Minding the Gap: Ethical Considerations for Therapeutic Engagement

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Abstract

This article emphasizes the nature and necessity of risk in the therapeutic relationship, which are often not well accounted for in ethics codes. The author proposes that enactments that might be viewed by some as unethical are actually common in a therapeutic dyad and can be considered an essential part of the therapeutic process. She further suggests that ethical practice involves "minding the gap" between intention and outcome, which requires ongoing attention to cotransferential interactions.

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Ring the bells that still can ring
Forget your perfect offering
There is a crack in everything
That's how the light gets in.
(Cohen, 1992)

Minding the Gap

Several years ago, at the end of a long day in a training group, we ran over our allotted time. Being someone who attends to such boundaries carefully, I commented after 10 minutes to the group leader, who replied, "I know, and I am mindful of it."

At the time, I was part of an ethics committee in the United Kingdom and was interested and puzzled as to why certain cases resolved smoothly while others became entrenched in an ongoing battle that needed the equivalent of the United Nations rather than mediation. I learned that practitioners who minded the "edges" of their practice (e.g., if they had done something that disturbed their client, they were interested in that), then the situation was usually resolvable. In contrast, when therapists were more prone to pathologizing their clients from a defensive/attacking position, then the ethics charge often escalated to a second- or third-degree reenactment, with the dyad lost to a courtroom-like drama.

In such situations, the job of the ethics committee became deciding whether there had been a breach of the ethics code rather than mediating. The therapeutic relationship was beyond repair, the therapist under scrutiny, and the profession under question. Often the therapist had done something that disturbed the client and the client responded with a complaint. Then the therapist defined the client's experience in relation to the client's pathology, and the switch occurred when the therapist ended up, at the most extreme, losing his or her professional registration. In transactional analysis, at a surface level, we might see this as a "Kick Me" game dovetailing with a "Now I've Got You" game (Berne, 1964). However, coming from this perspective did not enable thinking and understanding to emerge, and all parties were confused, unsatisfied, and thwarted in some way.

Returning to the group experience I mentioned earlier, what crystallized for me is that our responsibility as practitioners is to "mind the gap" between the therapist's and the client's perceptions—and that this minding sometimes matters more than what we do.

In the United Kingdom, "mind the gap" is a constant refrain at our underground train station, where loudspeakers advise us to be aware of the gap and potential danger as we step from the train to the platform's edge. Charlotte Sills (personal communication, 8 May 2010) tells the story of a Zen Master who, while visiting London, said, "Your underground system is very Buddhist. Today I heard 'mind the gap'; this train terminates, and all change.' That's all we need to remember about life." I use "minding" rather than "mind" to emphasize that this is an ongoing process and principle rather than a command (as at the train station).

"The gap" has, at this point, developed multiple meanings for me. I began by understanding it as the intersubjective space (a relationship). It then came to represent for me a falling

between minds, a primitive process that can happen when we forget and things/people/stories fall out of our minds. A prime example of this is children and young people in care, who often fall between the minds of parents, carers, and services and suffer from not being considered clearly and consistently within and between minds. It also refers to the gap between safety and risk (a clinical and ethical tension), and finally, it is a process that occurs at a cellular level in the synaptic gap where so much of life is regulated and deregulated (a biological function). Gaps opened up everywhere, and I fell down between them in what I was trying to articulate. So, for the purposes of this article, I will focus here on the first three, inspired by Leonard Cohen (1992), and see how I can weave them together.

The Challenge of the Gap

From my work on the ethics committee, I see ethics often used as a defense or shield. In our increasingly paranoid and litigious culture, admitting to a mistake or an unethical practice is hard to contemplate for therapists. This has led me to think about the "therapist's honor" as a defense. To be accused of acting unethically carries intense shame and is often felt as an attack on a therapist's professional integrity. It can touch on our most vulnerable narcissistic wounding, arousing our defences and can inhibit our thinking and productive meaning making.

It is my view that therapists often act unethically in their practices, not through gross misconduct but through inattention, going for an easy option (e.g., soothing rather than disturbing), or making poor interventions. These are more likely to be definable as unethical when therapists do not attend to the gap created by their actions. Such moments may be experienced as ineffectual, at best, and abusive, at worst.

The reason such actions may end up being presented to an ethics committee is that therapists fail to attend to the gap and then become defensive around exploring ethical implications between themselves and their clients in an exquisitely curious way that accounts for our vulnerability and intersubjectivity. Instead, therapists often operate and defend themselves using a shame-based response to the authority of a professional committee or the accusation/complaint from the client. Therapists' arrogance and need for certainty can inhibit their capacity to stay alert and learn.

One might think that the risk of litigation increases in direct proportion to the number of mistakes made by a practitioner, but research into malpractice litigation among surgeons shows no such correlation (Levinson, Roter, Mullooly, Dull, & Frankel, 1997). The significant factor in increasing the likelihood of litigation is the tone of dominance used by the medical practitioner in response to the patient (Ambady et al., 2002).

