Boundaries & Ethics in Therapeutic Work: Therapeutic & Secondary Containers

7/5/25

Introduction.

The guiding principle of psychotherapy is that more is going on in the client/patient's mind than he is aware of, therefore it is the task of the therapist to notice this and bring it to his attention, so that there is a closer approximation to 'truth' than is the case when only the conscious, cognitive perspective is available. It is, therefore, a curious thing, at least in my mind, that the moment there is a complaint about treatment, the relevant registering body throws this concept out of the window and dresses up as lawyers, limiting themselves only to what can be seen 'above the surface'. I believe this is because of a distorted view of the purpose of boundaries or rules of engagement in our professions. I hope to convey what I mean by this in this talk.

My first struggle with boundaries.

My first encounter with boundaries followed my promotion to manager of a therapeutic unit of a secure provision for dangerous adolescents at the ridiculously youthful age of 27. This was an experimental secure institution tasked with discovering whether it was possible to provide treatment for adolescents (aged 12 upwards) who had committed serious offences.

One of my earliest duties was to decide at what age we'd allow them to smoke (these were the days when everyone smoked). I found it an extremely difficult decision to make, continually unable to balance all the factors. After several days of indecision, I managed to extricate myself from the morass of pros and cons and look again at the task. It dawned on me that I was overwhelmed with the consequence of a belief that I was supposed to make the 'right' decision. Particularly that it should be morally and ethically correct. This perception allowed me to ask a different question, "If not that, then…'What was the point of such a boundary?' or, 'What did it serve to have such a rule?'

I was reminded of my contempt of the school rules at my old school. The first was, 'A breach of common sense is a breach of school rules' and the second, 'There will be no contact with girls during term time'. I had always thought that these two were in total conflict with each other; how could it be an act of common sense to avoid girls during term time, or any time, come to that? So why were they there? It was clear that the task for a boys' public school, at least as seen by the school, was to reduce all activities that were not in the service of the best performance of the boys, by which was meant, the best image of the school.

This insight led me to a realisation that, if boundaries are there to serve the best interests of the *task*, then it is only a way to define the shape of the 'container' within which the task takes place. Nevertheless, I was aware that I'd only understood a part of what had been getting in the way of a swift and pragmatic decision about the smoking rule. I thought that there was something I was less comfortable with confronting in myself. This idea seemed to open a new view. I had to acknowledge that I had been worried about the reaction of the kids. My conscious attempt to find the 'correct' rule was based on a less conscious idea that the correctness of the rule would be accepted by all parties and, therefore, *not a source of conflict or complaint*.

Further thinking led to turn this idea upside down, leading me to the realisation that a good boundary in the context of the therapeutic task was one that offered an opportunity exactly for what I'd unconsciously been trying to avoid, namely a lively encounter between staff and patients.

I realised that I'd been trying to avoid this because my image of 'conflict' was suffused by the behaviour of the kids that had brought them to our institution in the first place: violence.

Referring back to the 'development of the conscious, cognitive mind', you will recall that the most primitive state of mind is where *action* is the only available response to an intense feeling. It follows that the kid who is violent has lost the capacity to think about his experience of an intense emotion. This immediately raises the question, what would enable the experience of the 'feeling' along with a capacity to enquire rather than act?

I realised I was looking for a sensitive receptor; something that would reveal these internal tensions before they were escalated into action. How could we design a sensitive receptor, a membrane that would, like an ear drum, reveal otherwise invisible tensions? Suddenly it was obvious; I had wanted to design a boundary that would avoid what I was calling a conflict between child and staff.

Suppose the conflict that might appear to be between the kid and staff was more truthfully the representation of an *internal* conflict within the child in which those earliest methods of defence, splitting and projective identification were at work. Then the provision of a 'sensitive container' within which encounters between staff and children took place would enable the staff to notice these ripples on the surface of that container. Obviously it would be necessary for the staff to be 'identified' with this container, so that they would be sensitive to impacts upon it. Equally the kids would need to be signed up to this parameter, it would need to be clear, unambiguous.

To cut to the chase, this approach became the central plank for the design of the institution. We were able to establish 'rules' about the structure of the unit, the organisation of the timetable, the tasks for different activities, both those that were more obviously therapeutic as well as those that governed the nature of other activities like education and activities.

