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## **ANALYSTS WHO COMMIT SEXUAL BOUNDARY VIOLATIONS: A LOST CAUSE?**

The causes of sexual misconduct by analysts are discussed, as is the viability of rehabilitation for different types of transgressors. Common misunderstandings about the transgressor (such as the assumption of psychopathy and the likelihood of multiple offenses) are countered with a summary of data derived from the evaluation and/or treatment of over two hundred cases, most of them one-time transgressors. The typical characteristics of the analyst or therapist who engages in sexual misconduct are presented and discussed as qualities that are to some extent present in analysts generally. The temptation to deny this universal vulnerability is viewed as effectively replicating the kind of vertical splitting or compartmentalization that makes one vulnerable to sexual misconduct in the first place.

**S**exual misconduct is not a problem we can observe from a comfortable distance. The analyst who becomes sexually involved with a patient may be a former teacher, supervisor, colleague, or friend. Moreover, the persistence of this problem, even among the most highly educated, respected, and trusted of us, requires a microscopic examination that may be painful, humbling, and at times threatening. Perhaps this explains why, until this past decade, the problem has eluded our attention despite having been identified since the dawn of psychoanalysis.

Any question regarding rehabilitation, whether or not one considers it viable, presupposes both a general and a specific (case-based) understanding of the origin of sexual misconduct. We will discuss here both

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the causes of the problem and the prospects for rehabilitation, since both of us have had substantial experience in assessing and developing rehabilitation plans for this population. We also address certain misguided assumptions that are often made about sexual boundary violations by analysts and therapists. We are summarizing our combined experience evaluating and/or treating over two hundred cases of physicians, mental health professionals (including analysts), and clergy who have committed sexual boundary violations. It is our impression that a carefully monitored rehabilitation plan can be successful if certain factors are present at the time of the initial evaluation. However, we recognize that such efforts are futile where the potential for rehabilitation does not exist.

Sexual misconduct is commonly misunderstood. This misunderstanding is particularly apt to surface when a shocking or confusing case comes to light. The misunderstanding often involves three assumptions: (1) therapists and analysts who have engaged in sexual misconduct are probably psychopathic; (2) they have likely exploited more than one patient; and (3) they are not amenable to rehabilitation. While these three assumptions are indeed valid for a specific subgroup that accounts for a substantial number of victims, this profile does not fit the majority of transgressors.

In our combined experience, most cases do not fit the psychopathic profile, either at the descriptive level or on the basis of deeper, psychoanalytic understanding. Additionally, a review of the literature on this topic reveals that all of those who systematically evaluate significant numbers of transgressors come to the same conclusion. Schoener et al. (1989) have found, as we have, that a myriad of complex factors go into sexual misconduct and that psychopathic predators constitute a minority of transgressors. One of us (AC) has treated, supervised, evaluated, and/or consulted with 48 therapists or analysts who have engaged in sexual misconduct. Of these, only a small subset were multiple transgressors ( $n=12$ ; 25%), while the remaining 36 (75%) were one-time transgressors who had been involved in an ostensibly romantic long-term relationship. While we are not suggesting that these relationships are based on mutual or healthy modes of relating (despite frequent reports by the patient-victim of having consented to the relationship at the time), we are asserting that most therapists or analysts are not predatory. The other coauthor (GG) has evaluated, treated, or consulted with over 150 therapists, analysts, and

pastoral counselors who had engaged in sexual relations with a patient. Fewer than 25 percent were psychopathic or severely narcissistic predators. Moreover, not all of those involved with more than one patient could be characterized as psychopathic.

The objection can be raised that those sent for evaluation, treatment, or supervision are a skewed sample. Many psychopathic predators do not admit to the misconduct (even when multiple complaints are lodged) and refuse evaluation and/or treatment. Our data are consistent, however, with the findings of Schoener et al., whose experience over the last twenty years (with mental health professionals of all disciplines) often involved clinicians against whom one or more complaints were lodged and for whom rehabilitation was not viable.<sup>1</sup> They report that more than half of their cases involve single-victim transgressors who present with genuine remorse and are recommended for rehabilitation (Schoener, personal communication, August 18, 1991). Gartrell et al. (1987) found in their prevalence study that single-victim transgressors accounted for 66 percent of the transgressors they identified.

