

Confidentiality and Consent Issues in Psychotherapy Case Reports: The Wolf Man, Gloria and Jeremy

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Abstract

In this article I explore the issues surrounding confidentiality and consent in the writing of psychotherapy case reports. An important theme is the challenge of protecting a patient's privacy while furthering knowledge in the field through publication. I discuss some of the complexities as well as the relevance of present day requirements for informed consent, including a consideration of the provisions within the *Declaration of Helsinki* (1964, last revised 2013). To illustrate the difficulties inherent in writing about our work I give examples of three cases: Freud's patient Sergei Pankejeff (the 'Wolf Man'), Gloria (the patient in the 'Gloria Films'), and a contemporary patient, 'Jeremy', whose therapist published an account of her work with him. The writing of case material is complex and resists easy solutions; there can be no "one-size-fits-all" approach but instead the therapist writer's careful consideration on a case by case basis of his or her motivations for writing, what the patient is really consenting to, whether patient consent can ever be truly informed, and how writing and publishing a case might impact on the safety and well-being of the patient (including others connected to the patient), as well as on the therapeutic relationship itself.

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Introduction

One of many difficulties presenting itself to the psychotherapist who considers writing up a case for publication is how to protect the patient's privacy. Related to this is the issue of whether or not to inform the person that we would like to write about them, and whether to ask for their consent to do so, or even to turn the writing into a collaborative effort. This issue can also manifest itself before any writing takes place, as it did for me when a patient expressed to me her fear that I would write about her and her family. Specifically, she feared that I would write a book about her and that her friends and acquaintances would read the book and recognise her, resulting in her life being laid out for all to see. We talked about her fear and what this meant for her and for our relationship. At the same time, I had been grappling with this issue of writing about clinical material, something that I had not mentioned to my patient, but which nevertheless seemed to be uncannily alive in our interactions. Another patient fantasizes from time to time that I will write about him and encourages me to make a start; the fact that he is seemingly consenting, however, does not reassure me that it would be in his best interests for me to do so.

In thinking about issues of privacy, confidentiality and consent in the context of writing psychotherapy case reports I have consulted literature that is mainly but not solely of a psychoanalytic nature. I have also consulted the literature on ethics in healthcare and have summarised three cases to illustrate the difficulties inherent in clinical writing. A focus of this article is the question of how we manage the conflict between protecting a patient's privacy while at the same time furthering knowledge through publication. Many authors argue for the possibility of doing both, for example Goldberg (1997), who states that "there is a need both to safeguard the privileged communications of patients and to allow psychoanalytic science to progress by way of a free exchange of information" (p. 435).

Freud's Case Histories

Freud held a similar view to that of Goldberg, at least until 1920 when he became reluctant to write extensively about his patients because he thought that future patients might arm themselves against him with his own ideas about the analytic process (Pizer, 2000). Freud's case histories began to appear in 1893 with Frau Emmy von N., Miss Lucy R., Katharina, and Fräulein Elisabeth von R. The famous case of Fräulein Anna O. was also written in 1893, but by Freud's colleague Josef Breuer. All these cases aimed to investigate hysterical phenomena (Breuer, 1893; Freud, 1893).

In his preface to the later Dora case (1905), Freud addresses the issue of confidentiality. He points out that it is "awkward" (p. 7) that he is publishing results of his enquiries without there being any possibility of other specialists testing and checking them due to the clinical process being confidential. He also feared reproach because he was divulging information that was confidential to the patient. Freud notes that in writing up a case in any detail "intimacies" are going to be revealed and he suggests that had his patients known in advance

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that their admissions would be put to “scientific uses”, they would never have spoken (p. 2). Weighing against this, Freud thinks that the physician has duties not only to his patients but also to science, and that, as long as no harm is caused to the patient, it is a “disgraceful piece of cowardice” not to publish (ibid., p. 2). He then goes on to describe ways to mitigate harm. In the case of Dora, he describes keeping her treatment a complete secret from anyone apart from one other physician; waiting for four years until after the treatment ended to write about it; postponing publication until hearing that her life circumstances had changed; disguising all names, and publishing in a purely scientific periodical to guard against “unauthorized readers” (p. 8).

