



Towards an approach to Ethics and Complaints for psychoanalytic work. 18/9/23

In my last presentation to the SAP about ethics and complaints, I began with the claim that psychoanalytic work only occurs at the boundary. I argued that this means that boundaries for our work are not the same logical type as boundaries for the professional standards authority (PSA). As a consequence, we have to design an ethical code that protects both patients and therapists, whilst enshrining a psychoanalytic approach to understanding behaviour and relationships in the heart of any complaints procedure.

I outlined a model for approaching this challenge in which I suggested that a therapeutic container within which the therapeutic work takes place must be held within a secondary container, the purpose of which is to protect the work in the *inevitable* circumstance that the therapeutic container is damaged.

In today's presentation, I propose to look in more detail at how that secondary container can provide us with a model for ethics and a complaints procedure. To this end I shall describe the purpose, structure and function of the secondary container and show how the breach in the therapeutic container can only be properly understood if we start our enquiry at the beginning of the therapeutic engagement. This is a reflection of the standard shape of all complaints which tend to be some version of, "you never told me that you were going to..." I hope to show that this can provide an approach to understanding what happened that takes place within a language of enquiry rather than one of blame. In addition, I shall consider the case of sexual boundary violations.

Current approach.

Looking at the way our profession approaches the question of how to maintain good quality psychoanalytic work, there is much that fits with what I'm about to talk about. I take that as indicative of a semiconscious awareness of the problems that beset psychoanalysts in their work. For example, one of the things that teachers look for in trainees at the point of allowing them to qualify is whether they appear able to carry an internal supervisor in their minds during the work. Related to this is the expectation that the trainee has a deep understanding of the setting or frame. All institutions that I am aware of expect qualified analysts to continue to seek supervision, indeed there is a requirement for something called continuous professional development which contains the expectation that the analyst will be presenting their work to a peer group. All institutions have an ethics committee. All institutions have an ethical code which includes a complaints procedure. All that I am doing is to provide a model, which includes a rationale, that connects all of these apparently separate elements into a single concept.

It seems sensible to begin with a brief description of the model and its rationale following from the location of work at the boundary. Because of this, it is sensible to reduce the number of boundaries in the work so that those moments of impingement can be the more easily noticed. One of the most common examples is the expectation that patients pay for sessions they cancel. Another is the clarity about the regularity and length of sessions. More importantly, though often not stressed enough in the training, is the arrangement that



allows the patient freedom to say or do whatever comes into his mind but constrains the analyst to the role of a therapist who will try to understand the unconscious meaning of what the patient brings.

Every analyst is taught to look out for something called the transference and many trainings take very seriously the inevitability of the impact of projective identification. These are processes in which the therapist's identity as "therapist" has been changed by the patient into something else. My suggestion is that it is helpful to think of this as a boundary violation, not because there's anything bad or wrong about it, quite the opposite, it is because, in breaching these boundaries the patient reveals something about their own inner world, but which is perceived as occurring in the external world. A trainee who has developed skills to have their own internal supervisor does so to help them notice this process and, by noticing it, turn it into information about the patient. Free-floating attention or negative capability is a skill that enables the analyst to wait until his own unconscious can come up with and present a view to his conscious mind of what's going on in the room.

Successful therapy requires the capacity to maintain a third position in the mind to which the analyst can retreat and from there have a look at what's happening between himself and his patient. When this process is happening, therapy occurs, and the therapeutic container remains intact. An important way in which the analyst maintains this capacity in himself is when he reports his work in supervision or to a group of peers. The feedback he gets is an external recreation of the third position. The third position both enables and protects the work. This is what I describe as the secondary container in the mind.

However, none of us are omnipotent nor omniscient and, since processes like transference and projective identification often hook into parts of our own personality, there is always the danger that we simply don't notice that the boundary has been broken, so the breach remains.

