The International Journal of Psychoanalysis

Int J Psychoanal (2012) doi: 10.1111/j.1745-8315.2012.00615.x

Informed consent as a prescription calling for debate between analysts and researchers[1]

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(Final version accepted 14 April 2012)

This article is a review of the international scientific literature on informed consent and its use in some of the constituent organizations of the International Psychoanalytical Association (IPA). Because psychoanalysis comprises a theory based on practice, the dearth of clinical material for study, training and research purposes is a serious problem for analysts. Supervisions, presentations at scientific societies and congresses, publications and teaching material involve patients to an extent that goes beyond the work done in their sessions. Should consent be requested in these cases? This contribution addresses controversial and long-standing issues such as informed consent and confidentiality, audio recording of treatments, knowledge production, the ambivalence of participating subjects over time and the perspective of analysts and patients respectively. The authors consider the various alternative approaches available for the handling of these ethical dilemmas without losing sight of the patient's dignity and personal rights, while also taking account of the position of the analyst.

Keywords: ethics, informed consent, psychoanalytic psychotherapy, research.

Introduction

Analysts' training and professional practice necessarily entail certain actions that concern patients to an extent that goes beyond the work in their sessions. Should their consent be sought when their material is used for supervisions, presentations, publications and research? The answer, it seems, is not simple.

The practice of psychoanalysis, understood as a social activity, is conditioned by its situational context (Campagno and Lewkowicz, 2007). Given this context, psychoanalysis has recognized that in the last decade it has become isolated from other disciplines and the developments that have taken place within them. This isolation, which is strongly bound up with the history of training in psychoanalytic institutes, impacts on knowledge production in psychoanalysis. This situation was first considered by Wallerstein (1978), who concluded that disagreements existed from the beginning on the appropriate relationship between the training of professionals competent in

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clinical practice, on the one hand, and progress in the science of psychoanalysis, on the other.

More than thirty years on from that study, the dichotomy persists. Luyten *et al*. (2006) described the situation as the existence of two cultures within psychoanalysis. Wallerstein (2005) and Green (2005), acknowledged champions of the respective cultures, nevertheless agree that the future focus of psychoanalysis will be on theoretical validation based on work with clinical material, although they disagree on the necessary methods. Apart from this consideration, the availability of material is itself a problem that must be taken into account. Michels (2000) notes the surprising imbalance between theory and clinical data in the psychoanalytic literature, and points out that more than 25 years ago Anna Freud drew attention to the dearth of documented and complete case histories. Other authors, such as Thomä (1993) and Hanly (2009), have also stressed the importance of these issues, maintaining that the source of psychoanalysis remains clinical practice. A survey of the psychoanalytic literature published between 1969 and 1982, conducted by the Scientific Activities Committee of the American Psychoanalytic Association, took as its sample the most frequently cited contributions from the Association's publications and failed to find a single case study (Klumpner & Frank, 1991). Tuckett (1991, quoted in Michels, 2000) notes that only 26 authors responded to the request by the *International Journal of Psychoanalysis* for the submission of clinical reports for publication in 1991.

In view of this, it is essential to inquire about the reasons for this situation. Certainly, these include consideration for patients and their intimacy, as well as reluctance to disclose the analyst's working practice. How should these issues be reconsidered in order to overcome the imbalance mentioned earlier? Will this inconsistency be perpetuated in training, or can it be overcome?

Alongside this reality, there is the debate on the right approach to the publication of clinical material. In their *Ethical Considerations in the Conduct and Reporting of Research*, the members of the International Committee of Medical Journal Editors (ICMJE, 2009) suggest that the informed consent of patients featured in case histories must be sought. Tuckett (2000) explicitly rejects the guidelines put forward by the International Committee of Medical Journal Editors (2009) as undesirable in the field of psychoanalysis, and wonders whether guidelines are necessary at all. If they are, Tuckett considers that the material must be disguised and opposes the idea of compulsory consent.

The notion of consent has its origins in clinical practice as well as research, and raises ethical issues in both (Leibovich de Duarte, 2000; Michels, 2000). With regard to research in which clinical material constitutes units for analysis, certain questions arise in the psychoanalytic community such as the need of recorded material and the requirement of informed consent, on the part of both patient and treating analyst. These conditions often threaten the feasibility of such projects, because analysts can access recorded material but not the request for consent.

This shows that introduction of the use of consent entails an action on the level of clinical practice. For this purpose, familiarization with the issue

is necessary. The literature addresses some of the issues involved in informed consent, the debate on which may be useful for both clinicians and researchers, and specifically for a review of their inclusion in training.

What is informed consent?

Informed consent is an ethical prescription that serves as a guiding principle in various professional fields, as the outcome of a moral concern with the basic human right of self-determination (Bennett, 2000).

There are a number of definitions of informed consent, each of which emphasizes certain aspects in accordance with the relevant context of application. In the clinical field, the definition used by the American Medical Association (AMA) reads in part as follows:

> Informed consent is more than simply getting a patient to sign a written consent form. It is a process of communication between a patient and physician that results in the patient's authorization or agreement to undergo a specific medical intervention.

