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Writing About Psychiatric Patients: Guidelines for Disguising Case Material

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Abstract: The author addresses the need for guidelines for mental health professionals to follow when writing about psychiatric patients for publication or presentation. Clinician-writers who follow such guidelines may be better able to disguise case material to protect patients' rights of privacy and confidentiality, reduce the likelihood of compromising treatment, and lessen the probability of litigation against the authors, their employers, and their publishers. (Bulletin of the Menninger Clinic, 50, 511-524)

Discussions of ethics in medical and scientific writing usually center on giving credit for quotations or citations of the writings of others (e.g., Day, 1983). Clinician-writers may also be chided about the importance of originality and of copyright considerations. Although such discussions may focus on the patient's right of privacy and on the confidenti-

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ality of clinical communication, they seldom give particular advice on how to disguise information about the patient in such a way that the case presentation and the discussion of symptoms and treatment retain integrity while the patient remains anonymous.

In light of the frequency with which case material is reported in the psychiatric and psychoanalytic literature, one might assume that sufficient attention had been given to the matter of *how* to disguise it. Yet a search of the literature turned up only a few references to the matter of disguising (American Psychiatric Association, 1957/1984; American Psychological Association, 1986; Davidson, 1957; Day, 1983; Del Rio, 1980, 1985; Freedman, 1980; Hewitt, 1957; Klemmer, 1967; Kramer, 1967; Mott, 1986; Slovenko, 1983).

Professional organizations and writers in the mental health field express much concern about protecting patient confidentiality, but offer few specific suggestions for how to disguise case material.

It is essential to make any necessary modifications of the history to protect the privacy of the patient. Patients' names or initials should not be used and if the patient is likely to be identified for any reason, the clinically insignificant details of the history should be changed to disguise the identity of the patient. (Mott, 1986, p. 2)

Two of the largest professional organizations for those in the mental health field, the American Psychiatric Association and the American Psychological Association, have ethics statements that advocate protecting the privacy of patients. "Clinical and other materials used in teaching and writing must be adequately disguised in order to preserve the anonymity of the individuals involved" (American Psychiatric Association, 1973, p. 1063). Various interpretations of this principle have extended the mandate "to disguise" to those with whom the primary caretaker may consult (American Psychiatric Association, 1973), and have encouraged sacrificing "some scientific accuracy for the sake of preserving privacy" (American Psychiatric Association, 1979, p. 23) or obtaining informed consent for publication from the patient (American Psychiatric Association, 1979). The American Psychological Association (1985) states:

Psychologists have a primary obligation to respect the confidentiality of information obtained from the persons in the course of their work as psychologists . . . Information obtained in clinical or consulting relationships, or evaluative data . . . is discussed only for professional purposes and only with persons clearly concerned with the case.

Written and oral reports present only data germane to the purposes of the evaluation, and every effort is made to avoid undue invasion of privacy . . . Psychologists who present personal information obtained during the course of professional work in writings, lectures or other public forums either obtain adequate prior consent to do so or adequately disguise all identifying information. (p. xxix)

An even more stringent statement of patients' rights was adopted in principle by the World Psychiatric Association in 1977.

Whatever the psychiatrist has been told by the patient, or has noted during examination or treatment, must be kept confidential unless the patient releases the psychiatrist from professional secrecy . . . To increase and propagate psychiatric knowledge and skill requires participation of the patients. Informed consent must, however, be obtained before presenting a patient to a class and, if possible, also when a case history is published, and all reasonable measures be taken to preserve the anonymity and to safeguard the personal reputation of the subject. (cited in Del Rio, 1980, p. 3217)

Such ethical guidelines as these are modeled after those of the American Medical Association, which are historically based on the Hippocratic oath (Del Rio, 1985; Freedman, 1980). On the one hand, they emphasize strict adherence to confidentiality; on the other, they point out the treater's responsibility to "study, apply and advance scientific knowledge" (American Medical Association, 1981, p. ix).

On the whole, the issue of how to protect a person's right to privacy in what is written about that person may be best addressed by newspaper policies for avoiding libel and invasion of privacy (Powell & Angione, 1977). Yet the issues of privacy and confidentiality should be of prime concern to all clinicians who write about their work with patients, because discovery by a patient or a patient's family of unauthorized and undisguised—or minimally disguised—material written about the patient can cause embarrassment to all parties concerned, and may damage an ongoing or completed treatment process.

