



Ethics and Boundaries, why psychoanalysis is different to other professions in terms of a complaints procedure.

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My interest in ethics and complaints procedures was triggered in 1983 when I was asked to advise on the issue of a residential social worker who was deputy manager of a care home for difficult adolescents; she was being disciplined for misusing petty cash. I was struck at the time by two things: nobody had noticed how 90% of disciplinaries within the social service department were against residential social workers and, therefore, nobody had wondered why. Secondly that there didn't seem to be any interest in the investigation panel to know about the history of this deputy in her work in the unit. My investigation told a story of increasing pressure in this care home, the manager eventually went off on long term sickness, many of the staff were similarly unreliable and this deputy seemed to feel it was her duty to work way beyond her conditioned hours to make up the staffing.

When I relayed the results of my enquiry, I added that I thought that the employers had a duty of care for their staff, especially this person, which they'd completely abdicated. I suggested that the panel might feel the wrong person was in the dock.

Since then, I have found myself involved in supporting colleagues against whom a complaint has been made. I have no idea why this has happened, until this last year or two, I have not mentioned this side of my work in public. I mention it now because this experience, alongside my roles as senior manager in a range of services since 1978 which involved me in managing complaints and disciplinaries is why I feel I have something to say on these matters.

Specifically, this paper arises out of my concern that registering bodies of psychoanalytic therapy are moving, without any apparent sense of concern, towards total acceptance of a mechanistic approach to ethics and complaints in imitation of that which is operated by a wide collection of professional bodies, officiated by the Professional Standards Authority. Their entire approach rests upon the assumption that professional relationships can be governed by a set of rules that are absolute and certain.

I shall be arguing that psychoanalytic work *only occurs at the boundary*. In other words, boundaries in the psychoanalytic world are necessarily flexible and malleable; they are not precise and do not conform to a black-and-white perspective. This does not compromise the professional standard of the Hippocratic oath, to do none harm, it merely changes the way that we understand the ethics of encounters between patients and therapists.

I shall describe a model for managing the work and providing an ethical container that is designed to protect the work, the patient, and the therapist by applying a psychoanalytically informed enquiry at the point of therapeutic breakdown.

The essence of what I want to think about with you today is conveyed in this simple, schematic description of the psychoanalytic process that a therapist might tell his patient:

We are here to explore your mind and discover what happens that you cannot see in yourself that stops you leading a fulfilled and happy life.

We achieve this by making the following arrangement for the work, this is called the 'setting' and I'm responsible for maintaining it.

Your role is 'patient'; your task is to say or do whatever comes into your mind without censorship.

My role is 'psychotherapist'; my task is to work out from whatever you say or do what might be going on in your mind that you are unaware of to produce this behaviour.

We can consider this to be a contract and that the art of psychoanalytic work is to recognise that we only respond when that contract is broken, i.e. at what might be (dangerously) described as a boundary violation.

For example: a patient arrives and speaks to me in an angry way as if I'm some sort of depriving father stopping them doing what they want.

My primary role is to manage the setting. This is a breach of contract because the contract clearly states, I'm a psychotherapist (i.e. NOT a father), so my first task is to repair the setting.

My contract further obliges me to consider the unconscious meaning of their behaviour.

So, the boundary violation forces me to act and the result will be something like this:

"You seem to experience me as a controlling and depriving man," In this way I point out the boundary violation, then, in keeping with the commitment to describe unconscious processes, I might add something like, "this seems very like the way you described your experience of your father as you grew up."

Low and behold, I've made an interpretation!

Basic shared assumptions.

1. We have an unconscious, out of which our consciousness has developed and, because of that developmental trajectory, the beliefs that we acquire unconsciously distort our conscious views of the world we live in and of ourselves.
2. We may be affected unconsciously by others, as is conveyed by Freud's famous comment, "It is a very remarkable thing that the unconscious of one human being can react upon that of another, without passing through the conscious" (Freud, 1915e, p. 194).
3. One way one unconscious mind can affect another's is through a process known as projective identification, initially described by Melanie Klein (1946). As pointed out by Wilfred Bion (1962), an experienced psychiatrist with a deep understanding of inpatient settings, this process may have a profound impact on the object.
4. The awareness that others have an unconscious is commonly held, as is widely demonstrated in art, "old wives tales", poetry, theatre, and reality television programmes such as *Big Brother*. (In this, the audience enjoys the experience of being able to predict what will happen between the house mates long before the latter are aware of it, because the audience can "read" the unconscious of the protagonists.)
5. We cannot be directly aware of our own unconscious, even after years of analysis.



