Sexual boundary violations continue to be a misunderstood and under-treated problem within the helping professions. Eight risk factors are presented to enhance practitioners’ knowledge of the problem. These risk factors include: long-standing narcissistic vulnerability, grandiose (covert) rescue fantasies, intolerance of negative transference, childhood history of emotional deprivation and sexualization, family history of covert and sanctioned boundary transgressions, unresolved anger toward authority figures, restricted awareness of fantasy (especially hostile/aggressive), and transformation of countertransference hate to countertransference love.

Practitioners should use these risk factors to introspect and determine if or when they may be vulnerable to engaging in sexual boundary violations with a patient. Chapter 15 presents a measure derived from an empirically controlled study. This measure can be used for periodic risk assessment throughout a professional’s career. Knowledge of the ethical code has not been found to be preventative. Further, it is dangerous for clinicians to ignore these risk factors in the belief that those who engage in sexual boundary violations are fundamentally different from ordinary practitioners or from ourselves (Gabbard, 1996; Celenza & Gabbard, 2003). The data suggest that we all may be vulnerable to boundary transgressions at some point in our professional lives and it is important to be aware of how and when this might occur.

ENDNOTES


1. For ease of discussion, I will use the therapist-patient relationship as a template for a relationship that contains a structured power imbalance. All of the discussions that follow can be applied in a general way to academic and mental health professionals, including psychologists, psychiatrists, social workers, psychoanalysts, psychiatric nurses, mental health counselors, teachers, and clergy. While there are important differences in these relationships, they all rest on a basic and structured power imbalance that renders sexual relations unethical.

2. An often cited prevalence study (Holroyd & Brodsky, 1977) has unfortunately contributed to confusion regarding the prevalence of one-time versus multiple transgressors by failing to distinguish between multiple contacts with the same patient versus multiple offenses with different patients. That study, as well as Tillinghast and Cournos (2000), made use of the term recidivism in an idiosyncratic way to denote multiple occasions rather than multiple patients.

3. For ease of discussion, I will often refer to the transgressor as "he" or "the therapist" and the patient as "she" or "the patient," because this is the most frequent gender pairing.

I have learned to beware the phrase “I would never do that.” It has been a hard lesson to learn, however, since I have heard it uttered by both friends and colleagues, years before an eventual revelation of a complaint against them. It is also true that many other friends and colleagues, with no eventual charges or transgressions, have said the same, or other phrases such as “This could never happen to me,” “You just don’t do that,” or “I always suspected he....” (We are so wise in retrospect.) Best to keep in mind the epigraph printed above; the treatment context is an intensely emotional and involving relationship. Either member of the dyad may be in a desperate state. It can be scary; it can explode.

In this chapter, I present a composite case derived from my experience with over seventy therapists, psychoanalysts, and clergy who have engaged in sexual boundary violations. It is also a distillation of the characteristics most commonly found in these cases and is offered to anchor in reality the more conceptual issues that will be discussed in later chapters. Though the case is a composite, none of the material is fabricated.

In what follows, I emphasize and elaborate the internal experience of the therapist, since the primary purpose of this book is to identify pitfalls, vulnerabilities, stress points, and warning signs for all mental health professionals, academics, and clergy. In addition, I do not mean to discount, in any way, the experience of the victim and the ways in which she is harmed. This imbalanced focus of attention is unavoidable, however, in the effort to enhance our training and our preventative armamentarium.
It also must be emphasized that the case illustration that follows is a particular kind of sexual boundary violation. Dr. Burn is a one-time transgressor whose psychology and situation are not that different from most mainstream practitioners. I have selected his case as an illustration in order to present the difficult, subtle, and more frequent type of challenge that we all face. I firmly believe that more help and understanding is needed in order to adequately address this very prevalent problem. Dr. Burn is not a psychopathic predator. He is not a person from whom we can feel a safe distance, and therefore he is not so easily dismissed. At the same time, for victims who have been exploited by the more egregious multiple transgressor—that is to say, the psychopathic predator—this case will not speak to their experiences. Since psychopathic predators are not amenable to rehabilitation, I have not focused my efforts toward them. Instead, I am putting a large measure of my efforts toward a more frequent type of sexual boundary transgression, as I see a more pressing need in this type of case.

I hope to address several common queries in this effort: first, to demonstrate how commonplace the precipitating circumstances and predisposing mental state of the transgressor are—in effect, to demonstrate how much both the circumstances and mind-set are like those in which you or I would find ourselves. It may be tempting to distance ourselves from Dr. Burn’s dilemma and to convince ourselves that he is different. I am not so convinced. Further, it is important to remember that Dr. Burn was not in his usual frame of mind, nor was he at a typical time in his life. When he began treating the victim, Dr. Burn was about to turn 55, he was on the heels of a separation and divorce, and was in a dissatisfying new relationship. He was also dangerously isolated in his private practice, working too many hours, and was financially stressed. These situational stressors, often cited in the literature as the backdrop against which most sexual boundary violations occur, can facilitate the emergence of our less than optimal modes of functioning and states of mind.

Second, I hope to show how the road to ruin is most often paved with good intentions. At least on a conscious level, there are a great variety of rationalizations that serve to justify, for the therapist and sometimes for the patient as well, the seemingly harmless boundary crossings, even as these become closer to frank violations. They are always viewed with some sort of belief that the patient will benefit, will be healed, or will at least feel better in the short run. Sometimes this is indeed true, especially if the boundary crossings are the kind we all face. Accepting a gift, hugging at termination, or attending a wedding are not anathema to even conventional, mainstream practice. These crossings may be rare, but they need not be viewed as possibly signaling a downward trend on the so-called slippery slope—nor should they be glorified or relied upon in place of the more gritty and difficult work of everyday practice. Here, it is useful to be aware of Axel Hoffer’s (personal communication, 2006) distinction between boundary crossings and boundary violations, the former being a minor departure in everyday technique and, most importantly, capable of being discussed within the treatment framework. (See Gutheil and Gabbard, 1993, for a more elaborated discussion of these differences.)