From Freud’s perspective confidentiality appears to be relatively straightforward. He seems carefully to consider various factors relating to Dora’s situation before writing about her, and is concerned to protect her identity from curious others, however he dismisses any notion of discussing publication of the case with her. In fact, he writes “to ask them themselves for leave to publish their case would be quite unavailing” (Freud, 1905, p. 8). He assumes that patients would refuse to give consent and would not even begin to speak about their problems if they knew that they would be made public. Thus, while he acknowledges the difficulties associated with confidentiality he does not consider the issue of consent to be problematic.

The Beginnings of Informed Consent

Freud’s stance accords with the ethical principles governing medical practice at that time. Prior to the mid-twentieth century there were no requirements for informed consent for research or clinical care (Hamvas, et al., 2004). However, following experiments by German physicians during World War II and the subsequent Nuremberg Trials, the *Nuremberg Code* (1947) was drafted (cf. Shuster, 1997). The *Code’s* 10 points stress voluntary consent and an absence of coercion of human subjects involved in scientific experimentation. It was reaffirmed in the *Declaration of Helsinki* which was developed by the World Medical Association (WMA) in 1964 to outline the ethical principles for medical research involving human subjects, including research on identifiable human material and data (Article 1).

The current *Declaration*, last reviewed in 2013, contains some aspects which are pertinent to psychotherapists. In fact, the WMA makes the point that, while the *Declaration* is addressed primarily to physicians, other participants in medical research involving human subjects should adopt these principles (Article 2). Many, maybe most, psychotherapists would argue that as the majority of psychotherapists do not carry out medical research involving people, the *Declaration’s* ethical principles do not apply, however when we write about our work it does become public research which is very much to do with ‘human subjects’. It also strikes me that since Freud’s time we have increasingly moved towards complying with the *Declaration*, or at least with the articles that address issues of privacy, confidentiality and patient consent. The only relevant article that most psychotherapist writers would probably not comply with is number 26, viz,

In medical research involving human subjects capable of giving informed consent, each potential subject must be adequately informed of the aims, methods...[and] the anticipated benefits and potential risks of the study...[and] should be given the option of being informed about the general outcome and results of the study.

To what extent is this requirement relevant for psychotherapists writing about their work? Could psychotherapists comply with it and could it be helpful for their patients if they did? Before exploring these questions I will return to whether it is possible to ensure our patients' privacy is protected and their casework remains confidential after publication.

Confidentiality of Written Case Material – The Wolf Man

Of course we know now that Freud's efforts to protect his patients' privacy were successful for a limited time only. Due to Freud's iconic status many people have devoted their time to unearthing the identity of his patients. Thomstad's (1986) justification for this is that the patients deserve to be commemorated because of their contribution to psychoanalysis (p. 172). He cites Jones (1953) who had a similar opinion in relation to Anna O., arguing that since she had discovered the cathartic method, her real name, Bertha Pappenheim, deserved to be commemorated. Thomstad (1986) also notes that Freud's famous patient, the 'Wolf Man', felt himself to be Freud's collaborator. The analyst Muriel Gardiner was in contact with the Wolf Man, Dr Sergei Pankejeff, for more than 50 years and edited his memoirs in 1971. He was also interviewed by many analysts during his lifetime, all of whom kept his identity a secret as he himself was concerned to ensure that his anonymity would be preserved. However, after reading his memoirs, the journalist Karin Obholzer became determined to discover his identity. She eventually did so, met with him, and wrote a book about him based on 40 hours of interviews with him. The book was originally published in German in 1980, and was then translated into English in 1982.

Gardiner (1983), in writing about Pankejeff's ongoing relationship with the analytic world until his death in 1979 at the age of 92, is clearly dismayed by Obholzer's book when she writes "...the appearance of this book, revealing so many matters I had regarded as strictly confidential, gives me the unwished-for opportunity to add to some of them, and occasionally to put the record straight" (p. 879). Her concerns are not primarily related to Pankejeff's identity being made public as he had died a year before Obholzer's book appeared, but rather that so many details about his life, which she had considered to be private, and which had not been written about by her or other analysts, had been introduced into the public sphere. As an interesting footnote, a letter from Pankejeff was published in 1957 with his consent in *The Psychoanalytic Quarterly*. It was translated into English and his name and signature withheld, but his original handwritten letter in German was also included, complete with his very legible signature. Thus, it could be argued that his identity was known as early as 1957.