No less important, in the current litigious atmosphere, are the possible legal ramifications of violating a patient's trust. While information written about a patient may not be libelous (i.e., false), it may result in legal action taken for invasion of privacy, a right long recognized by the U.S. courts.

The makers of our Constitution undertook to secure conditions favorable to the pursuit of happiness. They recognized the significance of a man's spiritual nature, of his feelings and of his intellect. They knew that only a part of the pain, pleasure and satisfactions of life are to be found in material things. They sought to protect Americans in their beliefs, their thoughts, their emotions and their sensations. They conferred, as against the government, the right to be let alone—the most comprehensive of rights and the right most valued by civilized men. (Olmstead v. United States, 277 U.S. 438,478, cited in Powell & Angione, 1977, p. 259; italics added.)

In addition to claiming invasion of privacy, a patient who disputes the truth of what has been written about him may allege libel* as cause for a civil lawsuit. Although the truth of what is said or written is the strongest defense against allegations of libel, few mental health professionals would gain from being defendants in a libel lawsuit—particularly when it is joined with the accusation of having violated patient privacy and confidentiality.

This growing "doubt about the legal or ethical limitations . . . [of] making a disclosure about a patient" may indeed produce "a chilling effect on publication" (Slovenko, 1983, p. 110). Rather than inhibiting clinicians who write, however, awareness of the problem could lead them to focus greater attention on how to disguise case material. Unlike medical practitioners, who can write with impunity about the treatment of skin cancer or the techniques used in open-heart surgery, mental health practitioners must be concerned about disguising the identity of their patients because of the very nature of their work with people whose illnesses are intertwined with the fabric of their lives. The characteristics of some mental illnesses may be generalized, but a case report focuses on the specific manifestations of the illness and the course of its treatment in the day-to-day life of a unique individual.

In all likelihood, presentations of case material that may violate patient confidentiality or privacy do so inadvertently. Some clinician-writers may overlook the possibility that the patient may discover the paper because it is but a brief professional report (about an unnamed patient) that will be published in a scholarly journal with a limited circulation. Other mental health professionals may naively assume

*Libel has been defined as "injury to reputation" (Powell & Angione, 1977, p. 251), or defamation of character. Libelous material includes "words . . . that expose a person to public hatred, shame, disgrace or ridicule, or induce an ill opinion of a person" (Powell & Angione, 1977, p. 251).

that their purity of purpose exonerates them from violations of patient confidentiality and justifies their revelations of intimate details about their patients' lives.

Even if what an author prints about a patient is harmless, the author must take every precaution to obscure the patient's identity . . . Initials of patients should not be printed. Even a hospital case number may be known to the patient or to a relative who works in the hospital.

Suppose, moreover, a report of a case starts thus: "An Armenian merchant from Littletown entered Blank Hospital, New York, complaining of thus and so."

If there is only one Armenian merchant in Littletown, the author of that report has, to all intents and purposes, exposed the private concerns of his patient. (Hewitt, 1957, p. 87)

In any writing that includes material about a patient, the patient's best interests should carry greatest weight. When the question arises of whether to seek a patient's written permission to write about his illness and treatment, several factors should be considered. What implications would there be for the treatment relationship, if the patient, at any point, comes to believe that his right to privacy and confidentiality has been violated by the clinician, or that the treatment is secondary to the clinician's desire to publish what he has written? If a clinician hesitates to discuss with a patient his intent to write about the treatment, could it be because he himself harbors unconscious doubts about the suitability of doing so?

Of course the clinician can always argue for disguising the case rather than discussing it with the patient. To disguise may be easier than to seek—and obtain—permission. If the clinician is no longer in contact with the patient, or wishes to avoid subjecting the patient to a reexperiencing of previous trauma, or believes that the patient may arbitrarily deny permission, then disguising the case material is undoubtedly the best approach. The clinician may decide that he has sufficiently altered the details of the case, and that there is no need to broach the subject with the patient. To protect patients in such instances, the clinician should strive to make the presentation unrecognizable to them. Although a patient might wonder whether he is the subject being described, significant differences between the two could make identification improbable.