Before going further, I want to define several kinds of relationships that are relevant for the discussion of ethics in clinical practice. Martha Stark (1999) has defined three therapeutic modes: one-person (enhancement of knowledge), one-and-a-half-person (provision of corrective experience), and two-person (engagement in authentic relationship). She has described the advantages and potential dangers of each approach.

In parallel with other psychologies, transactional analysis has traditionally spanned the first two modes, with increasing emphasis on a two-person approach emerging in the last decade or so. Contemporary psychoanalysis has informed contemporary transactional analysis to remind us that while Berne wrote about the two people involved in a game, he did not emphasize the bidirectional nature of the therapeutic relationship but rather the nature of relationships generally. Hine (1990) wrote explicitly about the bidirectional nature of games, and several transactional analysis authors have elaborated on the depths of the intersubjective, cocreated nature of the therapeutic relationship (Cornell & Laindaiche, 2006; Hargaden & Fenton, 2005; Summers & Tudor, 2000).

Clinical Example: Ethics in Everyday Practice

Clients often alert us to the transference/countertransference dance through stories they tell about events outside the consulting room. One client, whom I will call John, arrived for

his session agitated and uncharacteristically late. He began with a story about how he had been tailgated down the hill by some irresponsible woman with children in her car. He was outraged, first that someone would drive in such a dangerous manner and second that she would put her children at risk.

This story came after a session in which we had explored whether John would reconnect with his children after several years following a major rupture between them. He could not find it in his heart to forgive them. I had found myself encouraging him to follow the lead of one of his adult children, who had made contact. I had put both feet in, stirred by my own experience of having successfully reconnected with my own father after years of estrangement. John, however, felt "tailgated" by my persistent encouragement and that I was missing his vulnerability. I had had a sense of pushing for reparation but no awareness of how he was experiencing that pushing. In his story, John indicated that the way he responded to the woman in the car was to slow down and drive well within the 30-mile-an-hour limit; by doing so, he felt he had gained the moral high ground and was powerful and in control.

We explored the meaning of this story for our relationship. When I asked, John agreed that he felt that I had been "tailgating him." He really did not want to return the call to his daughter. He not only felt pushed by my stepping into the frame but also by his desire not to disappoint me. We came to understand that he needed me to keep in the foreground my respect for him and his ability to find his own way, regardless of what that was, and that I not impose my own story or expectations on him. When I was able to express my desire for him to find meaning in the rupture with his children without defining the outcome and the best way of doing it, he felt heard and learned that being in contact with a "disappointed" woman can lead to a mutually respectful dialogue. He had no experience of this being possible and had always left at that point in prior relationships.

For me, moving into a two-person frame (Stark, 1999) meant risking uncertainty. Rather than continue to define John as frightened or unforgiving and afraid to make the reparative move, I had to understand how what we had created between us could be useful to him and, indeed, to me too. This could be a creative moment, and my job was to dare to seek deeper meaning before I knew what it meant. Petriglieri (2007) suggested that we "begin looking at stuckness both as an inevitable consequence and as the potential beginning of a solution" (p. 187).

In the case of John, it was he who brought a "third" factor into the relationship, a story from outside the room that offered supervision to the dyad. This raised crucial questions for me: Is it always the responsibility of the therapist to attend to the unconscious process? What does this imply for the inevitable asymmetry in the dyad? What is the client's responsibility in this given that he or she is not bound by a code of ethics but comes to therapy wanting help to resolve aspects of his or her past?

With John, I was able to maintain my curiosity and reflect with him. I suspect if that had not happened, he might have had to escalate to get heard. For him, that would probably have meant leaving abruptly, with a familiar payoff for each of us. When a therapeutic relationship ruptures, the therapist has a duty of care to the client, the therapist himself or herself, and the profession, a responsibility to bring his or her mind to the possible enactment they have entered into and that has resulted in a loss of the capacity for reflection.

I am interested in the everyday aspect of ethics. As a transactional analyst, I am curious to see where in my transactions I "fall from grace," and as I reflect on my work, I see this occurs many times a day. I do not see this as gross misconduct but as the result of the subtle sway of interpersonal relating within the complex professional framework. As a practitioner who values the two-person frame, the transference/countertransference matrix (Little, 2006; Ogden, 1991, 1999), and the enigmatic unknown of the unconscious, there are many ways to wonder about the richness of sitting with another person for an hour, week after week. The best I can do is to keep bringing my attention to the encounter and to be prepared to enter a space in which I do not need to know but can trust that meaning can be found.

How Does Our Understanding of Ethics Take into Account the Influence of Unconscious Processes?

It is important to distinguish between codes of ethics that guide practice and the procedures of an ethics committee for overseeing complaints made against practitioners. The latter involves a set of guidelines and rules that govern the way a complaint is handled so as to ensure fairness and justice for all parties and protection for clients (the public), practitioners, and the profession.