These findings have been reported in the literature over the last twenty years in a wide variety of journals, including psychoanalytic ones (Gabbard 1995; Celenza 1998; Gabbard and Peltz 2001). It is our impression, however, that much of the psychoanalytic community ignores such data. Misunderstanding appears to be especially widespread when institutes or overseeing professional organizations are required to adjudicate a prominent member of their group. It appears to us that when members of an institute are confronted with a shameful and shocking case, previously grasped knowledge about the nature of sexual misconduct seems to vanish and the stereotype of the psychopathic predator becomes the only explanation available.

This reaction invites the question of why these data have not been integrated into our general understanding in an enduring way. We believe that some of the problem lies in the dramatic presentation of the psychopathic predator. He (such transgressors are almost always male) captures our attention by committing perverse, egregious acts and by seducing a large number of victims. Such cases are also highly publicized in the media, by virtue of the lawsuits that invariably follow.

<sup>1</sup>An often cited prevalence study (Holroyd and 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 also made use of the term *recidivism* in an idiosyncratic way to denote multiple offenses.

Perhaps of greater significance is the sense we often share that these transgressors are different from you and me, at least on the surface. Because their overt grandiosity and psychopathy inspire a defensive disowning, an “us versus them” attitude, their behavior is with relative ease dismissed as a threat to our professional identity. These boundary violations are intentional and premeditated, and appear to cause no pangs of conscience in the transgressor. It is difficult for us to conceive of engaging in such blatant self-deception. Our resorting then to the psychopathic profile to explain all cases of sexual misconduct may be seen to involve at least three problematic tendencies. The first is the temptation to master our confusion by simplifying a complex problem. Second, the maneuver serves our need to have idealized figures in our midst by dismissing the analyst in question as not only fallible but fatally flawed (with the implication that our idealized role models remain pure and untainted by comparison). Finally, and most problematic, the psychopathic profile denies our own fear of vulnerability by sharply demarcating the type of character who engages in transgressive behavior. We are thus reassured that this cannot happen to us.

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In contrast, the profile of the one-time transgressor is, at least on the surface, too much like you and me. While most of us might still have difficulty imagining ourselves engaging in frank sexual behavior with a patient, it is much easier to resonate with the particulars of this type of case; we too have found ourselves in a transference-countertransference dilemma, and have entertained the fantasy of extreme measures that might solve an acute crisis. There are typical precipitating factors in this subgroup, most of which we can understand. We can all recall times when we crossed minor boundaries in a similar circumstance with a similar patient. Examples of such crossings come easily to mind but are usually shared only in private, informal contexts with colleagues and friends.

Another reason this profile is not securely fixed in our minds is that the analysts and therapists in this group can be cooperative and genuinely remorseful about their transgression. In addition, the analyst or therapist himself often has trouble advocating on his own behalf and defending himself effectively.<sup>2</sup> The adjudication of these cases therefore is often “silent,” absent media attention or secondary complications.

<sup>2</sup>Masculine pronouns are used because most of the transgressors referred to us are male. However, we will briefly address particular characteristics of women analysts who have engaged in sexual misconduct.

Even with those who do not initially present with remorse and are uncooperative with the assessment process (at least in the beginning), we have found that much of what determines the decision to rule out rehabilitation is related to the particular time in which the assessment or adjudication occurs and the way in which the transgressor presents himself. Those who remain attached to the patient, who still view the relationship as based on a special type of love, may feel an untoward (and, from an outsider's perspective, incomprehensible) reaction of betrayal and victimization by the patient-complainant. This reaction is particularly common when the transgressor had terminated the therapeutic relationship and so, in *his* mind, had adequately dealt with the boundary transgression and power imbalance. The transgressor may also feel attacked or threatened by the ethics committee or overseeing professional organization and may continue to rationalize or defend his behavior in response to the perceived attack. He may temporarily minimize the damage to the patient-victim, thereby presenting himself in a particularly unsympathetic way.

It is understandable for anyone being sued to experience anxiety over the prospect of an investigation. This reaction may heighten defensiveness and cause attempts at self-defense to include angry counterattacks. Charges of ethical violations, founded in truth or not, engender extreme anxiety, defensiveness, and even rage, as one's livelihood and professional reputation are threatened. Under such stress, people often behave in extreme ways that may not be typical of them and that present them in an unfavorable light. While people have characteristic ways of reacting to stress, we have found that these reactions taken alone are incomplete and misleading indicators of the professional's competence and underlying character structure. Extreme reactions—bona fide posttraumatic stress reactions occasionally accompanied by suicidal ideation—are not at all unusual, but are usually short-lived if the assessment process can be experienced as an attempt to understand the complexity of the process (while still holding the transgressor fully responsible). Some uncooperative transgressors may eventually become cooperative and amenable to rehabilitation, but the personal acceptance and ownership of what they have done may take some time. Still, it remains true that rehabilitation is not an option until this acceptance occurs. For some transgressors, the acceptance of full responsibility for the misconduct never comes to pass.

