Authority, autonomy, responsibility and authorisation: with specific reference to adolescent mental health practice

Adrian Sutton *The Winnicott Centre, Manchester*

Abstract

Standards for professional training and practice are defined by accrediting organisations or statutory bodies. These describe the arena in which the practitioner may speak with authority. The sphere of authorised practice is further delineated by the external resources available. Within this explicit framework, unconscious mental processes can affect the professional response in potentially adverse ways. This is particularly important in mental health practice. Professionals must be prepared to examine their own responses on this basis in order to enhance their knowledge of the patient and minimise the possibilities of the patient becoming the victim of the professional's own psychopathology. The maintenance of such a position in an institution or organisation requires a similar process within its structure in order to provide the necessary setting and define the limits of good practice. In this paper, the field of adolescent mental health is specifically examined.

"In sooth I know not why I am so sad:
It wearies me; you say it wearies you;
But how I caught it, found it, or came by it,
What stuff 'tis made of, whereof it is born,
I am to learn;
And such a want-wit sadness makes of me,
That I have much ado to know myself."

Shakespeare: The Merchant of Venice, act 1, sc 1, 1.1

The professional role

DEFINITION

The performance of a professional role is inextricably linked with issues of authority: an internal authority founded on knowledge, experience and any personal qualities relevant to that field and an external authorisation to perform that role. At its simplest, for example in relation to psychotherapy, a person

consults a professional who then recommends treatment and offers him/herself as therapist. The person may then accept him/her in that role. At this point of agreement, a "therapeutic contract" has been negotiated and the person becomes the patient. The therapeutic relationship is a continually unfolding process with the agreement of both parties being re-negotiated implicitly and explicitly, consciously and unconsciously, throughout the course of treatment.

Authority and responsibility – the ability and duty to respond appropriately – are also inextricably linked. The internal authority of the professional and the external authorisation by the patient are prerequisites for us to conduct our work. In working with children, authorisation is also directly dependent upon those with parental responsibility for the child and perhaps additionally indirectly on those in a position to influence them, for example, family, teachers, health professionals and social workers. For those working within institutions such as the statutory sector, for example, the National Health Service, local authority education and social services, authorisation also includes the provision of the resources necessary to fulfil their role: staff, offices, consulting rooms, in-patient facilities and therapeutic equipment as appropriate.

THE ROLE OF TRAINING

The principal objective of training is to equip an individual to speak with authority in an area of practice and to take on responsibilities for that work whilst simultaneously maintaining an awareness of the limits both of her own capability and the knowledge-base of her field. This requires the realisation that practice is a matter of probabilities not certainties, ie an ability to tolerate doubt and uncertainty and function within this is essential.

In some instances, after qualification there may be criteria which must be fulfilled for continuing accreditation. Where this does not exist, successful completion of training should be an indication that the person is capable of taking on personal responsibility for assimilating his further experience and relevant new information, thus enabling him to continue his professional development.

Key words

Professional role; knowledge, attitudes, practice; adolescent behaviour and psychiatry; defence mechanisms; unconscious processes; ethics.

In summary, the professional role involves being prepared to formulate an opinion (and risk being wrong), which expresses the bounds and limits of professional authority and authorisation (including areas of uncertainty), and defines what responsibilities can or cannot be accepted.

The aspiration is towards responsibly defining areas of authoritativeness or lack of it: the greatest pitfalls lie in being irresponsibly *unauthoritative* (an abdication of responsibility) or *authoritarian*. General guidance in these respects is drawn up by professional bodies in “codes of conduct”.¹

The impact of the patient and the professional role

The specific impact to be considered here is that consequent upon what Freud² termed “transference”. This describes a process whereby, without realising it (ie unconsciously) a patient experiences a therapist as if he is a significant person from her early life, for example, a parent, and behaves towards him on that basis. The following clinical example illustrates this:

Mary was a 30-year-old woman who had suffered severe physical and psychological abuse in childhood. A particular aspect of the latter involved both parents. Father would sometimes come home to have fabricated accounts of misbehaviour by Mary related to him by his wife. He believed her and this resulted in physical punishment by him which was the result anticipated by his wife. Mary would attempt to assert the truth but this only resulted in a worse beating.

In early adulthood Mary had twice been admitted to psychiatric units because of serious difficulties. These had been complicated experiences which had left her feeling that the psychiatric staff had not looked after her very well, particularly because of the close alliance they had formed with her parents, apparently accepting their accounts over her own if there were any discrepancies.