The literature contains many conflicting opinions about Pankejeff. These are not the subject of this article, however one is left wondering whether the intense interest in him and possible desire to 'commemorate' him was really in his best interests. Of course it is impossible to know, and there are certainly many indications that he both promoted his special position and benefited from it financially and emotionally. In speaking and writing so freely about his analysis he belies Freud's assertion that a patient would never consent to being written about (and that there is therefore no need to ask for consent). Some patients are very happy to give their consent but it is worth considering the conditions under which they give it, what they are really consenting to, whether consent can ever be truly informed, and the implications for both therapist and patient of publishing clinical work.

The Impossibility of Informed Consent

Some 120 years after Freud began publishing cases, views on asking patients for consent have shifted. As noted above, the impetus for this is likely to have come from wider social change, articulated in documents such as the *Declaration of Helsinki*. In considering this shift, Tuckett (2003) draws a distinction between the position of the International Committee of Medical Journal Editors (ICMJE) and that taken by, for example, the editors of the International Journal of Psychoanalysis (IIPA). He notes that after reviewing and debating the issue of disclosing data from patients in publications, the ICMJE decided that informed consent in relation to writing about patients requires that the patient be shown the manuscript to be published and that “identifying details should be omitted if they are not essential, but patient data should never be altered or falsified in an attempt to attain anonymity” (cited in Tuckett, 2003, p. 177).

Tuckett goes on to say that the editors of the IIPA considered themselves unable to follow the ICMJE guidelines and published an alternative approach “in which seeking consent had to be considered but could be rejected as not suiting the best interests of the situation” (p. 178). Thus, a differentiation between psychoanalysis/psychotherapy and medical disciplines is noted: “the nature of psychoanalysis demands rules about privacy and informed consent that others consider inappropriate and possibly unethical” (p.178). Tuckett adds that increasingly rigorous requirements regarding informed consent have prevented many psychotherapists from writing or speaking about their work, and that this is a major reason for a lack of detailed clinical writing in the literature. He also briefly considers whether the promise to maintain confidentiality may appear to be a belief in secrecy, suggesting a lack of accountability by the clinician.

In a review of the international scientific literature on informed consent, Quiroga de Pereira, Messina and Sansalone (2012) conclude by stating their own belief that, in line with the present-day emphasis on human rights, informed consent is the patient’s right, and an obligation incumbent on researchers and analysts. They call for “a new institutional culture in which the seeking of consent and the production of scientific knowledge are standard practice” (p. 977). This is certainly the stance taken by the American Psychological Association (APA) which requires that psychologists writing about their patients must not only disguise confidential patient information but *also* that patients must consent in writing, unless there is legal authorization to do otherwise (paragraph 4.07, APA Ethics Code, revised in 2010).

As noted, Tuckett’s main concern is that the increasingly rigorous requirements regarding informed consent have led to psychotherapists writing and speaking less about their work, resulting in a dearth of detailed clinical writing in the literature. There are, however, some who make a strong case for gaining consent before writing about patients. Stoller’s (1988) view is that not only should we seek consent from the patient but also that the patient should have input into the final written account. “We should not write about our patients without their permission to do so and without their view of the matters about which we write” (p. 391). He echoes Tuckett’s concern about perceived accountability in challenging psychoanalysts to “show your patients your descriptions of them. The failure to do so contributes to the defensively authoritarian tone sensed by people – not all enemies – outside analysis” (p. 385). Stoller gives several examples where consent was not sought and the patient (or supervisee) read about themselves and felt hurt, angry and betrayed. He also

acknowledges that the ethical problems related to seeking consent are full of contradictions and “may be insoluble” (p. 389).

