The unique nature of boundaries in psychoanalytic therapy and the implication for ethics and complaints procedures.

Published as follows:
Stokoe, P: 2023; Chapter 9 The unique nature of boundaries in psychoanalytic therapy and the implication for ethics and complaints procedures. In Sachs, A & Sinason, V, "The Psychotherapist and the Professional Complaint" Karnac Books, London

Introductory remarks

The work of the psychoanalytic psychotherapist creates a unique challenge to the design of ethical codes, complaints and disciplinaries. This is because the work occurs at the boundary. *The fact that we work on the boundary and will frequently be drawn across it means that our registering bodies should design ethical codes that reflect that reality. The unprofessional conduct cannot be defined as crossing a boundary but remaining there, (Stokoe 2020 p122) and the unconscious to unconscious pressures cannot be exaggerated.*

The location of psychoanalytic work is a relationship but not a 'normal' relationship. It is based on the psychoanalytic assumption that our problems, by which I mean our emotional and psychological problems, originate in beliefs, habits of mind or assumptions about ourselves and the world we live in that are held 'unconsciously'. That means that we are not directly aware of these ideas, only of the implications deriving from them in the way we see the world around us. Therapeutic work involves an emotional engagement that allows exploration of the patient's mind by the therapist. This means that a normal boundary between two people has to become permeable. The consequence is that the ethical codes and the complaints procedures have to be designed around *dynamic* rather than static boundaries.

The implications for successful help are:
- that the individual comes to the view that they need help, i.e. that they have a problem;
- the person providing the help is able to perceive the unconscious blockages to healthy function, and
- that they can activate and recruit the curiosity of the individual requiring help in areas that have previously been taken to be absolute, concrete facts.

I want to consider briefly the means to discovering someone else's unconscious functioning and the ways in which we might reactivate someone's curiosity, because both of these processes have implications for the formality of the setting in which helpers work. My thesis in this chapter is that those implications make psychotherapy very different from other professions.

You never told me you were going to…

Many psychoanalysts have written about the situation in which the analyst or therapist behaves in an unprofessional way (Gabbard, 1995, 2000). These studies are very helpful in anticipating the personality problems that might lead a clinician to lose contact with their professional task and enter a different type of relationship. My own experience of this area started shortly after I had qualified as an organisational consultant at the Tavistock Clinic in London in 1983. I was invited to advise on how to deal with the disciplinary process involving a deputy manager of a residential social work unit who was accused of stealing petty cash. I found myself wondering how many residential social workers were disciplined compared to field social workers. I should say that I had been a manager of a therapeutic unit in a specialist, secure centre for adolescents and had acquired considerable experience of the unconscious pressures on staff in such environments. The reader may not be surprised to learn that 90% of disciplinaries within social service departments were against residential social workers. The management who dealt with such disciplinaries must have been aware of this, but their lack of enquiry into it suggested that they hadn't really noticed or had not seen it as significant. I wondered, why? This led me to think about the period leading up to the event that triggered the enquiry. Was there a process that made sense of the behaviour? For instance, was it that this person was essentially untrustworthy and had chosen residential work because it was an ideal environment to act out? Alternatively, was there something going on in the complex intercourse between clients and social workers that might have had such a strong impact on this individual that they found themselves taking small amounts of cash designed for the everyday needs of those clients? My research into this case led to just such a story: a story so clear that it led the disciplinary panel not only to acquit the individual but, at my suggestion, to instigate weekly support meetings for the staff team to help them discover the impacts that the unconscious exchanges between their clients and themselves were having on each of them.

This led me to formulate a principle which I have applied to all of my work with supervisees, professional clients, organisations and teams since. I always start from the assumption that they are committed professionals trying to do a good job and that any behaviour or comments that seem to suggest otherwise must be unconscious expressions of the emotional material emanating from the work. This means that my first task is to search for whatever in the work might account for this behaviour. Usually something does, and that allows us to understand it so that it ceases to hold the individual in its grip. Sometimes no such explanation occurs, in which case we have proved that this issue really does belong to the personality of the individual. I shall expand on this later, but it represents my experience that the unconscious-to-unconscious-pressures cannot be exaggerated.