Some years later she had sought further help and had gradually been able to trust the therapist with information which she had held back previously. The therapist asked for permission to review her old psychiatric case notes and Mary readily agreed. However, she was extremely anxious travelling to her next appointment and preoccupied with whether or not the old notes would have arrived. In fact, they had not been sent for (see below). The therapist registered Mary’s intense concern and anxiety, immediately commenting on it with a link to the issue of the notes. He felt that the fear was born out of an unconscious anticipation of what would happen as a result of a relationship now existing between her present therapist and her previous psychiatric carers through the case notes. This relationship was now “equated” with that of her parents in her childhood and accompanied by the terrors of

her early experience as victim of her parents. The therapist was now experienced as the father who would come home, believe lies and punish her – and all the more so if she tried to represent what she saw as the truth – rather than the person who could be there wholeheartedly for her.

The transference has an impact upon the therapist which is termed “counter-transference”. This may be experienced by him/her in the emotional or cognitive sphere or perhaps a mixture of both. The main technical error that has to be guarded against is the failure to maintain it in that arena and for it directly to affect behaviour without proper processing. The same clinical example can illustrate this:

Immediately after he had asked to view the case notes, the therapist felt he had made a mistake even though Mary had appeared completely at ease in giving consent. Following the session, he reflected on the situation and registered that the main interest in seeking access to them was his own particular interest in the general constellation of issues presented in Mary’s case. This then led to the realisation of what the therapeutic relationship might actually mean for Mary at this point, ie the transference.

To what extent then was his interest to “hear” what had been going on, an attempt to maintain his usefulness to his patient and to what extent was it that he was “acting out the counter-transference” by being the father who was going to listen to the other version and believe that one whatever his child (patient) might say. An error had been made but examination of the actions as potential counter-transference phenomena had given a plausible explanation of the therapist’s experience. He decided therefore, not to obtain the notes. Mary’s presentation at the next session provided supporting evidence for the hypothesis. The interpretation was offered and made sense to Mary: the therapist also offered an apology for his mistake.

Allied to the concepts of transference and counter-transference is the concept of “projective identification”.^{3,4} This is an unconscious defensive process which occurs in relationship with another individual. An aspect or element of experience which is somehow unbearable or unmanageable if it is held as being of the self is separated off from the rest of the person’s mental life. This element is then “located” in another person (“projected into”) with whom the individual has a relationship: maintenance of this relationship offers the opportunity to hold onto a sense of personal integrity by then being able to identify with that person. To return to our clinical example:

The therapist was struck by the way in which the thought that he had made a mistake had hit him. There was an immediacy and power which was

unusual and which demanded further thought, particularly when set alongside Mary's apparent unconcern when he had asked to review her old case notes. One way of understanding the immediacy and the power associated with the thought of his mistake was to consider it in relation to Mary's experience of her father. The results for Mary of not acquiescing and insisting that her father was mistaken in believing the mother, had been terrifying and had threatened her physical existence. Ultimately, survival in such a relationship may only be achievable by disowning that part of the self which can see this mistakenness. The therapist thought that projective identification could offer an explanation which brought together the specific quality of the experience for himself at that moment and the past and continuing experiences of Mary, ie at this point possessing a sense of "mistakenness" could only be contained in the therapist not the patient.

For the purposes of this discussion transference, counter-transference and projective identification can be considered together as phenomena which can affect the thinking, feeling and behaviour of the professional as a consequence of his professional relationship with the patient. These issues are of paramount importance in the practice of psychodynamic psychotherapy but are relevant across the whole of the mental health field and beyond. The crucial point is that they can affect responses at an *unconscious* level, ie without the professional being aware of it. The unconscious can make black white, white black, white or black grey, but perhaps most importantly, it is likely to make grey into black or white. This demands that in our professional role we carefully consider what is governing our treatment of our patients, that we examine our thoughts, feelings and behaviour - in an attempt to make fully conscious what is ruling our conduct. By this means the patient can be protected as far as possible from that which belongs only in the personal life of the professional. The paradox is that our thoughts, feelings and behaviour cannot be other than personal in the sense of needing to be owned by ourselves. (For these reasons psychoanalytic psychotherapists are required to have undergone their own personal psychotherapy.)

Medical ethics

Raphael⁵ defines ethics thus: "Moral philosophy is philosophical enquiry about norms or values, about ideas of right and wrong, good and bad, what should and what should not be done". Gillon⁶ further defines this in relation to medical practice. He describes a principal function of philosophical medical ethics as being to make: "... [medicomoral] decision-making more thoughtful and intellectually rigorous". He does not view this as being in opposition to established "rules and codes of [professional] behaviour considered to be morally binding" but rather as

"... additional and complementary to [them]".