In the literature I reviewed, the main objection to seeking consent to write about a patient relates to concerns about how doing so might impact on the therapy. Wharton’s (1998) comment is fairly representative:

I want to emphasize that the mere fact of seeking consent is a powerful interference in the analysis, and it is one introduced by the analyst....The process of interrupting the analysis to request permission for publication puts considerable strain on the transference relationship and underscores the fact that the analyst has to exercise a fine judgment about whether a patient can sustain it....The patient is wrenched out of his natural transference and is called upon to relate on more equal terms....While there may be a considerable gain to the patient in this, it can also be experienced as a profound loss, akin to the loss of infantile dependence or the loss of innocence. (p. 210)

Aron (2000) adds that given the possible power of the analyst’s influence, it may be impossible for the patient to refuse consent. That is why, he says, we do not have sex with patients, even if it seems to be consensual, and why other areas such as entering into a business transaction or bartering arrangements need to be approached with care. He believes that most writers do not, in fact, obtain consent before writing about their patients, as there is a paucity of discussion in the literature about patients’ responses to reading the case write-ups and how their responses impact on their analysis. Aron does not make any recommendations beyond agreeing with Lipton’s (1991) suggestions that if the material we write is brief and could apply to many patients, consent may be unnecessary. However, if we plan to use extensive material then permission should be sought. Polden (1998) draws a similar distinction when she quotes from Bollas and Sundelson (1995), who state that consent should be sought for writing that might be easily accessed by a patient in order to guard against publication being experienced as a “potential psychic violation” (p. 343).

In our current digital age this issue of access is highly pertinent; the patient’s ability to easily access his or her therapist’s writing can now be taken for granted, as is widely acknowledged. While it was highly unlikely that Freud’s patients would have had access to the scientific periodicals in which he wrote, it is now almost routine for patients to google their therapists’ names (past or present) and then to search through any related links, including publications containing clinical material. In addition, we really are in the dark about where the digital revolution is likely to take us. What does seem clear is that there is an increasing expectation that information, including patient information, be easily and widely accessible, especially in public health and managed care contexts. How do we offer a confidential clinical setting for our patients in the face of this? And what are the implications for clinical writing, particularly if in doing so we fear litigation? While a detailed exploration of this phenomenon is beyond the scope of this article, it is an increasing part of the context in which we work and must be carefully taken into account.

In a paper exploring issues of disguise or consent when publishing clinical material, Gabbard (2000) suggests various mechanisms for protecting the patient’s privacy, including thick disguise, patient consent, the use of composites, the use of a colleague as author (following the principle that patients are more easily able to be identified if they can be connected to the author, their therapist), and, lastly, adopting a process approach, whereby little historical or other personal data about the patient is given but where the emphasis is

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placed on verbatim data and the clinical process. He introduces an interesting note in relation to asking for consent by highlighting the potential for guilt arising in the analyst if consent is given. “While they attempt to convince themselves that they are being ethical by obtaining patient consent, they are secretly ashamed of exploiting their patient’s trust in them by their writing” (p. 1077). He sums up by arguing for considering each case on its merits. This resonates with Stoller’s and Aron’s views that the ethical problems surrounding confidentiality and informed consent may be insoluble and that it therefore behoves any practitioner who is contemplating publishing clinical material to consider the factors applying to their particular case.

Gloria

In order to illustrate how difficult issues of consent can become and the importance of considering each case on its own merits, I would like briefly to discuss the case of ‘Gloria’. This case relates to a patient being filmed rather than written about but there are obvious parallels, as both media are for public consumption, or at least professional consumption. In 1965 Gloria was a young, recently divorced woman aged 30, and was in therapy with Dr Everett Shostrom. She had been in therapy with him for four years when he decided to make a training film for psychotherapy students and asked Gloria if she was willing to take part in it. She was told that the film was for educational purposes and that she should just be herself (Dolliver, Williams & Gold, 1980). She agreed to take part and Shostrom produced and directed a film called *Three Approaches to Psychotherapy*, more commonly referred to as ‘The Gloria Films’. In the film Carl Rogers, Fritz Perls and Albert Ellis demonstrate their different approaches to therapy with Gloria by way of individual half hour sessions with her. According to Rosenthal (2005), Rogers and Ellis were at the time unaware that Gloria was Shostrom’s patient.

