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PSYCHOANALYST ASSISTANCE CASEBOOK OF THE AMERICAN PSYCHOANALYTIC ASSOCATION

Author & Editor
Audrey Kavka, M.D.

Contributing Authors
Robert Galatzer-Levy, M.D. & Stephanie Schechter, Psy.D.

Associate Editors
APsaA Committee on Colleague Assistance

APsaA
American Psychoanalytic Association
309 East 49th Street
New York, NY 10017
info@apsa.org

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COMMITTEE ON COLLEAGUE ASSISTANCE
Audrey Kafka, Chair
Alice Brand-Bartlett
Rita Clark
Merle Edelstein
Steve Firestein
Robert Galatzer-Levy
David Joseph
Ellen Pinsky
Stephanie Schechter
Julie Watts

For information:
American Psychoanalytic Association
309 East 49th Street
New York, NY 10017
212-752-0450
info@apsa.org
www.apsa.org

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Foreword

By Glen O. Gabbard, MD

Psychoanalysts have long been reluctant to approach a colleague who is struggling with physical illness, cognitive decline or personal problems. Many excuses for this reluctance have been voiced over the years—"It's none of my business"; "He's my friend, and I don't want to hurt his feelings"; "She'll get mad at me if I bring it up"; and "I don't want to be responsible for getting him in trouble." There has been a collective denial that is frankly startling. At times it has appeared that unconsciously we all collude in an unspoken myth that a thorough analysis should confer some form of immunity against the ravages of aging, marital stresses, physical health problems, and professional boundary violations.

A further difficulty that we analysts have faced is that, in the absence of psychoanalyst assistance programs, ethics committees often have been the only recourse when there are concerns about a colleague. By their very nature, ethics committees conjure up visions of sanctions, i.e., punitive measures to deal with corruption, sexual exploitation, and other forms of egregious misconduct. To turn a colleague in to an ethics committee may feel like one is "ratting out" a friend.

In this context this new casebook is most welcome. It is a sorely needed document that will serve as a beacon of light in a dark corner of organized psychoanalysis. Under the able leadership of Dr. Audrey Kavka, the American Psychoanalytic Association Committee on Colleague Assistance has labored tirelessly to identify pathways to avoid an atmosphere of punishment and accusation and replace it with hope, empathy, and peer support. In principle, we all agree that colleagues must have somewhere to go for help, but we have been slow to implement viable procedures and strategies to preserve the integrity of the process. This publication teaches us how to do that with numerous vignettes illustrating the kinds of problems that occur and the difficulties that arise when we try to help someone in need. We have long known that there is no better way to teach than the case example, and the authors of this casebook have taken this to heart. The

colleagues portrayed and the dilemmas faced by those attempting to assist are realistically depicted. The reader will struggle with finding good solutions in the same way that colleague assistance committees must deliberate to be both firm-minded and fair.

We all owe a debt of gratitude to those who created this casebook. Let us hope that it is the beginning of a new era in psychoanalytic institutions characterized by a commitment to help our colleagues rather than punish them.

Acknowledgements

I want to acknowledge and thank those who have been part of bringing this casebook to print. It has been said before, but I now know how true it is to state that this book would not have been possible without the talented contributions and support of so many others. I begin with thanking the American Psychoanalytic Association for its vision in supporting the development of Psychoanalyst Assistance as a vital branch of organizational activity. I hope that APsaA's commitment to the health and well-being of its members, their families and the community attached to psychoanalysis shines through on every page.

Jerome Winer, M.D. is the man behind the original vision. He brought the role of assistance activities into awareness and gave the movement firm footing with a compassionate, non-judgmental point of view that shaped the foundations of all assistance programs, committees and activities.

Turning to the specifics about the writing of the *Casebook*: it began when Bob Galatzer-Levy asked the question, "Why don't we write a *Psychoanalyst Assistance Casebook* like the *Ethics Case Book*?" Bob's role on the committee has been to bring a voice of both clinical and administrative experience combined with a creative talent for communicating and bringing out the best in all of us. His simple question evoked a vision that is now realized here in this casebook.

The entire Committee on Psychoanalyst Assistance Committees, now renamed Committee on Colleague Assistance, has provided unwavering support for this project. From the start, the committee guided and inspired me to use vignettes to convey our ideas about colleague assistance.

That's when vignette-writer extraordinaire Stephanie Schechter came on board. Stephanie, Bob Galatzer-Levy and I co-authored the vignette collection with our own imaginations, experiences and voices. The strength of Stephanie and Bob's ingenuity, hearts and writing enhances this critical section of the *Casebook*. It is a gift to work with two such committed and capable colleagues.

As the vignettes were coming to life, I turned to Elise Miller for her expertise on psychoanalytic writing. Elise is a two-time winner of the annual JAPA paper award. She has been a warm, brainy, enthusiastic developmental editor from the very start. I am so grateful for her editorial input, mentorship and friendship.

Elise Miller, Glen Gabbard and Ellen Pinsky all provided crucial editorial review of the first *Casebook* draft. With their general and specific editorial comments and encouragement, I was able to move forward to restructure the *Casebook*, draft, and redraft to its current form.

I could not have been more fortunate than to work with Laura Marris as line editor for finalizing the manuscript. Laura is a poet by training, but she was always there for this exacting work with timely professional, knowledgeable input.

The final contribution to the *Casebook* was the Foreword written by Glen Gabbard. His expertise in the area of Professional Ethics is widely known in the psychoanalytic world and beyond, so it is especially affirming of the work we are undertaking to have his clear understanding and support so well expressed in the foreword. I feel very fortunate to be able to include Glen's excellent foreword.

Developing imagery for the book cover was a final challenge. Psychoanalyst Assistance is all about providing support to colleagues so that they can function with strength and resilience under various conditions. The cover is our visual metaphor for Psychoanalyst Assistance as one of the supporting understructures for the vital, reliable functioning of individual psychoanalysts and of the psychoanalytic community.

Lastly, I would like to thank you, the reader, for engaging with this new area of thought and activity. Our committee will welcome any thoughts or comments you might wish to convey.

With gratitude, Audrey Kavka, Chair, APsaA Committee on Colleague Assistance

Members:
Alice Brand-Bartlett
Rita Clark
Merle Edelstein
Steve Firestein
Robert Galatzer-Levy
David Joseph
Ellen Pinsky
Stephanie Schechter
Julie Watts

Chapter 1:

Making a Place in the Psychoanalytic Community for Psychoanalyst Assistance

Imagine this conversation between two psychoanalysts awaiting the start of a committee meeting during a national convention.

> Dr. East: I want to ask you about something that has been bothering me. It's kind of sensitive—do you mind?
>
> Dr. West: No, please go ahead.
>
> Dr. East: In our institute, there is a senior colleague who is rumored to be losing it.
>
> Dr. West: How so?
>
> Dr. East: Well, that's not entirely clear. He's someone I have always looked up to. He was my best supervisor during training, he analyzed a bunch of my friends, and he was a great teacher. I don't really see him much myself these days, but because of my role in the Institute, I hear questions about him.
>
> Dr. West: You think this could be serious?
>
> Dr. East: Yes.
>
> Dr. West: Has anyone talked to him about their concerns?
>
> Dr. East: Again, I hear informally that at least one friend approached him and was rebuffed. I think people are starting to get really worried that his patient care may be suffering. No one knows for sure if there's a serious problem, but given what I've heard, it doesn't seem right to just look the other way. I'm not sure what I can do. Does your institute have any arrangement for dealing with such a situation? I looked into it and found that my institute does not even though this isn't the first time a situation like this has come up.
>
> Dr. West: As far as I know, we do not either. Maybe both our institutes should.

What begins as a casual chat on a serious matter can lead to innovation and thoughtful activism. This fictional dialogue is based on a real conversation that started the psychoanalyst assistance movement within the American Psychoanalytic Association. These two colleagues did not set out to begin a movement, but they did recognize a type

of situation that called for thoughtful attention. Much study and activity has taken place since that conversation twenty years ago. Psychoanalyst assistance is now embraced as a new branch of organizational psychoanalysis, but the concept is still poorly understood or unfamiliar to many in our psychoanalytic communities. This casebook, a project of the American Psychoanalytic Association (APsaA) Committee on Colleague Assistance (CCA), aims to increase awareness, understanding and engagement with the issues of psychoanalyst assistance.

The questions that arise from the opening dialogue continue to shape the activities of the psychoanalyst assistance movement.

- Is there something wrong with our Colleague?
- If so, is it affecting his or her professional capacity?
- Dare we speak of it?
- I wonder if it's too sensitive to mention?
- Can we do anything about it?
- Should we try to do anything about it?
- What happens if we look away?
- Where do we turn?
- Do our institutes have any guidance for situations like this?

When Dr. East says a senior colleague is rumored to be "losing it," the implication is that something has changed. The rumor suggests that the colleague is losing something precious, namely capacity. Change is intrinsic to life and affects us all. This casebook is about us—psychoanalysts of all temperaments and types—who are subject to the changes taking place around us and within us. Some will be welcome and others will not. This casebook focuses on navigating life changes throughout the course of a psychoanalytic career.

With good health, we may be able to practice responsibly well beyond the generic retirement age of sixty-five. In a profession that values maturity and the wisdom of experience, age is often seen as an asset rather than a liability. But it is part of our organic destiny that the body changes in ways that eventually result in diminishing functions.

When health issues arise at any age, our capacity to practice comes under both conscious and unconscious internal scrutiny. Our personal analysis and ongoing self-analysis may prepare us to make reasonable decisions when unwanted change challenges our way of being in the world and calls for some adjustment of practice. But unconscious fantasies that a good analysis confers an immunity to unwanted change cannot be fulfilled. We will all experience changes in appearance, mobility, health, family roles, social roles, professional roles, financial status, and various aspects of cognition as we age.

These changes can occur anytime, at any age, and they raise questions that defy simple answers. At what point do changes in health compromise analytic capacity? Clearly, the answer to this question is always situation specific and case specific, involving layers of factors. We have probably all faced the dilemma of cancelling clinical hours for minor illness or lack of sleep. And we have probably all made the assessment (rightly or wrongly) that our work was good enough, even though we knew that we were not functioning quite up to par.

Setting "good enough" as the standard reflects the essential acceptance that analysis is a process between two very human individuals, analyst and patient. Transient fluctuations in capacity are not only expected, but also part of the fabric of analysis—these experiences are points of contact with the limits of idealized wishes for perfection in the patient and the analyst.

In contrast to these inevitable, passing experiences of off days, there are situations where analysts continue to practice in states of ongoing, compromised analytic competence. The desire and sense of responsibility to address these latter situations is at the core of

psychoanalyst assistance. This casebook considers individual and institutional roles in a spectrum of situations where illness and change impact analytic competence. This broadly defines the domain of psychoanalyst assistance.

At this point, you may ask, “What is it? Isn’t that the work of ethics committees? How is it done?”

Whether you are a curious reader with no direct experience of situations where analytic function is compromised by illness or a reader with analyst assistance responsibilities looking for professional resources, we hope you will find what you seek in these pages. We have designed the *Casebook* with this range of readers in mind.

The heart of this casebook is the vignettes section. The four introductory chapters lay out our definition, conceptual framework, and approach to psychoanalyst assistance which underlies all that follows, allowing readers to get the most out of the vignettes.

For readers who are involved with or planning to become active in psychoanalyst assistance, the two chapters that immediately follow the vignettes provide a more in-depth look at the issues of establishing an approach and a protocol.

Chapter 2:
Why Do We Name It Assistance?

Analyst assistance activities can be applied to a broad range of circumstances and proceed in various forms. The goal of the activity is the defining feature. This aim is consistent: to help the analyst make his or her own decision, based on the situation, about whether he or she is able to work. The form of assistance may be as informal and spontaneous as a spouse encouraging an analyst to stay home for a day to recover from a minor illness when it appears that the analyst is dragging him or herself off to work. This is not trivial. A spouse's nudge may "assist" an analyst to reassess the decision to go in that day. Although we do not register them as such, we probably all provide "assistance" to our colleagues quite regularly.

When a Psychoanalyst Assistance Committee (PAC) of a psychoanalytic organization initiates an assistance process with a colleague, the goal is the same: to assist the analyst in making the most appropriate assessment of capacity to work competently under the circumstances.

In this casebook, we look outside the norm of transient, minor fluctuations of health and readiness for practice to the spectrum of situations in which a change in health status may affect analytic capacity at a significant, lasting level. These are the situations that create an impetus to provide planned assistance to the affected colleague. The variables are considerable: temporary, chronic, remediable, non-remediable, a cooperative colleague, an uncooperative colleague, early recognition and intervention, late recognition and complex consequences.

Experience from psychoanalytic communities of different sizes and locations demonstrates that it is neither common nor rare for an analyst to continue practicing in a state of seriously compromised function. Knowledge of these situations often elicits emotional reactions as well as thoughtful concern. Some colleagues may be quick to judge from afar that the colleague should simply retire (and remove him or herself from

view). Other colleagues may express an opinion that it is no one's business, as if the problem disappears when they look away. As a community, we must expect and prepare for situations in which a psychoanalyst continues to work despite impairment of capacity to work. The *Casebook* is an invitation to develop your own thoughts about what it means to prepare for these situations.

The formation of psychoanalyst assistance committees introduces into psychoanalytic communities a taboo subject in order to act and to bring all members into the conversation about what it means to prepare for these situations. This book will not offer simple answers to complex, profound questions, but it will offer an opportunity to give some thought to important questions that are often neglected until a crisis develops.

Our committee's work has been guided by a philosophy of assistance, beginning with the premise that a psychoanalyst who continues to work despite compromised professional capacity is not a corrupt colleague but a colleague very likely overwhelmed with an unexpected and painful change in health status. Practicing psychoanalysis fulfills many personal and pragmatic wishes and needs, so it is no wonder that unexpected threats or actual disruptions of capacity to work may elicit powerful conscious and unconscious fantasies and anxieties that may affect the very personal inner assessment of working capacity.

Of course, not all changes in capacity are the same and not all analysts react the same way. Yet, it is crucial to psychoanalyst assistance to understand that change in capacity to work is likely to be experienced as a life crisis often activating and reviving inner conflicts and anxieties relating to issues of loss, endings, failure, shame, and even death. Responses to change in capacity, both at the internal and external level, are as highly varied as the psychic makeup of psychoanalysts. There are those colleagues who are able to make appropriate adjustments in their professional activities due to a change in capacity, and there are those colleagues who appear to continue professional activities as if a change in capacity does not exist. All colleagues experiencing health difficulties

deserve compassionate support and respect from their colleagues and professional organizations.

While some colleagues are able to readily recognize and take action to respond to a change in functional capacity, this may not be possible for others due to the nature of the state itself—in cases of dementia, delirium, or mania, for example. There are still others for whom the physical and emotional stress of the illness itself may interfere with judgment, making them unable to recognize and acknowledge their diminished capacity.