Staff became very skilled at noticing not only when they were challenged about a boundary but, often more useful, when they were enticed to join in with the breaking of a 'rule'. To this end, a supervisory system was created that was based upon the principle that these 'boundary infringements' were not wrong or bad practice. Bad practice is to remain in the situation of a broken boundary. They provided unconscious information about the work and the task was to notice that this had happened.

Another way of putting this, one that I have held to be an essential concept in thinking about therapeutic work is that **"Boundaries are where the work happens"**.

Supervision was necessary because these events were not always easy to see, they could occur unconsciously, and we can all get caught up unconsciously. The task of the supervisor is to look out for how the supervisee has been pulled across a boundary without noticing and help them not simply to reverse that but, in the process, to understand the information it provides about the child who has provoked this.

Therapeutic Contract

Putting this into the context of one-to-one work, one of the main boundaries of the therapeutic arrangement might be summarised like this:

- You patient;
- Me therapist;

- You express yourself without censorship;
- I will try to understand the unconscious meaning of this.

In my model, as long as the patient is getting on with expressing themselves and trying to understand themselves, there's very little a therapist needs to do. It is when the patient breaks the boundary that the therapist needs to engage in the work.

For example:

- The patient speaks to me as if I'm someone else (i.e. not a therapist), for example,
- as if I'm a judging man.
- Since the patient has broken the contract I indicate this.
- For example, I say, "You appear to believe I'm judging you"
- Then I keep to my part and look at the unconscious,
- for example, I say, "… like you felt your father does."

And so, as if by magic, I have made an interpretation exactly like the psychoanalytic textbooks decree.

I have come to call this the 'therapeutic container'. It is constructed from the clarity of the distinction of roles, i.e. the therapeutic role with its clarity of task and responsibilities along with the other elements of the frame or setting. As long as the patient is 'on task'; there is very little the therapist needs to do except possibly clarifying what the patient is saying.It is the moment that the patient impacts upon this container that the real work happens.

Therapeutic needs no explanation but I want to clarify what I mean by container. In this I'm drawing upon Wilfred Bion's concept of container/contained and I want to emphasise a particular point

Container/Contained

An immediate understanding of this concept is that of a mother 'containing' the baby, who feels contained. However, it is a crucial part of this arrangement to understand that only a mother who feels that she is, herself, 'contained', in other words, who feels there is an internal relationship that she can turn to in her imagination that helps her to think, will be able to provide this experience for her baby. Specifically, this consists of two essential qualities, the first is mother's inbuilt curiosity drive that we all experience as an urge to answer the question, "what's going on here?". The second, which is essential to the process involved in answering that question, is mother's ability to stay with or bear the infant's distress until she has a thought that provides that answer. This is something the baby picks up; mother's authenticity in offering containment is what makes the difference. This links very clearly to attachment theory, by the way. You could say that the internal arrangement represents mother's capacity to move to a third position from which to observe her encounter with her baby. This is similar to the idea of the internal supervisor providing support in an identical configuration to the therapist in relationship with his patient. In the same way that mother requires someone else to take over when things become a strain, so there will be times when the impact on the therapeutic container makes it crack and break. I shall come back to this. Before I do that, I want to address some criticisms that have been made about the need for clear boundaries and roles.

What is the problem with boundaries - a clear frame and roles?

Why do some therapeutic professionals feel uncomfortable about setting up contracts for the work or designing a clear and constant 'frame' within which to work? I think it is because, at a conscious level, they think that a boundary 'restricts' the patient/client. I hope that you can see from what I've been saying that the opposite is true. The provision of a clear therapeutic container offers a safe place within which the work can happen as well as a mechanism for picking up what's going on below the surface early enough for it to be worked on thoughtfully rather than letting it build up so much that when it does finally appear, it is in the form of an action that cannot be thought about, simply reacted to.

Another objection is that the belief that setting up an agreed contract for work requires 'informed consent' from patients, which is impossible because of their unconscious distortions that are part of what brings them for help in the first place. Of course, this is a spurious argument through *reductio ad absurdum* simply because, however much analysis any of us have, we never get direct access to our own unconscious, therefore, we can *never* give informed consent. This argument only occurs when informed consent is treated as if it is a static state. Treated dynamically, consent by the patient to the process of therapy is itself the object of analytic work, and therefore is a process, not a static or fixed position. (Stokoe 2021 p 108)

This is a subset of another principle that I believe to be essential to approaching any understanding of anything: **"truth is not a fact; it is a process"**. For example, it has been my experience that, when I make notes about my work and then re-read them, sometimes only a brief time later, I find myself thinking, 'oh dear, that wasn't quite right'. The passing of time offers a new perspective from which to look at something that appeared at the time to be true. This is a version of what Bion described as the constant movement from a paranoid/schizoid position (or pleasure principle as Freud defined it) to a depressive position (Freud's reality principle) and then back to paranoid/schizoid and so on. This was described with great clarity by Britton.