In the field of research, on the other hand:

> Informed consent relates to the voluntary agreement of participants to be the subjects of a research project after receiving the relevant explanatory information from the researcher concerning the research and its procedures and the risks and/or benefits arising out of their participation in that research. Willingness and the capacity to understand what is requested of them are necessary requirements if persons are to agree to participate as subjects in a research project.
>
> (Translated from Leibovich de Duarte, 2000, 49ff.)

These definitions are the result of a century of work and experience. The principles of informed consent were laid down in the context of American medical practice in a landmark case dating from 1914: Schloendorf vs. New York Hospital Society (Bennett, 2000). The judge ruled that every human being of adult years and sound mind has a right to determine what shall be done with his own body, following a surgical procedure (extraction of a malignant tumour) carried out on a patient who had previously refused the operation.

Many years later, the Nuremberg Code (1947) was drawn up as a reaction to the inhuman research practices of Nazi scientists during the Second World War. Three basic tenets of the Nuremberg Code deal with the issue of informed consent:

(1) that voluntary consent is essential for human participants in research;
(2) that the human subject must be free to discontinue participation if desired; and
(3) that the principal investigator must be prepared to end the research procedures if there is probable cause to believe that continuation might result in the injury, disability or death of a human subject.

Shuster (1997) describes the influence of these principles of medical ethics and human rights during the half-century since their declaration. She explains that informed consent has been universally accepted and has,

together with the Helsinki Declaration (World Medical Organization, 1996), served as a model for the present-day regulation of research. The practice today is for professional organizations to lay down codes of ethics to govern professional activity (Leibovich de Duarte, 2006).

Within the professional field, a number of organizations in the various geographical regions have codes of ethics that require the informed consent of the patient. For example, before the commencement of psychotherapeutic and/or psychiatric treatment, the ethics codes of the Asociación de Psicólogos de Buenos Aires [Buenos Aires Association of Psychologists] (1993), the Asociación de Psiquiatras Argentinos [Association of Argentinian Psychiatrists] (1991) and the American Psychological Association (2010) suggest that their members should consider seeking informed consent from their patients. Psychoanalysts' professional bodies, too – for example the American Psychoanalytic Association (1983) in its *Principles and Standards of Ethics for Psychoanalysts* – call on analysts in training to consider requesting such consent. The International Psychoanalytical Association (IPA), in its *Ethical Principles and Implementing Procedures* (1998), while not specifically mentioning informed consent nevertheless sets basic ethical standards for IPA members, individual psychoanalysts and constituent organizations. These include the observance of humanitarian values, psychoanalytic principles and professional obligations to patients and the public.

Informed consent and audio recording of treatments

While some analysts make use of the audio recording of sessions, others object both to the procedure itself and to the associated request for consent.

Research in psychoanalysis requires systematized recording of clinical material in order for it to be studied. Technological progress has yielded a vital methodological advantage in the form of the audio recording of clinical material. This overcomes the limitations of the therapist's memory, to which all other forms of recording are subject (Wallerstein & Sampson, 1971).

Among psychoanalytic clinicians, authors such as Michels (2000) and Tuckett (1995), while acknowledging the quality of data obtained from recordings and verbatim transcriptions, present an initial argument for debate – namely, that if analysts' reports are abandoned, analytic understanding cannot be captured. This argument has been considered by the scientific community. Shedler (2002) notes that the effort to eliminate clinical judgement and inference has made psychological and psychiatric research not more scientific, but only more superficial. Lancelle (1998) points out that no one but a clinician can make critical observations and raise clinically based problems, and that only a clinician can supply the material on which research is to be conducted. Bucci and Maskit (2007) state that audio recording permits the sharing of the observations and differing perspectives necessary for scientific research. Szecsödy (2000) argues that the most important finding of the studies of Bachrach (1993), Kantrowitz (1993) and Wallerstein (1995) is in fact that neither experienced medical practitioners

nor sophisticated psychological tests can predict the outcome of treatments based solely on the study of the patient.

According to a second argument, the repercussions of recording on an analysis must be taken into consideration. Gabbard (2000) writes that a request by the analyst for patient consent will inevitably influence the subsequent course of the analysis.

As long ago as 1968, Gill *et al*. noted that a recorded analysis can in principle be a genuine analysis. Examining cases of recorded and unrecorded psychoanalytic processes, these authors found that the essential attributes of analysis were preserved in both situations (Simon *et al*., 1970). However, they were concerned that some unknown problem might emerge in the patient. Some years later, in 1988, Kächele *et al*. (quoted in Kächele *et al*., 2009) conducted an in-depth study of audio recordings as variables in an analysis. Their results confirm that this influence can be fruitfully recognized and worked on in its various manifestations. Recording then becomes part of the silent background.