At this point, I want to expand on the function of codes of ethics rather than procedures. The Code of Ethics of the European Association for Transactional Analysis (EATA) (2008) offers clear guidelines as to the values and principles underlying our work with clients in all fields of TA application. These are designed to help practitioners make decisions about sometimes complex issues and to suggest ways to think about conflictual ethical dilemmas.

In her seminal paper, McGrath (1994) described a method of applying moral principles to ethical dilemmas. She highlighted two difficulties that may emerge as therapists apply ethical guidelines:

> First, therapists may confuse intentionality with good ethical practice, that is, they may assume that because they do not intend to hurt or exploit their clients that their clinical work must be ethical. Second, the fear of legal or professional liability may lead therapists to be so cautious that the potency of the clinical work is impaired, and the client is not offered the best possible treatment. (p. 8)

McGrath proposed the use of moral principles to navigate ethical complexity. However, while such principles may offer an excellent framework for thinking about our work, this idea assumes that we can be conscious enough to articulate and manage ethical dilemmas. The focus is on the practitioner as potentially objective rather than as immersed in a mutual process of subjectivity. McGrath hinted at the implicit in her writing, but I think this needs to be explored further in order to expand our frame to account for the intersubjective and implicit relational knowing that is foundational to our current understanding of what goes on between people in the consulting room.

One of the functions of a code of ethics is to account for the power dynamics or asymmetry inherent in the practitioner-client relationship. This has led to ethics codes being largely conceptualized and developed within a one-person and a one-and-a half-person psychological frame. However, the cutting edge of contemporary relational psychotherapy explores mutual regulation between humans. There is a shift from thinking about projective identification (Bion, 1967) to mutual inductive identification (Ringstrom, 2010). There is also a significant shift to authentic relating and, as described by Stern (2004), an acknowledgment of "moment[s] of meeting" (p. 244) that may result in deep intrapsychic change. This understanding of what works in therapeutic relationships involves an awareness that both parties must be available for change. So, a contemporary ethical challenge for us is discerning how we account for the reality of mutuality while also tending to asymmetrical power dynamics. In working with a theory of games as enactments, bilateral ongoing mutual influencing, and inductive identification, we enter a two-person frame (Stark, 1999).

Our present codes do not account for the subtlety and depth of unconscious, two-person psychological dynamics inherent in working with the edges of disturbance central in many psychotherapeutic practices.

Kearns (2007) talked of the intention to protect the client giving way to the need to protect the practitioner. She made a plea for procedures that "govern complaints made against therapists to embrace a wider range of relational possibilities as opposed to assuming that if a client is taking the trouble to make a complaint the therapist must have done something wrong" (p. 7). She went on to say, "The most common difficulties between client and therapist that may end up in a complaint arise from rupture in the working alliance, intrusions into the therapeutic frame, unwitting mistakes in managing the transference, the clumsiness that might come from inexperience or the carelessness that can come from stress and fatigue" (p.129). I want to add two other factors: lack of rigorous clinical

supervision and a rigid adherence to a one-person frame.

While I agree with Kearns's plea to allow for complexity in the complaints process, I suggest that it would be better if we brought such a perspective to the work before it gets to the point of someone bringing charges. I do not believe that minding the gap will protect therapists from complaints, but a two-person frame is needed in order to think about a rupture without foreclosing on the work. Without it, there is a greater likelihood of the practitioner moving to soothe or placate out of fear of reprisal rather than staying with the disturbance. There is also a danger that an ethics committee may become the projected Parent in the therapist's mind, which may kill any vitality in the work.

It is crucial to distinguish between what I am exploring here and gross misconduct wherein the therapist clearly abuses his or her privileged position by acting out and even acting illegally. In such cases, a confrontation of the ethics violation(s) and potentially a complaint are recommended for the protection of clients, the therapist himself or herself, and the profession.

Nevertheless, as stated earlier, my aim here is to explore the more ordinary ruptures and misattunements that occur as an inevitable and perhaps essential part of depth psychotherapy. As a therapist and client enter into this complex process, they can get lost along the way. They need a frame, principles, and some methodology to guide the work through such periods so that these can be fruitful, if difficult times that bring meaning and learning to both the client and the therapist. Winnicott (1954/1958b) phrased this eloquently when he wrote,

> I cannot help being different from what I was before the (process) started. The treatment . . . called on everything that I possess as a human being and as a psychoanalyst. . . . I have had to make personal growth (over the course of this period) which was painful and which I would gladly have avoided. Hopefully, the pain I have felt translated into being a better therapist. At least I believe this to be the case. (p. 284)

One challenge to our professional accountability is acknowledging the inevitability of mistakes and therapeutic failures. Seen from this perspective, it is clear that we may often act "unethically" in the course of a session. If we do not become interested in where the breaches of trust, fairness, and beneficience occur, then we miss the subtly of what ethics codes offer us, and we use them as a shield rather than a platform.