There is a similar argument against clarifying the difference in roles within a therapeutic relationship (you patient, me therapist etc.). Why?

This is often expressed as an issue of power as if difference is always an expression of power. When I am ill, I go to a doctor, because I believe that their training enables them to see something in me that I can't see (my illness), so that I can be offered a remedy. I don't feel that there is a power difference, merely a role difference, and I feel contained by that because I trust the benign intent of the Dr.

These are both distortions of a necessary reality, but I think they arise because, as essential features of the therapeutic container, they will also be the place where there will be an effort to break the boundaries. For instance, the patient might complain about the 'rigidity' of the therapist who keeps to a fixed frame or might try to turn the relationship of difference into one of power, creating an issue of dependence or of counter-dependence. My response to this is that this is exactly what we want, because both are unconscious communications about a view of the world or a view of relationships, that tell us about the patient's unconscious beliefs.

If we don't understand this, then it seems logical that, faced with the 'assault' on these boundaries, we create a 'reaction' (note that I'm claiming this to be in the form of an action) to throw away the frame or the difference in roles. Both actions will be accompanied by an argument for why we are

doing it, but it isn't a real 'argument' that invites discussion and a benign enquiry, it is really a statement of certainty, which is the external manifestation of an unconscious belief.

A good example of this is the extraordinary claim that we need to move away from something that is denigrated as the 'blank screen analyst' and, instead, offer a 'real' relationship. This begs a couple of questions, what do we mean by 'blank screen' and what is a 'real' relationship?

I've already said that my model of the 'relationship' is that it is professional. Now I should say what it is NOT. It is not a friendship. Friendships are the most common category of problem areas for patients who will feel both terrified and aroused to be told that they are now being offered something that has been a major problem. Perhaps the view is that we are going to model relating for them. Not only is this extraordinarily arrogant, but it is also horribly dangerous for the therapist (something I'll take up at the end of this talk) because they have no sense of a professional role that will help then notice when the patient attempts to draw them across the boundary of therapeutic engagement. The concept of a relationship is that a reciprocal, caring relationship exists in a broad continuum with abuse at one end and sexual at the other.

The silly description 'blank screen' is a caricature of what a psychoanalytic therapist is offering, which is a position of careful listening (using all the senses), without bringing their own personal preoccupations and quirks into the encounter, so as to pick up how the patient/client seems to be perceiving them. If we assume, as I do, that the patient would be able to solve their own problems if they could understand where they are coming from, then we are saying that something unconscious, an unconscious belief in fact, distorts their view of other people, as well as the world they are living in. By being available to be perceived in any way the patient wants to, we provide a powerful insight into those distortions. If we don't do that, we are liable to be turned into either their fear or some attempt to offer the opposite of what they fear. Neither of these things will help. The most important reason why real relationships as opposed to professional relationships are dangerous is because there is no protection for the therapist not to be drawn into an inappropriate relationship. I shall return to this when I discuss complaints at the end of this talk.

In my book, I define boundaries thus:

> They are not 'things' that exist independently of the activities of the working couple, they are part of the engagement of that couple. In fact, they act to stimulate conflict. Perhaps it is truer to say that they are not concrete 'rules' that prescribe the behaviour of the participants, as in a legal contract; they are emotional and psychological material that can be stretched and distorted so as to reveal unconscious information. The skill of the therapist and the therapeutic institution is to maintain a psychological balance that allows these apparent rules to be broken without ever completely losing the Hippocratic commitment to do no harm. (Stokoe 2020 p 110)

Therapeutic Fractures

Returning to the therapeutic container, I said that it is reasonable to expect that, given the amount of pressure on the boundaries, there are bound to be times when the container cracks and breaks, leaving patient and therapist together but without the safety of the therapeutic container. If we anticipate that these things are bound to happen from time to time, it is not only reasonable but actually a *duty* to provide for such a circumstance. I propose the concept of secondary container to meet this need.