In watching these sessions it is poignant how openly and freely Gloria speaks about her life and about what is troubling her. For example, Gloria begins the session with Rogers by asking whether and how much she should discuss her sex life with her nine year old daughter, who had been asking questions about male visitors to the house. Forty three years later, in 2008, Gloria’s daughter, Pamela Burry, wrote a book called *Living with the Gloria Films: A Daughter’s Memory*. In reviewing this book Moon (2009) notes how it highlights the serious issue of client consent in relation to confidentiality, as Burry details the film’s effects on Gloria and her children, and how the recording was subsequently misused with consequent suffering to the family. It was broadcast on television and on cinema screens, thereby going well beyond its original stated ‘training’ purposes. In addition, no-one could have predicted how recordings could become so prolifically widespread. It is now even possible to see these films on YouTube.

Gloria did give her consent for these films to be made, but we could ask whether it was explained to her, or even *could* be explained to her, how the films might be used in the ensuing years. More importantly is the issue of whether she had any free choice in consenting, given that Shostrom was her therapist. One possible opinion is that Gloria was an emancipated woman of the 1960s, well able to make her own decisions (discussed in West, 2002). However, this seems naive on several fronts, in particular with regards to the asymmetrical nature of the therapy relationship and the transference dynamics operating

within it. It is reasonable to propose that these dynamics would have prevented her thoroughly considering the potential impact of the film on herself and her family.

Rogers became a trusted figure for Gloria over the years. At a conference after the films had been made, she had lunch with Rogers and his wife and asked if they would “object if, in her thinking, she regarded us as her parents in spirit” (to which they agreed) (Rogers, 1984, p. 424). She corresponded with him up until her death 15 years after the filming and wrote this to him a month before her death:

As you may well be aware the Gloria films are no longer being shown on TV or in movie theatres [about] which of course I am pleased. I truly value those films and feel they have a special place in the trend of psychology yet I was offended by some of the ways they were being used. (quoted in Burry, 2008, p. 127)

Moon (2009) alludes briefly to the impact on Gloria’s daughter of these films being in the public arena. That Pamela Burry wrote her book is likely to be at least in part due to the impact of these films on her life. This alerts us to the importance of considering not just the patient’s privacy but also the privacy of anyone connected to the patient.

This is a particularly confronting example of how complicated issues relating to patient consent can become and how things can go very wrong. The Gloria films were made in 1965, only a year after the *Declaration of Helsinki*, so these matters may have only just become the subject of discussion. It is striking that the three therapists were all male experts in their field, middle-aged or older, and that the woman is young, troubled and visibly seeking reassurance and help from them. A feminist analysis or, in fact, almost any present-day analysis of this film would have to state the obvious: that under these conditions consent was very problematic. While Shostrom’s original intent may have been laudable, the balance between patient privacy, on the one hand, and furthering psychotherapy knowledge, on the other, was not struck. This begs the question of how we arrive at this balance, and whether any criteria might help us to achieve it. Before considering this further I turn to a more recent illustration of how things can go wrong in publishing clinical material.

Jeremy

While writing on this topic a colleague told me about a therapist he knew (who I shall call Jeremy) who had had a very painful experience as a result of being written about by his therapist. My colleague offered to put me in contact with Jeremy to ascertain whether he would be willing to tell me about his experience.

As Jeremy lives in another country, I wrote to him and he replied, telling me about what had happened. It seems important, given the subject of this article, to describe our process of communication before elaborating on Jeremy’s experience. It was as follows:

1. My colleague made the initial contact with Jeremy to explain my research and ask whether he would be willing for me to contact him.
2. Jeremy consented to my contacting him and my colleague gave me his email address.
3. I sent an initial email, introducing myself as a therapist and teacher who was researching confidentiality and consent issues in clinical case material, and asking Jeremy whether he would be willing to tell me about his experience of being written about by his therapist.

4. He replied that he would be happy to do so and then sent me a very full email detailing his experience.
5. I was struck by how generous Jeremy had been in sending me this very full material. I wrote and thanked him.
6. Some months later I sent Jeremy a draft of this article, including my interpretation of the material he had sent to me. I asked him to let me know if this accurately reflected what he had written to me and whether he wanted me to change, add or delete anything. I also asked him if he was still willing for the material to be published.
7. Jeremy responded with a few small alterations and confirmed his willingness for the article to be published. He added this comment: “for the part that is about my story, am dealing with the rich and peculiar meta-experience of seeing you writing about my writing on what it was like to be written about!”