For the sake of illustration, Kantrowitz (2005a) mentions the case of a patient who agreed with a senior analyst to embark on a treatment at very low cost in return for her permission to use her clinical material for research purposes and to make audio recordings of all her sessions. The patient said that this never bothered her and that, indeed, on two occasions when the tape recorder was not working, she felt that something was wrong: the recording was already part of the analytic setting, and her surprise when it was lacking could be deemed a dynamic effect.

However, there is no published evidence of any negative effects of recording, although possible risks have been addressed (Waizmann & Roussos, 2007).

As to the scarcity of audio-recorded clinical material, Szecsödy (2000) states that although a large number of psychoanalytic treatments have been recorded in the last 30 years, analysts nevertheless have powerful resistance to recording their sessions. Quite a few analysts nevertheless use this facility, which is occasionally employed for supervisions and also for the presentation of clinical material, as well as (albeit significantly less frequently) for research purposes. Yet patients are asked to give their consent much less frequently, perhaps because of the lack of debate on the subject, the form of any debate when it is discussed, and also the infrequent inclusion of clinicians in research teams. Lipton (1991) writes that, when a group of 15 senior analysts were asked whether they requested their patients' permission before using their clinical material for publications, seminars or teaching, the respondents were more or less evenly divided between those who did and those who did not seek consent. Oddly enough, the first analyst to respond asked not to be quoted as having given the response he would then provide. The author also cites some of the reasons why his colleagues chose not to seek consent for publication; these ranged from regarding patients as incapable of understanding the psychoanalytic literature to not having the courage to ask for fear of refusal. Among the analysts who did seek consent, only one case of refusal by a patient is reported.

Various rationalizations of the reticence to seek consent are expressed: 'the tape recorder is visible on the desk'; 'the sessions are for my personal

use only'; 'I don't work like that…', etc. What is involved here? According to Simon (1970), the request for patient consent has effects, regardless of whether it is for the purpose of presentations, publications and/or research. We contend that failure to seek consent will likewise have effects.

Some of the possible effects on the treatment process have been described, and those on the person of the analyst will now be addressed. Gill *et al.* (1968) consider that the effects of recording on the analyst are more pronounced and important than those on the patient. In a later study (Simon *et al.*, 1970), these authors infer a connection between this finding and the dearth of recorded sessions. Lancelle (1998) suggests that the effects on analysts should be seen as emotional issues on their part linked to the sense of shame, which have unconscious roots and come to the fore when their work is divulged to a wider public. Gill *et al.* (1968) describe various authors' reports of the experience that therapy cannot be carried out without mistakes, and state that some therapists are not prepared to disclose these and to risk gaining or losing the respect of the colleagues who might listen to the recordings. Both Roose (1960) and Knapp *et al.* (1966) hold that, while irrational reactions cannot be eliminated, they can certainly be analysed.

On the basis of the previous paragraph, it may be inferred that training is the best place to contend with these issues: not only because it allows the difficulties of this work to be addressed together with colleagues, but also because it permits integration of the various perspectives afforded by the study of clinical material, on the basis of different levels of observation such as those suggested by Thomä & Kächele (1993). A good example is the approach of Bucci & Maskit (2007), based on their finding that linguistic measures in the study of psychotherapeutic processes are consistent with psychoanalytic clinical classifications. According to Schachter & Kächele (2011), research on the process of psychotherapy has now passed to a new generation.

Informed consent and confidentiality

Respect for the confidentiality of patient information and its records (IPA) is an ethical obligation that is incumbent on every psychoanalyst. Garvey & Layton (2005) consider the problems of confidentiality arising as a result of psychoanalytic practice. Their study constitutes the outcome of work by psychoanalytic societies in seven countries in different geographical regions, reviewed by an IPA supervising committee. All share the following two principles: firstly, those in possession of confidential information within an organization or team are required to observe confidentiality in the same way as the treating analyst; and secondly, where material is disclosed to a wider public – for instance in publications, research and examinations – patient data must be anonymized.

Attention should, however, be drawn to certain exceptions noted in various countries in Europe, North America and Latin America, where the current study was conducted. Here, from our perspective, an issue beyond the scope of this contribution arises and calls for examination: the conflict between professional practice and the legal system. Consideration should perhaps

also be given to the professional practice of analysts belonging to each local institutional culture and how it does or does not reflect the relevant institution's code of ethics.

Within the Latin American region, mental health teams in Brazil must obtain informed consent before sharing clinical information on a patient. No information can be shared with the rest of the team unless this requirement of confidentiality is satisfied (Garvey & Layton, 2005). In North America – more specifically, the USA – a privacy law allows the disclosure of information obtained by analysts to other professionals who are also involved in the treatment of that given patient. Professional standards nevertheless require that consent be sought before such disclosure (*ibid.*). In Europe, and particularly in Germany, actual practice also proves to be stricter than the law. The latter permits the extension of the duty of confidentiality to the team, whether in professional discussions, training organizations or supervisions, although a distinction is made in the case of examinations and supervisions according to audience size. With a large audience the rules of anonymity apply, whereas the principle of confidentiality is extended to a small group of examiners or supervisors. However, at a professional level, failure to obtain informed consent would be deemed an infringement of confidentiality (*ibid.*).