> "It is a very remarkable thing that the Ucs. of one human being can react upon that of another, without passing through the Cs." (Freud 1915e p 194)

As well as that working principle, I learnt that the claim against the member of staff, whatever the specific wording, was always an expression of the formula, "you never told me you were going to …". The dots can be filled in with examples such as, 'steal from me', 'exploit me', 'threaten me' or, 'have sex with me'. In other words, the complaint raised in my mind the question, 'So, what did the professional say *would* happen?'

Putting it another way, any investigation of a complaint has to begin at the start of the professional relationship if there is any chance to make sense of it. Starting at the point of the complaint is bound to lose the narrative that will make sense of what is now complained about. Sadly, most psychoanalytic studies of complaints begin with the complaint itself. In my view, the complaint is the *end* of a process and you can only understand it properly by looking at what led up to that point.

I have indicated that the therapeutic work involves an unconscious impact on the clinician and that this can have a massive effect. The most common means by which this occurs is through projective identification and, although we can be aware that something has been stirred up within us, because we cannot see our own unconscious, we might well attribute it to something about us and, therefore, miss the discovery that it is actually something about our patient. The ubiquity of this phenomenon is why psychotherapy institutions insist that their members receive supervision. It is why I had recommended to that social service department that their residential staff receive staff support meetings. The reason is simple. We might not notice these unconscious impacts on us, but it is extremely likely that our colleagues will. In other words, the same principle that says that the unconscious determinants of a patient's problem will only be visible to someone else, applies to clinicians too.

Since the first ideas about psychanalytic therapy were presented, the characteristics of the venue of the work became an important area for agreement. Over time this has come to be described as the 'setting' or the 'frame'. The design of the setting was based on the understanding that the main material for analysis would be the way that the patient related to the analyst. The assumption was that those beliefs that distort a patient's view of himself in relation to others or to the world would be revealed in his relationship to the analyst. In order to *maximise* this phenomenon, it would be essential to *minimise* the true nature of the analyst's personality or life circumstances. The physical setting should be as impersonal as possible, and the analyst should retain an evenly suspended attention (Freud 1912e and 1923a). This is what I would like to call the therapeutic container.

The Therapeutic and the Secondary Containers.

If the work happens at the boundary and if this is a sort of emotional struggle in which the therapeutic relationship is the site of the struggle, then there must be times when the therapeutic container will crack.

My first encounter with boundaries followed my promotion to manager of a therapeutic unit of a secure provision for dangerous adolescents.

> 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…
> … 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. (Stokoe, 2020 pp 110-111)

Further thinking led 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. In fact, part of the work of designing 'safe container' was to recognise that violence was almost always the result of a patient's frustration not being picked up early enough; sensitive, thoughtfully designed rules enabled both staff and adolescents to pick up the tension long before it escalated into violence.

The next observation was that real [therapeutic] work always and only occurred at a boundary. Although useful development of skills and confidence would take place when the adolescents were using the environment appropriately, this was something that followed a usually painful or challenging discovery about their unconscious mind. Those discoveries *always* involved a boundary challenge: for instance, the perception of a member of staff as someone they really were not, through transference or projective identification. This would become manifest in the way the young person treated them disrespectfully or inappropriately – a boundary violation. We had developed the skills to recognise these events as opportunities to explore the unconscious meaning for that young person.

Part of the setting is the definition of the weirdness of the relationship we offer our patients, namely, 'you are a patient and can say or do whatever you like without censorship'; 'I am the therapist and shall attempt to understand the unconscious meaning of whatever you say or do'. As soon as we recognise that these statements are boundaries, then we can see that, for the patient to treat us as an angry father, is to violate the boundary (we are therapists, not angry fathers, we leave that outside the room). It is this assault on the boundary that should trigger the therapist to act. The action, when it is consistent with his part of the therapeutic agreement, will be to interpret the patient's need to 'assault' him in this way. He might link something that has just happened in the room to a belief that the patient holds about his own father.

We don't always notice what the patient has done to us. Sometimes it is only when we notice that we are behaving somewhat tetchily or feeling cross with the patient that we realise what is happening. Sometimes it is only after we have fallen into an argument, that we realise what is going on here. The point is that we often only know that we are picking up something from the patient's unconscious because we notice that we've crossed a boundary. (Casement 1985, Brenman Pick 1985, Carpy 1989).