This presents practitioners with a paradox. Ethics codes invite best practice, yet best practice in this work involves the willingness to make mistakes, be engaged in ruptures, and involved in enactment. Practitioners are measured and judged within their professional frameworks and communities by codes that are inconsistent with current thinking about how humans relate and how therapeutic change occurs. For example, emphasizing safety in the work can discount the need for risk. Authentic relating within the psychotherapeutic frame can be tricky, and therapists may avoid important therapeutic risks, as McGrath (1994) suggested, if their fear of complaints becomes the foreground.

To develop ethics codes and good practices relevant to a two-person approach, we need to utilize contemporary theories of mind and intersubjectivity. We need to help practitioners consider relational methods of working with the unconscious so that mistakes, ruptures, and enactments in the therapy are understood by clients, therapists, supervisors, and ethics committees as inevitable and even, at times, necessary.

The Intersubjective Space

The "gap" is an intersubjective space between the client and myself that is both conscious and unconscious. It is also the space between my intention in making an intervention and how the other receives and perceives that intervention (i.e., its impact). It is the gap between our minds. It is in this space that an intervention that is intended to be transformative can be experienced as abusive or unethical.

Winnicott's description of transitional space is helpful here. Transitional space exists in an intermediate area between the realms of fantasy and reality, subjective and objective, and/or internal and external. Transitional experience involves entering into this metaphorical space and requires the capacity to accept the paradox that

something is simultaneously real and illusory. It thus serves as a bridge between inner and outer worlds and as an alternative to mutually exclusive options of subjective or objective. Hence, the gaps that need minding are

> the cocreated transitional space and experiences in which the therapist and client are free to reenact, create context and meaning, and ultimately re-create/transform in newly configured forms the central organizing relational matrices of the patient's and perhaps the therapist's early life. (Davies & Frawley, 1992, p. 12)

The reality is that this approach involves ethical risks if one enters the transitional space and ethical risks if one does not.

The ability to use transitional space is closely related to the capacity to play. Winnicott's (1967/1971) writing on play has helped me to consider flexibility, fluidity, and experimentation in my work. He reminds us that we have the freedom to explore as well as a responsibility to do so:

> Psychotherapy takes place in the overlap of two areas of playing, that of the patient and that of the therapist. Psychotherapy has to do with two people playing together. The corollary of this is that where playing is not possible then the work done by the therapist is directed towards bringing the patient from a state of not being able to play into a state of being able to play. (p. 38).

Thus, as we mind the gap, we can only do so in a relational sense. If I believe that I can manage or mind the gap by myself, then I am at risk of operating arelationally and losing contact with my client. It is at this point that I begin to operate at the edge of what is ethical as I assume a one-up position over my client. The question is,"How can I bring my experience to bear without being overbearing?" Another gap emerges between the mutuality and the asymmetry of the therapeutic relationship. Here the tension between being "paid to mind" and being "coresponsible" is crucial.

Minding the gap is, for me, about attending to my interventions and their impact while staying exquisitely curious about what emerges and remaining available to explore the dynamic disturbance that may unfold. It is often at the edges of the relationship—the misattunements, absences, and ruptures—that the deeper, more unconscious forms of relating emerge rather than at the point of attunement and empathic inquiry. "The therapist must be able to accept the fact that such feelings are not only a story about the patient and the patient's need to engage the therapist in certain negative ways, but also a story about the therapist and the therapist's capacity to be so engaged" (Stark, 1999, p. 272). As therapists, we need to ask, "How are these feelings, engendered within me, both a story about my client and a story about me and my capacity to be affected in this way?"

Falling between Minds: From Enactment to Transformation

The last 20 years have seen more writing in transactional analysis about the unconscious, for example, in linking game analysis to enactment (Woods,1996) and, more recently, showing how an impasse can be enacted between therapist and client (Cornell & Laindaiche, 2006). In a two-person psychology, the focus is on authentic relating as a way of offering a corrective relational experience. There is something of a contradiction here between a two-person methodology and a one-and-a-half person goal. The therapist is more in the frame as an authentic subject rather than serving as a neutral or selfless object. The client-therapist relationship is the object of study, and the therapist is considered to be a coparticipant rather than someone who stands outside of the interpersonal field observing. The two individuals become companions in adventure. Safran and Muran (2000) wrote,

> From this perspective countertransference becomes the normal state of affairs rather than an episodic phenomenon, and the therapist who thinks he understands the nature of his participation in a definite fashion is in trouble. . . . To view the patient's feelings as nothing but transference can serve as a defensive function for the therapist and invalidate the patient's experience. On the other hand, to treat the patient's feelings towards the therapist completely at face value, without inquiring into their com-

plexities, multidetermined nature, can be to miss a valuable opportunity for exploration. (pp. 39-40).