We believe that the role of the patient-victim, especially in the case of the one-time (i.e., single-victim) transgressor, warrants efforts both to understand the misconduct as a transference-countertransference enactment and to revise (as necessary) the conventional wisdom regarding sexual misconduct. Note that our perspective places no responsibility for the misconduct on the victim's shoulders. It does, however, attempt to understand the obstacles to integrating the complexity of the problem within our professional psyches and in the general public as well (see Gutheil and Gabbard 1992). To put matters simply, the profile of the psychopathic predator coincides with sex-role stereotypes, avoids a politically incorrect "blaming the victim," and perhaps, more subtly, appeases the enraged and potentially litigious patient-victim in the case at hand. However, this stereotyped scenario obfuscates our efforts to understand fully the role of both parties in co-constructing the transference-countertransference enactment.

Finally, the problem of the one-time transgressor involves subtle and covert defensive processes, along with denied or disavowed impulses. The dynamics are not easily explained, especially in cases of respected and trusted leaders of psychoanalytic organizations. Many one-time transgressors lack the charm and charisma of the predator. Transference-countertransference scenarios in these cases are neither immediately accessible nor easily formulated; nor are they easily held in mind, especially when we consider that the analyst has been previously analyzed, may be a training analyst, or has even held positions on ethics committees. The defensive splitting or compartmentalization that must be posited here is of a type we usually attribute to more primitive personality organizations.

### **COMMON CHARACTERISTICS OF SINGLE-VICTIM CASES**

The following is a presentation of the characteristics typical of the analyst or therapist who engages in sexual misconduct with only one patient. In order to reflect the complexity and diversity of such cases, we find it helpful to conceptualize them as occupying a spectrum, with lovesickness at one end, masochistic surrender at the other, and many positions between these extremes showing elements of both (Gabbard and Lester 1995). We also present common precipitating scenarios that often provide the context within which the misconduct occurs.

Some of these aspects are situational, either in the life of the analyst or therapist or in the therapeutic context. Others are deep-seated personality characteristics or defensive styles that appear to represent long-standing vulnerabilities in the character of the transgressor. Still other elements are best described as intersubjective, as arising from within the codetermined transference-countertransference enactment of the treatment dyad.

The psychopathology of these analysts is variable. Most have narcissistic and masochistic issues, but these may not be apparent. Depression or despair may be overt or just beneath the surface. Omnipotence and grandiosity may also be at work. However, we are reluctant to pathologize this spectrum of analysts. Who among us can claim to be entirely free of similar struggles? Indeed, one could argue that a healthy dose of grandiosity is necessary to treat our most disturbed patients.

From the point of view of the analyst or therapist, the sexual involvement with the patient represents a one-time occurrence. By this we mean that though the relationship may continue over time (from weeks to years), there is only one patient with whom he has engaged in sexual misconduct. Boundary crossings with other patients may be reported, but these are not generally beyond the type or level that are committed at one time or another by all of us. It is common for a transgressor's other analysands to report acceptable analytic work being done concurrently with his ongoing sexual relationship with that one patient. In other words, the misconduct, though an extreme ethical violation, can occur in an otherwise ethically sound and competent practitioner.

For the lovesick group, the sexual relationship is experienced by both participants, at least for a time, as a true love affair. They usually share a fantasy that each is rescuing the other and that they are soul-mates who understand each other's needs like no one else. Rationalizations are employed, especially by the analyst or therapist, to support the therapeutic nature of the relationship (Celenza 1995). Role reversals occur in which the analyst or therapist discloses personal problems to the patient, often justifying this by citing examples of famous analysts (e.g., Ferenczi, Winnicott, or Jung) who had similarly transgressed. Finally, the analyst or therapist is typically in the midst of a life crisis such as divorce, a lifeless marriage, illness or death in the family, the suicide of a patient, malpractice litigation, or bankruptcy (Gabbard and Lester 1995).