Secondary Container.

The secondary container is the place where both parties can go to in order to think about how things seem to have broken down.

The secondary container function actually starts in the therapist's mind.

The Third Position

A crucial moment in the development of the baby's psyche, or mind, is when the containing, thinking space turns from 2 dimensional (based on a relationship with one other person) to 3 Dimensional Thinking. Most importantly for our purposes, this is the capacity to be engaged with the patient and then, in one's imagination, to move away from that to a third position from which to observe and think about what is happening between oneself and the patient.

One can then, as it were, 'return' to the direct engagement with the patient but now informed by a deeper understanding of what's going on between us. I think of this as the manifestation of the secondary container in the therapist's mind.

There is also an *actual* "third position", outside the therapeutic container, that can enable the therapist to get help to think about what's happening in his relationship with his patient. The first example of the secondary container 'outside' the therapeutic container is supervision.

The secondary container - supervision

The secondary container, therefore, includes the provision of supervision and clinical discussion with fellow professionals. To clarify this: the 'third position' is now located in the secondary container. This is where the supervisor operates. The therapist brings information about his experience of the work with the patient and the supervisor is stimulated to ask the question, 'What's going on here', which makes her think about the interaction between the patient and the therapist. She is looking for processes that the therapist hasn't noticed, unconscious processes, which she describes to the therapist, who gains insight that he can bring into the future work with the patient.

It seems self-evident to me that the battering of the therapeutic container will lead to it fracturing at some point. The secondary container provides a particular function when this happens. Its purpose is to contain and protect the *work*. It is easy to see how this is done in supervision and clinical discussion. When the therapeutic container has broken, the secondary container acts to provide a place where both patient and therapist are able to think what has gone wrong.

Point of fracture

The secondary container is made up of clinical colleagues, the therapist's institution and registering body. These can be activated in different ways depending on the nature of the initial fracture of the container. It works well as long as the central tenet of therapy is maintained, this is the assumption that these things happen because of unconscious processes. At this point therapy has stopped and the two protagonists are in a similar position of seeking help to understand what happened. The task of the secondary container, in the service of protecting the work, will be to try to understand those processes, starting from the beginning of the therapy and draw them to the attention of both patient and therapist. The two protagonists are in a similar position of seeking help to understand what happened.

In my view the therapeutic container breaks down much more often than we realise. If the therapist understands this, then she can be sensitive to evidence that this has happened before it reaches a point that the *external* secondary container has to take action.

Signs that the therapeutic container has fractured

Here are two very common signs of a breakdown of the therapeutic container, which the therapist can observe from her 'internal' third position. She can move in her imagination to that position, opening herself to the question, 'what's going on here?' She might notice a problem in the communication between herself and her patient; essentially that it appears to be stuck.

Another, very common symptom, which she will see if she considers her own behaviour, is that she turns out to be constantly repeating the same interpretation or intervention.
This is what Bion, Steiner and Britton call the 'overvalued idea'.

Complaints.

In this final part of the talk, I want to turn to something that seems to me to be a critical contribution that 'boundaries are where the work happens' and the idea of a secondary container make to the vexed question of complaints. I believe clarity about the nature of boundaries and roles in psychotherapy provides significant help in the face of complaints. Their absence leaves any therapist in a very vulnerable position.

I should say that for many years I provided consultation and expert witness testimony to panels on behalf of therapists against whom a complaint was made. What follows is my model for how complaints should be processed by the body to which they are made, usually the therapist's registering body or her employer. If these bodies understand the concept of the secondary container, it will be clear that this is also the place that receives complaints. In my previous roles as senior manager in health service and social care settings, I have been lucky enough to have been able to ensure that the approach I am describing here could be put into effect in those places.

There are two characteristics of every complaint.

- The first, rather obviously, is that a boundary violation has occurred.
- The second is that all complaints follow a particular template, they are all versions of "You never told me you were going to…"

The accusation of a boundary violation is an awful experience for every therapist; they feel as if the ground has been pulled away from under their feet. They are overwhelmed with anxiety and cannot get out of their minds a vision of their career about to be destroyed. This is irrespective of any conscious knowledge of being innocent. It relates directly to my claim that the work always occurs at the boundary, which means that we are *all* pulled across the boundary *all* the time. As I said before, the bad practice is to stay there.