6. If we are to discover how we are affected unconsciously in our work, whether through the distortion of our view by our own unconscious processes, or the impact that another's unconscious communications has on us, we shall need the help of others, usually our colleagues. This help, in the form of supervision and peer discussion groups, is so much taken for granted in our work that it is easily overlooked.
7. We experience the unconscious activity described above as feelings.
8. With the help of supervision or reflective practice we can transform feelings into conscious (manifest) information about the work.

Moreover, someone who has become aware of his own unconscious mind can never again claim that he did not know it existed, and that it would affect his conscious mind.

Work only occurs at the boundary.

Now, to turn to some observations about psychoanalytic work. First, and most important is one of Freud's first discoveries (1916-1917):

In the first place, then, when we undertake to restore a patient to health, to relieve him of the symptoms of his illness, he meets us with a violent and tenacious resistance, which persists throughout the whole length of the treatment...

... In psycho-analytic therapy... we urge him always to follow only the surface of his consciousness and to leave aside any criticism of what he finds, whatever shape that criticism may take; and we assure him that the success of the treatment, and above all its duration, depends on the conscientiousness with which he obeys this fundamental technical rule of analysis.

... The first thing we achieve by setting up this fundamental technical rule is that it becomes the target for the attacks of the resistance. The patient endeavours in every sort of way to extricate himself from its provisions. (pp 286-88)

Working with resistance is the key here, this resistance will affect the therapist, both consciously and unconsciously, indeed Freud's instruction to would-be psychoanalysts "[the physician] must turn his own unconscious like a receptive organ towards the transmitting unconscious of the patient" (Freud, 1912e, p. 115) makes it clear that the clinician must make his own unconscious available to that of the patient. Therefore, I want to emphasise the point that, if we are to be any good at the work, unconsciously, we *will* get caught up with our patients. Heimann's (1950) concept of countertransference is crucial here; she proposed a new conceptualisation of countertransference, perceiving it as the impact of unconscious communications from the patient on the unconscious mind of the therapist, via processes like projective identification.

Anybody working within a psychoanalytic model will be affected unconsciously and, therefore, temporarily, must be 'caught up' in the patient's unconscious world: the therapist will be ascribed a 'role'. The only way that we can extract ourselves from a given role is to become aware that we are in it and then, use that knowledge to understand how our patient is perceiving us. This requires a capacity to 'see' that we have been given a role.

The capacity to step outside the intensity of the dyadic exchange, and think about what is going on, is the hallmark of healthy coupling (Morgan, 2005). I propose that this is also the essence of a therapeutic encounter; that it is essential that the therapist has a capacity to



move to a third position (Britton, 1989) from which to observe the intercourse between himself and his patient. In my view, the absence of such a capacity makes therapy impossible. However, we sometimes also need an actual other who can observe our work. This observing process should be incorporated at every level in any therapeutic organisation, so that this aspect of practice can maintain itself as a continuing model.

The therapeutic system should seek to identify unconscious emotional impacts and turn them into information.

The phenomena I am describing are the consequence of resistance. It will, therefore, always be a challenge to the therapeutic arrangement, which means that it will always happen at the boundaries and it will take the form of inducing the therapist to give up the therapist role and assume another one organised unconsciously by the patient.

By the way, I should clarify that the word 'resistance' is misleading, although it may seem to be aimed at blocking the course of treatment, it is actually a true expression of the part of the patient that the work should be focussed: it *is* the work

These ideas lead me to suggest an ethical approach to the work based upon the following deductions:

- We are bound to be affected emotionally and psychologically by the work at an unconscious level; these 'impacts' take the form of feelings.
- We are obliged, therefore, to ensure that we set up mechanisms that allow these unconscious impacts to be registered and transformed into information.
- This can be done by creating a third position from which to observe the interaction between patient and therapist.
- The first manifestation of this is an internal construction within the therapist's mind (Britton, 1989; Morgan, 2005), a third position.
- Since we cannot know about our own unconscious directly, it is sensible to set up a structure to act as an 'instrument' to detect these impacts.
- Using principles from what is often called the Tavistock or Group Relations model which I have published separately as the healthy organisation model, it is possible to set up a description of the task and parameters of therapeutic work that will enable us to notice when any of them are breached. (N.B. my claim is that they *will* be breached, if you are open, unconsciously, to your patient; this is not bad practice – bad practice is allowing the breach to go unnoticed.)
- I believe this whole structure should be explicit, that is, written down and shared with the patient. The structure, an expansion on that schematic approach which I quoted at the start, might be described as a 'description of the work' rather than a contract and I'll be going into this in more detail later.
- The therapist's commitment to maintaining a third dimension in his mind constitutes, along with the engagement with the patient and the maintenance of the setting, the ***therapeutic container***.
- We know that there will be a limit to any therapist's ability to notice all the ways in which he has been unconsciously affected by the work, so the *ethical* approach is to face this truth by setting up a further structure in which help is sought. This help is in the form



of colleagues with whom one can discuss the work. In fact, it is now a duty of all psychoanalytic psychotherapists that they discuss their work with colleagues.

- Sometimes the work will be discussed in a formal meeting or conference as part of the scientific life of psychotherapy, in the same way as medics present their work for scrutiny by peers. One of the basic shared principles will be that the therapist will seek to disguise the identities of his patients whenever he discusses his work with colleagues.
- These colleagues and the institution that authorises (registers) the therapist constitute the *secondary container*.
- Once again, I believe the existence of this container should be shared with the patients because, if the therapeutic container collapses, it will be the *secondary* container that will step in to hold the work and make it possible to understand and even repair the breakdown. In other words, the secondary container is there to look after the work.
- Therapeutic containers are bound to break down from time to time (in fact they are continually breaking down and being re-built as part of the work) and it is unethical not to be prepared for this to happen.
- The reason for this is that the struggle, which I'm calling, after Freud, resistance, always occurs on the boundaries. The full discussion of this argument can be found in Stokoe, 2015.

I shall now expand on these ideas.

I have a great deal of experience as a senior manager responsible for handling complaints from patients and their families and also from one (or more) staff members about another. I have also represented or been an expert witness in cases where care staff and therapists have been the subject of complaint or disciplinary. These experiences made me aware of the way that complaints always carry a historical implication. They are often reducible to the form, "*You never told me you were going to...*" At other times the expression seems more immediate: "*This behaviour is unacceptable.*"

However, it doesn't take long to realise that there is history implicit even in that form of complaint as well, in the sense that the complainant clearly had a pre-existing idea of what constitutes *acceptable* behaviour. And yet, most enquiries about complaints start with the moment or the event of the complaint. It struck me as crucial to the process of trying to understand a complaint, *to start at the beginning*, not at the point of that complaint.

This observation led me to design a system for managing the process of therapy that would be applicable in institutions and for individual therapists working privately. This is what was summarised by that list earlier and has at its heart the concept of two 'containers', the therapeutic container and the secondary container. (Stokoe 2015.)

It is a sort of 'protocol' that allows the therapist and patient to know when the therapeutic container has been broken and which provides a containing process to offer the best chance to understand what went wrong and, therefore, the best chance of moving forward in a safe and therapeutic way.

The principles that it is based upon *must* be accepted by any organisation or body registering psychoanalytic psychotherapy because, as I have just tried to show, they are intrinsic to the work. You could summarise it thus: the nearest we will get to a full

understanding of what has happened in any human activity, has to include, at its centre, an understanding of the unconscious factors involved.

And yet UK psychoanalytic institutions, which carry the responsibility for registering clinicians, have done something very strange. The moment a complaint or disciplinary is raised, they seem to abandon all commitment to understanding the part played by the unconscious. Instead, these institutions typically replace a thoughtful, psychoanalytically informed enquiry with a superficial imitation of a court of law.

The reason I wanted to address this issue is that, even in institutions where such structures are apparently accepted, under the pressure of a complaint or disciplinary, they are not only abandoned, but often appear to be jettisoned completely. It is important not only to note and describe this but also to *try to understand why this happens*.

Furlong (2005, 2006) has dealt very effectively with the reasons why the legal approach to a psychoanalytic case cannot work. Her argument, with which I completely agree, is that the law treats human agreements and contracts as 'things' that are independent of the individuals involved. Such contracts or agreements are there to limit the behaviour of the participants and to avoid conflict. Therefore, it is possible to ask whether those individuals conformed to those rules or didn't.