In Philip Roth's novel, My Life as a Man, a patient while in the waiting room of his psychiatrist's office opens a magazine and is upset on discovering an article written by the psychiatrist. It's about him! The patient's identity was changed from Jewish to Italian, but that was not much of a disguise. (Slovenko, 1983, p. 110)

Thoroughness of disguise should be the writer's goal.

When it is desirable or necessary to obtain a patient's permission, a formalized authorization form should be used. At The Menninger Foundation, a Patient/Client Release Form* has been developed recently. A variation of this form is used when the patient is a minor. Previously, the authors of papers to be published in the Bulletin of the Menninger Clinic were held accountable for the wording and format of any necessary releases. The more formalized release now in use streamlines and standardizes this process. However, even with such permission, the case should be disguised as much as possible, a process that journals implicitly or explicitly delegate—and appropriately so—to authors, as the *Bulletin of the Menninger Clinic* does through its Copyright Transfer Form.*

On occasion, clinician-writers may want to disguise identifiable descriptions of other real people who appear in case presentations. As well as avoiding or eliminating pejorative comments, or downplaying descriptions of negative traits or behaviors that may be construed as derogatory, the writer should also avoid descriptive comments that may help pinpoint the patient's family, friends, or other treaters (past or present). In particular, the family's interests are no less important than the patient's. By identifying a family member, friend, or treater, the writer may identify the patient.

Guidelines for Disguising Case Material

In any form of writing, there are rules of action and inaction. When altering a case report to disguise a patient's identity, procedures to follow include (1) changing basic information, (2) considering the consequences of changes, (3) avoiding true specifics, and (4) arranging for external checks on the final product. Procedures to be avoided include (1) making faulty assumptions, (2) making blatant, easily traced changes, (3) overdisguising the material, and (4) giving unnecessary detail.

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Change Basic Data

Obviously, when data such as gender and marital status are crucial to the meaning of the case (particularly the diagnosis and treatment of the patient), they cannot be substantively altered. But a patient's name, age, occupation, and place of residence may often be changed automatically to something quite different. For example, use "Miss A," "Mr. B," or an obvious pseudonym (if initials are used, they should not be those of the patient), vary the age by at least 1-2 years, make at least a slight change in occupation, and vary place of residence by city size, geographic location, and time lived there. Sometimes a death in the patient's family can be changed to a divorce or an extended separation, with no effect on the case presentation. Or, if issues of separation are not a problem, a living family member may be mentioned as having died or moved away. Likewise, a deceased parent may be mentioned as being alive and healthy (Klemmer, 1967).

Consider Consequences

Clinicians should weigh the implications of changes made to disguise case material. A change of a patient's gender from male to female negates a description of "unusually feminine" characteristics. Keep in mind, too, the influence of sex role biases (conscious or not) in determining the disguising gender assigned a patient or any other person described in the presentation. Consider, for example, whether changing the gender of a former treater from male to female matters in a case where the treater is described as overreacting to a patient's temper tantrums by prescribing sedation or restraints.

Avoid True Specifics

While it may be true that the patient was admitted to the treatment unit on August 1, 1983, what purpose does it serve to tell readers this fact? If a time frame is important to a description of the onset and treatment of illness, two alternatives to giving the true date are possible: (1) Give an exact date but make it one that is not the true date, or (2) make the time general in terms of seasons, months, and years, and use qualifying adjectives such as several, a few, one or two, and about. While changing specifics to generalities may appear to be the most obvious or the easiest way to disguise the facts of a case, false specifics make it even less likely for patients to connect themselves to the patient being described. And, in fact, when generalities are used, they could be based on specifics that have already been altered (e.g., a true admission date of August 1, 1983, could be changed to March 3, 1984, then to a general time of spring 1984).

Arrange Checks on Your Work

Ask a colleague or someone else to review the paper, whether it is being prepared for an oral presentation or for submission to a journal. The person does not need to be familiar with the patient, nor does the person need to be a mental health professional or a professional writer or editor. Ask such a reviewer to take note of any identifying facts, as well as to consider the believability of the "patient" who is described. Double-check your methods for disguising case material by comparing them with those of colleagues whose writing includes case material. Ask other members of the treatment team whether they can identify the patient in the paper and, if so, what gave away the patient's identity. A self-critical stance also may be achieved by setting aside the completed paper for a few days, then re-reading it from the point of view of a family member or close friend of the patient—or the patient himself—checking for clues that would identify the patient.

