

Precursors to Therapist Sexual Misconduct

Preliminary Findings

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This article presents preliminary findings on the characteristics of and predisposing factors in therapists engaging in sexual intimacies with patients. Data were derived from comprehensive evaluations, consultations, supervisions, or analytically oriented treatments. Particularly salient were frequent misunderstandings of, rationalizations about, or defensive transformations of love and hate in the countertransference. Common findings involved (a) long-standing and unresolved problems with self-esteem, (b) sexualization of pregenital needs, (c) restricted awareness of fantasy, (d) covert and sanctioned boundary transgressions by a parental figure, (e) unresolved anger toward authority figures, (f) intolerance of negative transference, and (g) defensive transformation of countertransference hate into countertransference love. Coexistence of multiple levels of reality within the psychotherapeutic dyad is discussed as an area in which misunderstandings and rationalizations frequently occurred.

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

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might desire another person profoundly enough to risk one's entire professional career is at once horrifying and intriguing. Although 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 affect, 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 article presents data on a group of therapists who had engaged in sexual relations with a patient.

The data for these inferences came from therapies, evaluations, or supervisions of 17 offenders (14 male and 3 female). (This sample was a subset of a larger sample [$N = 30$] of mental health professionals who had engaged in sexualized dual relationships of various types. Only those mental health professionals who were therapists and who were sexually involved with a patient were 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 only briefly, whereas others sustained a longer term relationship. A few were involved with more than one patient, either simultaneously or over time.

The therapists were referred to me in a variety of ways because of my expertise in this area. Two sought treatment, and 2 others sought supervision after the suspension of their license. One female therapist sought treatment during her involvement with her patient. Two were involved in a patient-initiated consultation. Of the remaining 10, 3 referred themselves and 7 were referred by an overseeing professional organization or licensing board for a comprehensive evaluation after their licenses had been suspended. (Other therapists have sought treatment as a preventive measure in response to anxiety that they might become involved with a patient. Such cases are not included in the present discussion but illustrate the need for a less punitive atmosphere within the profession so that therapists feel free to seek consultation when they perceive the need.)

The evaluations included extensive interviews, a full psychological test battery, and, whenever possible, consultation with the therapist's supervisors, colleagues, spouse, and therapist, as well as the patient-victim. One

therapist is a psychoanalyst and 2 had had personal analyses. All were psychodynamically trained and conducted intensive psychodynamic psychotherapy. All saw themselves

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Table 1 Characteristics Examined

Response	1	2	3	4	5	6	7
Endorsed							
%	94	73	80	85	93	100	88
No.	16	11	12	11	14	17	14
Not Endorsed (no.)	1	4	3	3	1	0	2
Missing data (a)	0	2	2	3	2	0	1
Total assessed (b)	17	15	15	13	15	17	16

Note. 1 = low self-esteem; 2 = sexualized pregenital needs; 3 = restricted awareness of fantasy; 4 = family history of boundary transgressions; 5 = anger toward authority figures; 6 = intolerance of negative transference; 7 = defensive transformation of countertransference hate to countertransference “love.”

^aComplete information on all characteristics was not available for all therapists.

^bTotal number of therapists assessed for each characteristic.

as competent, experienced, and sensitive to transference–countertransference enactments.

Characteristics that were reflected in 73% or more of the cases are included in this discussion. (More than half of the characteristics were present in 88% or more of the cases [see **Table 1**].) These characteristics, derived from the convergence of test data (especially Rorschach scores and Thematic Apperception Test [TAT; Murray, 1943/**1971**] themes), background information, and clinical observation, may represent precursors to therapist sexual misconduct.

It is important to note at the outset that the findings presented here are not the result of a controlled study or a prospective study. At this point, it cannot be concluded that the findings predict therapist sexual misconduct or that the predisposing factors are characteristic of therapists who engage in sexual misconduct as opposed to those who do not. Because this is not a report on a prospective study or a study that included a control group, these findings are presented as preliminary and represent a starting point for future research.