In response to the health crisis, unconscious mechanisms of denial and disavowal may also come into play, so that the compromised analyst reports no conscious recognition of difficulty or impairment. It is with all of these situations in mind that we restate the first key premise of our committee philosophy: a colleague who continues to practice without appropriately accommodating a change in analytic competence is a colleague experiencing a very personal life crisis that appears to be overwhelming the capacity for self-assessment and appropriate judgment.

A second premise crucial to our assistance philosophy is that maintenance of standards of competent professional behavior and care is what is best for both the analyst and his or her patients, supervisees, students, family, and analytic community. No analyst expects to continue to work in a seriously compromised state. Each analyst's personal and professional integrity depends on being able to practice in a state of competence.

This integrity must be restored if it becomes compromised, and this is how the best interests of the analyst can be served even when the analyst does not wish to acknowledge or address the change in competence. Enabling the analyst to make an appropriate adaptation to maintain (or regain) full competence is the most effective means of protecting the well-being of his or her patients, family, and analytic community. In the case of lasting change in capacity, this support includes enabling him or her to retire. Even in the face of non-cooperation from the colleague, clarity about the mission

as assistance for the analyst, and for all those who depend on the analyst's competence, supports the challenging and sometimes painful work of psychoanalyst assistance.

Just as they guide our committee, these working premises will provide some guidance through the vignettes and the comments sections in Chapter 5.

Chapter 3:
Distinguishing Psychoanalyst Assistance from the Ethics Committee

Psychoanalyst assistance is a new branch of activity within the psychoanalytic community that may be viewed as parallel to the ethics committee branch of activity. The desire and moral responsibility to intervene in situations where an analyst may not be functioning at a level that meets the standards of the profession are what gives rise to both psychoanalyst assistance committees and ethics committees. Beyond that shared responsibility, the differences between psychoanalyst assistance and ethics committee activities are conceptually clear. This chapter elaborates on those differences and continues to convey our committee's conceptual vision of psychoanalyst assistance.

Ethics committees are generally charged with the responsibility of identifying whether or not a psychoanalyst has committed an ethical violation. Their activities begin with a *complaint* or *charge* of improper/unethical behavior by patients and colleagues. The named analyst is then typically considered the *respondent* or *defendant*.

Psychoanalyst assistance begins with concern for a colleague and concern about that analyst colleague's ability to practice. Therefore, the colleague is identified as *the analyst-of-concern* (AOC), not the defendant. Ideally, successful assistance intervention will redirect the analyst-of-concern towards adjustment of practice and away from potential ethical violations.

Ethics committees have legalistic proceedings that may even include hearings with legal representation for the defendant and for the committee. Assistance processes are mutual and collaborative with the analyst-of-concern.

In order to proceed from a verbal complaint to an ethics committee investigation, a complainant is required to submit a written complaint that charges the analyst with specific violations of the applicable ethics code. If an ethics investigation is initiated, this process will involve the gathering of what is viewed as evidence that supports or does not

support the charges. Because an ethics committee will be expected to make a judgment about ethical wrongdoing, the process is formal with significant parallels to a legal prosecution.

The analyst assistance process begins with *observations* from any source that raise sufficient concern to merit seeking more information. The individual raising the concern is not a complainant. It could be the analyst him or herself, the spouse of an ill analyst, a colleague, a friend, or a patient. Initial efforts are directed towards conveying concern and engaging the analyst in a process of assistance on behalf of the analyst and his or her professional integrity.

Colleagues and institutions need not wait to accumulate "sufficient evidence" to be assured that the analyst is impaired before intervening. Early, compassionate intervention may help the analyst-of-concern initiate appropriate treatment and modification of practice in a timely manner that limits potential damage to all professional contacts, including patients. Early intervention may also help the analyst-of-concern avoid crossing the line into unethical acts. Appropriate intervention serves both analyst and patients. At the same time, analyst assistance committees have an important responsibility to use care and sensitivity in determining when to proceed with an intervention.

From the outset, the question for ethics committees is "Did the charged analyst violate the ethical code?" With psychoanalyst assistance, the crucial question is "Do we have a reason to be concerned about our colleague's health and analytic function?" It is as important for psychoanalyst assistance as it is for ethics committees not to pre-judge or pre-plan the outcome of the assistance process. Premature assumptions about the nature of the problem or outcome, such as "it is time for him to retire," do not serve the analyst or protect patient care. *Thoughtful engagement*, *careful evaluation by outside experts, and ongoing support for the analyst* to actively address compromised function or incapacity are all in the service of the patients as well as the analyst.

At the conclusion of an ethics investigation, there is a verdict/finding of guilty or not guilty and the determination of an appropriate sanction based on the findings.

There are no sanctions in analyst assistance. The findings of the process will dictate the outcome. The vignettes that follow portray a wide variety of situations just as they come to the attention of colleagues. Many of the vignettes stop at the point of initial engagement, intentionally leaving the ultimate procedures and outcomes open to consideration, discussion, and imagination.

Chapter 4:
Introduction to the Vignettes

In keeping with the familiar saying "a picture is worth a thousand words," we have conceived of this casebook as word-drawn pictures of fictional but realistic vignettes that raise and explore questions of colleague assistance for debate. Our vignette drawings will illustrate principles and process described in the previous chapters and demonstrate the endless variety of situations that occur in the professional life cycle of psychoanalysts.

The vignettes written for this casebook are intended to accurately represent types of experiences—without representing any actual individual case or situation. *All case vignettes are fiction* in order to protect the privacy and confidentiality of our colleagues. In our experience, variations on the same situations and issues do occur in life, so it is imaginable that a reader will feel that his or her situation is portrayed in the vignette, but this cannot be the case. We have worked to create fiction that is realistic enough to illustrate ideas and raise thought-provoking questions.

There are many characters in every vignette, and each of their roles and situations demands our attention. These characters include the analyst-of-concern, patients, analytic colleagues, candidates in classes and in supervisions, institute leaders and faculty members, family members of the analyst-of-concern, and members of psychoanalyst assistance committees. We propose that when an analyst continues to practice in a compromised state, the best way to protect all those who are in vulnerable positions is to provide assistance to the colleague, the analyst-of-concern.

Although there are situations in which individuals may successfully act alone to informally assist a colleague, our committee has been studying the place for organizational psychoanalysis in taking responsibility for helping colleagues in need of assistance. We have come to the conclusion that psychoanalyst assistance is an appropriate and important responsibility of organized psychoanalysis.

With this conclusion in mind, many of the vignettes that follow assume that the local psychoanalytic organization has a Psychoanalyst Assistance Committee that fits the following definition: A psychoanalyst assistance committee (PAC) is a committee of psychoanalysts charged by the regional psychoanalytic institute, society, or center to develop, implement, and maintain a program to responsibly identify and provide assistance to analysts who may be functioning at an impaired level due to illness.

Chapter 6, "Focus on Approach and Process," follows the vignettes and will provide more details about PACs, psychoanalyst assistance programs (PAPs), and key reference points for a model psychoanalyst assistance process. These standards are based on our committee's philosophy and core beliefs, which are presented in Chapters 2 and 3.

Since the vignettes aim to inform, generate questions, and stimulate creative thinking about how psychoanalyst assistance can be implemented, we limit our comments at the end of each vignette to a few brief points that stand out to us. There are many other points of interest in each vignette that we hope you will discover as you read and respond. To move the field forward, we firmly believe that there must be room for ongoing questions and alternate frames to be thoughtfully considered and debated.

The vignettes are organized into groupings, beginning with a group that illustrates a broad concept of psychoanalyst assistance. The groups that follow range from vignettes portraying relatively uncomplicated cases with positive outcomes to cases of greater complexity involving difficult, thorny issues.

In Chapter 6, we pinpoint some of the tensions that come up when we propose our ideal model of psychoanalyst assistance, knowing that the ideal is not always achieved and may not even be achievable. Yet, our committee holds that this does not justify failing to attempt to constructively address the situation of colleagues who appear unable to practice competently. We have worked to convey the optimism of ideals while anticipating the pitfalls of implementation. We encourage you to read the vignettes and ask yourself if you feel that our vision is a good fit for the stated goals and circumstances.

Chapter 5:
The Vignettes

Group 1: Colleague Assistance as a Part of Daily Life

As a member of a psychoanalytic professional community, it is likely that each of us will encounter situations in which we learn from personal and/or professional contacts that a colleague is facing a clinical practice challenge due to changes in health. The response to these situations may be spontaneous, intuitive or carefully considered. This first group of three vignettes portrays three such situations in which colleagues respond without an assistance-focused frame or even an explicit intention to "assist." Two of the vignettes illustrate how supportive and useful such interventions can be. The third introduces the potential pitfalls of acting informally.

Dr. Doges

Dr. Doges, a healthy forty-five-year-old analyst, is enjoying a Saturday evening of dinner and the opera with her husband when somewhere between the main course and the dessert, she develops abdominal pains. In only ten minutes, these pains become quite severe. They leave the restaurant and go straight to the closest hospital emergency room. Dr. Doges receives immediate attention including intravenous medication for pain control, and she is admitted to the hospital.

Despite unrelieved pain and uncertainty about her medical situation, Dr. Doges worries about contacting her patients for the upcoming week. It's becoming clear that she probably has appendicitis and will have to undergo surgery. She will certainly be unable to work for at least one or two weeks.

When she wakes up on Sunday morning, she struggles to pull herself together to locate the phone numbers of her Monday patients to inform them of the necessary cancellation

for the week. Dr. Doges' husband notifies some close friends, and Dr. Black, a dear friend and colleague, decides to make a visit. When Dr. Black enters the hospital room, he finds Dr. Doges on the phone struggling with the task of contacting her patients. "What are you doing?" he asks. When she answers, he states without hesitation, "Give me the information; I will do it for you."

Although she had never considered this possibility, Dr. Doges finds that she is enormously relieved. With this trusted colleague taking charge, she can let go of immediate concerns about taking care of others and recognize how much she is in need of care.

Only later, during her recuperation from the appendectomy, does she learn the specifics of how well Dr. Black handled this clinical task. What he chose to disclose to her patients was very consistent with her manner of working, and he made himself available to her patients as needed until she was able to return to work.

Comments:

Given the solitary nature of a psychoanalyst's work, analysts are quite accustomed to being fully responsible for all aspects of their clinical practice. It is not difficult to imagine that Dr. Doges never even considered that she might ask someone else to take on the duty of informing the patients on her behalf.

It is even worth considering that analysts are more comfortable in a caretaking role than they are in a role that requires them to depend on others. Dr. Black acted without hesitation, and in this way, he conveyed his recognition of Dr. Doges' compromised state.

This intervention provided assistance at several levels. Dr. Black took care of the clinical responsibilities, and he assisted Dr. Doges in a process of transitioning from professional caregiver to patient-in-distress receiving care.

Dr. Yardley

Dr. Yardley, a recent graduate of her psychoanalytic institute, arrives at her regular study group meeting with the sad announcement that at age 42, she has just been diagnosed with breast cancer. Dr. Yardley adds that the diagnosis is especially threatening as her own mother died of breast cancer in her late forties. Immediately following the news, a mixture of alarm, concern, fear and compassion fills the room, but rather quickly, the group unifies around listening and providing personal support to Dr. Yardley. She chooses to provide more detail about the diagnosis and treatment plan, and as she does so, the group makes it clear that they care about her and want to help her in any way they can. At some point in the meeting, everyone feels that it's an appropriate time to turn their attention from Dr. Yardley's situation to the regular agenda of that evening's study group.

At the next monthly study group, Dr. Yardley updates her colleagues on her medical situation. She is optimistic about treatment and cure but anticipates that the course of treatment will introduce disruptions in her clinical schedule. The optimism is welcome, but the group seems to sense that Dr. Yardley's calm reflects a reluctance to focus on herself and to use the group for support. Dr. Ripley, a senior member of the group, speaks up from her own experience with cancer: "I hope you know we all want to help, but we also know that sometimes what is offered is not really helpful. Please let us know how we as individuals and as a group can be of help to you." This deeply touches Dr. Yardley who tearfully replies, "I can't thank you enough for that kindness. Knowing you want to help makes all the difference in the world."

With that said, Dr. Yardley expresses an interest in learning from her colleagues about how other analysts have managed through serious illness. Anecdotes and remembrances come pouring forth from her colleagues. Dr. Banks raises the suggestion that they all might benefit from thinking about the challenges of analyst illness and wonders whether

it would be worthwhile to use the study group to review and discuss the existing literature on analyst illness for a period of time. The suggestion is readily adopted, and a study plan is developed for the next several group meetings. As the meeting ends, Dr. Yardley again expresses her gratitude and indicates that she may well be in touch with individual group members about help she might need.

Before the next monthly study group meeting, Dr. Yardley contacts a couple of study group members for some practice coverage and even asks some others to accompany her to the hospital for various procedures. Within the study group, the ensuing discussions are rich and offer many opportunities to ask Dr. Yardley how things are going for her, including how she is managing in her clinical practice. She reports that she feels the clinical practice is going well, better than she had feared, but she feels confused by the opposing positions in the literature about disclosure of an analyst's health status to analytic patients when the analyst is ill. Dr. Mazzuna then asks whether Dr. Yardley might find it useful to present some current work to the study group with a special focus on this question of how the illness might be impacting the psychoanalytic treatment. Given their familiarity with each other and a sense of support and good will in the group, Dr. Yardley feels free to decline the invitation but adds that the study group work has really had an impact on her. She reports that she has just recently made arrangements to get regular private supervision/consultation focusing on the impact of her illness and has resumed seeing her analyst for personal support.

The group applauds her for taking these steps to take care of her patients as well as herself under the threatening circumstances of a serious illness and difficult course of treatment. One year after the announcement of the cancer diagnosis, the study group is delighted when Dr. Yardley reports that she is "cancer-free." She says she is nonetheless continuing her private supervision and personal analysis and would now like to present her ongoing work to the group.

Dr. Yardley is generous in providing process material. Though the group is very sensitive to the possible anxieties of their colleague in presenting her work, they pay close

attention to the clinical material and do not avoid raising their observations of the patient's fantasies about the analyst's illness. Dr. Yardley seems quite able to listen non-defensively to the patient and to work closely with what the patient is bringing into the analysis. She thanks the group for their part in helping her throughout her bout with cancer and especially for the group's ability to support her wishes to responsibly find her way through the clinical challenges when her personal anxieties were at a heightened level.

"I do not think you know how helpful this has been for all of us," Dr. Hardy replies. "I, myself have been suffering from a chronic illness for the last 15 years, and in all this time, only my wife and my two closest colleague friends have known about it. I felt I had to keep it to myself or lose the respect of my colleagues. I had to overcome a disturbing sense of shame in deciding to open up to the group now. This experience of Dr. Yardley's openness and the group's response has moved me and changed my mind about the possibilities for turning to colleagues" After a moment of shared surprise, the group thanks Dr. Hardy. They do not press for details but affirm that indeed the study group is one place where they can speak freely and anticipate support from colleagues.