Much of contemporary thinking about the mutuality of the therapeutic relationship centers on the concept of enactment (Jacobs, 1986). The term "observing participant" (as opposed to participant observer) was coined by Fromm in 1964 to capture the idea that the therapist's unwitting participation in an enactment is both inevitable and desirable.

I believe enactments (often thought of consciously as mistakes) are a potentially vital part of our work in that they bring the process alive. However, such times in therapy need to be deeply underpinned by ethical thinking and questioning on the part of the therapist. In working with people who bring their states of distress, dissociation, and despair into the room, we as practitioners need to be willing to be recruited into their unconscious worlds. This is inevitable, desirable, and risky. However, as these fragmentary self-states try to enter into the human conversation, they may evoke ethical disorganization in the therapist. This is when minding the gap between positive therapeutic intention and unconscious participation in an enactment becomes critical.

One Foot In, One Foot Out: Moving from Relational Unconscious to Relational Consciousness

"One foot in, one foot out" refers to the capacity to reflect on the intrapsychic and interpersonal dance of therapy. It brings together the intersubjective space and the tension between enactment and transformation. This capacity is crucial if the therapist is going to be able to help the members of the therapeutic dyad learn about and understand both their own unique potential to reenact disturbance and their subsequent potential to work it through.

It also means being available to all experiences in the dyad. The subtle ongoing dynamics that are inevitable and desirable involve transference and countertransference relating. For example, the transference with a client might involve a silent withdrawal that stimulates the therapist to work harder. The client may then feel defined and boxed in, at which point the therapist may pursue, seeking understanding but also fearing a rupture. Both dance the enactment of the impasse between revenge and compassion, cocreating an old but familiar routine. The relating has an I-It (Buber, 1923/1958), mutually objectifying quality, and the therapist has both feet in the countertransference. Both individuals have fallen into an inevitable mindlessness. Such moments capture the ethical tensions of our work. A crack appears. It is then a question of whether the two people can use the crack to see some light.

The therapist takes one foot out by adopting an attitude of curiosity and mindfulness and asking such questions as: What is going on here? What am I enacting of my own? What is the client showing me that I am not understanding? How have I stimulated this in the client and vice versa? Thus, the therapist takes his or her mind to the dyad in a different way. The aim, in so doing, is to also invite the client into wondering. The unconscious and the conscious are a dynamic duo, each needing the other to be meaningful.

Capers (1999) argued that two distinct capacities must come together within the analyst—the union of his or her receptivity to the client's projection with the analyst's capacity to distance himself or herself from them: "The analyst tends to fall spontaneously into a countertransference illness as part of his receptivity to the patient's projections, and he must cure himself of it if the analysis is to progress" (p. 114). This corresponds to Siegel's (2007) explanation of reflectiveness, which involves receptivity, self-observation, and reflexivity. These are three essential elements for minding the gap.

Duty of Care: Minding Gaps in Therapy and Supervision

During an ethically charged therapeutic conflict or enactment, the two parties may become polarized, partly mindless and with "two feet in." Therefore, generally it helps for the therapist to seek a "third" mind, usually a supervisor or consultant.

However, when the rupture has gone too far for the client to bear, the third may be a mediator or an ethics committee; this can bring in a mind or minds to bear witness and help make

sense and meaning of the therapeutic rupture. Unfortunately, in our present litigious culture, this often becomes a painful and terrible event rather than an ordinary reflective accounting.

I have learned that it can be exceedingly useful to have a third person or party attend to a therapeutic relationship that is in deep trouble. As a supervisor, I request that supervisees attend to and bring the difficult edges from their practice to supervision. During my work on the ethics committee, I often heard that qualified and experienced therapists felt they needed less supervision than they had when they were in training. There seemed to be a narcissistic difficulty in seeking a third and a failure to understand the vital function a clinical supervisor can play in protecting the work, the therapist, and the client. Acknowledging this function is rooted in our deepest sense of respect for our clients, the profession, and ourselves.

The transactional analysis community and the guidance it offers says little regarding supervision post qualification. There are clear guidelines before someone is certified as a transactional analyst (CTA), but nothing beyond that. In fact, the EATA codes for professional practice say more to guide us with advertising than supervision or consultancy. We need to support a community of lifelong learners and see supervision not just for trainees but for anyone who is serious about doing good clinical work.

To illustrate, I offer a case example. I was recently consulted by a clinician, whom I will call Maria, who was struggling with a particular client. The client had made many suicide attempts, and Maria was exhausted, overwhelmed, and incapacitated. The client was holding Maria "hostage" through her comings and goings, and Maria wanted to "get the hell out of there and leave her to her mess." I was concerned that the work had become a reenactment of the client's traumas and potentially Maria's as well. The two had become enmeshed in an unproductive, stuck, sadomasochistic relationship.