Szecsödy (2000) explains that, in the view of Freud, Stein, Lipton, Goldberg, Gabbard and others, the analyst's obligation to protect patient confidentiality always prevails. Leibovich de Duarte (2006) identifies Freud as a pioneer in addressing these matters, drawing attention to his caution in revealing intimate details of his patients that might lead to the disclosure of their identity. However, Szecsödy (2000) argues that there is an even more fundamental ethical obligation: that of respect for patient autonomy. Szecsödy also points out that the analyst has no right to violate patient confidentiality unless the patient so consents, and holds that Freud was fully aware of this hierarchy. In a note added to the Dora case history in 1923, Freud stated that, in the case of Little Hans (1909), the boy's father authorized and gave his consent to publication. In that of the Wolf Man (1919), the patient not only consented to publication but also insisted on it (Leibovich de Duarte, 2006; Simon *et al.*, 1970). An important point is that patients do not always give their consent when requested (Kantrowitz, 2004a). Simon (1970) argues that this is the best proof of genuine autonomy. Both acceptance and refusal by the patient may be used defensively, as may any other aspect of reality or technique in a normal analysis (Gill *et al.*, 1968).

Study of a patient's psychoanalytic process outside the sessions is another aspect of the presence of a third party and the risk to confidentiality, both from the legal point of view and in terms of institutional codes of ethics. A number of authors have considered this problem, which is of vital importance to the professional practice and training of psychoanalysts, to research and to the publication of material. A wide range of opinions are expressed. While some emphasize the possible loss of trust between patient and analyst, others deny that trust is guaranteed by the formal criterion of confidentiality, pointing out for the sake of comparison that neither the frequency of

sessions nor the use of the couch guarantees the analytic situation (*ibid.*). Some insist on absolute confidentiality, deeming the presence of a third party to be an intrusion, while others hold that this position reflects a difficulty on the part of some analysts involving self-concealment and a rationalization of reluctance to disclose what they do (Goldberg, 2004; Kantrowitz, 2005a).

Apart from the divergent arguments, some of the issues raised allow the subject to be taken further. One of these concerns is the intended audience (Furlong, 2005), while a second consideration is that writing about clinical material is equivalent to the introduction of a third party, given that a triadic structure is inherent in healthy development. With a gradual and sensitive approach, it should be possible to inform patients of the fact of writing and publishing material about them (Gerson, 2000). A third view (Pizer, 2000) is that the presence of a third party can supply a sense of containment and security, because not only the analyst but also the professional community is aware of the analytic exchanges.

Lastly, Kantrowitz (2005a) points out that, whereas analysts who are authors often take a more positive view of an external observer, the relevant meanings are not at all consistent. In Kantrowitz's opinion, patients' reactions to a request for consent are bound up with various issues, some of them transference-related and others involving intrapsychic conflicts, as well as reactions to the analyst's real characteristics and behaviour. Similarly, Lipton (1991), in a contribution on confidentiality including three clinical cases, notes that patients' attitudes to the public use of their material differed according to their individual psychology.

Kantrowitz (2005a) reports the reactions of 11 patients to reading or hearing clinical material published about themselves. These subjects volunteered spontaneously for the study and spoke about their thoughts and emotions concerning the relationship with their analysts and what happened when their case histories were published. The majority (six) reacted favourably; only two responded negatively; three reported an ambivalent mixture of feelings about the situation. As a rule, the negative feelings were concerned with a sense of not being respected as a patient, a lack of empathy in referring to them, the making of value judgements, comparisons with other patients, or the giving of interpretations not communicated at the relevant time during the analysis. According to the author, the negative reactions fell within a wider general context, in which the publication was unlikely to have been the only issue. Considered in this way, the dissatisfaction with the publication belonged within a wider dissatisfaction with the treatment itself. As for the positive reactions, these concerned the analyst's interest in the patients as reflected in the choice of their cases, which sometimes made the patients feel flattered and special on account of the extra time the analyst devoted to them outside their sessions. Another positive aspect was the knowledge that one's clinical material might be useful and beneficial to others. With regard to the context of the treatment and the publication of the clinical material, "patients' seeing the same empathy in writing that has been experienced in treatment is also seen to enhance their

sense of trust in the analyst's genuine care for them" (Kantrowitz, 2005a, p. 124).

Informed consent and knowledge production

Although this subject has been debated since psychoanalysis was first considered to be in crisis, Schachter & Kächele (2011) make an important point with their description of the lack of representation of psychoanalysis in universities, the decrease of subscriptions from university libraries to subscribe to psychoanalytic journals, the dearth of attention to psychoanalysis in psychiatric texts, and less interest on the part of publishers in bringing out books on psychoanalysis. These authors state that empirical research holds out the best hope of re-establishing respect for psychoanalysis and its efficacy as a treatment, because such research allows the principles of both theory and practice to be tested in a manner acceptable to the scientific community.