I believe that the central focus of the training, which is to develop the skills that I've just described, leads us to *overvalue* one of the key endeavours of our work, which is to interpret the material in the room in terms of the patient's pathology or unconscious world. The reason that I have come to this view is because of the huge number of examples of a therapist, subsequently complained about by his patient, who had taken something of the process that became the kernel of the complaint to a supervisor who supported his endeavour to find the *right interpretation* to unblock the analytic process. If it was more a part of everyday psychoanalytic discourse that, because the work occurs at the boundary, boundaries are liable to be broken fairly frequently, I believe that the numbers and types of complaint would reduce. This may become clearer if we think about the secondary container as an institution.

The secondary container as institution.

It is helpful to think about the way this is built. Partly because it will enable a smooth use of it as necessary but also because it helps to think about roles that have always been a part of psychoanalytic practice but not necessarily thought of in this way. I believe this model of two containers provides clarity for some of the complex conundrums that ethics committees often face.



The first thing to be clear about is the purpose of the secondary container, what might be called the primary task in institutional terms. My suggestion is that this is to protect the therapeutic work. This allows for a significant range of interventions including, removing the therapist from the work because repairing the boundary infringement seems impossible by any other means.

The second thing to be clear about is the point at which the secondary container takes over from the therapeutic container. We might liken this to a range of alarm bells. The most sensitive will occur at the interface of primary and secondary containers, the most serious will obviously be the point at which there is a complaint about the therapist. I hope that these thoughts enable us to identify roles that are essentially part of the secondary container and yet operate at the interface, because the awareness of the location of these roles might make it easier to move into a secondary container function.

I hope that I have conveyed something about the role that is both therapeutic container and secondary container when I was describing the importance of the therapist's responsibility to set up and maintain a predictable setting as well as an internal capacity to move to that third position from which he can review what's going on between himself and his patient.

If the therapist feels comfortable with the idea that the therapeutic container *will* break down from time to time, he is more likely to be able to provide a secondary container function at those moments *himself*. A good example of this sort of phenomenon that might enable a therapist to notice something had gone wrong with the therapeutic container is elaborated very well by Bion and subsequently by Britton and Steiner when they describe the difference between a selected fact and an overvalued idea. When therapy is going well, the therapist is able to allow himself to move into a state of mind without memory or desire (Bion) or free-floating attention (Freud) or negative capability (Keats). The way I understand this, is that we are able to trust that our own unconscious is continuing to work on the material that the patient is presenting, so we feel confident to wait, knowing that, at some point, the thought will come into our minds which helps us to understand what's going on. Bion called *this* the selected fact. At other times we find ourselves driven to repeat a previous interpretation in an expression of a belief that, if only the patient could see what we can see, things would improve. Bion called this the overvalued idea.

I think the continual rapping the patient over the knuckles with the overvalued idea is a point at which there might actually be a breach in the container. There are many examples of when this can happen, one is a dispute about paying for a session that the patient had cancelled. There is an extra component to this example, which is that it carries the same implicit message that, as I have claimed, all complaints from patients carry, namely, 'you never told me you were going to...' It would be good if the therapist could recognise this impasse, but that often proves difficult. If he *does* recognise that this is an example of a breach of the therapeutic container, then he can move to a position where *he* represents the *secondary container*. What I have in mind here is saying to the patient that we need to stop therapy for the moment so that we can think about the arrangement *for* therapy. In other words, we turn it into something a bit more like a business meeting. We set aside the



instinctive yearning to interpret this phenomenon in terms of the patient's pathology and, instead, review the contract and agree its nature going forward. Often this need only take few minutes in the session, but I believe therapist's ability to move to a different kind of meeting with the patient, one that is more like a business meeting, is much more likely to "protect the therapeutic work" than hammering away at some overvalued idea about why the patient is behaving this way.

A more important example of this kind of phenomenon occurs around the issue of safeguarding. There is a simplistic approach usually presented by those who carry the responsibility of the safeguarding officer in a therapeutic institution and implied by the nature of the advice coming from safeguarding procedures. That is that if a patient speaks about abusing a vulnerable other, the therapist should immediately call social services and set up an enquiry. I can understand why safeguarding procedures have been written like that because they arise from the position of trying to protect children who disclose that they are being abused. Whilst accepting that protecting children takes precedence over almost everything else, I do not think it takes precedence over thinking.