Comments:

It is the tradition of APsaA psychoanalytic training institutions to combine didactic seminars, a personal training analysis and supervision in their candidate training programs. In this way, analysts are directed from the very outset of training to be sensitive to the interplay between the working mind of the analyst and the clinical work. In this vignette, we imagine that Dr. Yardley and her study group colleagues are well prepared by their training to anticipate that the analyst's working mind might be impacted by the health crisis. Both Dr. Yardley and her study group colleagues demonstrate a clear commitment to safeguard the clinical work. The study group activity to support Dr. Yardley is an important part of this commitment.

With the aid of her study group, focus on the impact of the illness on their colleague, the probable impact on her patients, and the complex impact on the psychoanalytic process,

Dr. Yardley navigates her way through this particular situation. The group was quite aware of wishing to help Dr. Yardley in this special circumstance but likely did not see themselves as engaging in an assistance process per se.

In adapting the structure of the ongoing study group to the immediate situation, the group itself discovered a new invaluable role for its members. The group experience directly provided assistance to Dr. Yardley, indirectly provided assistance to Dr. Hardy and almost certainly helped every study group member develop a deeper academic and personal understanding of the impact of illness on the psychoanalytic process.

Dr. Endy

Dr. Endy never imagined he would be a healthy, socially outgoing, much-beloved and esteemed training analyst. As a six-year-old boy, he was taken out of school for six weeks and isolated in a sanatorium for children with rheumatic fever. He was told he could never participate in sports or even gym classes again, and he expected to be a loner forever. His physical recovery was excellent, but the psychological impact of childhood rheumatic fever led him to analysis in his teens and then into a career as a psychoanalyst.

Now, at age fifty-five, his life starts to change again when an infectious illness causes lasting damage to a heart valve that had been weakened by his childhood illness. Following a brief hospitalization, handled with little fanfare or disruption of his usual mode of practice, it is decided to manage the now-permanent heart condition with medication.

Unfortunately, Dr. Endy is one of those individuals who does not do very well with that treatment. He is advised that open-heart surgery to replace the valve is an alternative, but the surgery involves serious risk. Determined to avoid disruption of his very satisfying professional and personal life, Dr. Endy carries on in his practice seemingly unaware that he is not functioning properly. Fatigue due to poor cardiac function, sedative effects of

the heart medications, the see-saw of dehydration and excessive fluid build-up, and the ongoing anxiety about the dilemma of surgery interfere with his alertness, focus, concentration, and memory, all essential for analytic functioning.

This is evident in his routine contacts with his colleagues. Aware of Dr. Endy's serious commitment to high standards for himself, his best friend Dr. Good, a fellow analyst, decides to speak with Dr. Endy about his illness and his capacity to work. As soon as Dr. Good raises the issue of his clinical work, Dr. Endy goes into a fit of rage. He violently accuses his friend of rivalry and jealousy. He goes so far as to say that he believes Dr. Good wishes to steal his patients. The accusations are at the edge of delusional.

Dr. Good is stunned and quite disrupted by this searingly personal outburst. The uncontained explosive reaction seems out of character and a very worrisome indication of Dr. Endy's emotional state and capacity to function as an analyst. The good intention to keep the conversation private, between trusted friends, has backfired. The shocked and wounded Dr. Good finds he cannot persist in his efforts to address Dr. Endy's difficult situation, and he does not know where to turn.

Friendship and the best of intentions are not sufficient for the torrent of troubled emotions that emerge when Dr. Endy is confronted with an illness and disability he has been denying. The failed intervention has consequences. Though patients and supervisees tolerate the comings and goings of Dr. Endy's mind while he struggles to maintain his health, the patients and supervisees do not emerge unscathed.

Declining quality of life eventually persuades Dr. Endy to go forward with the surgery, which fortunately is highly successful. Dr. Endy is able to resume his work *presumably* without impairment, but colleagues are never certain and the broken friendship is never repaired.

Comments:

For Dr. Endy, and for most of us, the unexpected contributes to the shape of our lives. This vignette of Dr. Endy serves to transition us toward the world of formal, structured analyst assistance. It is a world where a life crisis for one analyst has repercussions for his patients, supervisees, and students. Any number of metabolic and psychological factors may have accounted for Dr. Endy's paranoid state prior to surgery. But Dr. Endy neither acknowledged nor informed his physicians of any difficulties. He did not seek evaluation beyond the specific question of the heart valve repair, although broader evaluation might have identified any number of treatable factors.

Dr. Good's distress represents the distress of colleagues, friends, and family. The vignette illustrates the repercussions when one individual attempts, unsuccessfully, to intervene alone and on the basis of friendship and concern.

Group 2: Positive Outcomes through Cooperative Engagement

In this group of five vignettes, we encounter a considerable variety of circumstances, but in each case, the interventions are successful in securing the cooperation of the analyst-of-concern. With cooperation, the parties involved are able to work through their concerns and achieve a reasonable assessment that reflects the strengths and competencies of the analyst in question. From there, they continue to work together to create a plan for adjusting the analyst-of-concern's practice to assure competent clinical care.

Dr. Jeffries

Dr. Jeffries, who has been in practice for over 40 years, shares an office suite with three mental-health professionals who are not analysts. The suitemates are friendly, having shared the office suite for many years, but they are not professionally affiliated and do not see each other outside the office.

Over the last several months, each of the suitemates has been approached in the waiting room by patients of Dr. Jeffries asking if they know where Dr. Jeffries might be, since she has failed to arrive for their scheduled appointment. Once the suitemates realize that this is happening with some regularity, they are concerned. Initially, they agree to "respect boundaries" and do nothing, until one day a suitemate finds Dr. Jeffries in the hallway struggling to figure out how to get her key into the lock on her office door. He assists her, and Dr. Jeffries simply thanks him politely as if nothing significant has occurred.

Following this incident, the suitemate feels he cannot ignore these signs of trouble. He knows Dr. Jeffries is a psychoanalyst, so he calls the local institute. He states that he is concerned about the health of one of the institute members. He is referred to the chair of the local PAC. The contact with the chair goes very well. The officemate describes the

cause for his concern but is reluctant to identify Dr. Jeffries by name. The chair is sympathetic to his reluctance and provides information about how the PAC works, referring him to the website posting the procedures of the local PAC and assuring the suitemate he can remain anonymous as an informant. Once the suitemate understands that he can preserve his anonymity, he reveals the name and feels very relieved that there is a process to follow for looking into Dr. Jeffries' situation.

The chair contacts Dr. Jeffries and asks if she would meet with him and Dr. Anderson, a member of the PAC. She agrees, and they arrange to meet with her in her office. In the initial meeting, they state that they have received information that raises concern about her health. They provide no details in order to maintain the informant's anonymity. Dr. Jeffries seems a bit puzzled and disorganized in her response. The chair asks basic questions about her age, her health, the status of her practice, and possible problems in her personal life. Dr. Jeffries is not especially defensive, but her answers are vague and uninformative. Her conversation is superficial and often repetitive as if she does not recall what she has already told them. In response to questioning, Dr. Jeffries reports that she has received no regular medical care for almost two years.

As the first meeting draws to a close, the chair is fairly convinced by this interview that Dr. Jeffries may be experiencing cognitive difficulties which could be affecting her capacity to practice competently. He is tempted to share this with her in the moment, but he decides to thank her for meeting with them and indicate that they will be contacting her again once he and Dr. Anderson have had the opportunity to talk.

The chair and Dr. Anderson meet immediately, as they both agree there is a real possibility of cognitive difficulty affecting her capacity to practice. Concerned about gradual but progressive dementia, the PAC faces the possibility that Dr. Jeffries is placing herself, her patients, and her family at risk while continuing to see patients. They note a childlike vulnerability in Dr. Jeffries' manner during the interview and wonder if this in some part accounts for her agreeability thus far.

With all this in mind, they decide to call Dr. Jeffries that very same evening to express concern about her health and ask her permission to contact her husband to engage him in a process of getting her medical attention as soon as possible. They are very glad when Dr. Jeffries seems relieved and is willing to involve her husband. They agree to meet together the next evening. In that meeting, they agree that Dr. Jeffries will take time off from her office to seek immediate medical attention. They plan to stay in regular contact with the PAC during the process.

Comments:

Due to its prevalence with increasing age, dementia is probably the first condition that comes to mind when we imagine analyst impairment. This vignette illustrates that the onset of dementia may be subtle, with slow, gradual progression. Capacity to work may be maintained for a considerable period of time after the earliest signs. As time and illness progress, signs of compromised function become more evident, while many aspects of memory and reasoning are unchanged.

This fictionalized account portrays a relatively idealized, smooth-sailing PAC intervention. When they meet with Dr. Jeffries face-to-face, the chair works with another committee member. Pairing up for these activities is aimed at helping each participant maintain a balance of subjectivity and objectivity. Together, the two PAC members use discretion, judgment, experience, knowledge, empathetic capacity, and the transparent procedures of the local PAC to address the issues raised by the informant and by the interview with Dr. Jeffries. And Dr. Jeffries does not resist. The latter may seem unbelievable, yet for some analysts, the opening up of a discussion about health and practice may come as a relief. Such an analyst may have been working under tremendous internal pressure to practice competently despite serious emotional or physical challenges.

The early involvement of a cooperative spouse can be an enormous aid in working through these challenging judgment calls and their execution. But many difficult

questions for the PAC remain. What if Dr. Jeffries seemed so overwhelmed by the process of facing her difficulties that she appeared unable to think about addressing her medical needs and professional responsibilities? How to know what is best in terms of immediate patient care pending the evaluation? What if Dr. Jeffries states that she is unable to suspend or limit her practice due to financial needs?

Dr. Towne

Dr. Towne has been a training analyst for over fifteen years, but referrals for training analysis have been slowing down. So he is particularly pleased when Dr. Shaw, a middle-aged woman hoping to become an analyst, seeks him out for treatment. Although he recognizes that her problems go "beyond simple neurosis," he does not anticipate an unusually long analysis.

In the course of the analysis, Dr. Towne develops a series of medical conditions that leave him neurologically compromised in what he thinks are subtle ways. Although he is aware that his patient is extremely sensitive to anything that could be experienced as a disruption in the treatment, he does not think Dr. Shaw notices any change in him. Dr. Shaw does notice, yet the problem continues in the analysis with neither the patient or the analyst addressing the issue. Having lost a parent in adolescence and feeling she had not "handled it well," the patient decides to stick with Dr. Towne even though she expects him to die during her analysis. She consciously thinks this could be a "second chance" to support a dying parent well. The patient does not disclose this fantasy to Dr. Towne, and the analysis is soon stalemated.

As she prepares to apply to the Institute for training, Dr. Shaw seeks supervision with a very experienced analyst. In this supervision experience, Dr. Shaw and the supervisor identify persistent difficulties in Dr. Shaw's clinical work. As they work together on the identified difficulties, information about the status of Dr. Shaw's analysis becomes a part of the supervisory experience. The supervisor eventually forms the impression that Dr.

Shaw's analysis is seriously compromised, that it is essentially a prolonged mutual enactment of a fantasy that is not being analyzed. He shares these thoughts with Dr. Shaw, and he advises her to take this up with her analyst. He also offers to speak with her analyst if she wishes. Relieved and wary, she agrees to both.

Not surprisingly, when the supervisor speaks with him, Dr. Towne recognizes his own denial of the impact his health was having on his ability to practice, and he feels very bad about what has happened. He recognizes that this analysis and perhaps others have not gone well, and that the combination of his own illness and his personal wishes has contributed in a major way to what happened. He decides to retire. In this poignant conversation, Dr. Towne wonders aloud about who else has witnessed his problems and associates to memories of other situations in which there were painful indications of his impaired state that others did not address. In tears, he asks, "Why didn't anyone talk to me long ago? I knew something was wrong. No one referred patients to me; no one asked me to teach. If someone had said something at least I could have spared this patient. I wouldn't have hurt her for the world."

Comments:

The collusion of patient and analyst to avoid evidence of the analyst's neurological illness puts this situation into the realm of PAC activity. It is unclear if the collusion is stalemating the treatment, or if the analyst's competence is affected by his illness, or both. Dr. Towne's own statements suggest that it was both. Here, a PAC could be instrumental in raising these questions and developing a plan for appropriate evaluation.

If the illness alone should not have been an impediment to competent practice, it raises additional questions. Was this analyst having an emotional reaction to his illness that jeopardized his analytic capacity? Was this an analyst with difficulties recognizing and working with enactments in analysis regardless of his state of health? Again, Dr. Towne's own remarks suggest that both factors were in play. While some analysts assume that they are being supportive or kind when they do not address a colleague's problems, some

colleagues greatly value knowing they can rely on others to inform them when they appear to be in trouble. Avoiding the pain and anger of a confrontation does not ultimately protect against widespread pain and personal damage.

Dr. Walsh

Dr. Walsh, a brilliant analyst who has long suffered from periodic depressive episodes, has his first clear episode of mania in his late thirties. Like many people with bipolar disorder, he has periods of great creativity before developing full-blown mania, and his contributions to psychoanalysis are extraordinary. The condition is partly controlled with medication, but it becomes clear that his illness can easily interfere with his clinical judgment. Sometimes he convinces himself that through elaborate, idiosyncratic therapies, he can treat patients whom no one else could work with, or he recommends treatments that further his research without benefitting patients. Once he recovers from these manic episodes, Dr. Walsh easily recognizes how inappropriate his actions have been, but during the episodes this insight is not available to him.

Dr. Walsh is fortunate to be affiliated with an institute that has a well-respected PAC, so he quickly comes to their attention. Dr. Walsh is cooperative and the PAC is able to obtain sufficient information directly from him and from additional outside sources to conclude that Dr. Walsh's illness precludes him from further treating patients. This assessment is conveyed to Dr. Walsh with considerable compassion and a clear emphasis on his continued value as a colleague and contributor to the psychoanalytic literature. Furthermore, the PAC offers to think with him about how his knowledge, not to mention his career, can be saved. They agree that Dr. Walsh will seek out the best possible treatment for his illness and will rigorously follow his psychiatrist's advice about the extent to which he can work. Perhaps Dr. Walsh can see patients in brief consultations that do not require long term commitments to the patient. Dr. Walsh can conduct research, provided his interactions with patients are monitored by another analyst, and he

can supervise and teach, provided his students are forewarned about the possibility of Dr. Walsh becoming manic.

Comments:

Though this arrangement was sometimes stressful for Dr. Walsh, it allowed him to continue working for many years. During these years, he was a successful academic, a contributor to the literature, and an influential teacher. When carried out well and in the right circumstances, a PAC can help an analyst sustain a career and contribute to the field despite serious impediments.

Dr. Pruett

Dr. Pruett is in the midst of a very acrimonious and public divorce. His wife is very well-known in their city as a generous benefactor of many charities. Her photo is often in the society pages of newspapers and magazines, and she is regularly seen at community occasions such as ribbon-cuttings, mayoral and gubernatorial inaugurations, and charity events. The Pruetts have eleven-year-old twin sons.