Third, I aim to show how the slippery slope is made up of small, easy-to-take, missteps along the way. Not one of these, especially at the initial part of the slide, can be taken out of context as a definitive signal that the therapeutic process is in trouble. It may be true that all sexual boundary violations begin with a slippery series of missteps, but it is also true that we are all always on the slippery slope and can engage in minor boundary crossings that do not eventually lead to more egregious boundary violations. The slippery slope is the terrain of everyday practice (Howard Levine, personal communication, 2001). Sexual boundary violations are not an inevitable outcome of slippery-slope missteps, however.

Simon (1995) has delineated a series of steps that can be viewed as constituting the so-called slippery slope in an effort to illustrate what the series of missteps that leads to frank boundary violations often looks like. These may start with a gradual erosion of the therapist’s neutral position, for example, addressing each other by first names. Soon the therapy sessions become less clinical and more social. The patient begins to feel she is treated in a “special” way, perhaps more like a confidant. This ushers in a tendency toward therapist self-disclosures and may even include times when the therapist touches the patient (for example, a pat on the back when leaving the session). This touching then progresses to hugs and embraces, usually when the patient is upset about something distressing in her life.

What is happening on a deeper level is that the therapist is gaining some measure of control over the patient, usually by manipulating the transference, that is, using the patient’s positive, idealizing, and perhaps loving feelings for the therapist in order to influence her to respond in ways he wants and needs. There may be negligence in prescribing medications or other routine aspects of the therapeutic role. Extratherapeutic contacts occur, therapy sessions are rescheduled for the end of the day, and/or therapy sessions become extended in time. Perhaps the point of no return has already been reached; however, it is certainly crossed when the therapist stops billing the patient. At this point, there is little semblance of a therapeutic process and it is not unusual for the therapist and patient to meet in an outright social manner, perhaps beginning with drinks and/or dinner after sessions. The final two steps, according to Simon, include dating and then finally sexual relations.
Although the slippery slope is never traversed in such an orderly way, these are reasonable descriptors of the ways in which steps are taken in many cases and serve as a good exemplar of what the dangerous slippery slope may look like. Davies (2000) has described her own experience on the slippery slope as more one of “a sudden awakening” where she is “perched on the tip of an inverted cone, with almost no room to maneuver and surrounded by treacherous slopes” (p. 223).

Lastly, in the illustration that follows, I aim to give a clinically contextualized picture of one therapist’s traversal of the slippery slope as it occurred with a particular patient. As a colleague once asked, after hearing of a mutual colleague’s transgression, “But how did he get out of his chair?” This is how.

**DR. BURN**

Dr. Burn, a middle-aged male therapist, sought treatment with me after his license was suspended for having become sexually involved with a patient. This therapy was mandated by the licensing board as part of a multifaceted rehabilitation plan that included restriction from independent practice, supervision, psychoeducation, and individual psychotherapy. We met once or twice weekly for eight years, though the therapy was mandated only for two. (After the two-year mandate expired, Dr. Burn was evaluated by the board members. This included an evaluation of the adequacy of all aspects of his rehabilitation program. He then was allowed to reapply for licensure. This required that he retake the licensing exam, which he successfully passed, and his license was reinstated.)

Dr. Burn was intelligent, attractive, and carefully groomed, and had an emotionally responsive nature and quick humor. He was psychodynamically trained and primarily conducted long-term treatments with adults. He was divorced, had several children from his marriage, and had been living with a girlfriend for about a year when he became involved with his patient. He was relieved to be out of his marriage but suffered greatly from the separation from his children. He also felt relatively unsupported in his new relationship.

Dr. Burn recalls feeling almost wholly isolated at the time of his involvement with his patient. His primary contact with adults, other than his girlfriend, was with his patients in his practice. Most importantly, his relationship with his girlfriend had been on a deteriorating course for several years. They were emotionally estranged and he felt little hope of regaining a more satisfying relationship. He was highly self-critical of his apparent inability to reach his girlfriend. He was attempting to engage a couple’s therapist, though his girlfriend was resistant to the idea.

Dr. Burn’s initial understanding of his transgression revolved around a sense that he had been in love with his patient and that he had hoped to provide for her a “corrective emotional experience” (his words) in repayment for her profound history of abuse by men. He felt compassion for her as a victim of domestic violence in her marriage and sexual abuse in her childhood history. He was aware of a strong desire, even need, to help her and relieve some of her distress.

Interestingly, the treatment with this patient had been difficult from the beginning. Dr. Burn had experienced her as hard-to-reach and withholding, with great difficulty trusting men. Previous treatments with female therapists had proved unsatisfactory to her so she contacted Dr. Burn with the hope of a different experience. She was depressed, married to an alcoholic man who was prone to violent behavior and who had hit her on several occasions.

The patient was resistant to talking about herself and spent many sessions in silence, vigilantly watching Dr. Burn as if she were afraid of him. Dr. Burn was initially respectful of her fears but was also aware of feeling frustrated at her inability to talk to him. He became more overtly reassuring to her and uncharacteristically offered to hold her hand or hug her; his conscious rationale at the time had been that he was attempting to help her feel safe. (During our work together, we learned that although this was the only patient whom he had actually physically touched, Dr. Burn tended to become reassuring or gratifying in nonphysical ways when he experienced his patients as frustrated, disappointed, or hostile.) He also had been dimly aware of feeling increasingly helpless and had begun to view the patient as willfully withholding. This had echoed Dr. Burn’s experience of his mother, who had overtly resisted his attempts to engage yet had been hostile and critical if he had withdrawn. In an analogous manner, the patient’s perception of Dr. Burn had paralleled her experience with her father, where she had felt intruded upon along with a continual pressure to prop up his self-esteem. At this time, however, she was greatly distressed and could not risk displeasing or losing Dr. Burn, so she responded to his advances.

Dr. Burn had become increasingly affectionate toward his patient, consciously attempting to help her feel safe and embracing the belief that she would be cured if she were loved in a constructive, caring way. The withholding and hugging at the end of sessions seemed to help, in the sense that she began to feel better. However, Dr. Burn overlooked the appeasing effects of his efforts (Apfel & Simon, 1985) and the manner in which these served to circumvent (at least temporarily) the patient’s hate and rage, preventing their emergence in the transference, at least for a time.

The affectionate advances began to include sitting next to her on the couch. She soon would lean into him and put her head on his shoulder, coinciding with...
a deepening of her ability to share her distress with Dr. Burn. In one particular session, she was acutely upset, saying she would kill herself if she had to bear another moment. Dr. Burn held her until the end of that session.