Intrapsychic factors vary, but common themes have been observed (Twemlow and Gabbard 1989; Gabbard and Lester 1995; Celenza and Hilsenroth 1997; Celenza 1998). A prominent intrapsychic factor in many cases is unconscious guilt in a male analyst or therapist, usually coinciding with a childhood history of having felt responsible for his mother's unhappiness. Needs for mirroring, affirmation, and recognition may have been neglected early in life. The analyst or therapist thus presents as a narcissistically vulnerable person who looks primarily or even exclusively to professional activities and relationships for sustenance and affirmation of self-worth.

Many clinicians on this spectrum display a compensatory grandiose defensive structure that functions in a covert, disavowed manner (such as identifications with a martyr-like "Jesus" imago or heroic and idealized self-representation). The therapist may enact this structure in a self-depriving and self-destructive rescue fantasy. The sexual misconduct represents one such enactment and often stems from conflicts around omnipotence, grandiosity, or neediness established as long-standing characterological features. Superego lacunae may coincide with this state of mind (a structural mechanism organized by a vertical split with separate id, ego, and superego features) whereby certain behaviors that are usually prohibited are permitted in the context of the misconduct. This contributes to a "slippery" type of morality different from that of the psychopathic character, whose immorality is based on a more stable and ego-syntonic absence of conscience.

A common theme in this group is a great intolerance of aggression, an intolerance stemming from childhood family situations in which conflict and aggression were not acknowledged, tolerated, or expressed. This difficulty in tolerating anger and destructiveness may occur within the context of a highly moralistic (or even frankly religious) family with a high level of constrained or unacknowledged conflict. While many pastoral counselors describe this background, we have found that similar childhood histories are common in analysts and therapists as well.

On an interpersonal level, it is important to recognize that for this type of analyst or therapist the treatment situation is experienced as a replication of the childhood trauma (in both preoedipal and oedipal configurations) in the sense that it is at once overstimulating, depriving, and forbidden. Often the analyst experiences the treatment of the patient with whom he eventually transgresses as especially challenging

and frustrating, such that the patient takes on the persona of a “bad” maternal object.

The transgression with the patient can be understood as an attempt to manage and dominate (through sexualization and triumph) the patient’s aggression, as well as the analyst’s own. On a conscious or unconscious level, the transgression can function as a masochistic surrender to the patient’s hostility, experienced by the analyst or therapist as intolerable and unbearable because of the way it replicates (for him) the despair experienced within the mother-child dyad. The sexual misconduct, then, establishes a sadomasochistic relationship that includes a projection of the analyst’s aggression into the patient, rendering the analyst masochistically tied to the patient’s cruelty and control. This description of masochistic surrender is not a sanitized way of explaining or excusing the transgressor’s or therapist’s behavior. It is an attempt to formulate the defensive transformations of his aggression, which have resulted in a pathological compromise formation, perhaps of the kind to which we may all be vulnerable.

By examining common transference-countertransference dynamics, we are in no way attributing any ethical responsibility to the patient for their actualization. It is our experience, however, that many of the victims in these cases are actively suicidal at the time of the misconduct, lending an urgency to the treatment. Thus, sexual misconduct can often be understood as an egregious mismanagement of suicidality (Eyman and Gabbard 1991; Gabbard and Lester 1995).

Many patients who are victims of sexual misconduct have histories of severe childhood trauma. For some of these patients, the enactment with the analyst is experienced as a loving and protective act, a sacrificing of herself to meet the analyst’s needs. Just as the patient may have rescued an abusive parent in childhood, so she may seek to rescue the analyst from his depression and despair (Gabbard and Lester 1995; Apfel and Simon 1985). We have found that such a rescue fantasy in the patient often defends against awareness of her own competitiveness, envy, and destructiveness, all of which, of course, remain unexamined in the context of the misconduct.

Many patient-victims also fall into the diagnostic spectrum of Cluster B personality disorders or dissociative disorders. As we all know, treatments of such patients are among the most challenging for any analyst or therapist, and phases of suicidality are often part of the process. The prospect of the patient’s suicide may arouse narcissistic

mortification and separation anxiety in the analyst, who feels he must do anything in his power to avoid losing the patient. The patient's deep sense of abandonment and intense ambivalence about closeness may also stir up countertransference hate in the analyst or therapist (see Maltzberger and Buie 1974).

Most of us abhor being cast in the role of the bad object and deny the hatred engendered in response to the patient's transference hate. In such a situation, we may choose to provide a defensive form of love that directs all of the aggression in the dyad to an outside party, usually the malevolent father or mother. This "disidentification with the aggressor" (Gabbard 1997) maintains our professional identity as a helpful and benevolent professional rather than a loathsome practitioner who is hostile toward or overwhelmed by a difficult patient. Overreliance on reaction formations of this nature is a problematic defensive style that we regard as a potential precursor of therapist-patient sexual misconduct (Celenza 1995, 1998).