Let us consider the case of therapy with an adult. It sometimes happens that the patient will say that they are doing something inappropriate with a child or that somebody in their household is doing this. This might well be a feature of the pathology of the patient that could be understood as making the therapist extremely anxious. That of course will have a huge range of meanings. The therapist will be trying to work out why the patient is making him feel so anxious. On the other hand, there will be a safeguarding obligation to make a report to social services. Although it is more likely that this is some kind of acting out in the therapy that has a meaning about the patient's inner life rather than his external life, it is clearly *unsafe* to continue in the *hope* that this is true. My view is that this is another example of a breach of the container. An early intervention based on a move to secondary container function, has the merit of, once again, protecting the therapeutic work. My advice to such a therapist would be to point out to the patient that making this kind of claim changes the nature of the activity in the consulting room because the therapist has a duty of care to vulnerable others who might be at risk of abuse.

If the patient is describing a risk presented by somebody else and it is clear that the nature of the meeting has changed to a discussion about the reality of his claim, this will often be a point at which he feels that it *is* possible to bring this information to a safe place where something can be done about it whilst at the same time protecting his confidentiality. If it is the patient himself, who is genuinely abusing vulnerable people, it is likely that the nature of the discussion in the context of a secondary container atmosphere will make clear where the truth lies. (I should add that these are not simply theoretical situations but events that I have been party to.)

The more difficult situation is the one in which the patient asserts that he really isn't going to be abusing his children. Once again I think that the notion of the secondary container is helpful in managing this kind of problem because the therapist is left with the responsibility to make a judgement about whether this is the truth or whether the truth was what the patient said in therapy. The feeling that you cannot be sure what is going on is normally the point at which any of us would go to supervision to get help.



I have tried to describe how the therapist himself *represents* the secondary container as well as operating within the therapeutic container. As with all institutional analysis, it is helpful to identify the primary tasks. The primary task of therapy is to help the patient to understand those parts of himself that he has no direct access to, so that he can see how they affect the way that he sees himself and the world that he lives in. This is the primary location of the therapist. I have tried to show that the therapist also has a role to protect the therapeutic work, which is the primary task of the *secondary container*. With this hat on he sets up the therapeutic container in the first place and he moves into a *secondary container* function when the *therapeutic* container has clearly been breached. In the example of the patient who says that he wasn't really telling the truth when he said he was abusing vulnerable people, I referred to another role within the therapeutic system for which an institutional location needs to be clarified, the supervisor.

The Supervisor.

The point in terms of the question of location of supervision within the world of the two containers, is that I see it as belonging to the secondary container. The good enough therapist is able to move to a third position during the therapy or, between the therapy sessions and, in doing so is retreating to a secondary container position in the mind, as I described earlier. I also said that one of the questions that training bodies ask at the point of qualification is: 'has the candidate demonstrated a capacity to use an internal supervisor?' In other words, the internal supervisor and the third position are different descriptions of the same phenomenon. This makes it clear that the location of the supervisor is within the secondary container.

For the sake of brevity my suggestion is that wherever the therapist turns to for help in thinking about his work with his patient, should be thought of as part of the secondary container. Clinical institutions and training institutions go to a lot of trouble to provide more than one version of secondary container. As well as supervision there is often a clinical unit where work gets discussed. There may also be a variety of seminars in which the trainee therapist and, in more enlightened organisations, experienced staff present their work. So, the importance of these resources has been recognised for a long time without, apparently, conceptualising them in the way that I'm doing here. Our registering bodies support one requirement for registration which is a number of hours of continuing professional development. We know that this means essentially time when we present our work in a group of clinical peers, referred to as CPD groups by some.

Obviously Training Committees are part of the secondary container as are colleagues and Ethics committees, although these have an additional role which I shall try to cover in due course. But you may well ask the question, where do training analysts belong in this model?