In the next several sessions, the patient's suicidality became a prominent and continuing focus. She began to complain that Dr. Burn was not helping her and that the hugging was not enough to make her suicidal feelings go away. Dr. Burn was shaken, feeling he was doing all he could to help her. Besides the hugging and being physically close, he thought he was trying to help her understand her feelings and help her feel stronger so she might leave her abusive husband. The patient began to express her fear that she was unlovable, unworthy, and undesirable, evidenced by the fact that Dr. Burn could never love her fully, especially outside of a therapeutic frame. She said she was going to kill herself and that this was the only way out. At this point, Dr. Burn kissed her and they embraced passionately.

Hugging and kissing became part of each session thereafter until they were involved in a full sexual relationship. Dr. Burn terminated the therapy relationship and they continued their involvement for another year. Throughout this year, the patient had become more trusting, and had exposed more of her feelings and situation to Dr. Burn. Not surprisingly, she had fallen in love with him and wanted him to leave his girlfriend. Dr. Burn thought he was in love with her as well and they talked about being together for life.

Dr. Burn recalled that during his tumble down the slippery slope, he had felt conflicted about his actions due to his awareness that he was violating the ethical code. Yet he also remembered feeling trapped by his patient's suicidality, fearing that she might actually kill herself and he would have felt responsible for her death. He also remembered feeling excited by the fantasy that he would be the one to save her, especially where other therapists had failed. He rationalized his romantic and sexual involvement with her through the belief that she would be cured if she were loved in a constructive and caring way.

Dr. Burn was not aware of competitive feelings toward her husband or toward the other therapists whom she had seen, but he did consciously entertain fantasies of rescuing the patient from her distress and teaching her to love in nondestructive ways. He reminded himself that his training emphasized the "healing power of love," which he interpreted to mean some kind of corrective emotional experience. He told himself that she had not been helped in previous, more traditional modalities and he thought he understood her in a special and unique way that other therapists would not understand. He knew he could not describe this therapy to anyone (a supervisor or a colleague) and he asked her to keep the treatment confidential as well. They both thereby constructed a thick insulation around their relationship from this point on, a kind of "hyper-confidentiality" or treatment bubble that is typical of these kinds of sexual boundary violations.

Once they became more fully romantically and sexually intimate, the patient's behavior toward Dr. Burn changed as well. She became openly affectionate and idealizing of him. He remembers having several powerful fantasies at that time in which he felt closer to God—perhaps identified with him. He recalls a dream in which he saw himself diving from a very high place into a small bit of water, yet surviving. He recalls experiencing, in certain private moments, an oceanic feeling—a oneness fantasy in which he felt empowered by the universe and felt he could accomplish anything.

Dr. Burn and his patient constructed a narrative about their love that rivaled any involvement they had ever experienced or seen previously. They understood each other's dreams and they could communicate without talking. In short, they were soul mates. Not surprisingly, the patient began to have the fantasy that Dr. Burn would leave his girlfriend for her. She became increasingly disappointed that he did not. Over time, their bliss was tarnished by her frustration. She began to experience him as weak and passive. He felt trapped and feared she would report him to the licensing board if he left her.

One evening, the patient saw Dr. Burn at a concert with his girlfriend. Something "clicked" in her mind. She suddenly knew that he would never leave his girlfriend. In an understandable rage, she wrote a complaint to the licensing board, sending along with the complaint copies of love letters that he had written to her. She also wrote a letter to Dr. Burn informing him of the complaint and stated, "I needed to get out of this trap with you somehow and I also know you need help. I have done this to help us both." The licensing board contacted Dr. Burn several weeks later, asking him to write a response to the complaint and instructing him not to have any contact with the patient from that moment forward.

**FORMULATION**

The following formulation is comprised of discoveries and constructions that Dr. Burn and I arrived at during the course of his psychotherapy (see chapter 11 for an elaboration of his treatment). It is a retrospective construction of how he was feeling and what he was responding to at the time of his involvement with his patient. Many of the insights that follow were not available to him at the time of his involvement with the patient, nor were they in his awareness at the beginning of his psychotherapy with me. Rather, they emerged over
time as we explored his feelings and memories, and did our best to construct a formulation of what had occurred.

As Dr. Burn recounted the sequence of events, it became clear that the gradual seduction of his patient had occurred when he had felt the therapy was reaching an impasse, at a time when hostile and angry feelings were beginning to emerge and be directed toward him. Of course, these should have been allowed to emerge and become articulated as the patient’s negative transference to Dr. Burn that he then should have explored. However, at the time, Dr. Burn was too narcissistically fragile and situationally stressed to tolerate her criticisms of him and his own frustration with her.

In a mutual way, then, it can be seen that the impasse had a countertransference component as well since Dr. Burn was unable to explore and bear the patient’s emerging hostility (later directed toward herself in the form of suicidality) because of his fragility and countertransference to her. Dr. Burn was reacting to his own emerging hostility and a fear that the patient would become angry or blaming of him because of his difficulty reaching her, helping her, and ultimately keeping her safe. Like his witholding and critical mother, Dr. Burn unconsciously experienced the patient as a cold and hostile maternal figure. This confluence of factors was intolerable to Dr. Burn at this barren and stressed time in his life. The seduction served to lure the patient away from her negative transference and reinforced a defensive idealization that both she and Dr. Burn found easier to bear.

Though unaware of his motives at the early phase of the relationship, Dr. Burn retrospectively surmised that he had been unable to tolerate his unconscious hostility toward this patient, felt in response to the patient’s withholding. Because his countertransference had included unconscious and unresolved transference elements from his own past, he had felt responsible for the patient’s dissatisfaction much as he had felt responsible for his mother’s unhappiness. In the face of the patient’s dissatisfaction, Dr. Burn’s need to remain connected with a benign, accepting maternal figure and his need to escape self-blame and anger had led him to abandon the therapeutic stance.

On a conscious level, Dr. Burn had misconstrued the meanings of the therapeutic alliance and the process of empathy, confusing understanding with loving and collaboration with providing a corrective emotional experience (see chapter 14 for a fuller elaboration of these rationalizations and clinical errors). This was a confusion that could be detected in his overall therapeutic orientation, a confusion that might have been addressed had he been in a careful and attentive supervision. Unconsciously, he had allowed his needs to be admired and accepted to influence his behavior in a way that manipulated the patient’s transference away from hate and rage toward admiration and love.