With regard to this powerful demand for knowledge production, some dissenting voices are heard; for example, Gabbard (2000) presents the analyst as confronted by a conflict of interest between the patient on the one hand and the needs of science and professional training on the other. Once again, the conflict in the training institutes mentioned by Wallerstein (1978) is found to persist today.

A comment by Michels (2000), together with the different interpretation of it by Szecsödy (2000), illustrates what each considers important in candidate training in terms of extra-analytic interests: "we should disapprove of analysts who have no analytic interests other than the analysis of their analysands. They are practitioners, but not professionals, since they fail to contribute to their colleagues or to future patients" (Michels, 2000, p. 364; Szecsödy, 2000, p. 401). These authors clearly demonstrate their differing approaches to training and the persistence of the conflict mentioned earlier. The former notes the importance of taking extra-analytic interests into account, describing them primarily in terms of professional competence, the personal vicissitudes of candidates in presenting a case, in their construction of the case and selection of vignettes, in what they reveal of themselves and of their participation in the analysis in so doing. The latter considers extra-analytic interests mainly in terms of the progress of psychoanalysis as a science, producing research to document the value and efficacy of psychoanalytic treatment and with a view to deepening dialogue with other disciplines.

Gabbard (2000) also addresses the matter of professional interests, with regard not to research but to publications. In his opinion, many analysts hasten to accept without further ado the patient's agreement to the publication of clinical material because they feel guilty about the manifest personal interest involved in it, given that it makes for recognition and personal advancement. Gabbard considers that analysts feel secretly ashamed of exploiting their patients' trust in them. From this point of view, it is appropriate to wonder how one ought to proceed, because it is quite possible that the publication of patients' material without seeking their consent might also make analysts feel ashamed. The probable effect on an analyst who

allows his work to be studied by others was considered by Gill *et al*. (1968), who emphasize the intense gratification afforded to both participants by the analytic situation. These authors explain that the analyst will have to forgo some of these gratifications and, furthermore, face the type of criticism that only an analyst can direct at another. Furlong (2006) makes another suggestion as to how to address possible clinical consequences: consulting a colleague for assessment of the potential effect on patients of what the analyst might be unconsciously communicating in the process of writing and in the request for consent.

Informed consent and the patient's ambivalence over time

The debate concerning the request for informed consent centres on the very possibility of such a request in the analytic situation, given the influence of the transference on the patient's decision (Gabbard, 2000). Kantrowitz (2005a) points out that the fact of writing about patients may influence their representations of themselves and of their analyst, as well as their reactions to the analysis itself.

In this connection, it is important to consider the way in which each therapist introduces the question of consent into his or her analytic practice and to try to minimize the time in which the transference might unfold before seeking consent. A possible alternative is to include consent as a part of the setting of the preliminary interviews, or to provide for it in accordance with the patient's analysability as indicated by these interviews (Etchegoyen, 1991; Braconnier *et al*., 2006). Again, account must be taken of the analyst's interest in a given type of approach (Berenstein & Puget, 1997). According to Lipton (1991), the best time to seek consent, from the legal perspective, is at the beginning of the analytic process. However, this might affect the subsequent course of the analysis, for example by inducing the patient to hold back important information. On the other hand, Lipton states that requesting consent well after termination might also have certain disadvantages, although this does not in his experience do any significant harm to patients. It is quite likely that patients who have given consent at a certain point may themselves change their minds during the course of the analysis or after termination.

Another issue raised by Gabbard (2000) concerns ways of allowing for patients' ambivalence towards the request for consent to publish material on their case. Certain considerations might be helpful in this respect. Lipton (1991) suggests giving patients time to process the information about the request for consent; ideally, they should not be consulted on the fait accompli of a completed manuscript, but instead asked about the idea of its future composition, to be undertaken if they agree. He also mentions the importance of the manner in which consent is requested and the form in which the report is written. Writing in the knowledge that the patient will read what is being written has, or should have, a direct effect on how we use language, which must be precise and exact in order to convey clearly what it is desired to communicate, while at the same time being respectful of and non-traumatic to the patient. Lastly, it may be appropriate to discuss the clinical

material with the patient prior to its publication, with a view to working on and diminishing any possible effect its publication might have on the patient's analysis or life.

Apart from the way in which consent is sought and the differences resulting from the specific point in an analysis when it is requested, it is important for patients to be able to rescind their consent at any time if they so wish.