At these times, the saving quality is the arousal of curiosity. The skilled therapist uses his interpretation to arouse the interest/curiosity of the patient, but it is also the curiosity of the therapist that finally causes him to think about what is happening to *him*. The earliest references to the K-drive were about something Freud and Klein thought of as the epistemophilic instinct. For them, this was not an innate drive but a fascination with sex or a fascination with mother's body. The point was that it always involved a wish to break through a personal boundary, either into the parental bedroom or into the body of the parent. Enquiries always have this sense of 'uncovering' something. Our work is about uncovering the truth, so we will inevitably open boundaries. This is how I have previously described the way psychoanalysis should think about rules or boundaries:

> 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)

Nevertheless, it must be apparent that, if the work is constantly on the boundary, this places a massive strain there. I prefer to call the place in which all of this work takes place a 'therapeutic container' (Stokoe 2015) and I do so to invoke Bion's concept of container/contained. This is a dynamic concept, not only a relationship between the container and the contained (usual mother and baby) but also an internal relationship between the container and an inner containing object. Indeed, without this, the mother's capacity to provide a sense of containment to the baby will be seriously compromised. 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.

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. The secondary container is the place where both parties can go to get help when things seem to have broken down. It is also an *actual* "third position" that can enable the therapist to get help to think about what's happening in his relationship with his patient. The secondary container, therefore, includes the provision of supervision and clinical discussion with fellow professionals. In my experience as a senior manager in the NHS and other health and social care providers, the secondary container is also the place that receives complaints. 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.

The first thing to say about the secondary container is that its purpose is to contain and protect the work. It is easy to see how this is done in supervision and clinical discussion, but I should say something about the way it appears when the therapeutic container has broken. At this point the secondary container acts to provide a place where both patient and therapist are able to think what has gone wrong. This is usually 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 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 aim for this enquiry is to see whether the patient's therapy can be protected. The primary aim is to protect the work, not to seek to blame either party. To this end, the enquiry should begin with the start of therapy, not the point at which the therapeutic container broke down. This enables a proper understanding of the process that led to that event. Only an understanding of such a process will provide a full perspective on the event of the breakdown. 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 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 a court 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.

The reader might imagine, therefore, the difficulty that those of us who act as expert witnesses in such cases face. Our role is to introduce to people who think they are part of a judicial panel, the concepts of therapeutic complexity, on the one hand, and compassion for both parties on the other. 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.

The complaint.

I have said that a complaint, 'you never said you were going to …' is often perceived in a very concrete way as 'you breached a boundary'. This enables the investigator to fall into the error of believing that the job is to ascertain whether or not such a violation of a boundary occurred. This simplistic approach is based on a premise that a boundary is a boundary: you either respect it, in which case you never cross it, or you don't, in which case you are ethically culpable.

I have previously argued that the fact that we work on the boundary and will frequently be drawn across it means that our registering bodies should design ethical codes that reflect that reality. The unprofessional conduct cannot be defined as crossing a boundary but remaining there. (Stokoe, 2020; p122) In this final section, I want to consider the extra difficulties that the registering bodies create for any chance to approach an understanding of the truth behind a complaint. This draws upon my experiences both as an advisor or an expert witness in such cases and when I was in senior management positions in therapeutic organisations charged with the task of managing complaints against my staff or my department. I shall not describe any actual examples for obvious reasons of confidentiality, but I shall draw upon the sorts of cases that would be relevant to the work of the editors of this book. In my experience as manager, I was able to apply two principles. First, turning to the full narrative of a process that has broken down (rather than starting the investigation at the point of breakdown). Second, anticipating that there will be constant activity across the boundaries of the therapeutic engagement, therefore inviting the question, was the clinician actively attempting to maintain his or her professional role or did they allow themselves to move out of a professional role and into something else? Many complaints have merit, but *all* have a meaning. Some are the result of mistakes or even unprofessional conduct by the therapist, some are expressions of the pathology of the patient or else arise from a third party that wants the therapeutic enquiry to be curtailed. In my experience as a manager, it is relatively straight-forward to tell the difference and resolve the problem without it ever escalating to an appeal.