In some areas of medicine, scientific evidence may offer a relatively clear basis on which to act: at other times, this is not available but a consensus may exist as to what is likely to be a good way to proceed. In these situations practitioners are able to work in the arena of evidence-based medicine and models of best practice. However, depending upon different theoretical frameworks or even within a particular framework, there may be competing claims as to what should be considered "best practice". If the answer to the question: "what *should* be done" cannot be supplied by these means, how are the questions "what am *I* going to do" and "why am *I* doing *this*" to be answered by the practitioner. At this point ethical debate may be helpful if not essential.

Professional and ethical matters

The preceding descriptions and discussion centre on the issue of "conduct" - what is correct or incorrect behaviour in general (ethics), what are the general rules about the way a person should be expected to conduct him/herself when contracted to work for someone (professional) and, specifically in relation to the mental health field, what lies more in the realm of technical considerations when judging the conduct of the professional in the relationship with a particular patient (counter-transferential). *We therefore find ourselves at a nodal point of clinical practice and ethical debate wherein the professionals themselves are the subjects.*

Adolescence and autonomy

The period of adolescence involves the assimilation of the physical changes of puberty, the concurrent personal and interpersonal changes resulting from these and the increasing psychological and social competence consequent upon general development. A key aspect of this process is the adolescent's own wish to take on more responsibility for her own activities and actions and the expectations of others that this should occur. In this period of increasing autonomy the personal authority of the adolescent will be tested out within himself and in his relationships.

In treatment settings the processes of transference, counter-transference and projective identification vary according to a number of factors. The developmental mental stage of the patient is important but the significance of that stage for the adult in contact with that patient can be equally important. Anna Freud⁷ observed that adults in psychoanalytic treatment often find it more difficult to talk about experiences in adolescence than those from earlier in their lives. The intensity and proximity of events may continue to have a powerful effect on mental life in adulthood; this may lead to the unconscious defensive processes of repression and denial (of the personal nature) of these and attribution to someone else instead

(ie projection). For those working with adolescents, their patients may present them with both a provocation in relation to unresolved personal issues, thus mobilising these defences, and a ready receptacle in which to “deposit” the disowned aspects of the self. The dynamics of the relationship may be enormously complex. The possibilities for confusion between appropriate action and inappropriate enactment of counter-transference experiences (ie “acting out in the counter-transference”) are rife. How then do we decide what is being responsibly authoritative and what is over-controlling and authoritarian? What is respecting autonomy, and what is abdicating responsibility?

Clinical examples

CASE 1

A 17-year-old girl was an in-patient on a psychiatric ward for assessment of an illness which included times when she would become agitated, over-active and run off the unit. There was concern about the possibility of suicide or deliberate self harm. On one occasion I was standing next to her just as she ran out of the unit. I ran after her, calling to her but she ignored me. I set off in pursuit and rapidly caught her. Her illness had led to considerable weight loss so she was very light. I picked her up and began to carry her back to the unit. Emotions (and heart rate) were running high in both of us but the situation suddenly seemed ludicrous to me. I said to her: “This is mad. You can walk perfectly well on your own.” I put her down and we walked back together.

In this case, I temporarily found myself in a state as un-thinking as the teenager’s. My behaviour was governed by hers. It was reactive only to a sense of danger about where she was going (and what fate might befall her) as opposed to her sense of danger about where she was and from where she felt she must escape (ie the fate which might befall her there). There was no notion of her “autonomy” in my reaction. Thinking and reason returned. My ability to articulate my interpretation of events as “madness”, restored to both of us the sense of her as an autonomous person, able to take responsibility for her own safety and welfare - now she could literally and metaphorically stand on her own two feet. However, if I had not acted in the way I did there might not have been a patient to whom I, or anybody else, could have made an interpretation nor whose right to autonomy could be debated.

CASE 2

A 14-year-old boy was on a paediatric ward, having attempted suicide by taking an overdose of tablets. He was seriously enough disturbed to require admission to an in-patient psychiatric unit. In addition he

had been physically abused by his father and an Emergency Protection Order had been taken out by the social services department.

On this particular day I was looking for him to tell him what arrangements had been made: these had been carefully discussed with him previously. When I found him I told him I’d been looking for him. “Oh” he said “to discuss what’s going to happen?” “No” I replied “to *tell* you what’s going to happen!”