My involvement was motivated by my concern and belief, perhaps grandiose, that I could bring some thinking to the dyad that might help. In response to the client's overwhelmingness, I commented to Maria that when my work becomes that intense, I often seek weekly supervision until the work is stabilized and my mind is recovered. I agreed to consult with her by telephone for half an hour a week, even though there were clues at the time that she was not enthusiastic about my involvement. I chose to understand those in terms of her anxiety and shame about feeling incapacitated, incompetent, and angry that I had not given her permission to stop working with that particular client. However, I could tolerate being the bad-object supervisor and suggested some reading as we acknowledged the fact that Maria did not have much experience working with someone so disturbed.

Soon after that, Maria fell ill and was advised by her doctor to reduce her workload. She had inadvertently received the permission she wanted and told me that she planned to stop working with that "stressful" client. Maria realized this was a terrible situation and that it would be a reenactment for the client, but what she could not think about was how this could be part of the process that needed to be worked through. It really felt to her as if it had become "her life or mine." I sought supervision and realized how I had imposed myself on Maria. She had felt deeply ambivalent about my supervision, had thought I would shake a "big stick" at her, and had acquiesced to working with me from a fearful and shame-based place. In fact, she had not entered fully into the consultation but had perhaps intended to use me to confirm what she had already decided in order to protect herself. I was confused and angry.

In our next phone supervision, Maria reported that two things were different. First, the client had managed to find some boundaries inside of herself. I wondered whether she was adapting to the therapist, who was now firmly in her mind as ill. Second, Maria reported feeling interested in seeing her client that day as well as anxious. I asked when she had last felt that kind of interest and she said she could not remember.

I then asked how the client had taken the news of Maria's decision to terminate their work together due to Maria's ill health. The client had been furious and realized immediately how she was being left again, just as she had been in the past. Maria had talked about having

a 3-month termination process so as to offer the client a different ending from those she had experienced before, but the smart client spotted the tyranny of a tidy ending and suggested that Maria was the one who needed that, not her.

My intervention was to invite Maria to reflect on the way she had objectified her client in deciding how the therapy should end and the grandiosity implied in Maria offering to her client something that others had not been able to achieve. A one-person/one-and-a-half frame looked good to Maria because it suggested that the therapist knows what the client needs. Fortunately, her client spotted the proposed ending for what it was, Maria's need.

I also began to reflect out loud about our supervisory relationship, how I sensed that I had imposed myself on her and wondered if we could explore this. She sighed with relief and described tingling sensations in her body. She admitted that she had, indeed, felt imposed on and that in her frame of reference therapists only had this kind of intense supervision in the beginning, when they did not know what to do. She experienced me telling her, a qualified therapist, what to do and not respecting her knowledge and competence. I restated that from my perspective, regardless of how competent we are as therapists, when working with the level of disturbance and intensity presented by her client, we need regular help (a third) to allow us to continue to bring awareness to the inevitable enactments that occur in order to protect our clients, ourselves, and the work.

From that point on, Maria and I were able to explore the parallel process of my imposing on her and her imposing on her client (her illness and the forced ending); we began to think together. I talked about how the client had also had a part in the ending and that they might explore this together. I asked Maria what she wanted to do with me, and she said she wanted to continue our conversations. I had decided/fantasized before the session about stopping the supervision (as in "get the hell out of there and leave her to the mess"). Ironically (and perhaps inevitably), I had identified with my supervisee's original stance in relation to her client, which I had previously considered to be an enactment. I had fallen into a state of ethical disorganization myself. However, by minding the gaps through my own supervision and with my supervisee, we were able to use these enactments to illuminate and guide the therapeutic work.

Ethical Implications

Capers (1999) made an interesting distinction in suggesting that by attempting to cure the client, we might act out the part of the patient's archaic superego (the Parent), manipulating his or her mental structure into a configuration deemed healthy or desirable. He described analysis as based on describing the client's internal object relationships without trying to alter them, which demonstrates trust in the client having a mind of his or her own.

> If the analyst can adopt this attitude (and regain it over and over when he loses it, as he inevitably does under the pressure of his countertransference), his work will manifest a deep respect for the patient's internal object world—a deep awareness of who the patient is and isn't and who the analyst is and isn't. This type of respect tends to foster in the patient both a sense of freedom or separateness from his objects, and its corollary, a sense of responsibility for himself. Together these two senses help him to have a mind of his own. (p.126)

This raises core ethical issues about who defines autonomy. I have a client who engages in sexual forums in a way that has challenged me profoundly. I have struggled with an internal dialogue as to whether her behavior is healthy, whether I should I confront her, whether I see what she does as pathological, and what it means to my view of myself as a woman and my relationship to my own sexuality. In my work with her, I did not know the contents of my mind clearly. As we have engaged in a dialogue about the meaning of what is stirred between us and how we might enact freedoms and limitations between us, she has made meaning of her triumph over disaster (Stoller,1975) in relation to a scene from her childhood when she was shamed. This helped me to understand my urge both to shame her and to feel ashamed myself. I have had to reexamine my own inner shame-based relationships and how I defend against feeling shame so subtly and mindlessly at times.