From the data under discussion, it appeared that the motivation for sexual transgression(s) most often involved unconscious, denied, or compartmentalized¹ conflicts about which the therapist had little insight. These

¹ Compartmentalization is used here to denote the conscious coexistence of a nonintegrated, often contradictory experience of the self. Perhaps through the mechanism of a “vertical split,” the unintegrated experience of the self may include instinctual, affective, ego, and superego elements.

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issues were usually related to personal conflicts in the character of the therapist, rendering the therapist vulnerable to enactments when intolerable helplessness, loss of self-esteem, or rage were evoked. In almost all of the cases, this formulation was based on interpretations of the data that the therapist confirmed.

Preliminary Findings

The first characteristic involved long-standing and unresolved narcissistic neediness and lifelong struggles with low self-esteem. Almost all of the therapists reported a lifelong struggle with a sense of unworthiness, inadequacy, or outright feelings of failure. One reported always feeling “empty and needy, like I was lacking in something.” He related these feelings to the punitive and shaming atmosphere in his home. He believed he had become a high achiever but could not derive satisfaction from his accomplishments. Another therapist described his mother as a “devastating critic” who was unrelenting and unpredictable in her hostility toward him. He believed he had internalized chronic feelings of self-doubt and “a sense of inner badness” with which he had struggled all his life. Still another therapist reported a “frightening feeling of bottomless need.”

Consistent with these reports were Rorschach indicators of characterologically based emotional neediness and interpersonal longing, noted in 75% of the cases. For example, texture scores occurred at a frequency more than three standard deviations greater than the normative mean (Celenza & Hilsenroth, 1997). There was also an abundance of percepts described as “damaged,” “wounded,” “chewed,” “broken,” and “killed.” Content scores reflected a preoccupation with body integrity, feelings of damage, and vulnerability, demonstrated in the preponderance of percepts involving anatomy, X ray, and morbid content (Celenza & Hilsenroth, 1997).

In all cases, the therapists acknowledged these feelings as longstanding. In the therapy in which he or she transgressed, the treatment purpose was typically subverted so that the therapist's needs had become the central focus. This may have begun in a subtle manner; for example, the therapist may have disclosed personal information from his or her life. This was then rationalized by the therapist as educating or guiding the patient or as an attempt to reduce a power imbalance by the sharing of personal information. It can be speculated, however, that underlying the technical rationale was a need for sympathy, or soothing, or a muted plea for rescue.

The patients often reported a perception of the therapist as highly powerful (at least initially) and were consequently unable or reluctant to

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deny the therapist's needs for attention. Of the therapists studied, however, 94% reported a paradoxical subjective feeling of powerlessness, especially in relation to the patient with whom they transgressed. Even though most of the therapists were aware of their fragile self-esteem, its pervasiveness and unconscious origin were not adequately appreciated or resolved. From a review of their practices and therapeutic styles, it was clear that these therapists tended to rely on their patients to meet their narcissistic needs and required that their patients always hold them in positive esteem. Many patients reported a sense that angry or disappointed feelings toward the therapist or the treatment were taboo.

The second factor was a childhood history of sexualized pregenital needs. This was reported by the therapists in a way that indicated no conscious awareness of having been overstimulated as a child. Only one therapist reported having been the victim of outright sexual abuse. More typically, the sexualization seemed to take the form of covert seductiveness and overstimulation in the context of an emotionally depriving relationship with a parental figure. Paradoxically, this covert seductiveness always occurred in the context of an emotionally repressed and sexually prohibitive atmosphere within the family. For example, one therapist who was raised in a conservative and highly religious family reported early memories of his mother undressing, not in an intentionally seductive way but in an asexual manner, seemingly unaware of the stimulating potential of her body. Another therapist described his mother as highly intolerant of physical touch, prohibiting her three young sons from hugging her or even holding her hand. He commented, “The more I tried to get close to her, the more frightened she became.” However, she enjoyed a vicarious titillation from hearing of her son's multiple sexual exploits when the two were older. According to the therapist, “My mother always enjoyed lusty sons.”