Six months ago, several tabloids began to run stories alleging an affair between Mrs. Pruett and Mr. Frey, a wealthy businessman who was recently listed in Forbes Magazine as one of the richest men in the country. Photos of Mrs. Pruett and Mr. Frey with their arms around each other, seemingly caught in an intimate moment, have been printed in numerous local and national publications.

Mrs. Pruett has hired a publicist to help her manage the fall-out from this recent exposure and her divorce proceedings. In an attempt to maintain her status in the community and control the damage from the negative publicity she has received, she launches a public attack on her husband. She is quoted in various articles describing him as an emotionally abusive, philandering husband. She states she is seeking full custody of their children.

As a long-time member of his analytic institute, Dr. Pruett receives a great deal of support from many members of the analytic community. At the same time, gossip about the Pruetts becomes rampant throughout the Institute. They are both well-known throughout the community, and they have attended countless social events at the Institute over the course of their twenty-year marriage. As the months progress, more and more details of their marriage, including aspects of their sex-life, emerge in the news—all based on accounts given by Mrs. Pruett. Dr. Pruett makes no comments to the press, despite pressure from friends and family to defend himself against the vicious public attacks he has endured.

Dr. Pruett is emotionally devastated by these recent events. Publicly humiliated, terrified about the outcome of the custody battle, facing possible financial ruin, and fearful of the consequences for his professional life, Dr. Pruett seeks out help and support from several close friends whom he feels he can trust. He is determined to maintain all his professional responsibilities including clinical work, supervision, teaching, and publishing.

Despite doing everything he can think of to responsibly manage his professional obligations, Dr. Pruett feels as if he is under a microscope at the Institute. Though he ceases to attend social gatherings, he makes sure to show up for every class, committee meeting, and session with each patient on-time and ready to devote his full attention. Yet he frequently notices that people abruptly end their conversations the minute he enters the room. He notices some people tend to avoid him, while others are overly solicitous. His closest friends tell him that the rumors have reached a fevered pitch and that almost every gathering among institute members inevitably leads to references, sometimes even jokes, about the Pruett divorce. Two of his supervisees end their supervision with him, both apologetically citing the distraction of recent events. One of his colleagues backs out of her commitment to write an article with him, offering the dubious explanation that she is over-extended with professional obligations.

Dr. Pruett feels he has little control over his situation and fears further damage to his work and reputation. He also fears that his work may suffer given the level of personal stress and pressure he is enduring in every facet of his life. This finally motivates him to seek out a meeting with Dr. Zakian, the chairman of the PAC. Although neither Dr. Pruett or Dr. Zakian can readily identify exactly how the PAC will be able to provide assistance, they both recognize that Dr. Pruett needs assistance to support and safeguard his professional integrity. Dr. Pruett finds himself feeling some immediate relief from the knowledge that an official committee of his institute is committed to working with him in his complex, difficult personal and professional situation.

Comments:

Dr. Pruett is a colleague at risk. His personal life is transformed; he has lost control of the boundaries of privacy; and he feels judged and ostracized within his psychoanalytic community. He is healthy and performing his functions as a psychoanalyst competently, but he is in need of assistance. Although friends and colleagues offer essential support to Dr. Pruett, forming a working relationship with the PAC provides him with a process of organizational consultation and support. If PACs are able to establish a record of reliability with a focus on assistance, analysts may seek assistance for themselves from the PAC on a proactive basis.

Dr. Bernstein

At age sixty-three, Dr. Bernstein is generally regarded in the community as a "good, sensible analyst." Never particularly physically active, he is about sixty pounds overweight and despite repeated, albeit brief diets, his weight has crept up over the years. His blood chemistries are repeatedly at the edge of a diabetic range, and his lipid levels remain just on the right side of normal with the help of Lipitor. He is, in the words of his internist, "set up for a heart attack."

It comes as no surprise when, in the late afternoon of a long day, he starts to sweat profusely and experience crushing pain in his chest radiating down his left arm. It happens that his patient is a physician who notices the sweating and asks if he is alright. When Dr. Bernstein says he thinks he's having a heart attack, the patient takes him to the emergency room, where the analyst is admitted and found to have a life-threatening coronary artery blockage.

At the hospital, Dr. Bernstein realizes that he assumed he would have a heart attack, which he thought would probably kill him. This fantasy was actually comforting, because his father had been an invalid for his last decade due to chronic heart failure, and his quality of life had sharply declined. Dr. Bernstein found relief in believing that he would simply be dead and not have to experience anything like that. In the hospital, Dr. Bernstein looks back over the last decade and recalls getting winded walking up a flight of stairs or feeling tired early in the evening. He had attributed this to age alone. After the heart attack, he increasingly re-conceptualizes these losses of function as cardiac symptoms. This is the beginning of an internal process that he later refers to as a "therapeutic heart attack": a realization that it might be reasonable to try to take care of his physical health.

Comments:

Whether it's experienced directly or vicariously, the "therapeutic heart attack" can lead analysts to make lifestyle changes that are so necessary in our sedentary profession. It is striking that while psychoanalysis is unique in expecting analysts to attend to their own mental health, there is no parallel community expectation for attention to physical health. Analyst assistance committees have until now focused on situations in which the analyst-of-concern is already in difficulty. The therapeutic heart attack points to a future development for local analytic communities to systematically encourage and support members to incorporate good health practices throughout their life and analytic career.

Group 3: When Neglecting Physical and Emotional Health Affects Clinical Practice

In each of the following three vignettes, the assistance process reveals that, for various reasons, the analyst-of-concern is neglecting his or her own health needs. With the assistance of the PAC, he or she can be directed towards treatment, including adjustments to clinical practice.

Dr. Bauer

Dr. Bauer's surgery for a herniated disk occurs in late June. He is told by the attending surgeon that he is likely to be fully recovered and able to return to all of his professional activities in September. However, he suffers complications from the surgery and does not return that early. Members of the community are pleased when Dr. Bauer once again becomes a familiar presence at the Institute's academic and social events in the late fall. Despite a fairly dramatic weight loss, he initially appears healthy and in good spirits. His off-beat sense of humor, well-known and cherished at the Institute, seems intact, and he jokes with the students in his class that he doesn't care how fat his thighs were, he is never going to let himself get talked into liposuction ever again.

In the next several weeks, however, Dr. Bauer's appearance declines. Typically a meticulous person, he appears at institute events looking unusually disheveled. At the monthly training analyst meeting, his friends and colleagues cannot help but notice that he arrives with uncombed hair, wearing two different colored shoes. Even more concerning is the fact that Dr. Bauer remains quiet for the entire meeting, despite the fact that a heated and contentious issue is being discussed. As the meeting adjourns, his friend and colleague Dr. Russo comments to another colleague that in his thirty years at the Institute, he's never sat through a meeting without hearing at least two or three of Dr. Bauer's opinions on a matter.

Dr. Russo phones Dr. Bauer the next day to ask how he is feeling, but the call is never returned. Dr. Russo becomes increasingly alarmed when he overhears a student in his class mention that Dr. Bauer had shown up 40 minutes late to their previous class and had offered no apology or explanation. Knowing Dr. Bauer to be a punctual and scrupulous person, he worries that Dr. Bauer's health is deteriorating as a result of his recent surgery. He decides to speak with a mutual friend and colleague, Dr. Macy, who knows him well and who has also observed him at the training analyst meeting. Dr. Russo and Dr. Macy both share a deep concern about Dr. Bauer's health, including his ability to practice professionally. They agree to invite Dr. Bauer out for coffee and broach their concerns with him. Dr. Russo calls Dr. Bauer and asks him to return the phone call as soon as possible, saying that he and Dr. Macy have something important to talk over with him. Once again, the phone call is not returned. Dr. Macy's call also goes unanswered.

Dr. Russo calls and speaks with the head of the Committee on Analyst Assistance (CAA). He explains that he has noticed a change in Dr. Bauer over the past weeks and is worried about him both personally and professionally. The committee meets several days later and decides to reach out to Dr. Bauer due to concerns about his well-being. Dr. James calls and identifies himself as a CCA member and requests a return call.

Dr. Bauer does return this official call, and arrangements are made for Dr. Bauer to meet with Dr. James and Dr. De Campos, both members of the CAA, several days later. They thank him for meeting with them, and explain that changes in his appearance and behavior have been observed in recent weeks and that members of the community are concerned about his health. They note his weight loss, silence at meetings, and withdrawn demeanor—all of which are so unusual to those who know him well. They ask how he is feeling. Dr. Bauer is silent for a long moment after listening to the committee members voice their concerns. Eventually he shakes his head, looks away and says tersely, "My health is just fine."

After another long, tense moment, Dr. Bauer discloses that his wife left him several weeks ago. He says, "I've had some trouble adjusting to the fact. I was not quite aware

my state of mind was so apparent to others." Dr. James tells Dr. Bauer that they are really sorry to hear about the problems in his marriage, and they sympathize with how hard this must be. He asks how they might be helpful to him. Dr. Bauer thinks for a moment and says, "I've obviously been broadcasting more misery than I'd realized." He notes that perhaps it is time to return to see his analyst for some help as he tries to regain his "equilibrium." Dr. De Campos asks if there is anything else they can do, and Dr. Bauer says no, he "got the message" and plans to get himself some help. They ask Dr. Bauer if they can check-in periodically to support Dr. Bauer in the process of maintaining his professionalism while seeking help with this emotional crisis. Dr. Bauer very reluctantly agrees.

Comments:

This vignette illustrates the dangers of a misleading situation in which some information may lead to premature and false conclusions. Since prematurely returning to work following surgery is a common occurrence among professionals, Dr. Bauer's health issue was a red herring. In this case, it may have helped to bring appropriate concern to the situation. It is likely that colleagues were more alert to the possibility that small lapses in Dr. Bauer's level of conscientiousness were possible signs of ill health because they knew of his recent surgery. The signs he exhibited might otherwise have been dismissed as relatively harmless or inconsequential. He was late to a class without apology, quiet in meetings, and did not return telephone calls. By themselves, none of these changes would be likely to trigger concern about health and functional capacity.

Dr. Bauer benefitted from early intervention thanks to concerned colleagues and a PAC that maintained the basic principles and process of analyst assistance. The PAC did not pre-judge the situation. They presented observed facts to Dr. Bauer with an open mind to learn more from him. In this vignette, the PAC was surprised to learn that Dr. Bauer was experiencing marital difficulties rather than post-surgical difficulties. Dr. Bauer indicated that he was unaware of how his marital strain was affecting his professional activities, but he ultimately accepted the reliability of the information and feedback the committee

provided. Dr. Bauer's reluctance to talk with the committee and to continue involvement with them also highlights the fact that, at times, the PAC can be useful despite the analyst's negative feelings about their involvement or intervention. This intervention hopefully helped him reach out and attend to his own emotional needs by returning to treatment.

Dr. Goldstein

Dr. Young, chairman of the local PAC, receives a call from a young woman who introduces herself as the granddaughter of Dr. Goldstein, a retired analyst. Ms. Goldstein explains that she is a psychology major and very close with her grandfather. She is concerned about Dr. Goldstein's emotional well-being, since he has been talking about returning to practice at age eighty, three years after full retirement.

Dr. Young meets with Ms. Goldstein who reports that things have changed drastically for her grandfather since his retirement. Initially pleased to have more time to travel, garden, and read, everything changed with the death of his wife one year ago and with financial setbacks from the falling stock market. She says that Dr. Goldstein continues to live alone, rarely leaving his apartment, sleeping poorly, losing weight, and not reaching out for any help. As far as she knows, he has lost contact with all his former colleagues.

Dr. Young suggests that Dr. Goldstein might not recognize that he is depressed. "Oh, he knows he is depressed," she replies, "but that has become part of the problem. He says he is depressed because he is not working. He has long winded explanations that he cannot feel good about himself if he is not working, so he plans to return to practice. I have tried to reason with him, but it's no use. When he started making calls to engage an office and asking me to help him write announcements of his return to practice, I decided I had to do something!" She goes on to explain that her father tried to talk to his father, "but when my grandpa told my dad in no uncertain terms that there were only two alternatives,

return to practice to treat his depression or commit suicide, my dad decided to let him try to return to practice."

Dr. Young asks if Dr. Goldstein is showing signs of cognitive troubles. "Who can tell? All he will say is that he has no reason for living and does not have enough money to keep himself going. He uses the computer to constantly check the stocks in his pension plan, so maybe his mind is ok. I don't know."

Dr. Goldstein's granddaughter says that she has no problem with her grandfather knowing she has sought help for him. In this situation, her willingness to be identified turns out to be very helpful in the early contacts between the PAC and Dr. Goldstein. Dr. Goldstein is so profoundly depressed that he is not open to concern from his colleagues, but he is responsive to the idea that he is causing great distress for his granddaughter and perhaps other members of the family. With Dr. Goldstein's agreement, involvement of his family in the PAC process is crucial to a successful intervention.

Comments:

This is clearly a high-risk situation. Dr. Young cannot make a diagnosis without a clinical contact, but he is concerned that Dr. Goldstein is seriously depressed and not seeking treatment. This retired analyst may even be at risk of suicide. There is also the danger of Dr. Goldstein returning to practice in a disabled state.

Untreated depression is a serious concern for an analyst post-retirement or at any time in a career. An analyst may seek solace from feelings of worthlessness in his or her clinical work. Many analysts report that being able to work when they are going through a difficult life experience is extremely important, but the analyst may not be able to objectively judge when he or she is not able to perform adequately.

It is not uncommon for analysts to return to work prematurely after having taken time off following a loss, an illness, a surgery, or another traumatic experience. Real and

imagined concerns about finances may pressure people to return to work before they have sufficiently recovered from the traumatic state.

In this vignette, the granddaughter is the informant, illustrating that there are no limits to who can reach out to a PAC for help. A struggling analyst may also seek assistance for him or herself from a PAC.

Dr. Chow

Dr. Chow is known for being an avid tennis player as well as an excellent analyst. Colleagues look to him for his clinical wisdom, which is often expressed with a humorous attitude towards the troubles and foibles of the human condition. His home and analytic practice have always been at some distance from the analytic training center, but he has been a dedicated and active candidate, young graduate, and mature training analyst. As the years progress, he is gradually seen at fewer and fewer institute activities and events. Colleagues assume this is a natural consequence of advancing age making it more difficult to drive to evening activities. By all accounts, he continues to have a busy practice with several training cases and candidate supervisees.

No one is worried about Dr. Chow until several analytic sibs (candidates simultaneously in analysis with Dr. Chow) share confidences and find they have all experienced him to be "changed" lately. He seems irritable and rather cutting in his interpretations. His waiting room greetings are less warm, he seems less tuned in about their lives, and he often shaves down the length of the sessions by ending a few minutes early. They wonder if he has made a theoretical shift and nervously laugh together about how to get him to return to his more affable style of interpretation.

