video interaction guidance in mother–infant therapies, where a mother can develop her capacity as a parent by watching herself operate in this role with her infant with the opportunity to talk about what is happening with her therapist. In these circumstances the timing of a request to write about the process of therapy might follow hard on the heels of a significant interactive event, and become part of the therapy itself. If this event is subsequently published, along with an account of how therapist and patient worked together to process what was going on, it has the additional advantage of already having “heavy disguise”: no-one else will have been privy to the event, and nothing needs describing other than the interactive sequence itself.

Selecting what to write about

It will be apparent that we favour clinical accounts that focus on the process of interaction within sessions, rather than case accounts that include the wide sweep of developmental histories that are drawn upon to “diagnose”

a “condition” and describe its “treatment”—language that emanates from a medical tradition. Nevertheless, there may be particular subjects that can be illuminated by case examples that call for a wider sweep. The privacy of the sexual relationship, shame associated with seeking out and enacting sado-masochistic fantasies, use of internet pornography, the trauma of a painful separation or loss, and so on, may make publication requests harder to integrate with the therapeutic process than, for example, when the issue has been a difference over parenting styles. The altruism of patients may then be the deciding factor, as the benefit may accrue to others and not to themselves.

Deciding how to write about it

While we maintain that the best “events” for written analysis are those “present moments” of meeting (Stern, 2004) when something mutative occurs, analytic reporting on the unconscious-to-unconscious communication between couple and therapist calls for care and sensitivity. How the therapist writes about his or her concordant and complementary identification with the partners, singly and as a couple, will affect patients who hitherto may not have been privy to this material or informed about the conceptual ideas that make it relevant. Although such countertransference entries offer a rich and necessary lens into the core dynamics at play, the couple may be negatively impacted by reading a paper that gives them entry into previously hidden parts of the therapist’s mind. Therapists will need to be selective and

thoughtful in deciding upon their material in order to mitigate any potential harm to patients, while preserving the authenticity of the countertransference account. For patients it can come as a shock to hear the therapist's professional voice, sometimes couched in technical language, which may come across as remote, uncaring, cold, or indifferent. The translation of something that has been part of a fluid therapeutic discourse into stark printed text can be received as a partial and over-clear description of a more complex experience. Keeping the patient in mind as reader, and making an effort to identify with the patient's struggles and moments of growth, can help mitigate the shock.

Case accounts that prove to be most distressing to patients are those in which they feel objectified, their experience reduced or represented in ways they cannot recognise, the disguise in which they have been cloaked feeling alien or insulting to them, and the whole experience leaving them with an overwhelming sense of having been pathologised. A "medicalised" approach to writing (in which an illness is diagnosed and its treatment described) can undo the benefits of the therapy by distorting the lived reality through oversimplifying a changing and nuanced process (a bit like freezing a frame of a film and claiming it is the whole), discarding the significance of dynamic process in favour of depicting a static, uni-dimensional tableaux. The likely consequence of this is to leave patients feeling robbed of their sense of reality and confidence, and angry at being misrepresented and misunderstood.

The more therapists remove themselves from clinical accounts the greater the risk of writing in ways that might result in such negative outcomes. This is another reason for focusing on clinical process and writing about detailed interactions: such accounts include the therapist who is acknowledged as having some part to play in generating a patient's feelings or behaviour, and who is not elevated into the impartial observer, unaffected by all around and capable of representing experience while being removed from it.

Therapists need empathy when writing—a capacity to put themselves into the shoes of those they write about and anticipate the likely affective consequences of putting pen to paper in describing specific issues. Halpern (2003) extols Winnicott's capacity to do just that, and especially his capacity to represent the reasonableness of reactions to environmental failure: "Winnicott's tolerance of the interplay of psychopathology and 'healthy' mental life seems to be what humanises his case writing" (p. 133).

Consulting with the patient

All that has gone before underlines what we consider to be the virtue of consulting with patients about how their situations are represented in publications, when not clinically and ethically contra-indicated. Rather than being extraneous to the therapeutic process we consider that this discussion

can sometimes be brought into the therapeutic dialogue. Because therapy is a consultative process, it may be hard to justify not showing patients what has been written, or not involving them at a stage when a writing project is in process and waiting until it is complete. Only by involving patients in the process are we in a position to learn from them. Consultation does not imply therapist and patient having to arrive at an agreed account, but may involve representing differences and trying to come to an understanding of what they might mean. This, of course, describes an aspect of what goes on in therapy. Consulting our patients over how we represent a shared experience is not simply a process of securing consent to publish. It involves a willingness to enter, or re-enter, the therapeutic space.

Acknowledging permission

For reasons of confidentiality, and to preserve the boundaries and relative asymmetry between therapist and patient, we would not recommend that accounts of clinical process are jointly authored, even when patients have contributed much and it might be desirable to include them in this way. Integrating the processes of seeking consent and psychotherapy should not be at the expense of blurring the boundary between therapist and patient in ways that might undermine either process. Co-authoring works best when there is a shared framework of knowledge, similarity of roles, agreement about the target audience, and a sense of common purpose in writing the

paper. Psychotherapy works best when there is clarity about who is the patient and who the therapist. In both these contexts co-authoring is likely to create more problems than it solves because it requires a change of roles. It may be no accident that published accounts of therapy tend to come either from therapists (most likely) or patients (of which there are a few examples), but not from both.

Permission to publish is a gift, and the least authors can do is to acknowledge the gift and express their appreciation. By acknowledging that patients have contributed and consented to the writing process therapists add weight and credibility to their accounts and conclusions. They also set a good example to their peers about how to relate to patients.

CONCLUDING REFLECTIONS

Realising the aspiration of finding ways to integrate consent-seeking and therapeutic processes is no easy task. Judiciously involving patients in the ways we have suggested gives therapists little comfort: it offers no guarantees of relief from the anxiety that requests might be unwelcome, or that they will create conflict with and for those from whom permission is being sought. It constrains the freedom of therapists to act independently of their patients when writing about them, and it calls for new skills in working collaboratively. Yet we believe that it is something worth working towards. If

we truly wish to behave in ways that accord with the highest standards of ethical practice, and that reflect the essence of psychoanalytic psychotherapy as derived from an interdependent, unconscious organisation of both patient and therapist, can we do any less? We may even find that the conflict between honouring the duty of care to patients and developing the profession may be more apparent than real.

We are sure that our proposal will have shortcomings; it may even be fundamentally flawed (although we do not think so). We recognise that it will not be suitable for all patients, especially if transference factors and unconscious phantasies have not been extensively elucidated. But we offer it in the hope that it might help in managing some of the moral dilemmas associated with using confidential information, and that it will be useful in stimulating thinking and discussion about how best to proceed in this most complex of areas of ethical practice. We conclude by expressing our hope that these ethical dilemmas will be debated openly within and between psychoanalytic societies, at national and international scientific meetings, as a means of contributing towards the development of our profession.

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Note

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