Another therapist considered his mother a powerful matriarch who could be warm and loving toward the therapist's nine sisters but was unaffectionate and unpredictable toward him, her only son. He felt that he could not please her and that he was often punished solely because he was a boy. This same therapist's father was described as a man who “enjoyed his manhood,” building cars, racing hot rods, and brandishing a “rape whistle” about which he would joke, “If you want it, blow it.”

Yet another therapist described his parents as “Edwardian, very formal, unaffectionate, and repressive.” His parents slept in separate bedrooms, had little contact with each other, and maintained an austere family atmosphere in the home. This therapist recalls being slapped on the hand in response to naughty behavior and longing to be slapped again,

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because this was the only physical contact he remembered with either of his parents. At the same time, his father had homosexual lovers who would visit the home in the afternoons and with whom he would shower. Although all members of his family were aware of these affairs, they were never openly acknowledged.

One therapist's Rorschach imagery expressed this dilemma poignantly. This therapist's projective testing reflected a perception of women as emotionally unresponsive except through sexual manipulation. On Card VII of the Rorschach (a card that typically evokes imagery associated with femininity or maternal figures), he perceived “two female puppets: You can put your hand in through the bottom and make them move whatever way you want.”

As other authors have noted (**Gabbard, 1994a, 1994c; Twemlow & Gabbard, 1989**), this childhood experience can result in unresolved needs that are then enacted in the therapeutic dyad on a part self-representational and part object-representational level. Intimate relationships are characterized by intense longings for understanding, acceptance, and acknowledgment of one's goodness; Oedipal-level issues of jealousy, rivalry, and whole-object relatedness are relatively absent. Consistent with this were sexual content responses on the Rorschach (**Celenza & Hilsenroth, 1997**), wherein 77% of images were perceived as isolated body parts (as opposed to integrated aspects of whole human responses). These responses were often associated with primitive, morbid, or aggressive content (e.g., “a bleeding vagina, it looks like it's splashing, ejecting with some force”; “a penis that's not fully developed”; or “a scrotum with just testicles, no sac”).

Third, restricted awareness of fantasy was observed in a majority of the therapists, especially those who presented with genuine guilt and self-reproach. Because a restriction in the ability to use fantasy impedes the capacity to imagine multiple levels of meaning (e.g., to recognize or consider transference, countertransference, and defensive functions), feelings are taken at face value. This speaks directly to the question of what mechanism failed to prohibit the therapists from translating their feelings into action. Minimal exploration of their feelings revealed an inability to perceive aggression in themselves or others. Notably, most had great difficulty acknowledging the transgressions as inherently hostile. Not surprisingly, these therapists were exceedingly moralistic and self-depriving. Conscious fantasies lacked aggressive play and other impulses considered by the therapists to be immoral or repugnant, representing, as **Gabbard (1994b)** has also observed, an impairment in fantasy functions.

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This accords with Freud's (1911/**1958**) early discovery that consciousness plays a central role in the capacity to delay, that it is those impulses that are unconscious that are most likely to be acted out.

One therapist stated that he considered it his job “to eliminate anger” and reported being unable to “sustain anger” in relation to his own past. Another therapist reported having had a panic attack at the memorial service of a coach who had excluded him from the high school basketball team. This therapist subsequently developed an anxiety disorder with periodic dizziness and fainting spells in situations in which he felt disappointed or frustrated. Later in life, with the help of personal psychoanalysis, he came to realize that he had unconsciously held the belief that his anger and frustration at his coach had somehow played a part in the coach's death. (He also had a conflicted relationship with his domineering mother, who was often in ill health.) Another therapist discovered, in the course of his therapy, that he had a “seething rage underneath a placid and good exterior” so as to hide his aggression from everyone, including himself.