In addition, as the patient’s behavior began to replicate a familiar but unresolved pattern from his past, he unconsciously used his sexual feelings for the patient to circumvent the recognition of his countertransference hate toward her. Thus, his “love” of his patient was being mobilized in the service of a defense against his increasing frustration, anger, and fears of abandonment by the patient as a maternal figure. In this way, his manifest “love” for the patient really had more to do with his hatred of her.

Other aspects of his relationship to his mother were replicated in this particular transference/countertransference (mis)fit as well. As elaborated in chapter 11, Dr. Burn felt that his mother had been depressed and chronically disappointed in her spouse. He had experienced his father as passive, weak, and totally controlled by his wife. Throughout childhood, he had felt his mother regarded her son as her savior, yet he had felt helpless to please her. He had developed grandiose, compensatory rescue fantasies of himself as a woman’s ultimate savior that existed alongside a view of himself as helpless and weak. He had feared exposure of this imagined incompetence, and this had intensified the pressure to act in the face of perceived disappointment in the maternal figure. (For an elaborated discussion of these dynamics as they emerged in Dr. Burn’s subsequent therapy, see chapter 11.)

THE ROAD TO RUIN

Many of the steps in the so-called slippery slope, if taken separately or in certain contexts, may be a part of a therapist’s natural style and may not necessarily be problematic. It is not uncommon, for example, for some therapists to have patients address them by their first name. This can often be the case with patients of the same age or generation. A hug, especially at the end of treatment, may not signal a problematic boundary crossing; indeed, the absence of a hug in certain circumstances may be more problematic, such as with the tragic death of a child or other extreme events in a patient’s life. Janet Malcolm, in a tragicomic novel about classical psychoanalysis, refers to an example cited by Greenson (1967) where a distraught young mother talks of her ailing baby. The analyst largely does not respond and then adds a comment about her resistance. Shocked at her lack of humaneness, she quit her analysis, stating on her way out, “You’re sicker than I am” (1981, pp. 74–75).

Clearly, the constricted and often caricatured image of a psychoanalyst who cannot express any compassion or human feeling is a trend gone too far. Contemporary psychoanalysts are more likely to integrate their humanity and empathic expressiveness in their routine mode of technique. Gutheil and
Gabbard (1998) emphasize the important role of context in establishing the meaning of a particular behavior. In addition, these meanings must be examined both from the therapist's and the patient's point of view. It is not unusual for a patient to understand a gesture or statement made by the therapist in quite a different way than the therapist had intended. Similarly, behaviors (including statements) can be understood differently (by either the patient or the therapist) when recalled at a different time and context.

Many behaviors and statements made by the therapist are accompanied by rationalizations that serve to justify (in the moment) their enactment. It is only after the fact (Renik, 1999), sometimes long after or perhaps never, that the therapist becomes aware of a self-serving or defensive aspect to his or her behavior that prevented the therapist from seeing the inadvisability of the action. Many self-disclosures fall into this category. The context that is likely to provide the fodder for a defensive reaction on the therapist's part may be the patient's emerging disappointment, sometimes stated directly but often just subliminally sensed by the therapist. If the therapist is unable to explore and tolerate the patient's frustration, he or she may react with a conscious rationale to become more revealing, perhaps by disclosing some personal information with the idea that the patient will benefit from learning of some similarity between them.

There is some concern that the increased awareness about maintaining boundaries will stifle creativity (Williams, 1997) or encourage a "politically correct" constraint in the way in which therapists embody their role. I have not found this to be the case. In my experience, the increased awareness of the precursors, motivations, and consequences of sexual boundary violations has helped those involved in the profession, including consumers of mental health services. How could it be harmful to learn more of the truth? The clearer we all are about where the pitfalls in our endeavors are, the better equipped we will be to provide sound care to our patients.

In the effort to more greatly understand the terrain of our work, it has become clear to me that it is not so much the behaviors that are problematic by themselves, but rather whether they are engaged in for narcissistically driven reasons. In each moment of the treatment, it can be asked, Is this for me or for the patient? The Exploitation Index (Simon, 1999) is a measure designed to indicate the degree to which behaviors associated with the slippery slope are part of a therapist's experience, repertoire, and/or current experience with a particular patient. This is a helpful measure to signal to therapists that they may be engaging in boundary crossings or violations. However, there is also a need for therapists to introspect, to be aware of internal pressures and situational stress in order to assess their vulnerability at different times in their professional lives (see chapter 15 for a useful tool exploring these factors).

It is important here to note the larger context in which Dr. Burn's relationship with his patient occurred. Dr. Burn was engaged in his own personal therapy of several years at the time. This therapist described himself as "humanistic/eclectic" in orientation. Dr. Burn reported that his therapist was aware of Dr. Burn's involvement with his patient and, according to Dr. Burn, explicitly encouraged the misconduct. (This therapist also knew the professional ethical code against such behavior.) The rationale for this astonishing aspect of Dr. Burn's situation had to do with the therapist's view that Dr. Burn was masochistic (a description of Dr. Burn's character that was largely accurate). Given his masochism, it was the therapist's view that Dr. Burn should not "deprive himself of the pleasure his patient might give him." The therapist reasoned that if Dr. Burn were to so deprive himself—that is, if Dr. Burn were to ethically maintain the treatment frame and not become sexually involved with his patient—the therapist would view this as an act of neurotic self-deprivation of which Dr. Burn had a long history. When the licensing board became aware of Dr. Burn's therapist and his views, he was called before the board and reprimanded. No formal complaint was filed against him nor was he limited in his ability to practice. He was told, "We're watching you." No further information about this therapist is available.

Now, before dismissing this entire case based on the larger context of Dr. Burn's clearly misguided personal therapy, it is important to note that in most cases the transgressing therapist is wholly isolated in his practice, discussing the case with no therapist, peer, or supervisor. In these cases, the therapist loses his way on his own and with no external encouragement. Another very common larger context is where the transgressing therapist does meet regularly with a supervisor, trusted colleagues, and/or a peer supervisory group. In none of these venues does the case with the victim/patient get discussed, however. Thus, a facilitating context is not always in the form of direct encouragement. It may take the form of an absence of input and the failure of a third or outside perspective (see chapter 13 for more discussion of the role of consultation and outside observers).