Don't Make Assumptions

When the choice is whether or not to seek permission from the patient, don't assume that the patient will never come into contact with what is being written. Many patients who are in psychiatric treatment—and their families—are well-educated, intelligent people who want to learn as much as possible about mental illness, about their treaters, and about the treatment milieu. In addition, more and more journals today are sending news releases to various media about the papers they publish.

Don't assume that a few minor changes, especially alterations from the specific to the general that still ring true for the patient (e.g., changing a "48-year-old patient" into a "middle-aged patient") will provide adequate disguise.

Don't Make Blatant, Easily Traced Changes

While simple facts may often be easily altered, the clinician should beware of making changes that are the exact opposite of reality or that otherwise may lead back to the real patient. Consider whether a patient who lived in North Carolina has been adequately disguised by changing the state of residence to South Carolina. And if a male patient named Andrew has been carefully disguised by changing his gender, what are the consequences of changing his name to Andrea?

Don't Overdo Disguising

While it is important to alter the recognizable facts of any case material, try not to get carried away in the process. If radical changes made in the name of disguising a patient's identity instead create an entirely unbe-

lievable "person," then the purpose of the disguising is defeated on yet another front.

Don't Include Unnecessary Detail

"Brevity is the soul of wit." Though first heard many years ago in Shakespeare's Hamlet, this aphorism still holds true today. Brevity can solve some problems in disguising case material by avoiding them altogether. Include only enough—but enough!—detail to substantiate the thesis of the paper. Remove data that do not "contribute materially to an understanding of the case . . . With any such item ask yourself honestly: Is this phrase necessary? When in doubt, take it out" (Davidson, 1957, p. 165).

Illustration of How to Disguise Case Material

Compare the following two "case examples" to see some of the ways to apply these guidelines for disguising case material. The bracketed comments in the second case example explain changes that were made to disguise the identity of this hypothetical patient. These suggestions for changes are not necessarily the definitive way to disguise this case or other cases. And, of course, specific changes in any case might vary widely from one writer to another.

Hypothetical "Real" Case Example

Mr. G, a well-to-do 50-year-old farmer from Atchison, Kansas, was admitted to the C. F. Menninger Memorial Hospital on August 3, 1985. Although not violent at the time, he was accompanied by his wife, who reported that he had threatened family members and neighbors and the day before had held their 15-year-old son at gunpoint for several hours, appearing not to recognize him. The patient's wife, a schoolteacher in Atchison, said that the patient had been "acting strange" for the past 23 months. He reportedly slept only a few hours a night, talked rapidly and breathlessly, and experienced extreme mood swings from listlessness and depression to hyperexcitability. At admission, Mr. G complained fearfully yet bombastically that "they" were out to "get" him. He explained that he knew this because he could hear them talking about him on television and radio, and he threatened to "get them first."

The oldest of three children, the patient was born only a few months after his parents married. His mother, who died of leukemia in 1982, was a year older than his father, who dropped out of school at age 16. The patient's wife reported that her mother-in-law ascribed her initial attraction to the patient's father to the fact that "he was the town bully." Despite his lack of formal education, the patient's father was a

worldly man who parlayed a small inheritance into great wealth through investments in oil, farming, and cattle, and then went on to become a state legislator. Now retired, he travels widely, often visiting his daughter, who is an interior designer in Chicago, and his middle child, who is a lawyer in Denver.

The patient is the father of three children, all boys, of whom the 15-year-old son is the youngest and the only one still at home. The oldest boy, now 20, left home at age 18 to join the Army. The third son, who is 18, recently dropped out of college to marry his high-school sweetheart and now works with a county road crew and lives in a nearby town.

The patient's wife reported that he had been under great stress because of financial problems, and she feared that he thought he was a failure. Falling farm prices had affected Mr. G's ability to repay several loans, and it looked as if they might lose their farm. Mr. G's father had offered to help him out financially, but he denied needing any help.