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The threat of suicide, of course, is the ultimate injury to the therapist's sense of professional mastery and self-worth. Patient and analyst may collude in the magical hope that the therapist has a capacity to omnipotently heal the patient's lifelong sense of badness and self-loathing. Meanwhile, the patient may secretly sense the therapist's defensive posture and recognize that enormous feelings of hatred lie just beneath the surface. The therapist's despair and rage at the patient's tendency to thwart all therapeutic efforts may lead to an escalation of boundary transgressions under the impression that only extraordinary measures can reach the patient. Sexualization may transform such despair into something exciting and positive (Coen 1992; Gabbard 1996). Ultimately, the childhood trauma is repeated through sexual boundary violations under the guise of "loving" the patient back to health.

In addition, the analyst or therapist may be prone to feeling intensely degraded, as indicated by the warding off of his own hostility and its projection into the patient. The analyst or therapist may engage in a hypomanically charged fantasy of being special to the patient, a fantasy that is fueled in part by the analyst's or therapist's reaction-formed hatred of the patient. Often in the course of a rehabilitative treatment process the analyst or therapist comes to recognize his escalating sexualization as an attempt to avoid the countertransference hate generated by the patient's undermining efforts, depressive despair, and frank suicidal threats (Celenza 1991, 1998).

## ASSESSING THE POTENTIAL FOR REHABILITATION

Any discussion of rehabilitation potential must begin with the acknowledgment that many analysts and therapists who have committed sexual misconduct are simply not amenable to rehabilitation. They may have serious character pathology, complete lack of remorse, and no motivation to examine their role in what has occurred. Others may deny the charges. Assessment under such circumstances is futile since the transgressor refuses to acknowledge a problem for which a rehabilitation plan is a solution (Schoener et al. 1989; Gabbard and Lester 1995). However, many analysts and therapists *are* amenable to rehabilitation, and the presumption that all such professionals are beyond redemption is unwarranted.

Independent assessments have become standard practice in the area of sexual misconduct cases (Schoener et al. 1989; Schoener 1995; Gabbard and Lester 1995). Because of the intense reactions of the psychoanalytic community to a transgressing analyst, the capacity for a local colleague to make such an assessment with any degree of objectivity is seriously in question; for that reason, independent comprehensive evaluations are usually provided by experienced colleagues in other locations. These evaluations are sometimes requested by a licensing board, sometimes by an advocacy organization (such as a physicians' health organization associated with a state medical society), and at other times by the ethics committee of a psychoanalytic society or institute. Transgressors themselves occasionally request such an evaluation when they realize they have made an egregious error in judgment and want to ensure that boundary violations do not occur in the future. Analysts who perform these assessments should have demonstrable expertise in the area of boundary violations, because evaluating the potential for rehabilitation is complicated and difficult.

When an analyst is referred for evaluation, all parties must understand that rehabilitation is clearly distinguished from any disciplinary measures or sanctions from an ethics committee, licensing board, or professional organization. In other words, the possibility of rehabilitation is not to be regarded as a way to evade punishment or substitute for it. The analyst performing the evaluation should have no personal or professional ties to the transgressor and should have no stake in the internal concerns of the referring organization or institute. The analyst

who is being evaluated must sign a release of information at the beginning of the assessment so that the evaluator can communicate the findings of the evaluation to the referring body. When transgressing analysts themselves request the evaluation, of course, no report is made to anyone except the analyst requesting the consultation.

Before an evaluation begins, most evaluators will insist on having collateral information about the boundary violation. The boundary-violating analyst may have a perspective widely divergent from that of the victim, and both perspectives are essential to reach conclusions in these Rashomon-like situations. In addition, investigative reports by licensing boards, written statements by family members of the patient, and perspectives supplied by the transgressing analyst's colleagues are all valuable. Some assessors will insist also on evaluating the spouse of the transgressing analyst, as marital difficulties are frequently part of the overall context. Collateral interviews may be conducted in person or by telephone, but letters or written reports are discouraged so that subtle implications and nuances in tone may be followed up.