And now to Jeremy’s story:

Jeremy was in individual and group psychotherapy with the therapist ‘Sophie’ during the late 1980s through to the mid-1990s. During his final sessions with Sophie she told him that she was finishing her latest book and had written a case study based on his therapy with her – “she offered to let me read it and I did so during my final therapy session with her”. He said that at the time of reading it he felt very moved as she had accurately captured their work together, and that he was “thrilled”. A month after this final session Sophie asked him to come to her office to sign some paperwork allowing her to publish the case study in her book. When the book was published he said that he read it eagerly and that his wife did as well. His wife then became angry and upset at how the therapist had described her and their marriage, and was also angry that neither Sophie nor Jeremy had considered how the book might impact on her. At this point Jeremy was shocked to realise the far-reaching implications of a client case study and that he had not considered how his wife might respond. As he had moved to another part of the country he made no effort to contact his former therapist or to register a complaint. In the meantime, she had fallen from grace professionally and when he heard others talking about her he felt “shame and anger”.

His next shock came when he received a phone call from a former neighbour who had decided to train as a therapist and had been given his former therapist’s book as the basis for her training course. She had recognized Jeremy in reading the case study, and he reports again feeling anger and shame that Sophie had exposed his marriage in print and that he had not considered his wife’s feelings about the case study. Also, he still felt: “a bit special, a leftover from that idealization, but hurt too. For a time it was like the hurt was the price I had had to pay to feel special”. In writing about this, Jeremy acknowledges that much of the strength of his feelings at that time was related to his “childhood story” and that he got the opportunity to work through these feelings in the years that followed. He now sees his former therapist in a different light, as being brilliant *and* flawed, and that she created enormous opportunities for his healing and learning, particularly in the time after he ended therapy. Also, that despite her errors he did feel her care and empathy was congruent, and that he has been able to model some of his own practice as a psychotherapist from his internalization of Sophie.

In hindsight, Jeremy feels that his former therapist failed ethically in bringing her writing into the therapy relationship:

How could I have read it during my session with any critical distance? I sometimes wonder what was in her mind that she did it this way. I certainly think that a client needs to be written about after the therapy has ended. If others are mentioned in the case study then they need consideration as well (personal communication, 15 July 2010).

The impact on Jeremy of Sophie's carelessness, or whatever else we might call it, was considerable and long lasting, and could easily have been worse. It is striking, but not unsurprising, that Jeremy 'forgot' about his wife while reading the case study in his therapist's presence. It is, however, surprising that his therapist did not discuss this with him. Jeremy has wondered if, during his six years of therapy, Sophie took sufficient account of splitting and being the "other woman", getting in the way of his marriage.

What has struck me in Jeremy's account is the extent to which he attributes his strong feelings of anger and shame to his own earlier experiences, and that he would like to continue to see his former therapist in a positive light. In addition, he emphasises that the experience has provided him with an opportunity for more self-development. This is a moving comment on the extent to which psychotherapists are trained, necessarily so, to view the world from the inside out, and in so doing to take more responsibility than is sometimes warranted. What can we make of the fact that Jeremy did not make a formal or informal complaint against his therapist, or that he continued to see her as a benevolent figure in his life? Did Sophie ever apologize, or make amends? Was there a process of forgiveness that would make sense of Jeremy's present day stance towards her? These unanswered questions highlight something about the therapy relationship – the strong bonds that are formed, the trust that develops, and the propensity of the client to hold the relationship dear in order to honour a mutual creation. This latter is, I think, almost inescapable on the part of the client where a good enough therapy has taken place, and this is where the asymmetrical nature of the therapy relationship comes clearly into focus. The therapist's integrity and ability to consider his or her position of influence would seem paramount in successfully negotiating this difficult territory.