The candidate sibs even voice a genuine concern that maybe they are not good enough analysands and that Dr. Chow might be adjusting his style because of their difficulties as patients. "Maybe something is wrong with Dr. Chow!" protests one of the group. Pain

and relief now color the discussion. But if something is wrong with their analyst, what can they do? Some report trying to take up the perceived change in style directly with Dr. Chow, but he has been dismissive and even a bit belittling.

They agree that one of the analysands will speak to her supervisor. The supervisor has great respect both for Dr. Chow and for the analysand supervisee. He listens carefully and seriously to her and responds that he himself is unsure how to approach the situation. He asks her permission to share the information with the dean. She checks with the other analytic sibs and agrees to grant him permission.

The supervisor and dean confer. Given Dr. Chow's age and the picture described by the analysands, they feel reasonably concerned that the reported changes might be early symptoms of a developing dementia. With this in mind, they determine that this situation would be best approached by a referral to the PAC.

The dean and supervisor decide to inform the candidates that they will follow-up on their concerns, but they will not provide specific information about what actions will be taken. They suggest that each candidate consider private consultations concerning their analyses and schedule a meeting with the dean to discuss all aspects of their training situation over the next three months. The dean then makes the referral to the PAC himself.

When the PAC chair phones Dr. Chow and asks to get together for a meeting with him and Dr. Stone (a PAC member), Dr. Chow sounds a bit nervous but agrees to the proposed visit. It is not explicitly stated that the visit is a part of the formal duties of the PAC, but it seems likely that this is at least surmised.

Upon first meeting, the chair and Dr. Stone find that Dr. Chow seems thin and rather haggard in his face. Dr. Chow does not walk with the athletic vigor and gait of times past. This eases the way for the chair to follow the friendly greetings with the clear statement that he and Dr. Stone are visiting as concerned colleagues and as members of the PAC. He goes on to say that in his role as PAC Chair, it has come to his attention that

colleagues in the community are concerned about Dr. Chow's well-being. "Well-being?" Dr. Chow repeats as if this is a novel perspective.

"Yes" replies the chair, adding that he himself can see a change in Dr. Chow's appearance and wonders about his health.

Dr. Chow falls silent for several minutes and seems to be struggling with something. He finally replies that he is in very good health and wonders why there is any question about that. He laughs in his old, good-natured way that he is not getting any younger. At this point, the chair feels it is possible to tell him that a certain change in his behavior and personality has raised concerns about cognitive changes. At this point, Dr. Chow eases. He confidently reports that his mind is intact, but that he is having other "old age" problems. He pours out his private struggle with pain due to multiple orthopedic problems. Worried that the pain would distract him from his work, he had briefly taken prescribed pain medications, but even at the lowest doses, he found himself less alert than he could accept. He stopped all the pain medications with a determination to find ways to manage the pain and keep working.

After several months of effort, he knew this plan was not working and had reached a decision to ease out of his practice over time. He feels it is his obligation to his patients to allow each one to have what he considers a full analysis including a proper termination when the time arrives. He had hoped that the gradual reduction of patients would work. The PAC members suggest that perhaps he is expecting too much of himself and not asking for enough help. They all agree that pain could account for the changes to his office behavior, but it is a good time to have a more formal evaluation. Dr. Chow agrees to see a pain management specialist, and to see a neurologist to rule out cognitive impairment. They plan to meet again in one month.

Dr. Chow follows through on all the recommendations. Neuropsychological testing confirms that he is not cognitively impaired. The pain-management consultation is encouraging about some adjustments that may be helpful, but it also confirms that he is

suffering from serious chronic joint pain that is not likely to improve significantly. The PAC team works with Dr. Chow to assist him in the recognition that his pain condition is affecting his work and that he is not sufficiently taking his own health needs into account. Dr. Chow's insistence on working until each analysis ends on its own schedule starts to seem more inflexible than virtuous. This leads to a collaborative plan for him to retire over the next 4-6 months. It is not ideal, but it is necessary.

The PAC chair continues to check in with Dr. Chow periodically to support him in the retirement process. In this case, Dr. Chow experiences considerable relief once he has a specific end date for his practice. He seeks consultation about how to present the termination to his patients, and he is able to work effectively in ending his practice. He receives considerable support from colleagues when he explains his situation and decision. He retires with dignity.

Comments:

This vignette portrays a reasonably positive outcome of an appropriate PAC referral. Dr. Chow's minimally defensive attitude strongly supported a constructive process. The role of the informant and the ethical utilization of anonymity are also key.

This vignette addresses the enormously difficult position individuals may find themselves in regarding the question of whether to reach out to a PAC. In this case, the informants are candidates faced with the excruciating decision of whether they should speak to the PAC concerning their own analyst. The emotional complexity of making such a choice cannot be overstated. Moreover, these candidates are invested in their analyses and their training, and they may well feel vulnerable about both. Reality and fantasy will uniquely interact for each candidate under the influence of that individual's stage of analysis, transference state, and character. At this point, the analyst's changes were not gross, unethical, or negligent, but clearly noticeable and disturbing for each analysand.

Given the real but subtle evidence of something amiss with the analyst, the individuals would almost certainly not have acted on their own. As they shared information with each other, they learned that as individuals they had blamed themselves rather than questioning the authority of the training analyst. Unconscious fantasies of analyst immortality and omnipotence are often powerful elements of any analysis. These fantasies are dynamically active and can affect the analysand's capacity to evaluate his or her perception of the training analyst.

In addition, actual and imagined concerns about hierarchy, power, and authority issues within the training experience influence a candidate analysand's readiness to seek help from the psychoanalytic organization. The supervisor and dean recognized the importance of keeping a layer between the analysands and the PAC/analyst experience. The PAC determined that it was not necessary to identify any of the informants, including the supervisor and the dean.

Keeping the informant anonymous immediately communicates that the emphasis is on concern and assistance rather than trial and judgment. The PAC goal is not to prove anything about the analyst. The analyst-of-concern may demand evidence, but the PAC conveys their message by making it clear that the analyst is not on trial and the PAC is not mounting a case against the analyst.

A policy of anonymity for the referring source has two important aims: the first is to overcome resistance to making a referral. Many individuals understandably feel concerned but reluctant to "get mixed up in that kind of thing." The second is to convey that the PAC itself becomes the concerned party and has the experience to work with the analyst-of-concern. This distance relieves the referring party of the burden of consequences from the referral. Each candidate will certainly have a unique response to the early retirement of Dr. Chow. Further analysis with new analysts and support from the dean may assist the candidates as they work through the never-quite-finished aspect of such an experience.

Although we characterize this vignette as positive, it also illustrates the multiple vulnerabilities of analysands when the analyst's compromised function and retirement-under-pressure shape the course of an individual analysis. Candidate analysands have additional complications in terms of training requirements to be met and in terms of impact on the analysand's role in the community. This suggests that the assistance process goes beyond the PAC's work of assisting the analyst. The analysands' situations require special attention from the dean and the training committee on an individual basis.

Group 4: Thoughtful Policies in Complex, Thorny Situations

In the following four vignettes, matters become more challenging for the assistance process, and although reasonable outcomes remain possible, the results are less clear and perhaps even controversial. With two of the vignettes, we begin to introduce defensive colleagues who are not particularly amenable to a collaborative process. With three of the vignettes, debatable issues concerning PAC policies illustrate that PAC activities follow from the philosophy, established policies, and procedures of the individual, local PAC. Given the challenges of each situation, these vignettes may stimulate a search for alternative approaches.

Dr. Haas

Mr. Haas walks into his kitchen late one Thursday morning to find his wife, Dr. Haas, sitting at the table, staring into a coffee cup. He is surprised, since typically she is in her office very early on Thursdays seeing her patients. When he asks her why she is home, she appears startled. She looks up at him, then at the clock on the wall. She asks him what day it is, and he answers that it is Thursday. Dr. Haas then mumbles something about having been confused and rushes out the front door.

Alarmed and uncertain about what to do, Mr. Haas calls his wife by cell phone several times throughout the day. Hours later, she finally returns his call. She assures him that she is fine and explains she'd gotten little sleep the night before and woke up feeling confused thinking it was the weekend. He asks if she missed any appointments with patients that morning due to her confusion, and she says that she did, but that she has called each of them, apologized, and "straightened it all out."

The following week Mr. Haas comes home from work to find Dr. Haas standing in the middle of the kitchen with drawers open, papers and cookbooks strewn everywhere. He is alarmed by this uncharacteristic behavior. She explains that she is looking for the recipe

for a chicken dish she has been making for years by heart but cannot now recall the directions. She looks quite upset but laughs it off lightly adding, “I guess it’s a senior moment.” At this point, Mr. Haas expresses his concern. He notes that this behavior and her confusion earlier in the week are unlike her, and he tells her that he wants her to see a doctor immediately. She laughs again and says that they are both beginning to get older, and it would be ridiculous for them to run to a doctor every time they forget something or make a mistake. Despite his insistent appeals for her to call her doctor, she dismisses his worries, saying that he simply needs to accept that neither one of them is a “spring chicken anymore,” and that she’s not ready to check into the old-age home quite yet. Two months later, Mr. Haas receives a call from Dr. Chu, a colleague of Dr. Haas’ at the teaching hospital where they both supervise residents. Dr. Chu says that he has spoken to two of Dr. Hass’s supervisees who have expressed concern that she has been extremely forgetful in their supervision sessions lately, mixing up details of their cases and repeating herself in a way that has been confusing and uncharacteristic. Dr. Chu says he has also noticed that Dr. Haas has been unusually repetitive and convoluted in meetings and has become concerned about her well-being. He says he spoke with Dr. Haas directly about his concerns but that Dr. Haas became angry and defensive, stating that the two residents were both problematic and obviously conspiring to blame her for their difficulties in the department.

Mr. Haas talks with his wife again about the recent changes in her behavior and the call from Dr. Chu. He tries to reason with her good judgment by advising medical attention, arguing that if she is having any sort of neurological problem, the sooner they address it, the sooner she can be helped. This time Dr. Haas becomes enraged and accuses him of betraying her by speaking with Dr. Chu and colluding in spreading rumors about her. She spends the next several days avoiding him, spending extra hours in her office and coming home late at night.

Mr. Haas is uncertain about how to help his wife confront this problem, and he decides to call the PAC committee of her analytic institute. Unsure whether they can be of help to him since he himself is not an institute member, he is reassured by the committee head,

Dr. McCarthy, who says that anyone can reach out to the committee for help. Mr. Haas explains all of his concerns about his wife to Dr. McCarthy. He also gives her the phone number of Dr. Chu so that they might speak directly about what he has observed at the hospital. Dr. McCarthy reassures Mr. Haas that he has done the right thing by contacting her and that she will bring these concerns to the committee to discuss how they can help Dr. Haas.

Comments:

Family members may be the first people to recognize an active analyst's changes in cognition and health status, but gaining the cooperation of the struggling analyst may be as difficult for a family member as for anyone else. In this vignette, the collaboration of spouse, PAC and concerned colleague was pivotal in engaging the defensive analyst in the assistance process.

This vignette once again raises the issue of ease of entry into a PAC procedure for any potential informant. It is worth repeating that potential informants are likely to identify the need for help but may fear the consequences of contacting the local PAC. Meeting misconceptions about PACs is to be expected. Providing information and conveying the focus and emphasis on assistance in all public materials and person-to-person contacts will help address misunderstandings. Readily accessible information for the public about the PAC and its policies and procedures is a very useful means for addressing the initial concerns of potential informants. Issues of particular interest for potential informants include the option of anonymity for the informant, clarity about the role of the informant, and information about the breadth and limits of confidentiality in the entire PAC process. Communicating an appreciation for the difficult position of the informant is always an important aspect of PAC activity.

Concerns for the professional standing of the analyst may discourage or even prevent a family member from seeking help from the local psychoanalytic organization. This is absolutely understandable, and yet it is our hope that experience will demonstrate the

benefits of effective PAC interventions over ignoring or standing by when health problems affect practice. The PAC can communicate a concern for the full situation of the Haas couple by prioritizing the health evaluation but also by being available to help them grapple with additional financial, ethical, and legal issues to be considered, including timely suggestions for consultation with outside professionals in those areas.

Dr. Lutz

Dr. Chase, Chairperson of the Education Committee, is startled to notice that his colleague Dr. Lutz appears especially thin and haggard when he sees her at the winter academic lecture in their analytic institute. Aware that Dr. Lutz has been struggling with congestive heart failure, he wonders whether his colleague's health has been deteriorating.

After the lecture, Dr. Chase mentions to their mutual friend Dr. O'Brian that Dr. Lutz looks terrible: "She looks like she's aged ten years since last May." Dr. O'Brian confirms that Dr. Lutz has been in very poor health lately. Apparently Dr. Lutz was recently in the hospital for over a week and suspended all her other professional commitments for several more weeks while she was at home on bed rest. Dr. Chase says, "She looks so frail I almost didn't recognize her."

Dr. Chase sees Dr. Lutz at the Institute the following Thursday night. He approaches Dr. Lutz, strikes up a conversation, and asks how she's been doing. They discuss Dr. Lutz's recent health problems. Dr. Lutz acknowledges she's struggled over the past several months, but that she's glad to be back at work seeing patients again, resuming her teaching, and working with her supervisees. Aware that Dr. Lutz regularly carried a heavy load of professional obligations, Dr. Chase asks whether she's decided to cut back on her workload at all. Dr. Lutz laughs and responds, "Sam, you know me! What do you think?"

The following week, Dr. Chase finds out from Mr. Keith, an analytic patient who is also a candidate supervised by Dr. Lutz, that he has only met with her three times in the past three months due to her cancellations. Mr. Keith says he's conflicted about what to do; he has worked with Dr. Lutz in supervision for two and a half years, and he deeply appreciates her understanding of his analytic patient. He feels that the help she has given him has been invaluable. However, he says he continues to need more consistent supervision than he has recently been receiving. He adds, "And when I do meet with her, her breathing sounds so labored I end up worrying about her and it's hard to concentrate on my case."

When Dr. Chase sees Dr. O'Brian at the next Education Committee meeting, he once again raises the issue of Dr. Lutz's health and her ability to function professionally. Dr. O'Brian tells Dr. Chase that he happens to know that others are concerned as well. He adds in confidence that he and others have contacted the chairperson of the PAC committee to voice concerns about Dr. Lutz. He does know that the PAC has reached out to Dr. Lutz and has been engaged in discussions with her about her health and her work, but that's all he knows about the PAC involvement. He adds that he has personally contacted Dr. Lutz's husband to express his concern of many months that Dr. Lutz is pushing herself beyond what her body can bear and his relief that Dr. Lutz is now talking with the PAC. Apparently Mr. Lutz has been imploring Dr. Lutz to retire, or at least seriously cut back on her professional obligations. Dr. Chase is relieved by this conversation and extremely glad to hear that Dr. Lutz's ability to practice responsibly is being addressed by the Institute.