628 At some centers the evaluation is done by a team that includes an analyst, a psychologist responsible for testing, and various consultants in specific areas of expertise, such as substance abuse, affective disorder, or complicated marital dynamics. Some evaluators work independently and collect all the information on their own. Most evaluations take several hours over two or three days, although some require more extended periods. In the course of the evaluation, a detailed account of the misconduct is constructed from the transgressing analyst's point of view, with an emphasis on the analyst's current understanding of what happened and why. Discussion of the analyst's understanding of why it is unethical to engage in sex with a patient is an essential aspect of the evaluation, though it frequently happens that the transgressor recites a sound but intellectualized rendition of the ethical code. In addition, the analyst's personal life circumstances, recent stressors, and difficulties in intimate relationships with spouses or partners are essential information.

Despite disparities among various accounts, evaluators must frequently remind both the transgressing analyst and the referring body that they are not a court of law and cannot determine the actual facts of what happened. Thus, the purpose of the evaluation is not to "find the facts" but to assess psychopathology in the analyst and the psychodynamics that are relevant to the misconduct.

Many analysts under evaluation feel they have been traumatized by the process of adjudication in their local setting and may plead their case to the evaluator that they are more “sinned against than sinning.” It is important for evaluators to empathize with what the analyst has been through and to make it clear that they are genuinely interested in the transgressing analyst’s point of view. Analysts who conduct the independent assessment must often struggle with countertransference wishes to rescue the transgressing analyst; contempt toward the analyst; anger at the mismanagement of the misconduct by the local institute or society; collusion with the transgressing analyst against the patient, who may be seen as “seductive”; and disbelief when the details are recounted (Gabbard and Lester 1995). In such cases, the evaluator may wish to seek consultation with an experienced colleague who is knowledgeable about boundary violations.

The assessment of rehabilitation potential hinges more on the attitude of the transgressor than on objective facts provided to the assessor. An essential characteristic that argues for a potential for rehabilitation is the presence of genuine remorse. Does the transgressor take full responsibility for the misconduct and demonstrate that he or she profoundly regrets what happened? Can he or she empathize with the damage inflicted on the patient and on the profession? Analysts who are remorseful show the capacity to evaluate their behavior and often recoil in horror at the rationalizations they employed, the compartmentalization of their behavior that they used, and their contextually shifting values. While some analysts may not have reached this point by the time of the evaluation, they are often progressing in that direction, and this may become apparent to the evaluator.

Remorse must be rigorously differentiated from narcissistic mortification. The latter refers only to regret for the ways in which the misconduct has damaged one’s sense of self-regard, self-worth, and reputation. Narcissistic mortification is present to some degree in most transgressing analysts, but an absence of appreciation for the damage brought to the patient and to the profession is a disturbing sign. Similarly, the assessment of whether remorse is genuine or feigned is crucial. Often the way the transgressor speaks about his responsibility may be more useful than the actual narrative of the misconduct. Evaluators look for an attitude of curiosity about his behavior, a sense of shock at the way his own values have been betrayed, and a desire to explain the behavior without disclaiming responsibility.

Other signs of rehabilitative potential may be found in the way the transgressor behaved during the enactment itself. Evidence of restraint such as terminating the therapeutic relationship, stopping the acting out at some point, or referring oneself for evaluation or treatment may indicate such potential.

Finally, the assessment process entails some efforts to enlist the transgressing analyst in a collaborative exploration that has a therapeutic component. Trial interpretations of the misconduct may be offered to discern whether the transgressing analyst is ready and willing to reflect on meanings relevant to understanding what happened. In other words, a process is begun in which the analyst who is undergoing evaluation is pointed in the direction of intensive therapy or further analysis.

As a general principle, transgressing analysts who are on the continuum from lovesickness to masochistic surrender are much more likely to be amenable to rehabilitation than those who are predators. Nevertheless, the categories sometimes overlap, and even those who may be passionately in love with the patient may have significant superego pathology that renders them unsafe to practice. Hence the fact that only one victim was involved does not automatically imply that the analyst is amenable to rehabilitation. Moreover, lovesick analysts who insist that there is nothing fundamentally unethical in their misconduct and that they are simply involved in “true love” lack the reflective capacity to undergo a rehabilitation process. At a later point the situation may change.

Our major focus has been on analysts who are men, largely because they constitute the vast majority of the boundary violators referred to us. Female analysts and therapists, though, are responsible for about 15 to 20 percent of the cases we see. Some of the dynamics specific to this gender have been elaborated elsewhere (Gabbard and Lester 1995), but much of what we have described about the continuum from lovesickness to masochistic surrender applies equally to female clinicians. They are often intensely involved in a rescue effort with a particularly difficult patient, and their overidentification with the patient’s suffering leads them to heroic and misguided treatment efforts. In our experience, the patient with whom the female therapist becomes involved is as likely to be female as male. Most of the female boundary violators we have seen are involved with only one patient. Because predatory psychopathy is rare in women, the potential for rehabilitation among female transgressors is particularly promising.