The case examples hopefully show how underinvestment (lack of care) or overinvestment (lack of respect for autonomy) in the client's outcome might violate ethical principles. Minding the gap helps me to stay grounded in the possibilities of accepting guidance from the client. While supervision is essential in working relationally, quite often our best supervision comes directly from the client (e.g., the tailgating example cited earlier). We often need to speak about our work to another (supervisor/consultant) so that they can help us listen more carefully. At such times, it can be the client who makes the therapeutic crossed transaction, illuminates the enactment, and facilitates learning and growth.

So far, I have talked about the need for a third person or entity to represent mindfulness in the face of inevitable mindlessness. This third can come from a piece of supervision from the client or from engagement with an external supervisor as a sign of commitment to competency. I also propose that ethics committees could be used as a consultative third by offering a place and time in which the members of a dyad can present their difficulty or stuckness and it can be thought about from the perspective described in this article. This would involve both client and therapist committing to the principles outlined here and the mutual bilateral nature of the work being explicit and involving for both parties. It would also involve the ethics committee holding a two-person frame in which to help the dyad find the light from the crack (or rupture) in the relationship to illuminate a way forward.

I propose that existing procedures for evaluating ethics complaints be used for examples of gross misconduct. This requires some agreement about what constitutes gross misconduct versus therapeutic enactment. In my experience, it is most often the attitude of the therapist toward the complaint that helps guide an ethics committee in making this judgment.

Safety and Risk

Tim Bond (2006) wrote about how ethics have traditionally been about making the client and the work safe. This is necessary, but what about beyond that, especially for competent practitioners working with deep disturbances and primitive processes? What do they use as a moral lens and compass?

I think we need a framework that accounts for working with the unconscious, including with clients who stimulate a strong level of enactment and powerful cotransferential relating. How do we hold an ethical framework when our theory and methodology invites us to acknowledge that we spend significant moments of our working time in unconscious enactments?

Risk and uncertainty are inescapable existential challenges that all humans face, including therapists and clients. We often talk of minimizing risk by skillful assessment, but perhaps we need skillful assessment to maximize risks! Risk taking can be an enlivening process in therapy, for example, when the therapist engages with difference, conflict, and play as the focus of the work. This requires that he or she have skills and self-awareness as well as a willingness to take account of the unconscious process of both the client and himself or herself. The clinician risks being changed for better or worse by the encounter. Oakley (2005) said, "There is no intimacy without reciprocity" (p. 226). Bond (2006) added, "There is no reciprocity without mutual vulnerability" (p. 78).

Winnicott (1950/1958a) talked about babies not needing satisfaction but rather someone to come up against. I think this applies to the therapeutic relationship as well. In an ordinary developmental process, there is a need for a certain amount of risk in order for the infant to learn, grow, and develop a separate sense of himself or herself. Panksepp (2004) talked about rough-and-tumble play and how critical it is to regulate emotions, develop an embodied sense of relatedness, and feel pleasure and joy. My understanding is that as we engage in the rough and tumble of a therapeutic relationship, we help clients expand their capacities to tolerate more pain and therefore more pleasure (this is my favorite definition of psychotherapy).

The implications of this are that allowing and seeking some risk in psychotherapy opens possibilities in the therapeutic relationship. This needs exquisite attention from the therapist as well as a commitment to our own therapy and supervision. In minding the gap, I believe we

also need to develop an ethical sensibility through consideration of potentially conflicting principles. Bond (2006) defined an ethic of trust as one that "supports the development of reciprocal relationships of sufficient strength to withstand the relational challenges of difference and inequality and the existential challenges of risk and uncertainty" (p. 82).

I would argue that when we only provide a corrective emotional experience (a one-and-a-half mode), we foreclose the possibility of something more vital emerging (i.e., the client finding himself or herself). Alvarez (1992), in her book *Live Company,* challenged us to consider holding out against what Bollas referred to as the opiate:

> Reassurance, or encouragement, or what has been called the "corrective emotional experience," have been considered by many analysts to interfere with the patient's bringing his true inner imaginative world, however cruel and devastating, into the transference relationship where it can be subjected to real, rather than superficial change. (Bollas as cited in Alvarez, 1992, p. 53)

I further suggest that we might be morally and ethically irresponsible to offer such soothing rather than to accept the risks we might take by extending ourselves in relation to our clients —that is, risking something authentic, dynamic, and unknown. Thus, minding the gap involves having a capacity and commitment to think about the risks we are taking or have fallen into unconsciously.

How do we engage in risks with our clients, minding the gap between danger and inertia? Whatever we do, however we find ourselves relating with our clients, requires rigorous consideration and minding. Building on Bond's work on an ethic of trust, I propose that it is important to explore with clients the sharing of responsibility for managing necessary safety and necessary risk in the course of therapeutic work.