But Dr. Chase remains deeply concerned that Dr. Lutz appears to be continuing to shoulder an extremely heavy load of professional responsibilities. As Chair of the Education Committee, he feels a particular responsibility toward Dr. Lutz's students and supervisees. He also harbors serious concern about whether Dr. Lutz is currently able to provide sufficient care to her patients. Through e-mail, he contacts the chair of the PAC and inquires about how Dr. Lutz's health issues are being addressed by the committee,

and whether the committee is doing everything it can to work with Dr. Lutz to consider the implications of her health on her professional practice.

Several days later, Dr. Chase receives the following response from the chair of the PAC:

The PAC understands and deeply appreciates your concerns about a fellow analyst and his/her ability to uphold professional obligations within the Institute, and in the community at large. However, it is important that you understand that in no way is the PAC required, obligated, or even permitted to compromise the privacy of the members to whom they reach out. Therefore, we are unable to provide you with any information about your inquiry. Once again, we thank you for your concern.

Dr. Chase is surprised and angered by this response. He feels he is acting within his role as chair of the Education Committee to ensure that members who act as analysts, teachers, and supervisors are able to function fully and appropriately within their roles. Moreover, he feels ethically obligated to work in concert with the PAC to this end, and that it is the role of the committee heads to work together to ensure the integrity of the Institute. He phones the committee chair and expresses these thoughts. Once again, he is told that according to the approved PAC procedures, institute members are entitled to confidentiality about their involvement with the PAC, so it would be unethical and inappropriate for any information to be disclosed.

Comments:

Adherence to transparent, written procedures is essential to the integrity of the PAC, but local institutes generally have complete freedom to design an ethical set of procedures that reflects the local community values. In this vignette, the PAC has chosen to privilege confidentiality of process.

It is quite understandable that the education chair would seek information about the state of competency of an analyst with many institute roles, but reporting to the administration

about PAC proceedings may alter the working relationship between the PAC and the analyst-of-concern to an extent that may compromise the assistance goal. This is something each local PAC should consider in the development and maintenance of local governing procedures.

No PAC is required to privilege confidentiality over reporting to appropriate institute leadership. Some PACs may choose to always designate an institute leader as a PAC member or as a consultant to the PAC. Some may have other reporting expectations. Most PACs are likely to include special situations in which the confidentiality of the PAC process may be broken such as when the situation triggers state regulated mandatory reporting. Non-compliance with the PAC may also constitute the basis for a referral to the Ethics Committee or for reporting to various institute officers or committees. Incorporation of this kind of reporting requires full transparency through clear description in PAC procedures and verbal communications.

The analyst-of concern may be encouraged by the PAC to voluntarily notify institute officers about his or her health status, plans for addressing health status, and how this will directly relate to clinical, educational, and administrative responsibilities. Even when the PAC is obligated to guard confidentiality, the analyst-of-concern has the privilege to breach that confidentiality.

Dr. Xavier

Dr. Xavier is a seventy-eight-year-old training analyst of considerable local repute. She has always been considered brilliant and creative in her thinking but has never been an easy person to work with. Once a highly sought supervisor, a later generation of candidates have shifted toward others. Dr. Xavier remains a faculty member but has been rotated off the teaching assignments for several years to allow fresh voices into the educational program.

Dr. Xavier approaches the young faculty member in charge of the psychotherapy training program to indicate her interest in teaching again. The program director has never had any direct contact with Dr. Xavier either as a student or supervisee, so he informally inquires about Dr. Xavier and hears from older colleagues that she is extremely knowledgeable with excellent clinical acumen. A few offer additional commentary that Dr. Xavier tends to the narcissistic. The program director concludes that this is a wonderful opportunity for the psychotherapy students to have direct contact with such a senior, experienced psychoanalyst. He contacts Dr. Xavier. They discuss which courses are open for faculty assignment and agree on the best fit for Dr. Xavier. They address all the practical arrangements, and everything is finalized rather smoothly.

Eight months later, the program director is a bit shocked when he is almost accosted by a group of disturbed psychotherapy students. The topic is Dr. Xavier and her course. It seems that Dr. Xavier has not kept to her assigned topic or course outline. She has focused almost exclusively on her own pet theory and substituted her own papers for the originally assigned readings. Some students complain that she has used the course as her own bully pulpit, not allowing any real class discussion to take place. Others express concern that Dr. Xavier seems to be in her own world, oblivious to the students. Given that the hallway between classes is not the time or place to work through the problem, the program director assures the students that he has heard them and will look into it and get back to them.

Later that evening, the program director begins to reflect on the encounter with the students. With distance from the clamor, the program director recognizes that he felt some defensiveness at the intensity of the students' emotions. He decides that when the time comes to bring the problem to Dr. Xavier, he should expect some defensiveness and plans to mitigate that with a non-accusatory approach and without emotional dumping onto Dr. Xavier. He also wishes he could avoid involvement altogether but feels it to be his responsibility as Program Director.

Upon reviewing the written course evaluations, he finds the majority are highly critical and almost unanimously report poor responsiveness to student participation or input. He calls Dr. Xavier and leaves a message that he wants to schedule a meeting to find out how things had gone with the teaching. Dr. Xavier returns the call and a time is set, but it requires quite a bit of accommodation to Dr. Xavier's schedule.

The program director experiences another shock when he meets with Dr. Xavier and asks her how the course had turned out. She calmly replies "very well." He asks her to give him some details, and she launches into a mini lecture on her pet theory. This seems to give the program director the opportunity to gently provide the feedback that some of the course evaluations had mentioned a dominating emphasis on this one theoretical viewpoint. Dr. Xavier nods her head in agreement, so the program director feels he can add that a number of the students have commented that the seminar meetings diverged from the stated purpose of the course offering. At this point, Dr. Xavier responds defensively and aggressively. She criticizes the students as inferior and asserts her credentials as a long-standing faculty member and training analyst. "If the students did not see the relevance, it was their problem," she informs him.

The program director then asks Dr. Xavier why she said the course had gone very well if she has this view of the students. Dr. Xavier replies that she wished to be gracious about the students but now he has pushed her to be more candid. Had she been aware that some of the students were dissatisfied with the course? "Absolutely not" she replies. At this point, Dr. Xavier states that she is ending the meeting to attend to more important matters.

As Dr. Xavier walks out on him, the program director finds himself feeling disturbed, much like the students who had engaged him in the hallway. He feels confused by the discrepancies between the student point of view and Dr. Xavier's point of view. It concerns him that her demeanor suddenly changed from calm and accommodating to angry and accusatory when he mentioned the negative reviews. He wonders what to do

with his conflicting feelings about a talented analyst who seems unable to tolerate any slight. He also dislikes Dr. Xavier's manner of pulling rank with him in the meeting.

To process his own feelings and attend to the problem, the program director starts asking around more specifically about Dr. Xavier. He recounts the experience to several colleagues, who remark that as far as they know, Dr. Xavier has always been like that, narcissistic and prickly. They advise him to leave it alone and not give further teaching responsibilities to Dr. Xavier. One colleague suggests that the recent eruption of alarm about Dr. Xavier's behavior might reflect changing times at the Institute or some new difficulties with Dr. Xavier. Both ideas resonate for the program director, who decides to make contact with the local PAC.

In consultation, the PAC chair affirms that this was a very appropriate situation for the PAC. The PAC will take up the responsibility for looking into the matter of Dr. Xavier's health. For the purposes of confidentiality, the PAC will not be able to let the program director know anything about the PAC process and outcome unless Dr. Xavier agrees to it. The program director does not hear anything further from the PAC or from Dr. Xavier, but he does learn within the year that Dr. Xavier has retired from clinical practice to devote herself full-time to her writing.

Comments:

This vignette raises the complicated question of character issues affecting psychoanalytic practice. Character style certainly influences all aspects of an analyst's professional activities. A narcissistic colleague like Dr. Xavier poses a challenge, since she has much to offer, but her perpetual self-pre-occupation and grandiosity eventually marginalize her from full community acceptance. Whether a PAC should even take up a case like that of Dr. Xavier's might raise controversy.

Although character does refer to the stable, long-term characteristics of personality, this vignette highlights the changing nature of character trait intensity, penetrance, and

rigidity throughout the course of an analyst's life. Shifts in character traits do occur with changing external and internal pressures. Emotional crises and physical health crises may affect character states on a transient, chronic, or progressive basis.

Experiences of failure, personal losses, fears of retirement, fears of death, fears of endings, and reactions to illness are just some of the factors that may contribute to internal instability and an intensification of difficult character traits. Aging brings with it many psychic challenges that may influence the state and expression of character traits. Traits that once had little effect on competence to practice may intensify and impact capacity to work. It is the evaluation of these changing expressions of character that suggest a possible role for PAC engagement.

Dr. Poletti

Dr. Poletti, a second year candidate, is presenting his first control case in his clinical seminar. He is particularly anxious to present this case because he feels he has struggled to make progress with this patient, and he is eager to get thoughts from his classmates and teachers about his frustrations with deepening the treatment.

In the course of presenting, he mentions several recent cancellations with the patient for his own medical reasons. The classmates gently inquire into the reasons for these missed sessions, and Dr. Poletti reveals that he suffers from a rare auto-immune disorder that flares up occasionally and causes him to miss sessions with his patients due to medical appointments or need for bed rest. One of Dr. Poletti's classmates asks him how he has addressed this issue with his analytic patient, and Dr. Poletti briefly appears disturbed and taken aback by the question. After a moment of thought, he acknowledges that he has never addressed his illness with his patient directly. He states that he needs to cancel appointments from time to time, occasionally more than one, but that he always goes to great lengths to make up the time, often seeing patients straight through weekends and holidays to reschedule missed sessions. He acknowledges that making up the

appointments is more challenging with his control case than with his therapy patients because of the frequency of the sessions and that the treatment has been more disrupted for that reason.

An awkward silence in the class ensues.

The teacher, Dr. Oliver, asks Dr. Poletti about his supervisor's thoughts about the issue of his chronic illness and cancelled patient sessions. Again, appearing confused and off-guard, Dr. Poletti acknowledges that he has not discussed the issue with his supervisor recently. He says he informed his supervisor at the beginning of their work together of his condition, and they had a fairly lengthy discussion at the time about Dr. Poletti's concerns about the rigors of analytic work, given the state of his physical health. The supervisor, Dr. Rauch, was extremely helpful and reassuring. He gave Dr. Poletti a great deal of praise for pursuing analytic work, telling him he seemed like a talented, thoughtful clinician and that the Institute and his patients were all lucky to have him. Since that discussion, the issue of Dr. Poletti's health has only vaguely been mentioned in the supervision and is never directly taken up as an issue in the treatment of Dr. Poletti's first control case.

One of the students in the class wonders aloud whether the patient may have feelings about the missed sessions, as well as fantasies about the reasons for them, which she does not feel she has "permission" to voice in the treatment. The other members of the class nod in agreement.

Dr. Poletti feels disturbed but also grateful for the feedback he has received from his class. Later that week in supervision, he raises the issue with Dr. Rauch. He tells Dr. Rauch that the class helped him to think that it may be important to talk with his patient directly about his illness, let her know the reason for his cancellations, and encourage her to discuss her feelings about it.

To his surprise, Dr. Rauch appears irritated. He says that he does not blame Dr. Poletti for being influenced by his classmates and teachers, but that this is a good example of people making proclamations about what should happen in a treatment without having a true understanding of the case. He states that this patient, who was forced to take on a parentified role in her family at an early age, would surely feel burdened by knowing about Dr. Poletti's chronic illness. He says it may seem to the class that giving this information to the patient would be in her best interest, but it would only serve to assuage Dr. Poletti's guilt and would cause the patient undue anxiety. Dr. Rauch adds that Dr. Poletti has done "beautiful work" with this patient and that there is no evidence that a disclosure of this nature would help the treatment in any way.

Dr. Poletti leaves his supervision session feeling utterly confused. He trusts Dr. Rauch's expertise and deep understanding of his patient, but he also feels that his classmates and teachers helped him identify something that he had been defensively unaware of. He is surprised by Dr. Rauch's intense reaction and feels uncertain about how to proceed.

The following week, after class, he approaches his teacher, Dr. Oliver. He tells her that he found the class the previous week to be helpful and also tells her about his supervisor's reaction to the class feedback. Dr. Oliver notices Dr. Poletti's obvious distress and confusion about the contradictory opinions about how to manage the issue of his chronic illness with his patient. She asks him whether he thinks a consultation of some sort may be useful.

Comments:

Dr. Poletti is a candidate with a chronic illness that impacts his life and the frame of his clinical work because of cancellations and rescheduled patient hours. There are many relationships in which these issues might be explored. He is in analysis, he receives supervision, he is part of a peer group of candidates, and he may meet with the dean of students. But what stands out here is that in the classroom, with his peer group, he seems

to begin to recognize the impact of his chronic illness on his patient and on his functioning as a psychoanalyst.

The vignette may lead the reader to be disappointed with the dismissive attitude of his supervisor, Dr. Rauch, but without more information, this would be a premature judgment. Certainly, analysts, including supervisors, are not immune from the tendency to push painful things under the rug, and illness may be one such thing. Yet Dr. Rauch may also be focused on several reasonable concerns. As the supervisor, he does not wish to encourage Dr. Poletti to suddenly "dump" his problem onto the patient. Dr. Rauch may have experience with group processes that overwhelm the presenter. He may choose to investigate whether group anxiety about illness and disruptions caused Dr. Poletti to "not remember" all the work they had already done in supervision and in the treatment to address this issue.

It is also possible that Dr. Rauch is reacting defensively, as if the candidates are intruding into the supervision. Unwanted intrusion is a difficult aspect of an analyst's acute or chronic illness. It raises the complex issues of ethical self-disclosure and matters of theory and technique. Having explored the role of Dr. Poletti's illness on his work as an analyst at the outset of supervision, perhaps Poletti and Rauch both unconsciously wished to be "done with" this unwanted reality. It now returns, perhaps as another unwanted intrusion.

Group process can lead people to assume they understand a situation based on a very small amount of information. And it is possible for a supervisor to feel that he is being intruded upon despite close attention to his supervisee's illness. Dr. Poletti is caught between these powerful attitudes and forces. Here is where consultation with an outside party may be useful, and the PAC may be able to serve that purpose. Though no system was in place in this instance, Dr. Poletti, or even Dr. Rauch, could have accessed the PAC to consult on this situation. Psychoanalyst assistance is not limited to formal committees or any single setting. Teachers, supervisors, the personal analysis, peers, and consultants

can all be sources of assistance to analysts. Open, thoughtful attitudes to the challenges faced by colleagues can transform criticism into assistance.

Group 5: Conundrums of Psychoanalyst Assistance

These final vignettes pose some of the most challenging issues that currently arise in relation to psychoanalyst assistance. One issue is the conundrum of information from the couch. The second problem occurs when illness and unethical behavior overlap.