Hypothetical Disguised Case Example

Mr. G [*name change unnecessary if already altered, but changing "G" to a visually similar letter such as "C" might be traced*], a Texas [*change in basic data to false specific*] feedlot operator [*change to false specific*] in his mid-fifties [*change from true specific to generality*], was admitted to the hospital [*deletion of unnecessary detail*] in the spring of 1984 [*change to false generality*]. Although not violent at the time, he was accompanied by his wife, who reported that he had threatened family members and neighbors and had once held her [*change to false specific*] at gunpoint for several hours, appearing not to recognize her. The patient's wife, who worked outside the home [*change from true specific to generality*], said that Mr. G had been "acting strange" for some time [*change from true specific to generality*]. He reportedly slept only a few hours a night, talked rapidly and breathlessly, and experienced extreme mood swings from listlessness and depression to hyperexcitability. At admission, Mr. G complained fearfully yet bombastically that "they" were out to "get" him. He explained that he knew this because he could hear them talking about him on television and radio, and he threatened to "get them first" [*symptoms not altered to retain validity of case*].

The older of two children [*basic data changed*], the patient was born shortly after his parents married. His father dropped out of school before graduating but, despite his lack of formal education, parlayed a small inheritance into great wealth through shrewd investments. Following the death of his wife a year earlier [*false specific added*], the patient's father began traveling widely, and he often visits his younger

child (a daughter in California) [*unnecessary detail deleted and some basic data changed*].

The patient is the father of three children, of whom a 13-year-old son is the youngest and the only one still at home. The other two children, both girls, are in college [*unnecessary detail deleted and some basic data changed*].

The patient's wife reported that he had been under great stress because of financial problems, and she feared that he thought he was a failure. Falling beef prices had affected Mr. G's ability to repay several loans, which threatened his feedlot operation. Mr. G had refused offers of financial help from other family members [*deletions and changes of some specifics*].

Summary

Clinician-writers who treat distinctly different individuals need to carefully consider how to disguise case material. While a particular patient may be an intriguing and easy subject for a paper or presentation, how may the real details of the patient's life be altered to prevent recognition by the patient, the patient's family, colleagues, hospital employees, other patients, or members of the community?

Guidelines for disguising case material may be helpful, but on some occasions a specific patient cannot be disguised and sometimes patients cannot or will not give permission for publication of information about their treatment. In such instances, there is still one other alternative: to form a composite "patient" by taking details from the treatment and history of several patients with similar disorders. Even this process is time-consuming and not necessarily fail-safe, and the writer runs the risk of altering the case so as to destroy its usefulness to the points being made in the paper. Rather than creating a new, composite patient, the writer may decide that the case material is best left unpublished. As Gitelson once noted, "The best cases are the ones you never hear about afterward" (cited in Kramer, 1967, p. 268).

Freud himself captured the essence of the dilemma facing clinician-writers who wish to write about their patients. In his introduction to the case of the Rat Man, Freud (1909/1955) emphasized the importance of disguising case material about patients, yet also questioned the validity of "distorted" case presentations.

If the distortions are slight, they fail in their object of protecting the patient from indiscreet curiosity; while if they go beyond this they require too great a sacrifice, for they destroy the intelligibility of the material, which depends for its coherence precisely upon the small

details of real life. And from this latter circumstance follows the paradoxical truth that it is far easier to divulge the patient's most intimate secrets than the most innocent and trivial facts about him; for, whereas the former would not throw any light on his identity, the latter, by which he is generally recognized, would make it obvious to every one. (p. 156)

The use of case material in presentations and in written papers is illuminating and educational. It enlivens the dullest prose by focusing on the treatment of "real" persons. Like a photograph, a concise case report outshines much wordier explanations. But in developing the case report, clinician-writers need to bear in mind their patients' rights to confidentiality and so disguise any identifiable features in case material used to illustrate their writing.

The honorable goal of helping to educate other mental health professionals by sharing treatment experiences (usually at one's own expense and without direct monetary gain) need not blind clinician-writers to their responsibilities toward their patients. After writing anything about a patient, clinician-writers might try to think of themselves as if they were that patient, exchanging places, as it were, long enough to read the case material yet again. How would the patient feel, think, and react upon reading what has been written?

The American Psychiatric Association (1957/1984) defines confidentiality as "the ethical principle that a physician may not reveal any information disclosed in the course of medical attendance" (p. 22). Likewise, the right to insist on or to waive the right to privileged communication (the communications made within a confidential relationship) is the right of the patient, not the therapist (American Psychiatric Association, 1957/1984). By adequately disguising case material, clinicians give evidence of their respect for their patients and for their patients' rights to privacy and confidentiality.

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