Informed consent and the perspective of analysts and analyst-patients

An issue that is naturally bound up with research is that of analysts' attitudes and practices when writing about their patients. In a series of contributions, Kantrowitz (2005a) explored patients' reactions and analysts' ideas on this subject. The author conducted a study involving analysts from all over the world who had published material about their patients in the *Journal of the American Psychoanalytic Association* (JAPA) and the *International Journal of Psychoanalysis* (IJP) in two separate periods: 66 authors who published between 1995 and 2001 and 43 between 1977 and 1981 were interviewed. In the first period, 70% of respondents resorted only to disguise when writing about their patients. The analysts in the later group were almost equally divided between those who sought consent and those who merely disguised. In the author's view, the standard approach changed over time; the attitudes of both patients and analysts were influenced by what was seen as current practice.

Kantrowitz (2005b) considers that certain important points are raised by the reported experience of analyst-patients on reading what their own analysts wrote about them. It cannot be assumed that analyst-patients will necessarily feel anxious if their analyst writes about them without permission. When disguise was seen as the norm, fewer patients appear to have felt anxious or distressed by this situation. At present, given the worldwide focus on patients' rights, and especially where analysts in training are concerned, the idea that one's analyst might write about one without permission is not so readily accepted. According to the interviews reported in Kantrowitz's article, it is increasingly common for patients to be asked for permission, for what is written about the course of the treatment to be shown to them, and for views to be exchanged on possible amendments and the elimination of material that they would prefer not to appear in print. The author explains that this does not mean that analyst-patients might change their minds with the passage of time. There is every indication that this will depend on the specific patient and the specific patient–analyst dyad.

Informed consent in training

Michels (2000) highlights some of the vicissitudes commonly observed in the presentation of clinical material during training in the societies affiliated to the American Psychoanalytic Association (APA). He points out that the analyst's words are not quoted verbatim, in the same way as those of the patient usually are. He also notes that, although candidates present their cases for the

purpose of learning, they wish to be appreciated by their teachers and fellow trainees and to avoid criticism and humiliation. Lastly, he quotes Kavka (1974), who describes the self-consciousness and shame of analysts in training even when their presentations have been sufficiently good. According to Kavka (quoted in Michels, 2000), this fact calls for explanation.

An important point made by Michels (2000) concerns the way in which candidates learn what to say and what not to say in a future case – that is, they learn to say what is deemed correct in order to secure approval, whereas this may feel somehow dishonest. According to Michels, this feeling may persist for years, and might help to explain the disappearance of case histories from our literature.

Once again, the problem of training mentioned by Wallerstein (1978) calls for reconsideration in terms of its ultimate purpose. Will it remain impossible to change established practice? Or will it be possible to include the scientific aspect of the profession in training? Will it be possible to contend with new difficulties arising instead of reproducing the established ones? In a recent contribution, Schachter & Kächele (2011) draw attention to the sterility of the debate on the epistemological status of systematic empirical research versus case studies, and point out that each method has a different type of knowledge in view or a different purpose.

Discussion and conclusions

On the basis of the arguments adduced concerning the request for consent, a number of issues have been addressed, indicating that analysts must consider their position seriously before deciding how to proceed in their clinical practice. These matters affect who one is as an analyst, how one thinks of oneself and of one's patient, and thus challenge one to reflect on one's contribution to knowledge production.

The dearth of clinical material may be the result of a range of factors. These certainly include consideration for patients and their intimacy, as well as disclosure of the analyst's approach to his or her colleagues. Will this inconsistency be perpetuated in training or can it be overcome? Again, if it can be overcome, how is this to be achieved?

As stated, once an analyst has requested a patient's consent, this will necessarily affect the subsequent course of the analysis. Regardless of the form of informed consent, and whether sessions are recorded or only the person of the analyst is present, however much one seeks to neutralize these influences they will always have some repercussions on the subjects of analysis – namely, the patients. Yet they remain valuable tools both for the analysis of patients and for the training of analysts.

The possible negative effects on the patient of seeking consent are usually considered in terms of theory. However, Kantrowitz (2005a) and Lipton (1991) also furnish evidence of other – positive – effects, such as the patient's perception of being in the hands of a professional who consults him or her on a decision with thoroughly ethical implications, the sense of the importance of the patient's analysis in that it might help others in a sim-

ilar situation, or even the feeling of collaborating in the process of knowledge advancement.

On the other hand, a request for consent involves action on the part of the analyst, and from this point of view can be deemed a part of the frame. This will differ as between a private patient and one seen in an institutional framework. A possible alternative might be for the community care centres attached to psychoanalytic institutions to inform clients and ask them if they wish to participate in the institution's research. If they agree, they must be given a clear and simple explanation of the aims of the research in which they are being asked to take part. This would eliminate at least an initial stumbling block: the treating therapist would not be involved in the request for consent, so the issue of authority and the transference relationship would not arise. However, this would of course entail a commitment on the part of institutions to the conduct of research and to a different approach to this traditional problem in psychoanalyst training.