Context, countertransference, conscious and unconscious defensive tendencies—all of these issues must be taken into account when considering a departure from standard technique. Still, there is no guarantee that any behavior or statement will be understood with the meaning that the therapist, at least consciously, intends. The crucial factor in all treatments is the extent to which interactions and events within the treatment can be verbalized and discussed as grist for the mill. In this way, boundary crossings become part of and contained by the therapeutic process (Gutheil & Gabbard, 1993). This is, in the final analysis, the purpose of the treatment in the first place—to render conscious and verbal that which was beyond words and outside of one's control.
In an effort to aid practitioners in this effort, I have derived a measure, presented in chapter 15, that quantifies several of the characteristics found to be precursors of sexual boundary violations. This is a measure derived from an empirically controlled study of transgressors (subjects who had been involved in at least one sexual relationship with a patient). These subjects were given a series of questionnaires designed to assess those factors that clinical experience has indicated are problematic features of sexual boundary transgressions. The scores on these measures were then compared and contrasted with therapists who had not been involved in sexual boundary violations at any point in their career. (See appendix A for an elaborated discussion of this study.)

Chapter 15 presents the Boundary Violation Vulnerability Index (BVVI), a 45-item questionnaire that practitioners may use to indicate whether or not they have the characteristics associated with boundary violation vulnerability. This is not a predictive measure but one designed to signal potential problematic areas. While these characteristics are those that distinguish boundary violators from nonviolators, there is also some overlap between these two groups. No studies to date have been performed that prospectively predict boundary violations; thus the measure is not designed to be predictive of future problematic behavior.

3

PRECURSORS TO THERAPIST SEXUAL MISCONDUCT

The therapist must recognize that the patient's falling in love is induced by the analytic situation and is not to be confused with the charms of his person; so that he has no grounds whatever for being proud of such a "conquest," as it would be called outside of analysis.

—S. Freud (1915, pp. 160–161)

There is an undeniable curiosity about what may lead an analyst or therapist to engage in sexual relations with a patient. The fantasy that one might desire another person profoundly enough to risk one's entire professional career is at once horrifying and intriguing. While most analysts and therapists would acknowledge having been sexually attracted to a patient at one time or another, the ability to tolerate such feelings and resist the temptation to act is not usually compromised, even when intense affects, fantasies, and impulses are aroused.

What leads some therapists to translate such feelings into action? Is it the intensity of the feelings, an unusual and specific affective state itself, something inherent in a particular dyad, or special vulnerabilities in the therapist? In an attempt to answer these questions, this chapter presents data on a group of therapists who had engaged in sexual relations with a patient.

The data for the present chapter come from therapies, evaluations, or supervisions of 17 offenders—14 male and 3 female. (This sample is a subset of a larger sample of mental health professionals who have engaged in sexualized dual relationships of various types. Only those mental health professionals who are therapists and who were sexually involved with a patient or client are included in this subset.) All male offenders' transgressions involved one or more heterosexual relationships. All female offenders transgressed in one homosexual relationship. Some therapists were sexually involved with a patient.
WHEN IS A COUCH JUST A COUCH?

Thus far, I have focused on the psychological and dynamic factors that play a role in sexual boundary violations. There are also concrete and tangible aspects of the therapeutic context that may take on symbolic value. What role do these aspects—the props, so to speak—of the therapeutic setting play in setting the stage for sexual boundary violations? In the analytic play space, the only concrete behavior permitted between patient and analyst is talking and we are accustomed to viewing talking as not doing. When doing becomes the mode of relating, polarizing these two truncates the play space in the sense that meanings are telescoped, at least in terms of what is being explored or elaborated. This is an essential characteristic of perversions and the use of a fetish, in that play is constrained, repetitive, and objectified (Stoller, 1979, 1985; Coen, 1992; Bach, 1994). Many perverse sexual acts hinge on the use of some concrete thing or ritual for sexual pleasure.

In the therapeutic context, sexual boundary violations have such a character of perversion. The doing gets going, the talking stops, meanings are enacted and not explored. There can be the use of a concrete aspect of the setting, such as the couch, as part of this drama. In this mode, the play space has collapsed and the analytic couch becomes just a couch. This can be described as the collapse of the symbolized and the symbol. What is symbolized is what the analytic couch represents, that is, the potential space and play between analyst and patient. The symbol is the couch itself.

In psychoanalysis, the talking is often about love and sex. In turn, the language of love and the language of sexual longing constitute what we mean by desire—the desire to be close, literally (i.e., physically) and intimately (on an intersubjective level). This desire carries with it the desire to possess and to transgress, that is, to be inside the other or to take in, devour, and have the other inside you. The treatment situation aims to symbolize all of these longings in verbal form. But this very talking presents an inherent challenge that is part of what can sexualize the treatment situation itself (Celenza, in press).
This challenge is the performative nature of sexual language—the fact that the language of sexuality is, in and of itself, erotic and arousing (see, for example, J. Davies, quoted in Slavin, Oxenhandler, Seligman, Stein, & Davies, 2004; Havens, 1997). Here’s where the polarization of talking and doing, seeing them as distinct and even opposite, breaks down.

So, the treatment situation can get very hot, rippled with unmet longings and frustrated desire. How to keep the action at the level of discourse and symbol, metaphor and play? When do the concrete aspects of the setting lose their power to evoke layered images, multiple, perhaps infinite, potential modes of relating and become instead co-opted into some degraded, concretized scenario?

THE FETISHIZED COUCH

Consider the case of a Christian minister, Father C. He became involved with a female parishioner whom he had been counseling for many months. Each session ended with a ritual—they would move to the chapel and join hands in prayer. One thing led to another and then they would have sex under the altar. The altar, this icon of worship, was inextricably bound up in creating the context for desecration and corruption. In Father C’s words, “This was a way to fuck God and fuck the church at the same time.” The desecration of a holy symbol was, for him, a way to corrupt love, a sacred act, and to blasphemize the church. (I am reminded here of the scene in Ken Russell’s The Devils where Sister Jeanne, played by Vanessa Redgrave, masturbates with a crucifix.)