My response was based in the relationship which was already established and in the knowledge that this was a boy who had experienced both his father **and** himself as unable to protect him from their own violent/suicidal impulses. I felt I was needed as an outside reference point from which he could re-find safety and responsiveness in a relationship with a *responsible* adult - an “auxiliary ego”⁷ in which the value of his existence and the containment of destructive impulses could be “held in trust” pending full re-emergence of this ability in himself. The two-sentence interchange served to encapsulate this. (A similar process can be seen to have occurred in case 1). The defence against criticisms of authoritarianism or medical paternalism⁸ would be based in a theoretical and clinical tradition which argued for the need for a *medical parentalism* in the relationship with the adolescent in order to ensure the avoidance of irreversible harmful consequences to the young person as a result of actions taken in acute states of high arousal or intense emotion. The latter emphasises that this does not assume a right or duty to take charge of all aspects of their lives, for example, the boy was allowed to move around the hospital without supervision since this appeared to be a safe situation for him, nor does it suggest an enduring or permanent expectation of taking such responsibilities.

These examples are of adolescents in crisis but it is well to remember that the lability, intensity and urgency of experience in adolescents does not always make the distinction between health and disorder obvious even to the expert!

Adolescence and autonomy: 2

So, what is the relationship between adolescence and autonomy? Should adolescence be defined as the developmental stage of moving from dependence to independence? I think not. It is, in fact, the period of moving from childhood forms of dependence and interdependence to adult forms of dependence and interdependence. This does not occur in a smooth flow but moves back and forth, sometimes with startling rapidity but with the expectation that the general direction will be towards the latter not the former. During this stage the individual has to give up various ideas and phantasies including the notion that there truly is some kind of completed, totally autonomous, always-responsible, “adult” state. Adolescence is a stage of *conditional autonomy* during which the adolescent and the adult are required in

various ways to negotiate which of them can "speak" with sufficient authority about a particular issue and therefore can assume responsibility for what will or will not be done. It is a dynamic state during which the anxiety, either conscious or unconscious, which is inherent in states of uncertainty can rapidly lead to unhelpful or even dangerous polarisations or alliances in relationships. These alliances may be directly with the adolescents or with the key people in their lives. In our professional roles these may result in acting-out in the counter-transference, for example, over-identification with an adolescent's or parent's wishes, demands or opinions. The principal dangers lie in taking a rigid, authoritarian stance or conversely in an abdication of responsibility.

A professional adolescence?

When does adolescence end? Laufer and Laufer⁹ suggest that in terms of the psychodynamic currents and trends which characterise the stage, it continues into the early twenties. I would like to suggest that there are further external influences in professional life which may resonate with the stage, particularly if we accept the concept of *conditional autonomy* as a key component.

In considering the postgraduate training of most professionals we see a move through from close supervision to greater autonomy when there has been clear evidence of the development of competence. This can be described as a "professional adolescence". It presents great potential for the unwitting re-emergence of unresolved conflicts around autonomy and authority which may then be enacted in the relationship between supervisor and supervisee: this has been referred to as "developmental resonance".¹⁰ If this occurs in the context of work in the field of adolescent mental health, one can see manifold opportunities for confusion and conflict to intensify as resonances are set up throughout the network of relationships involved.

Discussion

Adolescence has provided a clinical focus for consideration of issues of authority, responsibility and autonomy from a psychodynamic perspective. This developmental stage was chosen as it is a period of life during which these are brought sharply into relief not only for the adolescent him or herself but also for those who already occupy, or who come to occupy, key positions in the adolescent's life. In this respect, the features described stand as important ethical issues in their own right. Professionals involved in work with people of this age will be called upon to negotiate these issues, explicitly and implicitly, on a regular basis, particularly in the field of mental health practice. The limits of their jurisdiction and ability (perhaps even including physical capabilities) will be tested and demonstrated to themselves and others.

In this paper the principal purpose has been to consider broader issues of professional conduct in the context of a theoretical framework which states that individuals can come under the influence of forces of which they may not be aware, simply by virtue of offering themselves in a professional relationship. The power of these is such that at times thinking, and therefore decision-making, may be adversely affected, with consequent effects on behaviour. In this sense, the idea of "freedom of choice" in the professional position cannot be absolute. However, the potential for excusing mistakes or lapses simply or entirely on the basis of such influences could effectively lead to a complete abdication of responsibility and needs to be guarded against if a claim to professional practice is to be maintained. In psychodynamic practice proper technique requires acknowledgement of the possibility of becoming out of control through the impact of the patient upon the professional (a humbling thought). Good technique requires that the question: "why am I thinking/feeling/saying/doing this" is fundamental in order to ascertain if it gives information about the patient and to prevent mistaken actions by the therapist, with potentially serious or irreversible effects for the patient. Through this means the usefulness to the patient can be maintained and the potential for an adverse impact by the professional can be decreased or prevented. (Such a process is likely to require some form of continuing dialogue with colleagues in addition to an internal dialogue). Ethical practice demands just such a continuing examination of one's behaviour and reflection upon oneself on this basis in order to maintain oneself truly in the service of the patient.

