TALK ABOUT TROUBLE IN THE FAMILY.

PREFACE

Elizabeth Kerr

It is a real opportunity, almost relief to have Prof Gabbard here beside us to help in this conversation. I think it is the relief most Ethics Chairs and Committees feel, the relief to have someone to talk to, someone beside them, a third with whom to consult in situations, sometimes as complex and multilayered and as difficult as those that come before Ethics Committees. I think the same relief we can all feel in being able to engage in a conversation with an external supervisor or senior consultant in situations where the conversation with that INTERNAL supervisor/ consultant is either not enough or may simply go missing.

My paper today is an attempt to reference some of the many entry points for discussion and reflection in navigating the boundaries within clinical relationships, and within professional organisations.

It is to encourage and to reference that internal conversation necessary for all of us, throughout our professional lives and careers.

TALK ABOUT TROUBLE IN THE FAMILY

When ethical breaches on the part of colleagues within our Analytic and Psychotherapy Professions become known, the impact has been likened to an earthquake that can shake Institutes and Societies to their very core. (Burka et al 2019) Earthquakes can give rise to tsunamis, tsunamis of emotion, flooding the collegial group, threatening to wash away long held and cherished concepts of the group's identity and sense of self.

Or the effect can be experienced as a wildfire raging through the group, driven by anxiety, fanned by lack of information, sometimes fuelled by confabulation and half truths and hybrid truths, all taking on a life of its own.

And in the aftermath, what of the damage? How and where to begin? Sometimes it is questioned whether a colleague, a society, an institute, a professional community can ever recover?

This conference Navigating Boundaries - too far/too close, provides an opportunity for us to think

and to talk about these things, to put into action ‘the talking cure,’ rather than what can at times become within any institutional organisation, a retreat into silence or a defensive withdrawal. Sometimes, this can even be akin to a ‘protection racket’, protection of ourselves, of individual colleagues, or an institutional defence against the recognition and acknowledgement of improper conduct and behaviour from within. Prof Muriel Dimen (2016, P363) refers to an ‘institutionalised shared disinclination’ to address boundary violations in order to sustain the groups’s standing as a good object, only serving to prevent thinking about our ‘problems and flaws.’

We can equate the impact of both sexual and non sexual boundary violations with that of natural disasters - earthquakes and tsunamis, but ethical breaches within our Professional Organisations are of a different order. They are not natural. They are by definition against our natures, attacks on the nature of our care, attacks on what we do and on how we think of ourselves.

Trouble within the family of any individual Institute or Society not only effects that particular Professional family, the effects can go way beyond and into the whole extended family of Psychoanalysts and Psychoanalytic Psychotherapists, into all the various families to which most of us present belong.

More Formal Complaints are coming to Ethics Committees than ever before.

Climate change is being held to account for the seeming increase in natural disasters, could it be that a change in the climate of public opinion in some way accounts for the increase in Formal Complaints concerning what may be therapeutic disasters?

We live in an increasingly litigious community and one in which there is much greater attention and concern for those who could be considered vulnerable to exploitation and abuse. There is open recognition of child abuse and the need for protection, of domestic violence, bullying, of sexual harassment and exploitation, the birth of the Me Too movement. There is much greater awareness and outrage at revelations of systemic abuse and institutional defensiveness at the highest levels within what have been considered the most sacrosanct of places. The Catholic Church, Parliament House, on the Bench of the Supreme Court as well as within our own professions.

It seems that in every sort of organisation at all levels of our society, those in more vulnerable,

needy or dependant positions, now have a greater voice and a more receptive ear to their upsets and complaints. We are being called to account like never before.

One would hope we have come a long way from what has been the historical and traditional culture within psychoanalysis of a gendered power dynamic, a dynamic involving a basically patriarchal, asymmetrical relationship, historically frequently accompanied by the objectification of female patients, or perhaps within our Institutions of female colleagues. Vestiges of male supremacy within the psychoanalytic domain, clinical or collegial, have perhaps been challenged more directly in recent decades, as more women have become Members, acting as catalysts for greater gender equality.