With therapists who presented with little or no remorse, there appeared to be a more pervasive restriction in internal experience with minimal capacity to identify motivations or feelings that may have led to the transgressions. These therapists tended to externalize responsibility and had minimal insight into how their behavior was associated with past experience. They usually had had more conflictual relationships with parental figures, resulting in intense anger at authority figures. Although clearly identified with an aggressive parent, the

self-representations associated with such conflicted identifications were defensively disowned, as if occupying a space outside the boundaries of the self. One therapist recounted the seduction of his patient wholly in terms of being seduced by her, even to the point of disclaiming responsibility for his body's physiological sexual response. When asked why he did not simply leave the room when he felt unable to prevent his patient's sexual advances, he said, "My body responded; I did not."

For other therapists in this subgroup, libidinated aggressive fantasies were acted out in a compartmentalized way; that is, the boundaries demarcating a hated or feared "other self" were conscious, and actions associated with this other self became permissible in special, usually taboo contexts in which the usual superego prohibitions did not apply. These representations were conscious but were not sufficiently integrated within the self-structure; the therapists were able to recognize their behavior as motivated from within but were unable to accept it as part of their usual character or self-image. These therapists might report "being in a fog" or

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giving in to impulses they otherwise would struggle to keep under control with little understanding of their dynamic origins. One therapist reported, "I did with my ethics what I did with others' needs whom I violated: I simply set them aside."

Fourth, there was usually ample precedence in the family history of boundary transgressions by a parental figure. Reports of childhood histories reflected that the gratification of wishes was simultaneously overtly prohibited yet covertly permitted in a denied, unintegrated way. Many of the therapists reported having been aware as a child of parental extramarital affairs. For example, one therapist reported that his mother had had multiple affairs while his stepfather was away on work-related trips. Although the stepfather apparently never knew of the mother's extramarital involvements, the son (now therapist) knew her secrets and felt forced to keep them from his stepfather. This occurred in a context of otherwise rigid adherence to moral guidelines. It is easy to see how such a family situation may set the stage for the internalization of vertically split superego structures (one aspect of which is based on an identification with the transgressing parent), which prohibits overt need gratification yet permits the gratification of wishes in secret and forbidden contexts. This dynamic may mirror the patient's wish to reenact a sexual relationship with a forbidden object with which the therapist then colludes (**Gabbard, 1994c**). The therapeutic dyad presents a context in which these dynamics may be enacted.

Another therapist viewed his parents as strict, prohibitive, and sexually naive, although he acknowledged his father's reputation as a "Romeo." When asked whether he thought his father had been unfaithful to his mother, this therapist responded, "That's out of the question. He was too straight-laced.... Though now that I think about it, he was frequently away at night." This therapist then offered the belief that "people don't do what they actually do." Yet another therapist reported that his mother's first husband was his father's brother.

Fifth, there was usually intense and unconscious unresolved anger toward authority figures. Licensing boards or professional organizations often seem to take on this aspect of the transference. In one case, after several months of intensive psychotherapy, it became apparent that the therapist had the fantasy that he and I were in secret collusion against the licensing board to reverse the suspension of his license. This fantasy paralleled an unresolved Oedipal dynamic in which his mother had prohibited gratification while his father secretly had colluded with him (**Celenza, 1991**). Another therapist (a minister and pastoral counselor)

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experienced his involvement with his patient as an attempt to "f**k God and f**k the church."

Yet another therapist told a revealing story on the second card of the TAT. On this particular card, the therapist was asked to tell a story in response to a picture of a man raking a field, a pregnant woman leaning against a tree, and a young woman in the foreground:

There's ... a dark side of it—a flirtation—not dark, maybe ambiguous.... There's sexual tension between the man and his niece, because of her freshness, her openness.... That sets up a triangle. That newness catches his eye, catches his soul. I don't think anything [happens]. But there might have been, if that doggone pregnant woman weren't keepin' such a close eye. I think he'd probably like to.