This sort of enquiry cannot take place in the context of psychoanalytic work because the 'agreements' or 'contracts' serve 'for the majority of the time' *as the place of work for the patients and therapists*. In other words, although they really do constitute part of the 'walls' of the container, their main function is to enable the therapeutic struggle to take place.

They do not 'limit' the participants' behaviour; they actually provoke misbehaviour:

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)

Boundaries

I think we do not spend enough time thinking about the idea of boundaries. My first experience of their importance and, therefore, their availability to be unconsciously suffused with meanings that don't actually belong to them, was when I was put in charge of a treatment unit 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, including the capacity to make decisions about themselves. 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, '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*.

The result of these new and different ways of thinking led me to the conceptualisation of boundaries that I have referred to above. Although, at one level, they are parameters that define what is and what is not 'on task', more importantly, certainly within therapeutic work, they are the place where work happens. If the patient is actively engaged in developing a deeper understanding of himself in a session, it might be said that work is going on, but it doesn't include the analyst. What I mean by work is an active engagement between patient and analyst.

It was this understanding that led me to the concept of the container in which the real work only happens at the boundary. I had in mind the difference between the relatively minimal activities that a driver engages in while following a straight road and the engagement of the driver's actual driving skills. The requirement for these arises when the road ceases to be straight or when there is another vehicle that must be watched and avoided or when the weather makes the process more difficult. In the same way, people may engage in a therapeutic task, let us say to enable a patient to develop more understanding of his difficulties. The therapist has little contribution to make when the patient is listing and linking insights. It is only when the patient attempts to change the rules that there is a genuine therapeutic opportunity. *I gave the example earlier of the way that an interpretation is stimulated by a patient perceiving the therapist not as a therapist but as some figure from his inner world.*



In other words, these boundaries, which are essentially statements about acceptable and unacceptable ways that patient and therapist interact, are not, essentially, ethical parameters. Instead, they are parameters designed to enable the therapeutic task.¹

If the boundary is the place where real work happens, then designing the boundary will be informed by this fact. As I have said, these boundaries constitute the 'therapeutic container', and we can see that the work can be represented by continuous impacts on the boundary. Some of these boundaries in therapeutic environments are logistical, geographic, or behavioural but others are personal.

As I see it, we are all rather good at detecting the other person's unconscious and will have a sense of their vulnerability. In my experience, in therapeutic encounters, patients will unerringly recognise these personality traits in their therapists and use this sensitivity to provoke them to abandon their role as therapist. For example, I have spent a great deal of my professional life supervising trainees or taking part in clinical discussions with them. There is a shared vulnerability amongst many trainees to do with the worry that they aren't going to be good enough. This can have a number of effects, the most common of which is to attempt to behave like they think a therapist *should* behave instead of simply relating to their patient. But it is the related unconscious belief that is relevant to this investigation; the belief that they are not good enough. This offers a welcome home for the projections from the patient into the therapist of their own sense of inadequacy, shame, or incompetence. Because this projection fits the therapist so well, it is often the case that the feelings, created by the projection, are taken to be the therapist's own feelings and are then dealt with accordingly. Stimulated by the belief that they are not understanding their patient or are inadequate to deal with the work or have made a shameful mistake, the therapist is likely to behave in ways aimed at addressing these 'inadequacies'. As we view this process from our perspective as onlookers, it is easy to see that such behaviours on the part of the therapist are all forms of enactment. [What I mean by enactment is when a therapist joins a patient in actually performing a role or a part of life that really belongs to the patient not the therapist; for example, behaving like the patient's parent.] As adolescents demonstrate on a daily basis, acting is an alternative to thinking. If the therapist 'enacts', this is because there has been no *thinking* about the exchange with the patient.

From this external position, it is possible to see the whole process in all its dimensions. This is why trainees are given regular supervision and why all therapists in the UK are required to maintain a supervisory arrangement for their work. But for *our* purposes, it provides an image, or template, of a function that the therapist must develop for himself, the capacity to take up a third position.

There is no perfect way to do this, but the capacity first to allow oneself to experience a connection with another and then, in imagination, move to a different position from which

¹ Allannah Furlong makes this point most eloquently in her work (2000, 2003, 2005, 2006), focusing on confidentiality, in her abstract to an article on "Confidentiality with respect to third parties" she says, *Offered for discussion is a draft of a confidentiality policy with respect to third parties that is informed by psychoanalytic theory and clinical practice rather than by local legal jurisdiction or original disciplines' ethics codes.* (2005, p. 375)

we can view the interaction that has just taken place, as if we were not one of the players, is what I am trying to describe.