Janine de Pryer of the National Institute for Psychotherapies in NYC observed in working with a particular male patient that she was often left ' feeling objectified as a woman as well as devalued and disempowered as a professional'. (Pryer, de J 2002 P59) For some women, this experience within the consulting room can be equated with the experience of working with colleagues within our professional organisations.

One would hope we have come a long way from Freud's thinking when he cautioned his male compatriots about the need to bare in mind, ' The way these women manage to charm us with every perceivable psychic perfection until they have attained their purpose is one of Nature's greatest spectacles.' (Gabbard, 1999.P 209). Was Freud suggesting that good and vulnerable men are simply overpowered by disturbed, predatory women? At other times, he seemed to suggest that women are simply in need of a powerfully, penetrating man?

Hopefully, most of us have come a long way since then, although it is clear some of us haven't. Andrea Celenza of the Boston Psychoanalytic Institute draws to our attention the fact that between 9-12% of Members of the Helping Professions disclose they have had sex with a patient. This may be with one patient, many patients or one patient many times. (Celenza, A 2007). This statistic relies on self reporting and likely a serious underestimate. Many researchers, most particularly Prof Gabbard, have explored the damaging impact of sexual boundary violations. More recently, there is increasing focus and emphasis on the damaging and pervasive effects on patients as well as on organisations of not only sexual violations, but also non sexual violations.

It is very concerning that one of the two cohorts most likely to come before ethics committees

are Members occupying senior teaching or training positions or positions of power and influence within our organisations.

How can we possibly make sense of how and why this is happening? What is it about us, about the nature of the work we do and about the Professional Organisations to which we belong?

THE NATURE OF OUR WORK.

The nature of our analytic work resides within the context of a Therapist/Patient couple, taking place in a situation of just two people together. It is a confidential space, the whole context fostering the possibility of regression and activation of affect in both participants, along with the possibility of connection and intimacy.

The therapeutic process requires a fluctuating interaction within the mind of the Therapist of both regressive and progressive self- object identifications and differentiation. The capacity to identify with a patient forms the basis of empathic attunement and emotional resonance, while the capacity to dis-identify, to differentiate, provides a separate space for the Therapist to think, to couple within their own mind with their analytic theory, orientation and understanding. The therapeutic couple by definition presupposes a simultaneous coupling, or marriage within the mind of the clinician to their own analytic theory and orientation and it is this that introduces the third position, a space - not too close, not too far. This we know is what constitutes the frame, the analytic boundary transforming a dyad into an Analytic couple.

However, situations involving both sexual and non sexual boundary violations, result from the breaking down of the analytic couple within the Analyst's mind, and its perversion into something else. The nature of our work involves the activation of our own natures, including our own regressive urges and unresolved personal needs and difficulties. When these dominate and are allowed to intrude into the relationship, the internal analytic couple breaks down, Clinician and Patient become part of a different sort of special couple. The confidentiality required of an analytic relationship becomes corrupted into keeping secret what is really going on, sometimes even from oneself.

When the Analytic couple breaks down, other particular dynamic scenarios and coupling can come into play and be enacted. Therapist and Patient may become a mutually idealising couple, a very special Patient of a very special Analyst requiring a very special type of care, something

other than an ordinary analytic stance and technique. Or the therapeutic couple may break down into a sado - masochistic entanglement, pathologically locking both parties together in an impasse. The couple may be taken over by an erotic transference/countertransference enactment. There may be the development of a psychotic, delusional transference/ countertransference relationship where both parties go mad.
The difficulty could be to do with what Gabbard has identified as the 'love - sick Analyst', where the Clinician, consciously or unconsciously, eroticised or not, makes use of a patient in order to fulfil a narcissistic need to be loved and allowed to love. (Gabbard G.O. 2017) Or with what Celenza terms 'wounded healers', where the work thinly disguises 'a need to heal oneself.' (Celenza A. 2007 P60.)