It is not insignificant that I was 8 months pregnant at the time I evaluated this therapist! At the time, he displayed no awareness that he had revealed both his need for and hostility toward me as an authority figure.

In my consultations, it has generally turned out that the maternal figure was the authoritarian parent who was experienced as seductive yet prohibitive and rejecting. The unresolved authority issues are reexperienced in the negative maternal transference and may be projected onto the overseeing board or the professional organization. Among analysts who have transgressed, **Gabbard (1994a)** has found evidence of unresolved anger at or resentment of the institute or training analyst along with a concomitant fantasy of embarrassing these authority figures by disgracing oneself.

The most important characteristic (and one present in all therapists I have seen) was an acute intolerance of the negative transference in the therapists' patients. This was a factor not only with the patient with whom they had become involved but with all of the patients in their practice. One therapist, who was psychodynamically trained, was asked how he deals with the hostile or devaluing projections of his patients. He replied, "None of my patients feel negatively toward me. I have had no complaints." Usually, the patient with whom the therapist acted out sexually was experienced as particularly angry and hostile. As discussed subsequently, the seduction functioned to circumvent and at the same time express covert rage.

From a review of their practices and treatment styles, it was clear that these therapists tended to rely on their patients to meet their narcissistic needs and required that their patients always view them in positive ways. When patients were consulted, many reported a sense that angry or

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disappointed feelings toward the therapist or the treatment were unwelcome. Six of the therapists in this sample were pastoral counselors who, by training, are placed in multiple roles with respect to their patients (e.g., performing religious ceremonies, counseling, educating, and making home visits). For pastoral counselors, the ability to alternate among these multiple roles is seen as a virtue, and their education and training typically do not address the impact of these practices on transference. One therapist routinely hugged or affectionately (from his point of view) touched parishioners, many of whom were his therapy patients, as they exited church. His stance in therapy could be described as a kind of "naive goodness" in which he attempted to effect positive change by offering acceptance, nurturance, and insight. He divulged personal experiences to clients, gave them books to read, and informed them of workshops he would be attending, all in a conscious attempt to teach or guide. When a parishioner patient expressed disappointment or frustration in him or in the therapy, he would suggest a consultation or transfer the patient to another therapist. He even referred one patient for psychological testing, as though the patient's expression of anger were pathognomonic.

The last factor involved a circumventing of unconscious countertransference hate through the misuse of conscious countertransference "love." This was a defensive process triggered in part by the therapist's intolerance of his or her own aggression. As mentioned, many of these therapists had great difficulty viewing themselves as potentially aggressive, and there was a striking absence of discussion about this part of themselves in their personal therapies. One therapist, who had been in psychoanalysis before his acting out, reported that he "had never said a negative thing" to his analyst. He also reported that he rarely was aware of negative feelings toward his analyst and that, when he was, he never discussed them.

The defensive circumventing of countertransference hate was particularly related to the therapists' inability to view themselves as depriving (with which the abstinent stance of the analytic mode was associated). This led them to an overreliance on active and influential techniques with the view of therapy as wholly a "corrective emotional experience." In general, the therapeutic orientation of these therapists can be characterized as overly gratifying, suggestive, or even manipulative. One therapist, who sexually exploited a patient with multiple personality disorder, reported being drawn to "the alter who was open and accepting of me. She was demanding, upset, and angry in her other states."

On a conscious level, there were numerous rationalizations that reflected an overvaluing of countertransference "love" with an underlying

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intolerance of countertransference hate. These therapists always needed to be viewed as “caring” and “giving.” This issue calls to mind a familiar statement of **Winnicott (1971)** in which he refers to the mother–infant dyad analogously to the therapy relationship:

If all goes well, the infant can actually come to gain from the experience of frustration since incomplete adaptation to need makes objects real, that is to say, hated as well as loved ... exact adaption resembles magic and the object that behaves perfectly becomes no better than an hallucination. (p. 11)