When I trained, my institution espoused the reporting model for the training analysis. This means that my analyst was asked for her advice as to whether I was ready to start training in the first place and then, at each developmental stage, whether I was ready to take that step. Many people felt that this interfered with the opportunity to have a full and confidential analysis. I certainly think that it did. The institution no longer expects a report from the analyst and, though I cannot know whether this is true, has probably discovered that any



role that a training analyst might play in protecting the therapeutic work is covered by safeguarding. In other words, all of us who have therapists or trainee therapists as patients also have a duty of care for the patients of our patients and that duty requires us to take seriously any sense of inappropriate or dangerous behaviour on the part of our analysands; in other words, to deal with such events as I described earlier when thinking about safeguarding. I think that this combination of not including the training analyst in the secondary container and yet expecting them to behave like therapists obliges them to take seriously any safeguarding anxieties, and helps enormously with a separate problem to the one that I am addressing today but which has afflicted so many psychoanalytic institutions throughout the world, namely the overvaluing of the role of the training analyst.

The obligation of membership of the secondary container.

It seems important to reflect upon this aspect of membership of something that I have called an institution. Institutions aim to achieve the primary task but do so within parameters that are often called governance. These are essentially the limits upon the way that the primary task can be achieved and include ethics, morals and something that many of us have called the personality of the organisation. For our purposes today, I want to single out the most important of these is it affects the way that members of the secondary container should be approaching their work. It is that the protection of the therapeutic work must take precedence over all other considerations. This principal derives from the change of perspective to the 'third position', which treats both participants equally, i.e. that each of them must be observed with a psychoanalytic eye.

If we have the impression that a colleague in our CPD group has become caught up in, or has instigated a situation in which a boundary violation continues without any attempt to address it; it is an act of care, of kindness, to bring it to the attention of our colleague and, if there is any denial about it, to treat the therapy as having stopped, i.e. that the therapeutic container has broken, and set up procedures to manage the situation. This invokes the same procedure that would occur in the event of a complaint. The fact of there having been a complaint is in itself evidence that the therapeutic container has broken. If there is any chance of looking after the therapeutic work, this only occurs by moving quickly to a process of secondary container intervention.

The purpose and trigger of the secondary container intervention is not an assessment or judgement about whether what is complained of has happened or might have happened or is likely to have happened or whatever nonsense the current ethical system defines at this point. It is simply an acknowledgement that the therapeutic containment is broken therapy is not working.

The next thing is to set up a benign enquiry to discover the story that must have begun earlier than the point of complaint because the complaint will always be a reference to a prior expectation. This, of course, includes the situation where a colleague or supervisor is concerned about the behaviour of the therapist because, once again, there is an assumption that the therapist had signed up in the past to a code of ethics that provides further boundaries for the therapeutic container.



Key to this way of working will be the ethical code of the organisation and the primary task of the ethics committee.

Ethics committee.

One of the things that clinicians accused of boundary violations have been complaining about since the new system, espoused by registering bodies and imposed on the member institutions, is the awful experience of having absolutely no support. The Public Standards Authority (PSA) requires these bodies, upon receipt of a complaint about a therapist, to make an assessment as to whether the claimed violation *might* have happened. If so, their duty is to set up a process of enquiry that has the form of an investigation *about* the clinician rather than *with* him.

In health and social care institutions there is a requirement to suspend the clinician and instruct his colleagues to have no contact with him. Obviously, this is based on a belief that, since the subsequent enquiry might involve interviews with those colleagues, they are liable to be influenced in their replies by such a contact. In other words, that they will be contaminated by the person complained about. It doesn't take a genius to see that this, in itself, is an act of influence/contamination because it stems from an a priori supposition of guilt. The existence of this unconscious communication also affects panels set up to judge the complaint, who find themselves under pressure to make some sort of sanction against the clinician, even when the substantive complaint has been dismissed.

We might ask ourselves, what unconscious belief leads to this situation? The only one that I can think of is that there is a confusion between empathy or concern about someone in this mess and a wish to avoid the reality. I am very grateful for my 12 years at the start of my career working with the most dangerous young people in the country, many of whom had committed awful crimes. It was crucial to the best chance of helping them that the staff group could be clear about the fact that these crimes *were* dreadful, and therefore never losing that sense of the kids having *actually* done these things, so that they could address their therapeutic endeavour both to helping them come to terms with what they'd done and also work through aspects of their personalities that enabled them to do these things. In other words, it is not kind or loving to collude with denial, it is damaging. The psychoanalytic project has this belief at its centre. With this in mind, we can turn to the role of the ethics committee which might be thought of as the final bastion of the secondary container.