Case Example: One-Person Ethical Thinking versus Two-Person Ethical Thinking

Often at the end of my wits, in weekly supervision to recover my mind, I wondered about my peers, those who closely held me in this work. I often fantasized that they thought I was mad to continue with a certain client, whom I will call Sharon. I was never sure. She had overdosed, was parasuicidal, and self-harming to an alarming degree. She had involved me in these scenes on several occasions, and the work was intense and overwhelming for a period.

One of the most significant, transformative moments between us occurred when I shared the risk with her. She knew that by continuing the work without more medical support (which she refused and sabotaged), I was risking the possibility that if she could not keep herself alive, I would be questioned about why I had not intervened more heavily or withdrawn from the work. I was the only person with whom she risked sharing her desperate internal state and her desperate acts of violence on herself. She brought these to me by both sharing them verbally and involving me in creative and disturbing ways.

I had to find resources in myself and from others to keep myself thinking and engaged with her. I felt deeply disorganized ethically. Whichever way I turned, I could argue ethically for and against myself. If I stopped the work because it appeared too unsafe, I would repeat some aspect of both of our lives. But how long could I hold out/on when doing so was another potential reenactment? I was cornered. It was a powerful communication to me from her and deserved a powerful response. Eventually, I managed to bring the danger we were both experiencing into the space between us by talking to her and demanding that we share the risk and that she take some responsibility for the disorganization. In sharing the risks, she gained some efficacy in her own treatment and eventually her own life.

In such cases, bilateral contracting takes on its full meaning, and the client is invited to bring his or her good will to the therapy in the knowledge that, should we get into difficulty, a third person or entity can be used as an effective support and resource for the dyad rather than as something to uphold a right/wrong perspective.

In the "Roundtable on the Ethics of Relational Transactional Analysis" (Cornell, 2006), Allen talked of the "necessity for the therapist to be fully aware—or aware as fully as he or she can

be—of the implications of constructing meaning, because whatever develops between the therapist and the client is going to be a construction" (p. 114). Summers, in the same roundtable, suggested that "the dialogic idea of inclusion is important because I think it can offer a conceptual frame for holding different realities simultaneously and exploring the tension between them" (p. 115).

A Final Comment on Deep Ethical Practice

In his book *The Talent Code,* Daniel Coyle (2009) explored how skill is developed through a long process of myelination of neurons that fire together and have wired together. He talked about the importance of deep practice as vital to the process of building skill and attributed three aspects to this: "chunk[ing] it up" (p.79) (this involves breaking skills down into smaller pieces, taking one step at a time), working out mistakes, and repeating over and over. I think in transactional analysis we have our core pillars to help us "chunk." For example, transactional analysis training should build practitioner skill in structural, transactional, games, and script analysis. Similarly, I teach transference and countertransference and projective identification as if they are three different processes because they need to be "chunked" to be learned. In practice, however, they involve a multilayered, complex experience of intertwined processes.

What is often missing in training is a focus on therapeutic failures, Coyle's (2009) second point. I was impressed several years ago when I heard that a Jungian school had their students write up a therapeutic case that had gone wrong. I thought this was a profound way of teaching that mirrored minding the gaps. To be able to learn from our mistakes is crucial; to be willing to look, face, relish, and use mistakes involves putting one's ego aside and being more committed to the work than to being a "good" therapist (which probably means something different to each person). For me, being a good practitioner means being committed to deep practice. I often say to trainees and supervisees that the challenge is to make the work available for scrutiny, which requires that they bring themselves into the discussion as well as their client. If they are overinvested in looking good, or in the pathology staying in the client, this undermines the heart of the therapeutic relationship and the work.

Coyle's third point about repetition refers to practicing our craft and being immersed in a reflective practice that keeps us on our toes. Like learning many skills, be it baseball or playing the piano, being a therapist requires dedication to detail, disciplined practice, and a passionate commitment to getting better every day. For me this work involves a lifetime of practice, with qualification serving only as a marker of basic competence for entering into deep practice.

Thus, I propose that our main ethical challenge is to develop the deep practice of minding the gap.

Conclusion

In this article I challenge the notion that ethical practice is about making therapeutic work safe and suggest that it needs to account for unconscious enactments as commonplace in the work. Building on McGrath (1994), I highlight the dangers of considering ethical questions from a dogmatic, introjected stance. The value of developing ethical mindfulness from an integrated perspective is further developed by embracing vitality, risk, and play to underpin a mature ethical framework that invites therapists to think beyond the limits of their tolerance into the unknown. Minding the gap describes how therapists are challenged to bring their minds to the intersubjective, bidirectional nature of the therapeutic relationship. A framework for ethical thinking is offered that accounts for risk as a desirable and necessary aspect of working at depth with clients and growth.

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