Dr. Trudeau

Mr. Platt, a third year candidate, has been in supervision with Dr. Trudeau, a training analyst, for one year. Dr. Trudeau is also the instructor of the third-year seminar in Object Relations Theory. Mr. Platt has greatly enjoyed his relationship with her as both a supervisor and a teacher. In both roles, he values her insight, her capacities as a thoughtful listener, and her talent at helping him think about unconscious process. She has helped him talk with his patients in ways that have allowed him to deepen his work, and she has been adept at helping him navigate his own anxiety about transitioning one of his long-term psychotherapy patients into a four-session-a-week analysis.

Dr. Trudeau has occasionally been 5-10 minutes late for their early-morning supervision appointments; this behavior has generally been accompanied by brief apologies for "running behind" or "bad traffic." Mr. Platt has never made an issue of this, or mentioned the fact that she does not extend the time of his appointments when she runs late. He feels satisfied with the supervision, and he does not want to say anything confrontational which might jeopardize their relationship.

But lately, Dr. Trudeau has been increasingly late; most recently Mr. Platt sat in her waiting room for twenty minutes on a Friday morning. When she finally rushed into the office, she offered the explanation that her car battery was dead and she had to take her husband's car and drop him off at work on her way. Mr. Platt also noticed that, despite her obvious attempts to focus on his material, she appeared distracted and forgetful, and he was forced to repeat some facts about events in his patient's life that he had already

covered in recent supervision sessions. This time she allowed the supervision to run over their usual time by eight minutes and then abruptly cut it off when she heard her first patient walk into the waiting room.

Mr. Platt also notices that Dr. Trudeau appears disorganized as a teacher. Despite her depth and breadth of knowledge about the literature and capacity to integrate clinical material, she frustrates Mr. Platt and his other classmates by assigning readings that are unavailable to them on the Internet, and she forgets to give instructions for the librarian to provide them copies. The second time this happens, she tells the class that the librarian has been very difficult to work with and that from now on, she will only assign articles which they can find on the Internet. The third week into the course, she arrives at class 15 minutes late and apologizes as she walks in, explaining that she has been involved in an emergency hospitalization of one of her patients.

Mr. Platt chooses not to attend the Institute annual holiday party but asks one of his classmates, Dr. Winston, how it went. She tells him the party was just ok, "somewhat boring actually," and that the only interesting part occurred at the end of the night when she and her boyfriend went to find their car in the parking lot and saw Dr. Trudeau stumbling toward her car, obviously drunk. She tells Mr. Platt that she and her boyfriend approached Dr. Trudeau and asked if she needed help, which she promptly refused. Uncertain how to proceed and worried it would be dangerous for her to drive, Dr. Winston offered to give Dr. Trudeau a ride home, at which point Dr. Trudeau became sarcastic and belligerent, telling them she was "fine" and just needed to "leave this god-awful party," all the while slurring her words. Dr. Winston says her boyfriend, in skillful and authoritative maneuver, approached Dr. Trudeau, gently removed her keys from her hand, informed her she looked as if she were not feeling well and deftly guided her to the back seat of their own car. They proceeded to drive her home, and she sat quietly in the back seat, thanking them as they approached her house, quickly explaining that she had the stomach flu, should not have chosen to attend the party and greatly appreciated the lift.

In his own analysis the next day, Mr. Platt tells his analyst, Dr. Hirsch, the story of the holiday party and says he has put this information together with his own recent experiences of Dr. Trudeau. He strongly suspects she has a drinking problem. He says, "all the pieces make sense now," referring to the lateness, forgetfulness, disorganization, frequent excuses and the recent display of inebriation. Dr. Hirsch, alarmed by this compelling data about Dr. Trudeau, asks Mr. Platt if he has considered bringing this information to the Analyst Assistance Committee of their institute so that they might reach out to her. Mr. Platt immediately says he would never consider such an action and that he has absolutely no interest in getting Dr. Trudeau "in trouble."

Dr. Hirsch explains that the purpose of the committee is not to get anyone in trouble or to mete out punishment. The purpose is to offer help to a colleague who is having difficulty functioning and may be at some risk. Mr. Platt again states emphatically that the last thing he wants to do is get involved in any sort of complaint against his supervisor. He expresses concern about possibly risking his own relationship with her and having to place his trust in other colleagues he does not know to discreetly handle his information.

Comments:

It appears that Mr. Platt and Dr. Winston have no thoughts of seeking help for Dr. Trudeau despite their out-of-the-ordinary experiences with her. Judging the behavior of others is always a bit risky, but it may feel especially so for trainees when it comes to judging their teachers and supervisors. Trusting the PAC to treat the informant and the analyst-of-concern with discretion is crucial. Without informants appropriately raising concern, the PAC has no activity. If the PAC is not responsible about the anonymity of the informant, the consequences for the informant may be considerable.

With the issue of trust in the background, those who have reason to be concerned about a fellow analyst may struggle to determine in their own minds whether the concern is "sufficient" to contact the PAC. Informants give up control of the process to the PAC with the hope of a good outcome, and they are aware of potential adverse consequences

for themselves and the analyst-of-concern. Seeing our potential future selves in the situation of the analyst-of-concern may also influence an informant's decision-making process.

This vignette also introduces the clinical dilemmas of how to work with information "from the couch" about the functioning of another analyst. When clinical and ethical considerations are inextricably wound together, as in this vignette, the analyst may feel conflicted about what is best for the analysis and analysand. Each analyst will work with the material in a way that is consistent with his or her approach to clinical psychoanalysis. In this case, Dr. Hirsch initially explored Mr. Platt's anxieties and concerns about Dr. Trudeau and her recent behavior. Although Dr. Hirsch does not advise or pressure Mr. Platt about what he could or should do, his raising the possibility of bringing the information to the PAC might be viewed as just short of a suggestion. In the face of Mr. Platt's response, Dr. Hirsch provides educational information about the PAC and seems to leave the situation open for further reflection.

Dr. Hirsch is in a complicated position for which there is no clear answer. He now holds concerning information about his colleague Dr. Trudeau, but he is well aware of his duty to maintain the confidentiality of the analysis. In the event that Mr. Platt chooses not to contact the PAC, Dr. Hirsch may even have thoughts about whether to contact the PAC independently. Issues related to information from the couch remain highly controversial in the psychoanalytic community. With this in mind, Dr. Hirsch may wish to seek consultation with the local Ethics Committee and/or peer consultation about Mr. Platt's ongoing analysis.

Dr. Long

At seventy, things are not going well for Dr. Long. In fact, he feels badly treated by life. He now believes that his classical training analysis did nothing for him and sees it as a sham he didn't fight. In reaction to the unresolved disappointments in his own analysis,

he is given to what he likes to think of as acceptable boundary crossings rather than boundary violations. His colleagues know little about the specifics, but he sometimes jokes with analyst colleagues that he is less uptight about self-disclosure than they are. He justifies his technical methods as necessary actions to help engage patients more effectively. He seems to view himself as an unappreciated outsider—in his analytic community and even at home with his family.

When he finds out he needs open-heart surgery, he feels particularly betrayed. Knowing that his heart had been damaged by rheumatic fever when he was a child, he has spent innumerable hours working out and adhering to stringent diets in an attempt to stave off heart disease. Now he feels he has wasted all that time and effort. Despite these difficulties, Dr. Long avoids letting anyone know of his problems for fear they might hurt his reputation. His problems with his training analyst are never mentioned, and his cardiac disease is kept secret.

Dr. Long's sole conscious concern is the financial impact of the several weeks he anticipates taking off from work to recover. Although the surgery was recommended years earlier, he had postponed it until he began to suffer from extreme fatigue, which severely limited the times he was available to see patients. At seventy, Dr. Long has almost no savings. Money has been spent on lifestyle and health care. Now he is worried about the loss of income, and he fears losing patients if he stays away from work for too long. Dr. Long feels an enormous pressure to get back to work as soon as he can.

Following the surgery, his recovery is slower than anticipated. Dr. Long often feels foggy and confused but does his best to seem normal. His cardiologist provides routine instructions to restrict his physical activity and not drive a car following discharge, but the cardiologist approves his return to work saying, "after all, you just sit and listen to people all day." His doctors do not systematically evaluate Dr. Long's mental status when he is cleared to return to work.

Dr. Long resumes his practice four weeks after surgery despite not yet fully feeling like himself. His old tendency to disregard conventional professional boundaries increases dramatically. He urges multiple patients to meet him "in the real world" outside the office. He describes his operation in detail, needing to repeat it again and again at the patient's expense. He also insists on giving odd gifts to several patients. This all ends in an ethics complaint from a patient after he tells her that she caused him intense sexual arousal.

Comments:

Although little is known about the supposedly "benign" boundaries Dr. Long has crossed over the course of his career, the post-operative invitations to meet patients outside the office and the insistence on giving gifts to patients can be classified as non-sexual boundary violations. Telling the patient of his sexual arousal could be considered a sexual boundary violation. All three of these boundary problems might very well result in an ethics complaint rather than a referral to the PAC.

Dr. Long's situation can be thought of as a perfect storm of problems. Let down by his analysis and continuing to struggle in most spheres of his life, a medical crisis becomes the straw that breaks the camel's back.

Following a major illness or procedure, the question of when it is appropriate to return to work always requires assessment. When there are well-established and clear guidelines (such as needing to lift a certain amount of weight or remain seated for a given amount of time) the determination of whether a person is fit for work may appear quite clear. However, even such seemingly straightforward assessments are sufficiently challenging that a whole field of study is devoted to assessing impairment. Non-psychiatric physicians often do not understand what analysts do, and they do not appreciate the intensity of the pressure under which analysts work. Without this understanding, the treating physician may be limited in advising analysts as to when they are well enough to

return to work or predict a date for their return. Of course, such assessments are even more difficult when the analyst pressures the physician.

With their clear knowledge of what is required of working analysts, analyst assistance committees have the professional experience and expertise to provide an assessment of analytic capacity. PACs can be used in collaboration with the treating physician to provide appropriate advice, helping to avoid the type of tragedy described in this case.

Dr. Lewis

Dr. Lewis was respected and liked by his peers and faculty throughout his candidacy. He was a conscientious student, an open and non-defensive presenter of his own clinical material, and a reliable member of his training group. After his graduation at age thirty-eight, he is no longer active within the local analytic community, but he shares an office with other analysts and seems to have a vibrant office practice. He participates in a post-graduate study group and explains his absence from the larger psychoanalytic community as a matter of not liking the politics of organizations.

All this makes it even more surprising when Dr. Stevens, a colleague and officemate, sees Dr. Lewis at an outdoor cafe engaged in what appears to be flirtatious intimacy with an attractive woman whom Dr. Stevens recognizes as a patient he has often seen in the shared waiting room. Dr. Stevens feels uncomfortable and avoids making contact with the couple. He cannot be certain that the woman is a patient of Dr. Lewis, but he is sure Dr. Lewis is married. Dr. Stevens tries to convince himself that maybe he over-estimated the flirtatious quality of their interaction when he glanced away so quickly. He also knows that he glanced away because he felt he was seeing something that should not be seen.

Since he does not feel it's fair to jump to conclusions, he tries to forget about it. But one day, Dr. Stevens walks out of his office to find the same woman, tears streaming down

her face, pounding desperately on Dr. Lewis' office door. When she sees Dr. Stevens, she pleads with him, "Please make him see me! I cannot bear life without him." She collapses on him and sobs. Dr. Stevens disentangles himself from the physical contact and suggests that she go home and try to reach Dr. Lewis later. She says she cannot leave and starts to pour out the story of a love affair with Dr. Lewis that has soured.

Dr. Stevens recognizes that he cannot simply walk away from the drama now taking place in his waiting room. He initiates a brief crisis intervention to restore her to a state in which she can safely remove herself from the office premises. In the course of this intervention, the distraught woman details the existence of an ongoing affair with her analyst, Dr. Lewis. As Dr. Stevens listens, she calms down, and he provides her with a referral to a colleague for consultation and further crisis intervention. He also suggests the Institute Ethics Committee as a resource for her. She says that she could never do anything to harm Dr. Lewis.

This is the last time Dr. Stevens has any contact with the woman. When Dr. Lewis brushes him off in the hall the next day, he decides to make a referral to the Ethics Committee.

The Ethics Committee takes up the matter in accordance with written protocol. The patient never contacts the committee. But Dr. Lewis does not deny the sexual relationship, and rather oddly, he seems neither defensive nor contrite. The closest thing to an explanation he offers is that he has been having headaches for the first time in his life and has not been feeling quite like himself.

As part of the investigation process, the Ethics Committee mandates independent psychiatric evaluation. The evaluator recommends that Dr. Lewis consult a neurologist about the onset of headaches. Dr. Lewis complies, and a MRI reveals an operable brain tumor. Dr. Lewis agrees to surgery. Surgery is successful, yet he is told that that this type of tumor is likely to recur.

The unexpected discovery of a brain tumor raises the question of its relevance to the investigation within the Ethics Committee. A review of the literature of sexual boundary violations leads them to conclude that a causal relation between a physical illness and a sexual boundary violation is quite rare. Some members of the committee consider the tumor irrelevant to the proceedings. Other members of the committee suggest that rare does not mean never. Still others make the point that unless Dr. Lewis is expelled from the Institute, he is a member with a serious medical problem that may recur, and he should probably be referred to the PAC.

Comments:

When ethical misconduct and illness coincide, controversy seems to follow. Determinations that seem clear and easy in the abstract often feel messy and unclear in the experience of actual cases. Hopefully, this vignette will elicit some of that messiness and generate discussion with opposing points of view.

Historically, there have been concerns about sociopathic ethical wrongdoers using illness as a means of avoiding the consequences of their actions. These concerns may be quite valid. Yet this case still raises special questions for the Ethics Committee.

- Did the presence of the brain tumor account for the unethical behavior of this analyst with no previous history of boundary problems or other questionable ethical practices?
- Should an ethical breach committed in the context of a serious or life-threatening illness be treated any differently than an ethical breach committed in a state of physical health?
- Are there provisions for the Ethics Committee to refer an accused member to the PAC without altering the course of the ethics investigation?
- If the Ethics Committee adjudication finds that the analyst must enter into a supervised program of rehabilitation and return to work, would the PAC be an appropriate resource of support for the analyst during this process?

- If a sexual boundary violation occurs in the context of Alzheimer's Disease, could the PAC assist the analyst towards retirement?

It is appropriate to ensure that ethics committees and PACs have autonomy of process and separate functions. There may be cases in which active involvement by both committees may go on simultaneously to best address the individual situation.

Chapter 6:
Focus on Approach and Process

In Chapters 2 and 3, we presented our core beliefs and our vision of psychoanalyst assistance. You have read through the vignettes and wondered for yourself what would be the most appropriate way to proceed in many of the situations. In this chapter, we present a series of reference points to create a frame for exploring, understanding, and intervening to assist colleagues based on the core belief that impairment of functional capacity is a personal crisis for a compromised analyst.

In the bullet points below, you will find both core beliefs and process issues.