What is the function of the prop, the altar? Did it matter that the deed was done in a chapel under the altar? I would say, yes, it mattered very much. Would it have happened anyway, were a chapel not nearby? Yes and no. Yes, it would happen anywhere because the boundaries, or lack thereof, are, in the end, internal. Without an altar, however, it might not have happened in just this way. Still, we can use the visual-spatial arrangements in the external setting to help elucidate the unconscious drama that is being played out (Celenza, 2005) since they play a crucial role in the mind of the transgressor whether they are physically present or not.

In a psychoanalytic context, the analogous object to the altar, undeniably, is the couch. So, we may ask, when and how does a psychoanalytic process, along with its setting, become degraded, as in sexualized boundary violations? Or, when is a couch just a couch? I would say that in psychoanalysis, a couch is never just a couch, but there is a way in which we can say that the play space—that sacred, multilevel, expansive area of the mind and intersubjective space—can collapse such that the couch becomes a concretized object, that is, just a couch, functioning much like a fetish. It is this couch that plays a part in the staging for sexual boundary violations in psychoanalysis.

But to refer to the couch in the psychoanalytic setting is already to refer to a fetishized object. The phrase “Are you on the couch?” has been shorthand for “Are you in analysis?” I say “has been” because I know that today there is a greater appreciation for psychoanalysis according to its intrinsic features—that is, as an intrapsychic and intersubjective process that cannot be simply defined by extrinsic criteria such as frequency of meetings or where one sits or lies down (Gill, 1984). Still, historically the couch has symbolized psychoanalysis and, in that sense, remains an icon.1

So to ask “Are you on the couch?” is to conjure up a set of images, attitudes, and feelings associated with psychoanalysis. If this same question is asked in reference to sexual boundary violations, “Are you on the couch?” really means “Which couch are you lying on?” There are two couches that are relevant in sexualized boundary violations: the degraded icon of psychoanalysis (that is, the fetishized object) and the furniture. This couch, in both of these functions, is not the couch of the analytic play space. The psychoanalytic couch functions in multiple domains, containing the potential for multiple relational configurations, as in parent/child, analyst/analysand, man/woman, friend/lover, and perhaps colleague too. Obviously, not all of these potential modes of relating are cultivated or developed (Mitchell, 1993; Modell, 1990), but they remain potentials in the room. The couch of sexual boundary violations is one where the collapse of the symbol and symbolized has occurred; it is a concrete couch that functions solely in two domains—a place for both analyst and analysand to physically lie down (that is, to have sex) and a place to desecrate and degrade. When the analytic couch is concretized, it retains its symbolic function as a degraded icon.

DIRECT AND DISPLACED OBJECT SCENARIOS

When psychoanalysis is the stage on which this drama is played out, it also is important to ask, Who is being degraded in this use of the couch as a fetish? We can approach this question on a visual-spatial level as well, by asking whether the drama is a direct one or essentially a displaced scenario incorporating a third object in the mind of the transgressor.

The direct perverse scenario is an example of a classic perversion where the perverse act is focused directly on the other. In classic perverse fantasies,
there is usually an attempt to degrade the other in an attempt to manage, control, and reduce (that is, objectify) the other's potentially dangerous subjectivity. This is essentially a direct unconscious scenario in that the drama revolves around the other who is objectified, thereby reduced from a separate subject to an object, and then sadomasochistically controlled. Most sexual boundary violations have this structure.

However, some sexual boundary violations, perhaps the most notorious type, make use of a displacement object and thereby are more accurately referred to as a displaced perverse scenario. In these cases of sexual boundary violations, the effort to degrade is not primarily directed to the other but is directed to the profession, the body or figure that oversees the dyad—not the use of the symbol of the couch, the icon of psychoanalysis, as a place to enact this perverse scenario. In this sense, the couch represents a third object and in this way, symbolizes psychoanalysis. The patient is a displacement object—a stand-in, so to speak—for an aspect of the setting or context.

The question of who is being degraded and whether the unconscious drama is essentially direct or displaced depends on the type of sexual boundary violation. As has been discussed in previous chapters, it is possible to broadly categorize the different types of sexual boundary violations into two types (Gabbert & Lester, 1995a; Celenza & Gabbard, 2003). One includes the egregious, notorious cases that have attracted statewide and sometimes national attention. These usually involve a therapist or analyst who is a psychopathic predator and who has sexually exploited multiple patients multiple times over many years. Though this is probably the best-known type, largely due to the extensive media attention such cases typically attract, fortunately these predatory actions are not representative of the most prevalent type of sexual boundary violations.

For the psychopathic predator, the unconscious drama that is being played out is best characterized as a displaced degradation. It is largely the profession that is being degraded, though, of course, the patient, in the way she is used, objectified, and even minimized in dynamic importance, is degraded along the way. In the main, however, she plays a relatively small role in the unconscious psychic drama of the transgressor, and by this I don't mean to downplay the traumatic effects such an experience can have on her. But in the mind of the transgressor, she is usually replaceable by multiple others who may or may not be involved contemporaneously. The externalization of the drama extends as well to the staging and props, including here and perhaps especially so, the couch. Analogously, Father C was not fucking his patient but was using her to fuck God and the church, symbolized by the altar.

So, in this way, the perversion of the psychoanalytic process—largely aimed at corrupting the profession itself—is brought about by using the very means of healing in order to exploit and harm rather than help, and to do so in a sometimes flagrant manner. We all know the cases that have involved chairs of ethics committees, the most trusted "analyst of analysts," or the couple's therapist who, while treating the couple, has sex with the wife between sessions. These are, invariably, displaced dynamic scenarios and, even when these psychodynamics are understood, it is difficult to put ourselves in the transgressor's shoes.

DIRECT PERVERSE SCENARIOS

As I have described in previous chapters, the other and most prevalent type of sexual boundary violation involves a heteroerosexual male analyst or therapist who becomes sexually involved with only one of his patients. Gabbert (1994a) refers to this type of offender as lovesick; I have called him narcissistically needy (Celenza, 1998). As described in chapter 1, the analyst or therapist of this type is usually midcareer, isolated in his practice, and is treating a difficult patient in a highly stressful time of his life. The "love" relationship that ensues is an intensely absorbing love affair (at the time). It may last for several years and the couple may feel that they have found "true love," at least initially. Sometimes the therapy relationship is terminated while the sexual relationship continues. If the relationship is brought to an end by the therapist, this is the time when a complaint is most likely to be filed by the patient.