If we consider this from Sophie's perspective we can imagine a busy therapist trying to juggle dual relationships (Jeremy was also in group therapy with Sophie) and publish a book, not permitting herself the time to attend to the countertransferential dynamics. On the face of it, it seems shocking and negligent that Sophie initiated a consent to publish process during their final therapy sessions together, that she had already written the study, and that the process was so rushed, giving Jeremy no real opportunity to consider what he was reading and the potential implications. Sophie may have believed that asking for consent earlier in treatment would have negatively impacted on the therapy (Aron, 2000; Wharton, 1998, 2005) but the process in the final therapy session suggests that at this point she was primarily serving her own interests as an author, and had lost sight of her role of therapist. In addition, and what eventually caused much pain for the client, was that she had gone to insufficient lengths to disguise him and his wife in her writing.

I would like to add a footnote to the outline above of my communications with Jeremy. As it was initially Jeremy's wife who objected to what had been written, I found myself wondering what she might think if she knew about this latest writing. I pondered whether to raise this with Jeremy, wondering if that would be too intrusive or, on the other hand, if something traumatic might be repeated due to my oversight. I also wondered whether I had sufficiently disguised Jeremy's experience. Overall it seemed to me that writing about the initial writing was quite a step removed from Jeremy's therapist writing about him, and of

course the relationship is very different. Jeremy knows me only through email communication, therefore I am more of a neutral researcher for him in contrast to the intimate therapist/patient relationship. As well, however, I am mindful that in taking part in my writing, Jeremy has had to revisit a painful experience, and I can only hope that there were more benefits to him than otherwise.

My own ruminations on this reflect, I think, some of the difficulties inherent in writing about clinical material. How will the person respond when reading it? Will they recognise themselves, and if so how could that affect them, our relationship with them, and their relationship with others? Given that we would wish for it to be possible for therapists to write about their cases in order to progress knowledge and learning in the field, it needs to be acknowledged that balancing the roles of therapist and writer is a precarious but necessary endeavour. Ideally, writing about a patient would be helpful to the patient as well as to the profession.

A Possibility of Integrating Therapy and Writing

As noted above, the *Declaration of Helsinki* requires that patients involved in research should be informed about the outcome of the research and share any benefits resulting from it. The relatively recent phenomenon of analysts writing about their patients with their permission as a vehicle for facilitating the analytic work (Kantrowitz, 2005) could be seen to relate to this requirement. Kantrowitz gives examples provided by nine relational analysts who published papers in *Psychoanalytic Dialogues* from 1995-2003. She interviewed these analysts to ascertain their attitudes and practices in relation to their writing and the impact on patients of reading about themselves. Ways in which patients were seen to make use of reading about themselves were as follows:

1. For validation. For example, some patients felt validated by what the therapist wrote, and in particular how it conveyed the therapist's trust in the patient's process, enabling the patient to feel more trust in themselves.
2. To clarify misunderstandings in both directions. For example, where the patient reads something and is then able to discuss it with the therapist, or to see something in a new way.
3. To heighten awareness of transference-countertransference interactions and to make past experience more emotionally alive in the present.
4. To detect and examine the analyst's thoughts and feelings about the patient.
5. To facilitate a process of de-idealisation. (p. 371)

Kantrowitz (2005) writes that the analysts she interviewed felt relatively free to ask their patients for permission to write because they believed that their patients benefited from reading the material and, in particular, that it helped them (the analysts) to focus on central transference issues. She notes that this approach is part of a relational analyst's philosophical orientation and that relational theory underlines the analyst as contributor to the analytic process and is a "two-person process" (p. 366). As well, there is a belief that engagements during the therapy promote psychological change and that interactions, conscious and unconscious, are co-constructed by patient and analyst (p. 385). Kantrowitz points to the possibilities this creates, and also the difficulties. She concludes that while some patients may benefit from this approach, it needs to be employed "reflectively and judiciously" (p. 393)

and that the long-term ramifications need to be studied. When considering methods for preserving confidentiality, she too argues for considering each case on its own merits.

In thinking about how this approach might differ from the case of Jeremy and Sophie, it seems that similar difficulties could be encountered, specifically to do with patient vulnerability related to transferences, and therapist awareness - or lack of awareness - of countertransferences (which I think accounts for Kantrowitz's reservations). For this reason it is unclear to me, and I think also to Kantrowitz, why a relational analyst would, in the context of writing about a patient, have significantly different concerns from an analyst with a more traditional approach. Gabbard (1994) describes the converging consensus of both relational and classical analysts that the detached, "objective" analyst is in our times a very rare phenomenon, and that "countertransference enactments are ubiquitous, probably unavoidable, and potentially useful" (p. 1084).