Indeed, this third position can be seen as an internal structure that keeps curiosity alive in a situation in which thinking might otherwise stop and be replaced by acting, which is another form of certainty.

As I described above, the provision of a third position becomes the template for the design of the entire therapeutic system and includes the known presence of the secondary container. The phrase, 'the known presence' raises a couple of questions; how is it 'known' and how is it accessed?

The secondary container

In previous papers and at the start of this, I have referred to a contract between therapist and patient. I realise this is often misunderstood. I am very grateful to John Churcher and Allannah Furlong for their comments on this (IPA Congress, 2019). The difficulty with the concept of a contract hinges on two issues, the psychoanalytic concept of a contract and the notion of informed consent. I have addressed the former in the section about the difference between the way the law considers contracts and agreements and the way psychoanalytic therapy should consider them. But I want to add something; the most important thing about the psychoanalytic view of an agreement is the way that it operates unconsciously. It has been my observation, throughout a long career of supervision, that everything the supervisee says, from the start of the meeting, turns out to be relevant to the eventual topic that emerges in the supervision. Irma Brenman Pick recently expressed exactly the same view. I would say that this is true precisely because the 'agreement' operates at two levels simultaneously, the conscious *and* the unconscious but it is the unconscious commitment to the shared enterprise that produces the phenomenon that I've just described. I believe that the same thing is true in the agreement to engage in psychotherapy, the unconscious of the patient is always on task, this is what gives the therapist the confidence to address that level of meaning in the thoughts or behaviour that the patient believes to be entirely the result of conscious intention.

I would approach the second of these issues (informed consent) thus, the usual criticism from psychoanalysts that an agreement of contract with a patient cannot be attempted because it requires 'informed consent', which is impossible because of the patient's unconscious distortions are part of what brings them for help in the first place and those unconscious distortions mean that their consent is not 'informed', in the sense of consciously unambiguous. Of course, this is a spurious argument through *reductio ad absurdum* simply because, however much analysis we have, we *never* get direct access to our own unconscious, therefore, we can *never* give informed consent. Such circularity in thinking is almost always the result of a false category somewhere. In this case, it is the treatment of informed consent *as if it is a static state*. Treated dynamically, consent by the patient to the process of psychoanalytic therapy is itself *the object of analytic work*, and therefore is a process, not a static or fixed position.

The reason that I believe it necessary to make a formal agreement of some sort is because of the issue of authority. This is something that is revealed by every complaint I've ever



been a party to. If we are going to respond to a patient who has arrived looking very flustered and claiming that his lateness is entirely the result of delayed trains and traffic by saying that we understand how angry he is about what we said in the last session, we need to speak with authority. Many therapists take the view that this is some sort of personal authority but I would say that authority to work can only derive from an agreement from all parties to that type of work in the first place.

If we design a boundary (and a contract or 'description of the work' *is* a boundary) with the knowledge that it will be a place where work will happen, we create something that has a paradoxical identity of delineating what is not acceptable and, at the same time provoking the participants to break that boundary. The reason I go on insisting on something of this sort is partly because of what we know about the universal shape of a complaint: "You didn't tell me you were going to..."

When we attempt to give space to think about what an apparently inappropriate behaviour might mean, rather than simply forbidding it and disciplining the clinician, we are sometimes accused of 'protecting' a colleague. It is as if trying to understand something is the same thing as condoning it. When I presented a proposed complaints procedure to a psychoanalytic organisation and stressed that the response to a complaint had to involve an investigation of unconscious as well as conscious factors, some colleagues said that allowing the unconscious story to be told was allowing people to 'get away' with unacceptable behaviour. Rather naively, I was shocked by this. My view remains that the opposite is true. Once we know we have an unconscious, we can never again pretend we didn't know. Instead, we have a duty to provide a system for monitoring our unconscious. The unconscious story is not an excuse. It is an important part of the truth.

I have been arguing that the boundaries around the therapeutic work are the sites of that work. We cannot make deep contact with our patients without being drawn into their unconscious world and our attempt to understand this, what Patrick Casement called 'Learning from the Patient' (1985). This requires the development of a structure that offers a third position from which to look at the interaction between therapist and patient and such a third position is something that the therapist must develop within himself and also provide through a secondary container.