When we think of this type of sexual boundary violation, it is tempting to think that it's about love or even sex. But in my work with these cases, I have not found love in the air. This type of sexual boundary violation usually occurs because there is danger in the air. From the analyst's perspective, something is dangerous and it has to be managed. More than love, or even sexual attraction, this type of sexual boundary violation happens when a narcissistically fragile analyst or therapist feels that the treatment process is threatening his own delicate narcissistic equilibrium. He feels threatened by the patient, by the instability of the treatment, and is in a subjectively helpless, desperate state. A related point, it is important to note, is that acute suicidality in the patient is a major feature in over half of these cases (Celenza, 1998; Celenza & Gabbert, 2003). This is not an intersubjective engagement, as in subject/subject, but one better characterized as subject/object or doer/done to (Benjamin, 2004).

Here, I believe, the degradation, though unconscious, is primarily aimed at the patient (as opposed to a third object). It is a sadomasochistic relation, focused on the other who is objectified and reduced from subject to object. This is an example of a classic perverse scenario where the dangerous subjectivity of
the other is controlled and reduced through objectification (for other examples of sadomasochistic perversion, see Stoller, 1979, 1985; Bach, 1994; and its relation to pathological dependency, Coen, 1992). I say this because in this type of sexual boundary violation, the seduction occurs when the therapist believes that the therapy is at an impasse, a time of threat, acute suicidality, or some other type of critical juncture (Celenza, 1991, 1998). The sexualization serves to shift the process from one of enormous frustration and challenge to one of seduction and sexual gratification. It also manages to transform the patient’s emerging negative transference toward the analyst or therapist to a positive idealizing transference, a much more comfortable mode of relating for such a narcissistically fragile analyst or therapist. This is not the mutual surrender of healthy loving (Ghent, 1990; Maroda, 1998) but a perverse submission because it occurs in the context of threat and turns a setting of healing into one of domination and control.

Thus, the degradation in this type of sexual boundary violation is primarily focused on the felt danger in the patient. It is a direct, unconscious scenario in the mind of the transgressor and here, the couch or the setting is a less important prop on the stage. In my experience with this type of boundary violation, the sexual act is at least as likely to occur in the patient’s home as in the office, home office, or hotel. In other words, the official props of the setting are less important; the transgression occurs more in and between the minds of the two.

THE DANGER IN THE ANALYST

The felt danger charging the atmosphere in most cases of sexual boundary violations comes not only from the patient’s subjectivity, however. There is also the danger that the patient may feel in the analyst’s subjectivity. In this sense, the danger is mutual. The potential dangers for the patient inherent in psychoanalysis are illustrated in any number of New Yorker cartoons: the analyst’s lack of caring (as in clipping his toenails, sleeping); the analyst’s aggression (poised with a dagger, about to strangle); or the analyst’s judging or shaming response (shaking his head or laughing). All of these revolve around fundamental questions: Do you like me? Am I safe? Will you hurt me? And again, Why can’t we be lovers?

Liking is one of many aspects of our subjectivity that forms the basis of the alliance, the background of safety (Sandler, 1960) that makes it possible for the analysand to reveal herself. But liking is only meaningful if “not liking” is also a possibility. This brings me back to the couch and to aspects of the patient’s motivation to get the analyst on the couch with her. The New Yorker cartoons are humorous because they depict as real our worst fears—that behind our back, the analyst is laughing or sleeping (I’ll leave out the one with the dagger). Whether or not we like our patients (and this is just the precursor to the question, Why can’t we be lovers?) can become a matter of life or death for some patients. Again, it is worth reminding ourselves that acute suicidality in the patient is a major feature in over half of cases of sexual boundary violations. When the patient’s desire is focused on the analyst, the refusal to engage in a sexual/love relationship can become a life or death struggle between them.

An analysand of mine has gone from total sexuality to hiring prostitutes. I’ll respectfully call him Randy. He says in comparison, my fees are low because my services are limited. He tells me there’s a benefit you can sometimes get where she will “do the girlfriend thing.” This means she will pretend that she likes you. Some charge extra for this; others throw it in as a freebie.

This was just the beginning of Randy’s emerging erotic transference toward me. He began with a hint that he needed to know that I liked him. The implications of what he gets from prostitutes and what he does not get from me loomed large in the room. Soon, he more directly revealed a desire that we have sex, run off together, and live happily ever after. When I refused to return his desire in the ways he wanted, he felt devastated and then a humiliated fury emerged. He called my Hippocratic Oath “my Hypocritical Oath” and said he felt trapped, depressed, and wanted to kill himself. This eventually took the form of a fantasy to stab me with a knife (see Celenza, 2006, for a more elaborated discussion of this case).

What would it have taken to get me to respond in the way analysts and therapists do when they sexually violate boundaries? Fortunately, I do not have now (and hopefully never will) the characteristic features of those transgressors. I was able to withstand the danger, bear it, seek consultation (a lot of it), and remain in a terrifying but affectively healing relational position with Randy. Had I been in a different mental state, perhaps at a different time of my life, and under extreme situational stress, I might have needed to manage this danger in a different way. Perhaps in desperation, sexualization might have seemed an option.

So, the motive to love and be sexual on the couch (or anywhere) is a mutual desire in this type of transgression. Here, I do not mean to shift responsibility in the direction of the patient, just to describe the transference/countertransference pressures that are part of the unconscious drama and to emphasize that it is a two-person act, though only one bears the responsibility of maintaining boundaries. I also do not mean to excuse the transgressor, just to explain what I have learned.
It is tempting to think that words might suffice in this context. Why not just tell Randy I like him? Or love him, especially since I do? But as Randy has often put it, "Ora non verba"—Latin for "Action, not words" (or so he tells me). Words are thin and have an excruciatingly short lifespan. (In effect, you just said you love me, but what about now?) The only lasting truths are those we feel, the ones that are informed by our guts, our ability to intuit, feel, and recognize as real what is already in the atmosphere between us. These are the skills I try to help Randy and all of my patients hone, to pay attention to what they know because they can feel it. Knowing from that level is more reliable compared to what anyone might say. (After all, people lie.) In this sense, analysts and analysands who engage in sexualized boundary violations, especially of the direct type, are trying to make real—that is, feel—by doing rather than saying. The need to make real by physical touch is, at times, an attempt to make the body feel where emotions are mistrusted or too weakly recognized. Words increase in power only as they resonate with a recognized internally felt state.