All situations of boundary violations involve the activation and enactment within the relationship of unresolved needs, frustrations and difficulties within the Analyst or Therapist. Our whole analytic context and frame invites patients to bring their most disturbed, primitive, perverse, destructive aspects into the room and into the relationship with us. It is when these dynamics move into the mind of the Clinician and rather than being processed, held and contained, become enacted in an ongoing, persistent, pervasive, sometimes even unrelenting way, we fail in our ethical duty of care to put the needs of the patient first. If we are not managing in an ongoing way to contain a therapeutic relationship, we have a responsibility to get enough help in order to manage, or help to terminate the treatment in the best way possible for the patient. We can't project or lodge in the patient our own disturbance in analytic functioning, and conflate this with whatever the level of disturbance a patient brings to us, no matter how disturbed.
Whatever, the specific and particular nature of the disturbance and dynamic scenario within the dyad, and whatever the cause of this disturbance, it always reflects serious impairment, or perversion of the Therapist's internal analytic couple, and collapse of the analytic space. It is the collapse of our analytic and ethical duty of care.

The impact of boundary violations are usually devastating for both patients and clinicians. However, there is very often also devastating collateral damage way beyond those immediately and directly involved, most obviously to Colleagues, Members, Candidates and Trainees

within the Professional Organisations concerned.

Serious breaches of analytic boundaries generally involve a delusion that this is ‘just something between us’, there is no ‘third’ anywhere. However, although Ethics enquires are absolutely confidential, when there is trouble within the professional family, there is generally some talk somewhere, it is very rarely kept ‘just between us.’ It may in fact be the case that what is already actually known, or suspected, may simply have remained unspoken, as part of conscious or unconscious group collusion and denial.

THE NATURE OF OUR ORGANISATIONS.

What is it about the nature of our Professional Organisations that makes us so vulnerable to such psychic fallout?

Unlike many Professional Organisations, where Members train elsewhere, we train our own. The fundamental component of our training is our personal analysis or therapy, involving the development of intense transference, countertransference relationships, most particularly with our own Analysts and Therapists, but also beyond with supervisors and others throughout the whole of our training experience.

Our Institutes and Societies are characterised by genetic lineage and long standing trans-generational attachments, associations and loyalties.

We train, produce, give birth to our own next generation of colleagues and in this sense, our Professional Organisations are not just that, they really do constitute a trans-generational family of conscious and unconscious dynamic, fantasy infused, ongoing relationships.

No matter how appropriate the management of the termination phases of an analysis, research suggests that the Analyst/ Patient/ Candidate relationship, even many years post termination, never becomes simply Collegial. Our Training Analysts/ Therapists are always our Analysts/ Therapists and we always remain at some level their Patients. (Gabbard, Glen O and Lester, Eva. 2007) Gabbard, Celenza and others draw attention to the fact that it is very often senior, Colleagues, Training Analysts, holding positions of power and influence, often also charismatic, who come before Ethics Committees.

When a Colleague breaches their ethical duty of care to a patient, this simultaneously breaches a duty of care to the Institute or Society to which they belong. Our Societies and Institutes function as a moral container, binding us together. What affects one of us, affects all of us. When this is ruptured, particularly by a Senior Colleague, the group can be overtaken by intense and primitive anxieties and defences. The experience of past trauma within the group, particularly breaches in ethical conduct and behaviour is reactivated in group memory, further impacting the present.

Members of the Psychoanalytic Institute of Northern California, conducted a study into the effect on the conscious and unconscious functioning within their Institute of two ethics enquires within three years. It was not disclosed whether these breaches were of a sexual or non sexual nature, but they concluded that 'both sexual and non-sexual boundary violations break the incest taboo by breaking inter-generational trust.' (Jane Burka et al 2019) It is to breach the generational protection and boundary required of professional interactions within our analytic families, because of the ongoing generational lineage and ongoing transference, countertransference elements of those relationships, even post termination. It is the perverse nature of the collapse and betrayal of the inter-generational distinction between Analyst/Parent and Patient/Child that is so disturbing for the group. It reveals the betrayal of the marriage of the analytic parental couple within the mind of the Analyst, obliteration of the generational boundary and a perverse re coupling with a patient.