The secondary container is the home of the capacity to provide a literal third position to support that which we learn to develop as therapists, in the work. Here is the requirement that we all seek supervision because this is the evidence that we take it as axiomatic that we will all be affected unconsciously by the patients, in the work. Therefore, we look after the work by talking to colleagues who can provide a clear eye to our unconscious. This is an identical ethical position to the situation in the time of Covid by which wearing a mask and having a vaccination are more importantly in the service of looking after others. It is so often the case that we don't notice how we've been affected by the unconscious dynamic that it is only afterwards that we can see it. These effects might be described as 'assaults' on the boundaries but only to convey that they have an impact.

Because these assaults on the boundaries, caused by the patient's resistance, actually have a real impact on the therapist and, therefore, on the boundaries themselves, there will be



times when the therapeutic container is fractured. At such points, the secondary container has another role; to hold the therapeutic couple in an attempt to protect the work and to protect the two (or more) participants.

At this point I want to introduce an idea that might, at first sight, seem to complicate the issue but I hope that I can clarify this in a little while with reference to the impact of Covid on psychoanalytic work. The idea that I want to introduce was already there in the concept of the therapist's capacity to move to a third position during the therapeutic work. I want to add the nuance that, sometimes, such a view reveals that there has been a temporary collapse of the therapeutic container. This will be revealed by a focus on the setting. For example, the therapist might need to change an appointment, or the patient might build up a significant payment debt. The therapist will have attempted to interpret the consequent 'material' in a way consistent with the therapeutic task but to no avail and it becomes clear that there is a need to return to the 'agreement'. It is my contention that recognition that the issue is now a 'business' issue rather than simply continuing the therapeutic task, has the merit that it can recommit both parties to the therapy. For example, addressing the unpaid bill in terms of the way that it makes continuing therapy impossible, will give the best chance of resolving the problem. At this point therapist and patient will be talking about the therapy in a different way, much the same as when they first met to set up the arrangement in the first place. I consider this as the equivalent of stepping back into the secondary container without actual recourse to a third party involvement, so that both patient and therapist can re-commit to the therapeutic task or agree that this is no longer viable. I believe that these sorts of events are much more common than one might think but much more effective if they can be properly acknowledged by the therapist.

The more recognisable move into the secondary container because of a clear fracture of the therapeutic container is an action. I would describe action as part of an ethical code. It might be stimulated by the patient in the form of a complaint, by a colleague in the form of some concern about the situation, or by a supervisor who sees that therapy has stopped. Whatever the source, a psychoanalytic organisation *must* provide an intervention that understands that the boundaries are not rigid rules. This means that there has to be an investigation informed by psychoanalytic understanding of the ways in which therapists are drawn into roles by unconscious processes, but which does not neglect that therapists might be doing the same to their patients. An assessment can be made as to whether this activity demonstrates culpability, neglect, or conscious abuse by the therapist, or else an unconscious assault on the mind of the therapist, possibly followed by a conscious attack on the professional role which is characteristic of the patient's pathology.

There will always be evidence that the therapist 'crossed a line'. The question at the heart of it will be: Was anything he could have done to repair the situation? Any legalistic approach to boundary violations will always find some evidence against the therapist. Indeed, I would be deeply worried about a therapist who wasn't pulled into roles by the patient; how much is this therapist actually available to his patient?

It is these factors which make the therapist uniquely vulnerable to accusations of ethical code violations and complaints and is why a tailored response needs to be put in place to deal with them. One which recognises that the standard complaints procedure for dealing



with healthcare professionals is insufficient for psychoanalytic work and instead addresses directly the complexity of the therapeutic relationship. It is up to us as professionals in the field to communicate this difference to ensure the creation of ethical codes and complaints procedures that will be fit for purpose and help our patients and the therapists involved.

It would be the subject of another paper to consider why psychoanalytic organisations so easily give up the psychoanalytic approach in the face of a complaint but I can say that it is to do with anxiety about being the one complained about. Solomon Asch (1950s) carried out a famous experiment to demonstrate the power of the urge to conform: he assembled college students for a simple test: shown a single, vertical, black line of a certain length, they needed to identify which of three separate lines matched it in length. All but one of the students had been told beforehand to choose an obviously 'wrong' line. The other, isolated, student gave his opinion last. In nearly 40 per cent of the cases, the isolated student chose the obviously wrong answer. We must stand against a pressure to conform which, if we give in to it, directly undermines our capacity to work and genuinely to care for our patients and our colleagues.



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