With regard to requests for consent to the publication of clinical material or its presentation at scientific centres and/or congresses, some institutions in Argentina (such as the teaching hospitals) give patients a written statement of the rules governing treatment when they are admitted, in effect constituting a setting in which it is stated explicitly that clinical material may be used in one of these potential situations. It is at this point that patients sign their consent form. All professionals in the institution's teams who come into contact with this material are likewise subject to the same duty of confidentiality as the treating analyst, patients' anonymity being safeguarded (Garvey & Layton, 2005). In these cases, given that the institutions concerned are teaching hospitals, consent to the likely presentation of clinical material is usually a condition for commencement of a treatment or diagnostic evaluation.

On the other hand, in the case of private patients and in accordance with the view of Gill *et al*. (1968), confidentiality can be construed in terms of its meaning for patient and therapist in their work together – that is, in terms of the trust that the patient may place in an analyst who shows himself or herself to be worthy of it. A firmly grounded analyst–patient relationship can withstand the possible vicissitudes of both recording and consent to the publication of material during the course of an analysis. With regard to the experiences reported by Lipton (1991) and Kantrowitz (2005a), it is vitally important not to lose sight of the aspect of care for the patient, as manifested in extremely cautious and respectful language that reflects an empathy with the subjective experience of each patient and is neither artificial nor purely technical. Pre-publication discussion is another valuable example of co-construction of the material to be presented, which may or may not give rise to amendment by the patient, thus minimizing the risk of potential negative reactions and even possibly having positive consequences.

With regard to the training of competent professionals, the only way of achieving this objective, as Wallerstein (1978, 2005) and Green (2005) contend, appears to be theoretical validation on the basis of clinical material. If the source of psychoanalysis is clinical practice, how is the approach to work and research to be transmitted to candidates and/or analysts in train-

ing in a clear didactic manner without infringing patient privacy? Is it sufficient today to anonymize information and to use disguise in a clinical vignette? This is evidently a serious dilemma, because it highlights the enormous inconsistency between the intentions and requirements of training a good professional on the one hand and what can feasibly be done to arrive at a complete study of clinical material on the other. As far as analysts themselves are concerned, the meaning of exposing their work to view varies considerably. A position must nevertheless be adopted on this point in order to overcome the inconsistency perpetuated in training and in psychoanalytic knowledge production. However, unless the local institutional culture so allows, it will be virtually impossible to consider candidates in training and their position in terms of interest in their first patients, the study of those patients' material, and the possibility of research and even of publication.

In view of the opposing indications presented in this contribution on the use of informed consent, analysts who wish to engage in research must consult their institutions' codes of ethics, while also considering how to proceed in order to contribute to the development of psychoanalysis as a science without placing their work with their patients at risk. The key to achieving the necessary change probably lies in recognizing the importance of debating and thinking about the subject in a climate designed to integrate the criteria of professional training and the production of scientific knowledge, in both training institutions and the local institutional culture.

What, then, would be the effect of consent and the recording of clinical material if this were established training practice? There might be an attenuation of the feeling that one needs to say what one thinks one ought to say in order to gain approval or to convey a good image to colleagues. What was said was what could be said, and it cannot be altered. Clearly, issues of professional ego often limit self-exposure when giving an account of one's work as an analyst, possibly giving rise to feelings of shame or fear of a negative evaluation by one's peers if clinical material of one's own is presented. Sometimes the factor preventing access to clinical material is that it is impossible for the analyst to ask for consent; wishing but being unable to do so may cause one to forgo this valuable source of information and learning. However, given the current debate on consent, the matter is bound to arise when working with clinical material, especially for younger analysts and candidates.

Lastly, it is important to note that consent is a conscious manifestation on the part of a patient and that, as Leibovich de Duarte (2006) writes, the focus on unconscious mental processes introduces an element of complexity that must be considered. Here again, the analyst/researcher must be prepared to call a halt to the research if there is any likelihood of harm to the patient. Therefore, it is essential to bear in mind the principle of informed consent mentioned earlier as point 2 of the Nuremberg Code: *that the human subject must be free to discontinue participation if desired*. This limitation is inherent in any intervention by a profession as sensitive and intimate as the psychotherapy or psychoanalysis of human individuals. This uncertainty will persist in psychoanalysts who engage in research

throughout their work, and must be accepted by them as honest, ethical professionals.

The arguments presented in this article demonstrate its authors' belief that, in terms of the human dignity of patients as free and autonomous subjects, informed consent is their right, as well as an obligation incumbent on researchers and analysts. The present-day emphasis on human rights may facilitate a reconsideration of the use of consent from the stage of training onwards. As we know, Freud was able to revise his views over the course of time, and it is desirable for his example to be followed in the training of professionals; by the establishment of a new institutional culture in which the seeking of consent and the production of scientific knowledge are standard practice.