This situation is often the result of a complaint by the patient (or third-party) or the result of anxiety on the part of a supervisor or clinical colleagues. Wherever the concern originates, the first response, initiated by the secondary container, is to clarify that the therapeutic container has collapsed. The *action* should be to enable the therapist to stop being a therapist and become an equal party to understanding what seems to have gone wrong.

I should point out that this does not necessarily mean a meeting between patient, therapist and a representative of the secondary container; if the complaint or anxiety has come from a colleague or supervisor, the discussion might be limited to the therapist and a manager. If the complaint has come from the patient, initial discussions should be between management and patient and, separately, between management and therapist. It may appear to all parties that a three-way meeting would be helpful, but this should not be a default assumption.

The reason for this is that what is taking place is a benign enquiry into what appears to have gone wrong. The *primary* aim is to protect the work, not to seek to blame either party. The aim for this enquiry is to see whether the patient's therapy can be protected. Seeking to blame will *always* pull the enquiry into a fundamentalist state of mind.

Pursuing an enquiry that seeks both conscious and unconscious processes reflects the psychotherapeutic principle that a search for truth must involve understanding unconscious processes. It doesn't guarantee discovering *absolute* truth, but it does mean that the process leading to the complaint can be understood in the deepest sense. Only this will lead to clarity about culpability.

To this end, the enquiry should begin with the start of therapy, not the point at which the therapeutic container broke down. This follows the formula for a complaint, 'you never told me you were going to…' It seems to me that this is a clear communication that one should start with the beginning, including what both parties thought they had agreed should happen… once again, the importance of boundaries and roles. This enables a proper understanding of the process that led to that event. Once that is understood, the secondary container can suggest actions to be taken both to protect the therapy and to manage concerns about either party.

It has been my experience that this kind of facility in a therapeutic institution produces an agreed way forward in over 90% of cases. Please note that I am not suggesting that protecting the patient's therapy means forcing them to stay with a therapist with whom they cannot work. Quite the opposite; it makes it possible to be clear exactly *why* another therapist is a sensible move. Very occasionally the outcome is that therapy should not continue at all because it is not appropriate.

I have described the secondary container that can be created within a therapeutic institution. There is no reason why this kind of provision should not or cannot be provided by the registering or membership body to which the therapist belongs. In fact, I think that it is the duty of these bodies to provide *exactly* this service. Sadly, those in the United Kingdom have decided against such a provision and have chosen to ignore the special nature of boundaries in psychoanalytic work and, instead, have modelled their complaints and ethics systems on those professions in which boundaries *can* properly be described in black-and-white terms. In simple terms this has changed a membership body from a place that could provide respectful containment for both patient and therapist into one that treats *its own member* as a potential criminal. This has resulted in unnecessary complexity in the process of hearing a complaint; a complexity that begins with the imitation of the Crown Prosecution Service deciding whether a complaint, on the balance of probabilities, has merit and should proceed to a formal enquiry. Neither patient nor therapist feels contained in this process, the one having become the accused and the other the accuser, and the language having reduced the fundamentalist one of blame.

It is a sad irony that I am describing a process of restoring an idea that you only get close to the truth about something if you can take account of the unconscious process underlying the apparent

behaviour; this idea having been given up in favour of a superficial, cognitive level assessment of guilt or innocence. Bear in mind that 'truth' is a process, as I defined earlier in this paper; each new perspective on a view that seemed 'true' at the time (usually occasioned by time passing, which provides that new perspective) triggers the question that represents the activity of the curiosity drive

A final, but important thought to add to this is the 'definition' of 'truth': in my view, truth belongs in the capacity to perceive nuance, a quality of the depressive or 'reality facing' state of mind. Truth is not a fixed 'thing', it is an ever changing and developing process. For example, my experience of reading my notes about a session with a patient always involves the same reaction to any interpretation or 'understanding' of my patient expressed in those notes. Essentially the sometimes-embarrassing realisation that I would not say the same thing now. And sometimes that 'now' is only a short time after writing up the notes. We should not be surprised by this; in the interval my view of what was 'true' at the time has changed and this is not because the previous expression was 'wrong', merely that truth is a process, the new view arises from a different point in time, a new perspective, requiring an answer to the question, 'what's going on here'.