## THE REHABILITATION PROCESS

Does rehabilitation work? We have seen numerous examples in our experience that convince us that in many cases it can be effective. However, we accept that no data will ever satisfy the skeptic, because follow-up information is limited to independent and measurable events such as the subsequent filing of complaints or the revocation of one's professional license. An analyst's self-report of no subsequent transgressions and meticulous attention to the maintenance of professional boundaries is often entirely convincing to the rehabilitation team, but would not satisfy a skeptical scientist because of the possibility that the transgressor is concealing subsequent violations. Self-report, in any case, cannot be regarded as the sole outcome measure in a well-designed empirical study. Still, it is our experience that rehabilitation processes can result in an expansion of the transgressor's insight, affect tolerance, and self-control such that he can be regarded as a trusted and valued colleague and practitioner. Further, due to the intensive self-scrutiny involved in the rehabilitation process, some former transgressors may end up with a keener appreciation of the subtleties of boundary management than has the average practitioner who has never transgressed.

Rehabilitation plans are individually tailored to the specific situation of the analyst being evaluated. Typical components of such a plan include the following (Gabbard and Lester 1995).

*Assignment of a rehabilitation coordinator.* A rehabilitation coordinator is assigned to monitor the overall plan and make any necessary reports to licensing bodies, professional health organizations, or other monitoring bodies. This position is usually held by an analytic colleague knowledgeable about boundary violations and agreeable to interviewing the transgressing analyst at regular intervals. The position must not be filled by a friend of the analyst undergoing rehabilitation. The coordinator may receive reports from supervisors. Assigning the reporting function to the coordinator allows for (1) a synthesis of potentially disparate points of view (in the case of multiple supervisors as well as mentors, educators, or other persons involved in the rehabilitation) and (2) in the case of the treating analyst, a more narrow breach of confidentiality as compared to reporting to the overseeing professional agency directly.

*Individual psychotherapy or psychoanalysis.* The transgressing analyst must return to treatment to explore the factors that led to the

boundary violation and to discuss any difficult countertransference situations that arise as he or she returns to practice. The reports of the treating analyst go to the coordinator and are generally limited to one-sentence statements of whether the patient is attending the treatment or whether a premature termination has occurred. Some licensing boards try to encroach on this confidentiality, but the treatment is irreparably compromised if the analyst undergoing rehabilitation knows that frank disclosures of erotic countertransference will be reported to a monitoring agency. In the ideal rehabilitation plan, the treating analyst only reports attendance to the coordinator.

An important component of this treatment usually is the thorough exploration of the transgressor's negative transference to the treating analyst, especially as it involves aggression, competitiveness, and struggles over power and authority. To aid in the identification of problematic areas, the treating analyst or therapist is encouraged to request and read a copy of the evaluation before beginning the treatment. However, there may be an explicit understanding that the report, to guard against intellectualizing the treatment process, will not be shared with the transgressor.

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*Supervision.* In most rehabilitation plans, one or more supervisors may be assigned to the analyst. The analyst being rehabilitated should not be allowed to choose these supervisors unaided, lest personal friends or sympathetic colleagues be chosen. The rehabilitation coordinator or the oversight body usually selects two or three supervisors with appropriate expertise among whom the transgressor may choose.

Each supervisor should be thoroughly familiar with the independent assessment and with the circumstances of the transgression. Supervisors must focus on blind spots in their supervisee and should examine boundary issues as they arise. An understanding of the misconduct and the management of boundaries in general must be the principal goals of the supervision. Usually, special attention is paid to enhancing the transgressor's appreciation of power imbalances and ability to identify, tolerate, and manage countertransference hate and anger.

*Practice limitations.* Depending on the evaluation, some analysts may be allowed to work only with certain subgroups of patients. In extreme cases, for example, a male analyst may be limited to treating male patients. More commonly, an analyst's practice might be restricted in such a way that patients with severe childhood trauma and severe personality disorders are referred elsewhere. Some analysts thought

to be at high risk in an independent practice situation may be limited to work in an institutional or group practice setting.

*Education.* Many analysts have very little education about professional boundary issues. Tutorials or seminars in ethics and boundaries may be useful as part of the overall strategy. However, it has been our experience that this aspect of the rehabilitation plan addresses only conscious intellectual factors that are easily denied.