Adrienne Harris states that the breaking of the incest taboo creates ' a dramatic even violent plunge of all surrounding persons into the sight and reality of the primal scene'. (forthcoming) This constitutes a disavowal and attack on the containing function of the Institute or Society. Anxieties about the integrity of our Psychoanalytic work, integrity of our group, even the ongoing viability of an Institute can overwhelm. Jane Burka, of the Institute of Northern California, after discovering egregious breaches of confidentiality by her own Analyst, put it this way, 'My trust In Psychoanalysis as a Profession, and Psychoanalysts as practitioners (was) severely damaged. Questioning the integrity and transparency of one successful Analyst led me to question all : who are these people really? I am one of them.' (Burka 2008 P184)

If our Senior Colleague/ Parents can breach basic boundaries, could we? Our own anxieties are activated. Gabbard suggests, there can also be for some of us, a secret admiration of those

who have dared to break the rules, ‘who have entered into the forbidden territory symbolically equated with the incest taboo’ (Gabbard and Lester 1995 P189)

WHAT CAN WE DO?

What can we do about these situations and how can we work to prevent them? It is a struggle and challenge for all of us. Institutes and Societies have an enormous responsibility to work to establish and to maintain an ethical culture. As Members we all share in this obligation.

Education is important, but only so much can be taught. A clear sense of personal and analytic boundaries is not something that can simply be taught or learnt. It is much more to do with the degree of integration in terms of our own emotional functioning and a developmental capacity to establish and to maintain a third position. This capacity is certainly enhanced if there has been the experience and an opportunity for a trans generational internalisation of a firm ethical core and analytic stance within our own Analysis or Therapy. If we can internalise the experience of this throughout our training, in our experience of our Training Analyst or Therapist, in our supervisors, as well as within the whole ethical culture and ambiance of the group, this can certainly help to hold us in challenging times.

It helps if an Ethics Committee can have an active presence and considered a facilitating resource, rather than isolated, remote or conversely, even a feared and unwanted intrusion. However, an internal ethical core either within ourselves or within our institutions, cannot be presumed a constant and static entity. It requires work. Consultation, supervision, being part of a peer group, the avoidance of isolation, all help in keeping that internal ethical core, that analytic muscle active and toned. It is our professional fitness that helps us keep a grip on ourselves, avoiding the ‘slippery slope’ into becoming slave to our own narcissistic needs and law unto ourselves.

It helps to have a Colleague Assistance Committee, able to offer care and support for those of us who may be becoming more vulnerable at particular times, helping limit and contain difficulties, which might otherwise escalate.

Clearly, what helps and most protects us as individuals and certainly as a group is being able to talk about things, brave enough to talk about trouble in the family, troubles in all of our families, hopefully before they escalate and certainly when they do.

There is a cultural change within the community in terms of supporting those in vulnerable positions, and this is also reflected within our Societies and Ethics Committees. There is generally greater emphasis on the vulnerability of patients, but also on that of our own Colleagues. There is the need for support and rehabilitation for those of us, except perhaps the most egregious or recalcitrant offenders, who come before our Ethics Committees. The imposition of sanctions post enquiry are no longer considered simply a punitive and stringent imposition, but much more considered in terms of providing a possibility and opportunity for help, reflection and rehabilitation.

IN CONCLUSION.

I think it is sobering, but protective, if we can bear to entertain the thought, tolerate within ourselves and our professional organisations, the thought , 'There but for the grace of God'.

I don't think anyone ever imagines they could end up before an Ethics Committee, but some of us do and more of us are. There is a long standing fantasy that most people who come before Ethics Committees are exploitative predators or thoroughly reprehensible characters, but the vast majority are not. Our own natures, the impact of life events and stages of life, the nature of our work, the nature of our organisations can at times bind together to create a 'heady mix' of vulnerability and human frailty.

Left unattended, this can potentially get us into serious trouble with a patient and bring trouble upon the professional family to which we belong.

As specialists in the unconscious, in the ethics of the unconscious, in spite of all we know, we can seriously underestimate its power both within our patients and certainly within ourselves. We can underestimate the power of the transference, countertransference relationship and all involved in that. We can underestimate the power of our own vulnerability and unresolved emotional needs, particularly at certain times and certain stages of our lives and careers. We can easily make use of denial or enact a punitive superego position to deflect from addressing issues within ourselves and failures within the professional families to which we belong. As Freud himself warned, this is a dangerous profession.

This thought takes us back to the beginning of this presentation. - to the need, relief to

have someone sitting beside us externally, internally, clinically, a third, - not too close, not too far, to help us manage as best we can, the sometimes enormously difficult, but also, the extremely important, enriching and meaningful work we do.

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