It is important to understand that to be the recipient of a complaint, is a horribly traumatic experience. First, it is almost always unexpected, so it comes like a sudden assault, shocking and frightening. Secondly, it quickly generates the feeling that the clinician's career might be destroyed. I am aware that a naïve assessment of such a reaction would be that, if they are innocent, then they should feel confident about the outcome. This is naïve for two reasons that I have already alluded to. Firstly, the shock of the accusation will throw the accused into a paranoid-schizoid state of mind. Massive anxiety always does this, to all of us. It is our default state of mind and I prefer to call it the fundamentalist state because it is a view of the world in which there is a sharp contrast between perfect good and perfect evil, perfect love and perfect hate. Everything is certain and it feels as if there is no need for any kind of thinking (which would be based on a starting point of not knowing). In this state of mind, the accusation that one has done something wrong requires only one of two responses, yes or no. But any good clinician will have accumulated loads of examples of boundary infringements, if they have fully understood this work (i.e. being open to unconscious communication), so they will instantly worry that there must be something like that in the background of the complaint. They will imagine that they might be seen as guilty by the black and white judge so powerfully present in this fundamentalist state of mind. It is important to bear in mind that a central feature of trauma, the capacity to symbolise in the emotional and psychological zone of the trauma, is lost. In this way, traumatised soldiers leap for cover when a firework goes off; this is not because the noise is *like* that of the bullets in the traumatic experience, being 'like' something is symbolic. No, it *is* the bullets. Thus, the accused clinician cannot think that past infractions of the boundary are *like* unprofessional conduct, they *are,* or at least will be seen that way by the judge.

The second reason that the view that innocence should protect the accused from such terrors is naïve, is that a clinician might feel there is a potential for feeling safe if they felt that their registering body had, *a priori*, established that the issue of boundary violation is different for psychotherapy work. Sadly, the clinician knows only too well that their registering body has not taken that stand, so, as well as the shock of the unexpected assault, they feel completely alone and exposed.

It is easy to see that, at this point, the traumatised clinician understandably operates from a paranoid-schizoid state of mind. This means that they, like their registering body, will tend towards an absolutist solution to their plight.

If we design the secondary container as a mechanism to provide the best chance to protect treatment of the patient and, if we agree that this will be most likely to be achieved by understanding exactly how the collapse of the therapeutic container occurred, then the first thing to establish is what might be described as the 'personality' of this external container. Lest it sound a bit bizarre to speak about the personality of a system, it is worth saying that writers from the discipline of the psychoanalytically informed approach to organisational consultancy have taken this concept seriously for many years (Jaques 1951, Stapley 1996, Armstrong 2005). Another word for 'personality' might be the 'attitude' of the organisation or system. For example, some psychoanalytic training organisations have taken the approach towards applicants for training of seeking to avoid accepting those who are not suitable. The experience for anybody coming to such an institution is very intimidating; they are immediately confronted with an idea that somebody is scrutinising them to establish whether they are right or not. The alternative is for the institution to welcome interest in their work and application to train; this is expressed in the commitment to receive all who are interested in psychoanalysis and help them to find a place that best fits their skills and interests. The former attitude arises in a paranoid state of mind, the latter from a benign wish to engage and enquire. Thus, the attitude of a secondary container can be defined as a commitment to benign enquiry.

Such an attitude, taken alongside the understanding of boundaries in the psychoanalytic engagement as I described above, is a basis for an effective containment process. The next thing is the understanding that a proper investigation should begin at the start of the therapeutic work, not at the point at which it broke down. The benign enquiry seeks to understand how it came to such a point. Intrinsic to this process will be the understanding that any such enquiry will only come close to the truth if it includes an awareness of unconscious processes including those taking place within the enquiry itself. In the context of the judicial version of a complaints procedure, one of the most important interventions leads the panel to see how they have been drawn into a dynamic which has been a feature of the therapy. This is central to understanding how it all collapsed.