- Impairment due to illness is a reality of life. It is not a weakness or a personal failing. Personal shame is often part of the problem and contributes to an avoidance of seeking help.
- An analyst who continues to work despite impaired capacity to function competently is likely a troubled analyst failing to adapt to a painful reality.
- The focus must be on assistance for a colleague presumed to be in a troubled state. The word assistance is not a euphemism.
- Concern is the basis for the commitment to assist a colleague.
- Concern is based on reasonable, available information.
- The analyst assistance process begins with communicating that message of concern to the identified colleague.
- The identified colleague is likely to go through varying levels of acceptance or rejection of concern, and assistance requires support through every phase of this process.
- Appropriately directing the colleague towards independent diagnostic evaluation, treatment recommendations, and prognoses is essential. This is true for situations in which the analyst-of-concern openly acknowledges that there is a problem and for situations in which the analyst-of-concern does not acknowledge the existence of a possible problem.

- These outside evaluations should include reports of relevant physical examination, relevant mental status examination, and all relevant test results and reports that then form the basis of the independent health professional's evaluation of functional status.
- Pending the results of the most appropriate evaluation, the assistance process focuses on supporting an independently executed treatment plan directed towards regaining full competence, retiring with dignity, or otherwise modifying professional practice.
- At all times, from beginning to end of any PAC activity, the PAC must be knowledgeable about state laws relevant to PAC activity. Knowledge of mandatory reporting laws is crucial. An individual acting alone to informally assist a colleague may also be subject to state reporting requirements. It is recommended that questions pertaining to compliance with state laws be addressed with competent, experienced legal counsel.

Is the Ideal Real?

In an ideal world, we would all make good enough decisions about our health and competence to provide outstanding analytic work in all our professional endeavors at all times. We would know when to ask for assistance, and our colleagues would always be available to assist us with our best interests in mind. In fact, this is not the case as we know it.

In our attempt to address this problem of reality, we have proposed still another ideal, an ideal vision of psychoanalyst assistance. We have chosen to emphasize the seriousness of the problem and the hope that we can work as a diverse, thoughtful community to face what we know.

We now turn attention to some of these potential deviations from the ideal vision to provide a fuller picture of psychoanalyst assistance in action.

Psychoanalyst assistance intervention demands a balanced concern for all involved, but this balanced concern is always vulnerable to disruptions. As you directly experienced in reading through the vignettes, shifting identifications with the analyst-of-concern, the analyst's patients, and the members of the PAC are inevitable. These identifications are important as they bring a sense of immediacy and contact with the human suffering involved in each of these vignettes. Yet, unrecognized powerful identifications can disrupt thinking and balanced appreciation of the trauma for all parties involved. Balanced concern must constantly be restored. Ongoing collaboration and consultation between two or more PAC members supports the process of restoration when disruptions of balanced concern do arise.

One special, noteworthy concern is the possibility of analyst assistance interventions that do not conform to the basic principles outlined in the introductory chapters. Is it possible for PAC activity to be misused maliciously with personal or political motivations? The answer is reluctantly, yes, and such activity threatens the very viability of PACs. Is it possible for a PAC to wrongly pre-judge a situation and prematurely press for a particular outcome? Again, the answer is a reluctant yes. We have outlined the basic principles with the hope that attention and adherence to these principles provides some measure of protection against the destructive potential of misused PAC activities.

Finally, we wish to point out the tension between the constructive, analyst-focused concern underlying PACs and the seriousness of the possible outcomes. Serious judgments are made in the PAC process. It is the job of PAC members to reflect deeply and thoughtfully about their assessments considering a colleague's capacity to practice competently. To ensure that interventions are driven neither by personal nor political motivations, independent external sources provide the medical and psychological evaluations the PAC uses to form a judgment. But, ultimately the PAC is charged with making a judgment of capacity to practice competently, and this judgment and its consequences may have profound effects on the analyst-of-concern and his or her practice. Ideally, these judgments will be well-informed and made with the participation of the analyst-of-concern, but if you are an analyst receiving a call from your local PAC,

you are unlikely to welcome it as a friendly, benign contact. It is more likely that an analyst will initially experience some combination of shock, fear, anger, humiliation, and intense anxiety when they are contacted by a PAC.

On first contact, PACs may well be experienced as intimidating. The PAC is conveying painful information, and the analyst may have been oblivious or defensively in denial about problems in their professional behavior and contacts. PACs act with the conviction that taking measures to assure competence to practice *is* supporting the best interests of the analyst, but even the most appropriate outcomes may feel disastrous or devastating. For some, the careful work of the PAC may help to develop a positive collaboration between PAC and analyst, but for others, the PAC will remain a threatening intrusion, introducing disturbing information and reluctantly accepted outcomes.

As we build an ideal vision of analyst assistance in this casebook, we too must be careful not to be oblivious or defensively in denial about the challenges of both the work and the development of this new branch of institutional activity and responsibility. We hope we have left space for your own appreciation of the tensions we have outlined and your own creative responses to these situations.

Chapter 7:
Developing a Protocol that Fits Your Local Analytic Community

PACs and PAPs

Within, APsaA, there is now an established recommendation and tradition of forming psychoanalyst assistance committees within each local institute, society, or center. As each PAC must be suited to the unique qualities of the specific psychoanalytic organization, there is no standardization or ideal template for how to form and maintain a PAC. However, we have explained our core beliefs and provided reference points for processes and procedures. These references offer a frame local organizations can use to creatively build a PAC that reflects the specific site.

If a local institute, society, or center prefers not to establish a standing committee, a psychoanalyst assistance program (PAP) may provide a totally suitable resource for addressing assistance situations when they arise. Although a PAP can eliminate the need for a full standing committee, experience suggests that it is still best practice never to work alone in an assistance process. Assistance works best if two analysts go together to meet with the analyst-of-concern. This protocol ensures that there is a witness to what is said, and the presence of the second analyst can diminish the possibility that the analyst-of-concern interprets the intervention as a personal matter between colleagues.

Whether your community elects to form a PAC or a PAP, you will need to develop a protocol of policies and procedures that are:

- transparent to members
- based on the core beliefs of psychoanalyst assistance and
- respectful of the state laws governing your jurisdiction.

This brings us to the next topic, PACs and the law.

The Role of Legal Counsel

Knowing when to obtain legal counsel and how to use the legal advice provided will be crucial in decision making about the design and implementation of your PAC or PAP. Engaging an attorney early in the development process is strongly recommended.

Although this chapter offers some guiding ideas, it is important to understand that nothing in this chapter or casebook should be interpreted as legal advice. To obtain legal advice, seek the services of a competent attorney with extensive experience with the licensing boards in your state. In the experience of most institutes, societies, and centers, attorney consultation initially focuses on the liability risks of forming a PAC. The attorney may identify potential lawsuits that could be brought against the organization and would have to be defended whether the suit had merit or not. This can present itself as a significant deterrent due to the high costs of litigation. Hopefully, your attorney will understand your organization and why you wish to have a structure in place to address the situation of a possibly impaired colleague. Knowing the full range of potential liability is important but incomplete unless your attorney provides additional information and advice *based on knowledge and experience with licensing boards in your state*.

Do be prepared to ask necessary follow-up questions. Ask your attorney to provide information about whether any of these potential suits have actually been brought in the state in which you are located. What has been the outcome of these suits? This is crucial as the liability assessment is really quite analogous to the risk and benefits information and discussions needed for a patient to provide "informed consent" for medical procedures. All the possibilities are identified in advance for consideration, but it is also expected that counsel provide information about the likelihood of these adverse consequences. It is important to have a sense of what is a high probability and what is a low probability event just as it is when one agrees to surgery or medication after being informed of all the possible adverse consequences.

A good legal consultation will also address the alternatives to forming a PAC or PAP. Choosing not to have either may also result in negative consequences. Questions that would be helpful to pose to your attorney at the outset include:

- Are there requirements imposed on a PAC or PAP by state law?
- Are there any state reporting requirements related to impaired practitioners that may impact the operations of a PAC or PAP?
- What are alternative options to forming a PAC or PAP?

Additional questions you may want to pose to your attorney as you consider the decision to form a PAC or PAP:

- If there are rampant rumors and gossip about an analyst seeming impaired, is there liability to the organization even when there is no PAC or PAP?
- Are there circumstances in which individual members aware of a possible impaired colleague could be individually held liable if there is no PAC or PAP?
- What are the consequences if a PAC or PAP inadvertently fails to meet state law requirements?

Given the potential consequences of turning a blind eye to the problem of colleague impairment, many organizations do choose to form a PAC or PAP. This leads to the next issue for your attorney to address: how to reduce your liability risk if you choose to proceed to form (or have already formed) a PAC or PAP.

This in turn brings up the issue of mandatory reporting laws. Professionals are licensed by the state and regulated by state laws. These regulatory laws may vary from discipline to discipline (M.D.s, Ph.Ds., M.S.W.s) within an individual state.

Most states have laws concerning mandatory reporting of impairment of a health care professional. Interpretation of laws is complicated and requires professional consultation as the wording of the laws may be crucial to understanding their application. It is

important to consult with an attorney who can advise on state law and any legal obligations practitioners have related to psychoanalyst assistance, including legal obligations to self-report impairment or to report to the appropriate authority a practitioner one suspects may be impaired.

There are some states in which the governing statutes explicitly grant permission to form assistance committees, but the onerous requirements included in the law may be so impractical that they serve to strongly discourage PAC or PAP formation.
Ask your attorney about the state attitude towards and history of enforcement of the reporting laws. The expert legal consultation should provide clear information about when it is essential for an individual or PAC to report to the state licensing board. This may be important information to convey to an analyst-of-concern and is important information to consider when determining whether to form a PAC.

The bottom line is that state laws really do vary. Licensing rules governing the different professions of psychoanalysts also vary. Obtain legal advice from an attorney knowledgeable about state laws, enforcement history, and risks pertinent to the formation and activities of a PAC or PAP.

Chapter 8:
Concluding Thoughts

At one time or another, every psychoanalytic organization has members in need of assistance. How to effectively and responsibly attend to those who need assistance in a caring, thoughtful, ethical manner is a challenge that exists.

We have laid out our vision of psychoanalyst assistance and psychoanalyst assistance committees. We have shared our experience in the form of vignettes and the commentary. We have not offered answers as there are no simple answers. Like with clinical psychoanalysis, every situation is unique. We do offer core beliefs and basic principles of process that we believe are the foundation of an ethical approach to analyst assistance.

We hope the reading of this casebook will stimulate thought and discussion. The concepts and vignettes may even stimulate controversy. Thoughtful attention, openness, and creativity will provide the environment in which this new branch of psychoanalytic organizational activity will develop and mature.

As we conclude this first edition of the *Casebook*, we would like to identify areas in need of further exploration and research.

It seems unrealistic to imagine that we will ever be able to prevent all situations that call for assistance. However, we can develop more emphasis within our psychoanalytic communities on our individual and collective responsibility to encourage analysts' physical, emotional, and financial health from early in candidacy to the end of a long career. A proactive approach to analyst health is worthy of much more attention and could include programmatic development and education in the area of wellness.

In the *Casebook*, we have almost exclusively focused on assistance to the psychoanalyst. We have not directly taken up the possibilities for organizational response to those who have experienced pain and disturbance due to the continued professional activities of an

analyst with compromised competence. Unintentional as it may be, many are hurt when an analyst is not functioning with full competence or ethical adherence. This group includes patients, students, supervisees, colleagues, family members, and probably a broader net than we can name. In theory, there is no conflict between providing assistance to a troubled analyst and attending to the pains of those hurt by the troubled analyst's actions. Practically, this may be quite challenging. Local groups are encouraged to consider the organization's role in helping those who have been hurt in one of these tragic situations.

Last but not least, we must de-stigmatize aging, mortality, human frailty, and vulnerability within our psychoanalytic culture. Analysts, like all others, must personally face the issues of finite time, finite capacities, loss, and endings. In the area of psychoanalyst assistance, taboos and stigma about our vulnerabilities impede progress. With this casebook and its underlying philosophy, we hope to work toward acknowledging and changing the stigma associated with our own human condition.

Reference Addenda

Working Premises of APsaA Committee on Colleague Assistance

1st Premise: A colleague who continues to practice without appropriately accommodating a change in analytic competence is a colleague experiencing a very personal life crisis that appears to be overwhelming the capacity for self-assessment and appropriate judgment.

2nd Premise: Maintenance of standards of competent professional behavior and care is what is best for both the analyst and his or her patients, supervisees, students, family, and analytic community.

3rd Premise: Professional integrity depends on being able to practice in a state of competence.

4th Premise: This integrity must be restored if it becomes compromised.

5th Premise: Assisting the analyst to make an appropriate adaptation to maintain (or regain) full competence is the most effective means of protecting the colleague's integrity and well-being. In the case of lasting change in capacity, this support includes enabling him or her to retire.

6th Premise: Assisting the analyst to make an appropriate adaptation to maintain (or regain) full competence is the most effective means of protecting the well-being of the colleague's patients, family, and analytic community.

Core Beliefs That Inform Assistance Activity

- Impairment due to illness is a reality of life. It is not a weakness or a personal failing. Personal shame is often part of the problem and contributes to an avoidance of seeking help.
- An analyst who continues to work despite impaired capacity to function competently is likely a troubled analyst failing to adapt to a painful reality.
- The focus must be on assistance for a colleague presumed to be in a troubled state. The word assistance is not a euphemism.
- Concern is the basis for the commitment to assist a colleague.
- Concern is based on reasonable, available information.
- The analyst assistance process begins with communicating that message of concern to the identified colleague.
- The identified colleague is likely to go through varying levels of acceptance or rejection of concern, and assistance requires support through every phase of this process.
- Appropriately directing the colleague towards independent diagnostic evaluation, treatment recommendations and prognoses is essential. This is true for situations in which the analyst-of-concern openly acknowledges that there is a problem and for situations in which the analyst-of-concern does not acknowledge the existence of a possible problem.
- These outside evaluations should include reports of relevant physical examination, relevant mental status examination, and all relevant test results and reports that then form the basis of the independent health professional's evaluation of functional status.
- Pending the results of the most appropriate evaluation, the assistance process focuses on supporting an independently executed treatment plan directed towards regaining full competence, retiring with dignity, or otherwise modifying professional practice.
- At all times, from beginning to end of any PAC activity, the PAC must be knowledgeable about state laws relevant to PAC activity. Knowledge of

mandatory reporting laws is crucial. An individual acting alone to informally assist a colleague may also be subject to state reporting requirements. It is recommended that questions pertaining to compliance with state laws be addressed with competent, experienced legal counsel.

Website Resources on PACs for APsaA and IPA Members

For APsaA members, a brief introduction to psychoanalyst assistance including five actual committee protocols can be accessed from the members' section of the APsaA website.

IPA members can access the same brief introduction to psychoanalyst assistance, including five actual committee protocols, from the homepage of the members' section of the IPA website.