Nevertheless, these examples of clinical writing are thought-provoking. In contrast to the way in which Sophie wrote about Jeremy, the analysts interviewed by Kantrowitz were writing during the course of the therapy, with the patient's consent, and the writing was being continually discussed between therapist and patient as a way of increasing understanding of the therapeutic process. Taking into consideration the reservations about this approach, it does come close to complying, at least partially, with one element of the *Declaration of Helsinki*; that the patient is being informed about the "outcome" of the "study" and the benefits of the "study" are being shared with the patient.

Conclusion

As this exploration has shown, publication of case material is complex and without hope of easy solutions. The examples described above indicate the potentially harmful consequences of not giving adequate attention to issues of consent and confidentiality. Yet such clinical material is essential to the training and ongoing professional development of psychotherapists. When considering publishing their clinical work, psychotherapists need to be mindful of the myriad of difficulties they might encounter, that these need to be carefully thought about, and that there is no "one-size-fits-all" solution to these difficulties. There is an increasing number of psychotherapist writers who advocate for asking the patient for consent to write, including some who suggest a collaborative writing process with the patient. This is certainly in line with current societal attitudes to informed consent, and may include benefits for the patient and for the therapy process. However none agree that this is *always* the right course of action to take. The therapist must decide whether to write with or without consent, and whether to write during or after the treatment. To aid in the decision-making process, a number of questions can usefully be asked:

1. Can the patient be adequately disguised? Is the patient (or the patient's relative, colleague, friend or acquaintance) likely to recognise himself/herself if they read the therapist's account of the work?
2. Can a composite case serve the same purpose?
3. Would anonymity be better preserved if a colleague was presented as the author of the work?
4. How little personal information can be included while still retaining the critical elements of the case?
5. How might publication affect the patient and other people in the patient's life?

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6. Could publication be helpful for the patient?
7. Could the preparation and publication of the material be a collaborative effort between the patient and the therapist?
8. At what point in therapy should consent be requested?
9. What might be the effect on the therapeutic relationship of asking for consent?
10. Can the patient actually give informed consent?

Psychotherapists who wish to publish clinical material also need to be able to bear the tension between their desire to further the practice of psychotherapy through sharing their work and the need to protect their patient and people associated with their patient. Most importantly, however, is a searching examination of one's own motivations for writing, and of the nature of the therapeutic relationship. I would suggest that this is the case whether the patient is still in treatment or the treatment has long since finished. Given that it is highly doubtful that true informed consent can ever be given by a psychotherapy patient, it befalls the psychotherapist writer to ascertain whether it is likely that the patient has/had enough confidence in the therapist and in their particular therapeutic process to tolerate being written about. A guiding question for considering this might be "what is the patient really consenting to?" The answer to this question is likely to be as complex as each person's individual history and relationship with their therapist.

We have seen that Sergei Pankejeff came to see himself as Freud's collaborator and spoke freely and at length about his analysis, including with the analyst, Muriel Gardiner, who after 50 years of contact with Pankejeff then edited his memoirs. In the case of Jeremy, he acknowledged initially feeling thrilled, moved and rather special in response to feeling that Sophie had accurately captured their work together. Although the experience of being written about was ultimately a painful one, Jeremy continued to view his therapist in an essentially benevolent light, and took care to focus on the benefits he had received from the therapy. Despite the difficulties endured by Gloria when the films were shown on television and at film theatres, she held Rogers in a special position and continued to correspond with him until her death.

Taking into account transference dynamics, issues of coercion, and the probable impossibility of informed consent, I would suggest that alongside this, in consenting, the patient is essentially saying that their experience of the therapist is such that they trust him or her enough to write about them. This calls for much integrity on the therapist's part to approach the consent and writing process in a respectful and sensitive manner, including being aware that it may have a lasting impact on the therapy and the therapy relationship.

When reflecting on the two patients who have mentioned my writing about them I notice a feeling of protectiveness towards them and trepidation about writing. Perhaps that is a good place to start.

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