Interestingly, the seduction of the patient frequently occurred when the therapist believed that the treatment was at an impasse (**Celenza, 1991**), that is, in response to frustration of his or her efforts to help the patient (**Searles, 1979**) or when the patient had begun to express anger or disappointment in the therapist. As mentioned, the patient with whom the therapist transgressed was usually experienced by the therapist as particularly difficult and hostile. From the therapist's point of view, the seduction seemed to represent a desperate attempt to connect with the patient in a way that protected the therapist's fragile self-esteem. Another therapist reported, “I was reaching the end of my rope. I didn't know how to help her. So I seduced her because I knew how to do that.” This therapist's conscious experience was of overwhelming helplessness; he used his sexuality to ward off unconscious hostility toward the patient and wrest control of the process.

Case Example

Dr. B, a middle-aged male therapist, sought treatment with me after his license had been suspended for having become sexually involved with a patient.² This therapy was mandated by the licensing board as part of a multifaceted rehabilitation plan that included restriction from independent practice, supervision, and psychoeducation. We met once or twice weekly for 8 years.

Dr. B's initial understanding of his transgression revolved around a sense that he had been in love with the patient and that he had hoped to provide for her a “corrective emotional experience” (his words) in reparation for her profound history of abuse by men. Interestingly, the treatment with this patient had been difficult from the beginning. Dr. B 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. B with the hope of a different experience.

² This case has been reviewed elsewhere (**Celenza, 1991**).

The patient was resistant to talking about herself and spent many sessions in silence. Dr. B 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 touched, he had tended to become reassuring or gratifying in nonphysical ways when he perceived 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 his experience of his mother, who had overtly resisted his attempts to engage yet had been hostile and critical when he had withdrawn. In an analogous manner, the patient's perception of Dr. B had paralleled her experience with her father, in which she had felt intruded upon, along with a continual pressure to prop up his self-esteem.

Dr. B 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 affection eventually culminated in a sexual relationship; at this point, Dr. B terminated the therapy relationship, and they had continued their involvement for another year. Although Dr. B had felt conflicted about his actions as a result of his awareness that he was violating the ethical code, he simultaneously had felt trapped by the patient's fears, responsible for their resolution, and stimulated by the fantasy that he would be the one to save her where other therapists had failed. Throughout this year, the patient had become more trusting, had exposed more of her feelings to Dr. B, and had fallen in love with him.

The initial seduction of the patient by Dr. B seemed to me to recapitulate an early childhood pattern on his part involving countertransference feelings he enacted rather than examined. As he recounted the sequence of events, it became clear that the seduction of his patient had occurred when he had perceived that the therapy was at an impasse, at a time when hostile and rageful feelings were beginning to emerge in the patient's transference. The impasse also included his emerging hostility and his fear that the patient would become rageful or blaming of him because of his difficulty reaching her. At this time, the therapist unconsciously experienced the patient as a cold and hostile maternal figure. This confluence of factors increased the pressure toward action. The seduction served to lure the patient away from her negative transference and

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reinforced a defensive idealization that both she and Dr. B found easier to bear.

Although unaware of his motives in the early phase of the relationship, Dr. B 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, 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. B's need to remain connected with a benign, accepting maternal figure and to escape self-blame and anger had led him to abandon the therapeutic stance.

On a conscious level, Dr. B 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 (Celenza, 1995). This was a confusion that could be detected in his overall therapeutic orientation and that might have been addressed had he been in 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 manifest transference 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 counter-transference hate toward her. Thus, his "love" of his patient was being mobilized in the service of defense against his increasing frustration, anger, and hatred of her 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.

Dr. B's difficulty in tolerating hateful and rageful feelings was conspicuous by the absence of such feelings in his fantasy life as well. He consciously strove toward positive, idealized visions of himself and others, adopting a passive, if not masochistic, attitude toward conflict. For example, if someone treated him aggressively, he would admonish himself for not being able to transcend the pain and would focus on what he believed to be the other person's underlying benign intentions.