The position of "authorisation" in relation to providing services in the public sector has been alluded to although not extensively described. Technical problems in practice may arise through pressure upon a therapist emanating from the patient coming into conflict with other duties and responsibilities in relation to the provision of an overall service. Shortcomings in resources may have an impact directly, for example, absence of staff, physical facilities, or indirectly by impairing the therapist's ability to reflect upon her practice, for example, insufficient time, excessive caseloads, preoccupations with threats to service provision. Responsibility in this respect lies within the managerial and policy-making structure. Without suitable provision, the therapist is in effect not being authorised to practise. If such a situation arises, good professional practice is to speak with appropriate authority about the minimum requirements for adequate care of patients.

Conclusions

Maintaining good standards of professional practice involves an individual in a complex network of relationships. Some aspects of this can

be readily identified and parameters set to protect both patient and professional. Other aspects belong more specifically to the particular individuals and/or organisations concerned in the situation. Influence will be exerted by the relationships which appertain at the time and by aspects of the "still-living history" of their past relationships and experiences. These factors can be of significance in all professional practice but when the work is in the field of mental health and disorder, the need for practitioners to examine themselves becomes more acute and insistent. This is a particularly demanding position to take and maintain and requires appreciation within training, accrediting and employing organisations and institutions.

Adrian Sutton, BSc(Hons), MB, BS, FRCPsych, is Consultant in Child and Family Psychiatry in the Department of Child Psychiatry at the Winnicott Centre, Manchester.

References

- 1 General Medical Council. *Duties of a doctor: guidance* from the General Medical Council. London: General Medical Council, 1995.
- 2 Freud S. *Introductory lectures on psychoanalysis: Pelican Freud Library [vol 1]*. Harmondsworth, England: Penguin Books Ltd, 1981.
- 3 Laplanche J, Pontailis JB. *The language of psychoanalysis*. London: Karnac Books and The Institute of Psychoanalysis, 1988.
- 4 Juriedini J. Projective identification on general psychiatry. *British Journal of Psychiatry* 1990; **157**: 656–60.
- 5 Raphael DD. *Moral philosophy* [2nd ed]. Oxford: Oxford University Press, 1994: 8.
- 6 Gillon R. *Philosophical medical ethics*. Chichester: John Wiley & Sons, 1995: 2.
- 7 Freud A. *The writings of Anna Freud. Problems of psychoanalytic training, diagnosis, and the technique of therapy* [vol 7]. New York: International Universities Press Inc, 1971.
- 8 See reference 6:67–9.
- 9 Laufer M, Laufer ME. *Adolescence and developmental breakdown: a psychoanalytic view*. New Haven and London: Yale University Press, 1984.
- 10 Sutton A. Initiating and developing a psychoanalytic approach to children. *Psychoanalytic Psychotherapy* 1991; **5**: 247–59.
- 11 Sutton A. Deprivation entangled and disentangled. *Journal of Child Psychotherapy* 1991; **17**: 61–77.

News and notes

GAEIB: Eighth opinion

The Group of Advisers on the Ethical Implications of Biotechnology (GAEIB) to the European Commission has adopted its 8th Opinion

The group was consulted by the European Commission on 1st April 1996 on the particular issue of the patenting of inventions involving elements of human origin. This consultation occurs in the context of the proposed directive on the legal protection of biotechnological inventions (COM(95) 661 final), prior to its first reading by the European Parliament.

In its response, the GAEIB stresses three ethical guidelines:

– following the ethical principle of *non-commercialisation of the human body*, the human body, as well as its

elements, do not constitute patentable inventions; according to this principle, the remuneration of the person from whom the samples are retrieved is to be excluded;

– it is important that the *informed and free consent* of this person should be respected;

– the granting of a patent to an invention derived from the knowledge of a human gene (or a sequence of it) is acceptable only if, on the one hand, the identification of the function associated with the gene allows for new possibilities (for instance the production of new drugs), and, on the other hand, if the intended use of the patent is sufficiently specific and identified.

News and notes

King's College London wins Queen's Anniversary Prize

King's College London was one of the winners in the 1996 round of The Queen's Anniversary Prizes for Higher and Further Education.

The College's submission, *Medical law and ethics: teaching, research and public debate*, was made by the Centre of Medical Law and Ethics. The announcement is in recognition of the centre's academic

excellence, entrepreneurship and services to the community.

The Centre of Medical Law and Ethics (CMLE), established in 1978, was set up to encourage and facilitate the interdisciplinary study of issues which cross the boundaries of medicine, health care, law and philosophical ethics.