Translations of summary

Die Frage der Einverständniserklärung als Voraussetzung erfordert eine Debatte zwischen Analytikern und Forschern. Dieser Aufsatz gibt einen Überblick über die internationale wissenschaftliche Literatur zur Frage der Einverständniserklärung und ihrer Anwendung in einigen der konstituierenden Organisationen der International Psychoanalytical Association (IPA). Da die Psychoanalyse aus einer auf der Praxis beruhenden Theorie besteht, ist der Mangel an klinischem Material zu Untersuchungs-, Ausbildungs- und Forschungszwecken für Analytiker ein beträchtliches Problem. Supervisionen, Präsentationen bei wissenschaftlichen Gesellschaften und Kongressen, Publikationen und Lehrmaterial drehen sich um Patienten sowie die Arbeit, die in ihren Sitzungen durchgeführt wurde. Sollte in diesen Fällen eine Einverständniserklärung der Betroffenen eingefordert werden? Dieser Beitrag beschäftigt sich mit umstrittenen und seit langem bestehenden Problemen wie Einverständniserklärung und Schweigepflicht, Tonaufzeichnungen von Behandlungen, Erkenntnisgewinnung, der Ambivalenz der teilnehmenden Personen im Verlauf der Zeit und der jeweiligen Sichtweise der Analytiker und der Patienten. Abschließend betrachten die Autoren die verschiedenen alternativen Ansätze für den Umgang mit diesen ethischen Dilemmata ohne dabei die Sicht auf die Würde und die Persönlichkeitsrechte des Patienten zu verlieren, während gleichzeitig die Position des Analytikers in Betracht gezogen wird.

Consentimiento informado como prescripcion a debatir entre analistas e investigadores. Este trabajo es una reseña de la literatura científica internacional sobre el consentimiento informado y de su uso en algunas de las organizaciones que forman parte de la Asociación Psicoanalítica Internacional (API). Como el psicoanálisis consiste en una teoría basada en la práctica, la escasez de material clínico que pueda ser utilizado para el estudio, la formación y la investigación constituye un problema serio para los analistas. Las supervisiones, las presentaciones en sociedades científicas y congresos, las publicaciones y el material de docencia involucran no solo el trabajo realizado en las sesiones, sino también a los pacientes mismos. ¿Debería solicitarse su consentimiento en estos casos? Esta contribución se ocupa de cuestiones controvertidas que se vienen discutiendo desde hace mucho tiempo, tales como el consentimiento informado y la confidencialidad, la grabación de tratamientos, la producción de conocimiento, la ambivalencia de los sujetos participantes con el correr del tiempo y la perspectiva de analistas y pacientes. Para concluir, los autores consideran los distintos enfoques disponibles para manejar estos dilemas éticos sin perder de vista la dignidad y los derechos personales de los pacientes y, a la vez, tomando en cuenta la posición de los analistas.

La nécessité du consentement éclairé: un débat entre analystes et chercheurs. L'auteure de cet article passe en revue la littérature sur le consentement éclairé et son usage au sein des organisations qui constituent l'Association psychanalytique internationale (API). Dans la mesure où la psychanalyse correspond à une théorie fondée sur une pratique, le manque de matériel clinique pour l'étude, la formation et la recherche pose un véritable problème aux analystes. Les supervisions, les communications présentées au sein des sociétés scientifiques et des congrès, les publications et le matériel utilisé pour l'enseignement impliquent les patients et le travail fait en séance. Leur consentement devrait-il être requis ? Cet article traite de quelques unes de ces questions qui de longue date nourrissent nos polémiques, par exemple: le consentement éclairé et la confidentialité, l'enregistrement des séances, la production du savoir, l'ambivalence des protagonistes sur le long terme et enfin, la position respective des analystes et des patients. Pour conclure, l'auteure examine les différentes conceptions qui pourraient nous aider à résoudre ces dilemmes d'ordre éthique, en préservant à la fois la dignité et les droits du patient et la position de l'analyste.

Il consenso informato come requisito: una questione da dibattere fra analisti e ricercatori. Questo lavoro passa in rassegna la letteratura scientifica internazionale sulla questione del consenso informato e il modo in cui viene usato in alcune delle organizzazioni che appartengono all'Associazione Internazionale di Psicoanalisi (IPA). Poiché la teoria psicoanalitica si fonda essenzialmente sulla prassi, la mancanza di materiale clinico per lo studio, la formazione e la ricerca costituisce per gli analisti un serio problema. Le sedute di supervisione, le presentazioni a società scientifiche e congressi, le pubblicazioni e il materiale didattico coinvolgono il paziente in un modo che va oltre il lavoro svolto durante le sedute di terapia. In questi casi, sarebbe allora opportuno valutare se sia necessario richiedere il consenso dei pazienti in questione. Questo lavoro affronta controversie e annose discussioni : dal consenso al segreto professionale, all'audioregistrazione delle sedute, alla divulgazione di casi, all'ambivalenza dei soggetti partecipanti nel corso di una ricerca, alla necessità, infine, di considerare sia la prospettiva dell'analista sia quella del paziente. L'autrice conclude poi considerando i vari approcci alternativi a disposizione per la gestione di questi dilemmi etici, senza perdere di vista la dignità del paziente e dei suoi diritti personali e tenendo conto al tempo stesso delle esigenze dell'analista.

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