In the context of his treatment with me, the various defensive transformations discussed in relation to his patient emerged within the transference. Initially, the negative maternal transference was salient. Dr. B was very concerned with my judging him harshly and experienced me as withholding and silently condemning. This led to associations of experiences in his childhood in which "to be known was to be condemned."

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Strikingly, at the end of an early session, he turned to confirm our next appointment and, as he did so, winked. I was stunned yet curious at the extent of his poor judgment, and he was embarrassed at his impulsive seductive behavior. When we later explored this incident, the patient began to reflect on his tendency to use seduction as a way to mollify my anticipated hostility, to forestall potential retaliation, and to strengthen our connection to prevent abandonment in the maternal transference. (Later discussions, described subsequently, revealed additional meanings associated with the paternal transference.)

Other aspects of his relationship to his mother were replicated in the transference as well. Dr. B 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, which had intensified the pressure to act in the face of perceived disappointment in the maternal figure.

This conflict emerged in the transference in the following way. On one occasion, he made a humorous remark and, in response, I laughed. After a moment, he became preoccupied with whether he had manipulated that reaction out of me and thereby caused me to lose my “analytic neutrality” or whether he had actually made up my reaction altogether. (Here, his defensive undoing momentarily caused him to question his perception of reality; that is, had I laughed, or was it his fantasy?) In this way, he recapitulated the dynamic of simultaneously feeling powerful but destructive (by causing me to err) or feeling he had no effect on me at all. He was unable to enjoy giving me pleasure without attacking himself, as if the wish for me to enjoy him was bad. Instead, he rendered himself inefficacious in his mind to avoid the awareness of his sadistic wish.

Despite an intense conviction that I was hostile toward him, Dr. B was unaware of aggressive and hostile fantasies toward me. He was exceedingly moralistic and would not tolerate destructive wishes toward me or anyone else, even on a fantasy level. After several years, he reported a fantasy of revenge toward a hostile coworker. He then remarked, “I’d prefer that the image not be associated with a destructive impulse—I need something to come between,” as if something could prevent him from the awareness of these wishes.

Dr. B’s conviction that I was hostile toward him also reflected facets

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of a paternal transference and was notable in that he was readily accepting of my perceived hostility. He frequently prompted me to agree with his poor self-image by referring to himself as narcissistic or grandiose, smiling slightly when recounting self-deprecating stories as if attempting to induce me to agree with him that he was bad and that his masochistic attitude toward himself was good. In our discussions of this, he wondered whether he was in fact, seeking to be punished, feeling that he had never struggled or endured a “rite of passage” into manhood, as he imagined other boys had. He wondered whether his behavior was self-castrating to compensate for the absence of the wished-for Oedipal phallic father.

A later development in the paternal transference occurred when he began to experience me as the more gratifying, collusive father. He remarked on my “unconventional hair,” which led to a fantasy that I was conspiring with him to obtain his license back, in secret collusion with him against the licensing board. This led to memories of his father, grandfather, and uncle, who would engage in conspiratorial behaviors against his domineering mother, all carried out with the implicit demand “not to tell.” This experience of me revealed another meaning of the wink: an indirect acknowledgment of our “conspiracy.” The childhood experience had apparently become internalized as a split in superego structure in which gratification of wishes was prohibited in one part of consciousness yet permitted in another.

As Dr. B became more tolerant of a positive connection between us, erotic longings with underlying pre-oedipal wishes emerged. In one session, he expressed the wish that we go to conferences together, walk along a beach, and stay in a motel. He quickly became sad and noted his avoidance of eye contact “because I want your acceptance and recognition so badly it hurts.” Tearfully, he commented that the yearning would just lead to more yearning, making him feel helpless and passive. He concluded, “Therapy is a place where I can get what I want yet feel tortured at the same time.”