Going back to the first principles, the function is to look after the therapeutic work. However, the role of being the 'last bastion' of the secondary container carries a particular implication for the *location* of an ethics committee viz a viz the organisation. As a general rule in designing roles and accountability in organisations, I've found it helpful to consider the 'worse case scenario'. In this, given what I've said about the confusion or lack of clarity about the roles of supervision, reflective practice and colleagues, there is a high probability that one or all of these functions in any organisation might be drawn into an attempt to maintain the therapeutic container rather than enable a move to addressing any problem from the secondary container. In which case one can imagine (and, indeed, this is not an infrequent occurrence) that either party within the therapeutic container, might lodge a complaint about the way a breakdown in therapy has been managed. The ethics committee has to occupy a position from which it can address such a complaint impartially. This means



that it has to operate independently of the management and accountability structures of the parent organisation. I have frequently come across arrangements in which a member of the ethics committee sits on the board, for example. This compromises the freedom to investigate the board if it becomes necessary. It is, of course, the board's responsibility to set up the ethics committee in the first instance, but as an independent, advisory committee that would have a duty to report to the board without being subject to direct management by that board. It is, therefore, available to the board and to every other member of the organisation as a resource to give advice about ethical issues. This can work well as long as the terms of reference are clear from the outset. Central to these terms of reference would be the maintenance of therapeutic work within the agreed ethical framework whilst also being a source of support for any member of the organisation facing a complaint. It is not difficult to set up a protocol for this; an example would be to have two separate members or groups from the committee attending to the complainant on one hand and the member on the other. These can report back to the committee which will have the task of deciding how to proceed with the complaint. At the heart of the work of each sub-group, will be the task of discovering the full story of the therapy, so as to make an assessment of the truth of the underlying complaint, 'you never told me...'

My critics will argue that providing support to the member who is subject to a complaint compromises the committee's impartiality in making an assessment. This goes back to the point I made earlier about the nature of psychoanalytic work, namely that it is based on the principle that facing reality *is* the main aim of the work.

I shall turn now to a specific 'boundary violation'.

Sexual Breaches

For obvious reasons, I have been asked to offer some thoughts about this particular sort of 'boundary violation'. Many of you will know of the work of Glen Gabbard in this area and I shall begin with some quotes from his 2003 paper with Andrea Celenza which might help to orient us. In their summary at the start of the paper they write:

Sexual misconduct is not a problem we can observe from a comfortable distance. The analyst who becomes sexually involved with a patient may be a former teacher, supervisor, colleague, or friend. Moreover, the persistence of this problem, even among the most highly educated, respected, and trusted of us, requires a microscopic examination that may be painful, humbling, and at times threatening. Perhaps this explains why, until this past decade, the problem has eluded our attention despite having been identified since the dawn of psychoanalysis. (p 617)

They go on to say:

Sexual misconduct is commonly misunderstood. This misunderstanding is particularly apt to surface when a shocking or confusing case comes to light. The misunderstanding often involves three assumptions: (1) therapists and analysts who have engaged in sexual misconduct are probably psychopathic; (2) they have likely exploited more than one patient; and (3) they are not amenable to rehabilitation. While these three assumptions are indeed valid for a specific subgroup that accounts for a substantial number of victims, this profile does not fit the majority of transgressors. (618)



In contrast they describe from their actual clinical work with such clinicians that:

... the profile of the one-time transgressor is, at least on the surface, too much like you and me. While most of us might still have difficulty imagining ourselves engaging in frank sexual behavior with a patient, it is much easier to resonate with the particulars of this type of case; we too have found ourselves in a transference-counter-transference dilemma, and have entertained the fantasy of extreme measures that might solve an acute crisis. There are typical precipitating factors in this subgroup, most of which we can understand.