ANGER IN THE AIR

In all cases of sexual boundary violations, whether two or three are represented in the unconscious dynamic scenario, it can be difficult to empathize with the position of the analyst. The question comes up, How does one cross that boundary between talking and doing, loving and actually having sex?

To understand how this may come about, it is necessary to appreciate the complexity of the feelings the analyst is trying to express or control. It is never simply love or sexual attraction. In all cases of sexual boundary violations, it is common to find a vast reservoir of unresolved anger toward authority. This factor is evident in the transgressor's history as well as in current preoccupations. Though they often can present themselves as highly remorseful (which is genuine), the exploitation itself represents a rebellion against the authority of the profession and an underlying desire to break the rules.

In the displaced scenarios of the psychopathic predator, I have found that the expression of unresolved anger toward the profession is primary and is rooted in an unconscious, unresolved aggression-laden drama toward an abusive parent. Like Father C, the hostility is aimed at the figure of the third, the overseer of the dyad, as in God and the church. Why did he do it? The triumphant response is, because he could! Derived from unresolved anger toward an authoritarian parent, the licensing board, ethics committee, and/or professional organization can take on this aspect of the transference. This is a crucial phase of the subsequent treatments of transgressors (see chapter 11).

For the one-time transgressor, this hostility is expressed within the dyad, directed toward the patient and directed inwardly, in an unconscious self-destructive move that usually results in the expulsion from his profession.

Sexualization and concretization (or objectification) are defenses employed by the analyst who commits a sexual boundary violation. These defenses serve to transform the meaning of the analytic play space from one of expansion and potentiation to one of constriction, objectification, and degradation. Whether the unconscious dynamic scenario is direct or displaced, someone or something is being degraded. As mentioned, the degradation of the profession, the third object in the displaced perverse scenario, is effected largely through concretization—a transformation of the icon to its base function. In the direct perverse scenario, the other is objectified, the harm is in being dehumanized and dominated. In other words, sexual boundary violations turn a couch into mere furniture, thereby enacting a perverse ritual that degrades a place of healing, and turns the setting into its opposite, a place of exploitation and betrayal of trust, the very opposite of what the symbol was meant to represent. This is my preferred meaning of perversion, to use the tools of a healing process in the service of an opposite aim, to harm.

WHY CAN'T WE BE LOVERS?

So, why can't we be lovers? Isn't this the fundamental question we all have of each other? Most answers dodge it: That's not our purpose, we didn't agree to that, it's not our contract. "But things change!" is the reasonable response. Or, You didn't know me then. Haven't I made myself irresistible? Don't I have that power? And finally, Some analysts do it!

One response gets closer: We can't because of transference. If this were all there was to it, however, no marriages could be condoned. So, the question "Why can't we be lovers?" is only satisfactorily answered by referencing the immutable and undeniable structure of the psychoanalytic setting itself (see chapter 5). By virtue of the fact that it is the structure of the psychoanalytic setting that inherently embeds transferences, the imbalances organized by this structure are thereby rendered irresolvable. In the psychoanalytic setting, transference is structuralized, that is, it is embedded in the structure of the setting, and thereby rendered immutable.

Here again are ways in which the concrete aspects of the setting may be used to symbolically represent efforts to equalize the various power imbalances.
in order to deny the immutability of the psychoanalytic structure. For example, an analyst may believe that lying on the couch with the patient creates equality between them. This, however, is an empty gesture, and usually effects a denial only in the mind of the analyst. The transferences developed when roles and expectancies were assigned. Lying on the couch together does not transform the analysand into an adult; she becomes a parentified child.

It is also true that there are multiple potentials that exist in any interpersonal relationship, lovers being one example. In the psychoanalytic setting, many potentials are purposefully not cultivated (Mitchell, 1993) or developed when the treatment contract is agreed upon. While it can be said that in most relationships, the undeveloped potentials remain as real potentials by choice, the psychoanalytic situation and the structure that defines it limit the extent to which such choices remain unencumbered. This is why sexualized boundary violations are deemed unethical, even when the patient is an adult. It is not simply by virtue of being under the influence of transference, however, but also for the fact that the transferences are structuralized and therefore immutably constraining.

In contemporary theory, it is generally recognized that transferences always organize the various ways of experiencing self and other in relationships. Even Freud recognized that it was impossible to distinguish between transference love and love in real life (Freud, 1915). It is not that “true” or “real” love has no transference in it, but that loving in real life (i.e., outside the psychoanalytic setting and structure) is negotiable (theoretically, at least) and thereby accessible to new experience. The structure of the psychoanalytic situation is designed to evoke those ways of experiencing that unconsciously foreclose new experience, thereby rendering loving in the psychoanalytic situation constrained by old patterns of relating.

ENDNOTES

This paper is derived from a 2006 paper by A. Celenza, “Sexual boundary violations in the office: When is a couch just a couch?” Psychoanalytic Dialogues, 16(1), 113–28.

1. The first-year candidates engage in constant questioning about who has bought a couch, where you get one, what type, and so forth. Buying your couch is a ritual that symbolizes the indoctrination into the analytic community. One candidate analogized it to losing her virginity, where who did it first becomes pertinent. (I am indebted to Ellen Golding, Ph.D., for these thoughts and anecdote.)

2. The term “third object” as used here is differentiated from some of the ways in which the concept of the third is used in contemporary theory (see Benjamin, 2004; Britton, 2004; Hanly, 2004, for helpful reviews). In the present discussion, the use of the third object is to be rigorously distinguished from the intersubjective third or symbolic third in that there is no recognition of a separate subjectivity in the mind of the transgressor. Rather, the third is used as in Benjamin’s (2004) “negative third” in complementarity or doer/done to relations, as Ogden’s subjugating third (1994), or the way in which Aron (1999), Greenberg (1999), and Spezzano (1998) use the concept, as representative of the analytic community.

3. I am indebted to Lew Aron for encouraging me to admit this universal truth.