Conclusion

The shift to a two-person perspective in contemporary psychoanalytic theory has broadened awareness of the therapist’s involvement within the treatment frame. For some, this has broadened technique, for example, the extent to which a therapist may self-disclose (cf. **Davies, 1994; Renik, 1995**). These modifications in theory and technique, as well as the prevalence of sexual misconduct, raise intriguing questions about what is

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meant by the analyst’s or therapist’s involvement, especially in relation to neutrality (cf. **Hoffer, 1985; Hoffman, 1994**) and countertransference as a capacity to respond to the patient’s promptings (**Davies, 1994; Levine, 1997; Sandler, 1976**).

In the countertransference, the demarcation between fantasy and action can be broadly or narrowly drawn, expanding or restricting the space for the therapist's involvement on an overt level. However, the therapist is always involved, whether or not his or her involvement is expressed directly. Sexual misconduct represents a breakdown of the frame such that, from the therapist's point of view, the realm of affective engagement on a conscious, experiential level is restricted and enacted concretely.

Although it is possible to describe factors that may increase the risk for the loss of boundary between fantasy and action, the question of what accounts for the breakdown of controls can be answered only in the context of a particular case. For any one individual, risk factors may increase the internal pressure to act, but these risk factors are not predictive if viewed outside the context of the individual's particular psychic organization. Although vulnerabilities may be observed, these factors do not necessarily outstrip the capacity for containment or control, even in the face of intensified pressure toward action.

The degree to which affect and impulses are integrated within a coherent self-structure delimits the capacity for containment. An individual's psychic organization, considered from a one-person perspective, must be coherent and integrated if it is to be capable of affect containment, a prerequisite for mutual, two-person engagement. Fantasies associated with conflicted identifications, for example, may be defensively disowned and thereby occupy a space outside the conscious boundaries of the self. Or intolerable affect and impulses may be compartmentalized, the boundaries demarcating a hated or feared "other self" enacted only in certain forbidden contexts. Thus, the capacity to tolerate the full range of affect is inherently connected to the coherence and integration of self-structure.

For therapists and analysts, such integration is necessary to maintain a background of containment and holding while bringing into focus the transferential and countertransferential elements that arise from each person's past. Simultaneously, the therapist or analyst and the patient are involved in the "intersubjective creation of a new reality," an ordinary relationship and the mode of relating framed by the therapeutic endeavor (**Modell, 1991**). The therapist or analyst strives to maintain an awareness of these simultaneous yet irreducible levels of reality as neither mutually exclusive nor more or less real (J. Slavin, personal communication, January 7, 1997).

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All levels may be influenced by transference and countertransference as well.

Tolerating the irreducible tension among these levels allows for the greatest openness to the patient's experience. In the case discussed, however, the therapy relationship was experienced by the therapist as replicating an intolerable childhood scenario involving early unmet needs and anticipated hostility. This stimulated a sadomasochistic solution in the therapist because of his need to dominate the relationship, a solution that evoked self-representations and object representations that were essentially outside the boundaries of a conscious and coherent self-structure. In this way, the therapist was disconnected from his past and lost awareness of the transferential and countertransferential influences as such. The repetition of the past was mistaken for a created new reality, one that required the therapist's overt participation if he was to maintain control of the relationship. It was, in essence, a sadomasochistic relation in that it involved the annihilation of the patient's subjectivity and required her submission to the therapist's needs (**Benjamin, 1988**).

Unfortunately, when therapists are at risk for engaging in sexual intimacies, they may be least likely to obtain consultation. This is presumably related to their fear of exposing inappropriate feelings and their shame at losing the capacity to maintain the boundaries of the therapeutic frame. In some cases, the resistance to obtaining consultation may also be related to an anticipation of being told to end the relationship (G. O. Gabbard, personal communication, July 1, 1994). The inherent difficulty in sustaining the irreducible tension among the multiple levels of the therapist-patient dyad (**Modell, 1991**) should be more openly acknowledged. This would encourage therapists to view periodic consultation as an expectable need for all involved in intensive and mutually absorbing engagement with their patients.

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