Then, crucially to my claims about the nature of the boundary, they add:

We can all recall times when we crossed minor boundaries in a similar circumstance with a similar patient. Examples of such crossings come easily to mind but are usually shared only in private, informal contexts with colleagues and friends. (620)

If we consider these comments alongside my arguments about misunderstanding the nature of a secondary container, we would predict that those who might be offering clinical support to colleagues *can* get caught up in a misunderstanding of the role and over-value the idea of finding the right interpretation to create change in the therapeutic situation, particularly because of the wish to avoid the thought that colleagues who appear just like ourselves might be caught in an enactment that violates a sexual boundary. One of the ways to manage this is to wrap a spurious envelope of confidentiality around the issue, more easily done if the supervisor/colleague/therapist misunderstands or has no concept of the secondary container function and principles.

The result can be that several, often many colleagues either have direct evidence or, more often, a *sense* that something has gone wrong but, because of a combination of errors about confidentiality on the one hand and the challenge that these really are people like us, not psychopaths, on the other, everyone becomes caught up in a communications vacuum. When this happens, the eventual 'disclosure', stimulates a move to distance us from any danger of identification with the 'perpetrator' (as he becomes), which makes the process of thinking about the situation fill with guilt and anger that can threaten to get in the way of analytic processing.

The following is an amalgamation of situations I have been involved in. A much-loved manager of a clinical service was suddenly removed from his post. No explanation was given, beyond a potential disciplinary action, and staff were forbidden to speak to the manager or to each other about the manager. I was available as a facilitator to the staff group and took up firstly the acquiescence to the apparent 'confidentiality' issue. My challenge to the group was complaining about the embargo on speaking either to the manager or to each other, was not convincing to me because nobody had actually complained to the management system that had set this injunction in the first place. I suggested that this was evidence of unconscious ambivalence about the beloved leader.

This intervention had the effect of gradually and then almost torrentially releasing a series of thoughts, worries, anxieties and concerns that (as it turned out) the majority of the team had, but had not shared, over some time. Only a couple of them said that they'd actually



addressed their worries to the manager, who had reassured them that nothing was happening. It took a little while before the staff team actually named the main anxiety, which was a sexual boundary violation.

The next stage in the group discussion was a rapid move from idealisation to denigration of the manager. I pointed this out to them. At first this drew the response that they were feeling like this because they were so let down by his behaviour. It took several meetings before the staff group began to consider something else, their guilt that they had not taken their concerns about the manager more actively. It was guilt because, in parallel with this was an idea that, if there had been a way to do that, they might even have been able to stop the behaviour before it happened, particularly because they had noticed that their first worries had been during clinical discussions about their clients in which the manager had presented material from his work with a particular client.

Summary

I have tried to show how the idea and existence of a secondary container, properly embedded in the minds of all therapists, can enable the two major dangers of the work to be processed. The dangers arise from the nature of the psychoanalytic task, which make it different to other professions. The first is the nature of boundaries. As I put it in my book:

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. (p 110)

The second is the aim of helping the patient to face reality. Too often this becomes lodged in the therapeutic container and encourages those advising about the work, to remain blinkered to any sense that the therapeutic container has broken down, and that there needs to be a secondary container approach to addressing the therapeutic work, which means facing the reality of what has been going on from both participants.

I want to throw in a final thought, which is a challenge, rather than anything else. In modern times most couples have formed in a workplace. Celenza & Gabbard address this at the end of their paper:

Another way to address the problem turns the whole question of sexual misconduct on its head. Rather than ask why sexual misconduct occurs, we might usefully consider why in most cases it does not. Love of one sort or another regularly finds its way into the intensely intimate experience of the psychoanalytic process. Why, then, aren't boundary violations more common? What are the safeguards most of us employ to prevent our crossing boundaries all the time? (pp 634-35)

Thank you for your kind attention.



References

Bion, WR 1962a, Learning from Experience, London Karnac, C23, p72

Britton, R. Steiner, J. 1994. Interpretation: Selected Fact or Overvalued Idea? Int. J. Psycho-Anal., 75:1069-1078.

Celenza A & Gabbard Glen O; 2003; Analysts Who Commit Sexual Boundary Violations: A Lost Cause? Journal of the American Psychoanalytic Association, 51:617-636

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