*Mediation.* In some cases an evaluator may decide that a mediation process is indicated as part of the rehabilitation plan. An experienced analyst knowledgeable about boundary violations meets with the patient and the transgressing analyst for several sessions to provide an opportunity for the patient to recount how he or she experienced the betrayal by the analyst. Such feedback to the transgressing analyst may help him or her empathize with the impact that the transgression has had on the victim. Mediation also provides an opportunity for the transgressing analyst to offer an apology to the patient. Finally, mediation often facilitates the reimbursement of the patient for fees spent on a process that was seriously misguided and harmful. Such restitution may obviate the need for further litigation. However, the process of mediation should not be initiated as a substitute for the formal filing of a complaint by the patient. Mediation is much more effective *after* the patient's concerns have been heard by an ethics committee or similar body.

The duration of a typical rehabilitation plan ranges from three to six years (Gabbard and Lester 1995). Before the transgressing analyst can return to unsupervised practice, the analyst must undergo a careful reassessment. Sometimes the independent evaluator who made the original assessment is enlisted to reevaluate the analyst. In other situations, an independent assessment from a fresh perspective may be sought. The rehabilitation coordinator's regular reports to the ethics committee or oversight body may help determine at which point return to unsupervised practice is appropriate. Even in cases where rehabilitation has been successful, analysts who have undergone the program are advised to continue using supervisors or consultants as long as they practice.

### **CAN THIS HAPPEN TO YOU OR ME?**

One of the most common responses to news of serious boundary violations by a colleague is "I can't imagine how that could ever happen

to me.” Yet we are all more similar than different. The characteristics of the transgressor as outlined above do not have hard-and-fast boundaries between them. They often shade into one another. Elements of each can be found in the others, and we can find aspects of each in most of us. This raises again the persistent question, How different are these transgressors from you and me?

A useful way to address this question is to note the multilayered way in which the problem of sexual misconduct currently exists in our own minds. A common reaction on first hearing of misconduct is to disbelieve the allegations or to see the analyst as victim of a destructive patient. An extreme reaction that may follow is to demand the transgressor’s immediate expulsion from the analytic community. This reaction usually arises from an inability to imagine ever trusting the transgressor again, an inability or refusal to identify with his or her circumstances and state of mind, or extreme anger at the damage done to the reputation of the analytic community.

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Once the initial shock has worn off, however, questions linger in our minds as we struggle to come to terms with the problem. In response to the precipitating factors and in an attempt to put ourselves in the analyst’s place, we find ourselves saying, “I can resonate with this dilemma.” Then a countervailing thought emerges: “But I wouldn’t do *that*.” Another reaction follows: “I can imagine a fantasy of surrendering to . . .” or “With a patient like this, I *have* crossed . . .” And then a counterresponse: “But I can’t imagine feeling *that* way or *doing that*. What is it about him that’s different from me? He does have those inhibitions or that specific vulnerability.” And finally: “Is that different from me? Maybe yes, maybe no.”

Such obsessional ruminations are common in all of us. They are part of an introspective process in which we should all continuously engage as we monitor the impact our work is having on us. We believe that the “us versus them” mentality in effect replicates the very compartmentalization or vertical splitting that makes one vulnerable to committing boundary violations. It disavows vulnerability and, perhaps grandiosely, denies fallibility as well.

Another way to address the problem turns the whole question of sexual misconduct on its head. Rather than ask why sexual misconduct occurs, we might usefully consider why in most cases it does not. Love of one sort or another regularly finds its way into the intensely intimate experience of the psychoanalytic process. Why, then, aren’t

boundary violations more common? What are the safeguards most of us employ to prevent our crossing boundaries all the time?

The answer is not a simple one. A fundamental belief in the value of analytic treatment is essential. An altruistic determination to put the patient's needs ahead of our own is basic to the analytic process. However, we know that excessive self-deprivation over long periods can be a precursor of sexual misconduct. Regular use of consultation from trusted colleagues early in a process, before transgressions occur, may help prevent disaster.

We end by addressing the question in our title: Are analysts who have engaged in sex with their patients a lost cause? We think the question must be answered on a case-by-case basis. We are convinced, however, that many transgressors, perhaps even most, are amenable to rehabilitation efforts and that it is misguided to dismiss every analyst who has made a serious error in judgment. If these analysts are always a lost cause, then so are we all. The fundamental issue is this: Do we believe people can change? If we do not, we are in the wrong business.

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