There are two types of example. In one case the complaint was that the therapist had wrongly charged the patient for sessions which the patient had not attended. The patient's complaint was not only that he had been wrongly charged but that therapy had become impossible because the therapist would not let go of this issue. The therapist's presentation at the panel was high-handed and confrontative. It was clear that the panel were rapidly pushed into an irritated and judgemental attitude towards the therapist. It was only through the process of listening to the patient description of the way that the therapy had proceeded that it became possible to understand what was happening between panel and therapist. The story that emerged was of a therapy in which the therapist seemed to struggle to remember what has been going on and appeared to become more and more rigid in his interpretations. When the panel were freed from their emotional response to the therapist's attitude, they were able to take a more adult and benign approach, understanding that the therapist was suffering from some sort of illness. The panel were able to make a judgement that attended to the disability of the therapist in such a way that the patient also felt understood and was able to consider engaging in a new therapy with a different therapist

The other example is one in which the complaint, on the surface, sounded very similar; the patient complained that the therapist had changed from being supportive and helpful into being critical and attacking, leaving the patient unable to trust in his therapist or in the process of therapy. The panel seemed very caught up in an idea that they were there to right a wrong. In other words, although they hadn't noticed it, they had already convicted the therapist. The revelation of the story of the therapy showed a patient with particularly powerful borderline personality characteristics; the beginning of therapy was marked with her continual idealisation of the therapist, suddenly brought to an end by a very trivial incident in which the patient felt the therapist had turned into an enemy. The pattern was that these incidents were followed by a return to what might be described as a state of merger with the therapist until there was another incident leading to conflict. The breakdown of the therapy occurred at a point at which the patient had also formed a relationship with a boyfriend. The power of the belief that there really was an attack, a belief that repeated at intervals, suggested that there had been an experience of something abusive early on in the patient's life but that this could only be approached through this form of projection. When the panel were able to see that they were being invited to assume that there *must* have been an abuse, they were able to free themselves sufficiently to make a more dispassionate judgement about what really happened.

The most important point about all of this is that I am convinced that neither of these cases had to go to a panel. If there had been a functioning secondary container at the time of the complaint, I have no doubt that the understanding that I have just described would have been available at the point of the initial enquiry and a containing solution could have been found without putting either party through the agony of this formal, judicial enquiry. These processes are enormously destructive to both patients and therapists, and they occur only because the governing bodies of our psychoanalytic institutions will not take a measured, adult and clear stand on behalf of the complex nature of boundaries in the psychoanalytic engagement.

References:

Armstrong, David: 2005,"Organization in the Mind: Psychoanalysis, Group Relations, and Organizational Consultancy", H. Karnac (Books) Ltd.

Bion, WR 1962a, Learning from Experience, London Karnac,

Brenman Pick, I. (1985). Working through in the countertransference. International Journal of Psychoanalysis, 66: 157–166.

Carpy, D.V. (1989). Tolerating the Countertransference: A Mutative Process. Int. J. Psycho-Anal., 70:287-294

Casement, P 1985; On Learning from the Patient, London, Routledge

Freud, S. 1912e. Recommendations to Physicians Practising Psycho-Analysis. The Standard Edition of the Complete Psychological Works of Sigmund Freud, Volume XII (1911-1913) pp 109-120.

Freud, S; 1915e; The Unconscious; The Standard Edition of the Complete Psychological Works of Sigmund Freud, Volume XIV (1914-1916) pp 159 – 215

Gabbard, Glen O.; 1995; The Early History Of Boundary Violations In Psychoanalysis, J. Amer. Psychoanal. 43

Gabbard, Glen; 2000, Disguise or Consent: Problems and Recommendations Concerning the Publication and Presentation of Clinical Material; Int J Psycho-Anal 81: 1071-1086 (Ethics)

Jaques, E, 1951, The Changing Culture of a Factory; a study of authority and participation in an industrial setting, London Routledge & Kegan Paul Ltd.

Stapley, Lionel F. 1996; The Personality of the Organization: A Psycho-dynamic Explanation of Culture and Change Paperback; Free Associations Press

Stokoe, P; 2015: Ethics and Complaints Procedures for Psychoanalytic Organisations: Some Thoughts About Principles. In: Couple & Family Psychoanalysis 5(2) 188–204

Stokoe, P; 2020; The Curiosity Drive: Our Need for Inquisitive Thinking, Bicester, Phoenix Publishing House