Articles

SEXUAL BOUNDARY VIOLATIONS: A PSYCHOANALYTIC PERSPECTIVE

Howard B. Levine

ABSTRACT The problem of sexual boundary violations in psychoanalytic therapies was endemic for the founding generation of psychoanalysts and remains so for analytic therapists to this day. Its persistence in our field reflects the fact that each of us contains powerful unconscious forces that can drive us towards boundary crossings and boundary violations. Contemporary views of the analytic process, including the impossibility of neutrality, objectivity and abstinence and the therapist's irreducible subjectivity, are used to explicate the dynamic forces involved. Personal and institutional responses to sexual boundary violations are considered.

Key words: boundaries, boundary crossings, boundary violations, transference, countertransference, subjectivity, abstinence, neutrality, transference love, claustrophilic collapse, triangular space

In the 1980s and 1990s, the Boston psychoanalytic community was shaken by a series of disturbing scandals that received detailed coverage in the local newspapers.

- The widow of a psychiatrist, who was in therapy with an analyst after her husband was murdered by a psychotic patient, complained to the medical licence board and the psychoanalytic society that her therapist had initiated a sexual relationship with her.
- A senior supervising and training analyst, who held a position of extraordinary prestige and power within the professional and lay communities – he was known as 'the referral doctor' and reportedly did

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300–500 consultations and referrals for treatment each year! – was accused of having improper sexual relations with a female patient. When the accusation became public, several more of his female patients, past and current, came forward and joined the complaint against him.

- Years later, the analyst who led the ethics committee investigation which resulted in the expulsion of 'the referral doctor' from the analytic society was himself charged with having sexually inappropriate relations with a female analysand. He, too, left the society in disgrace and, several years after that, as incredible as it may seem, the head of his ethics committee investigation resigned from the society, when word of an affair with one of this analyst's female patients became public!
- An advanced female candidate, who had been trying to treat an apparently psychopathic, drug-addicted male medical student in an intensive analytic psychotherapy, was sued for malpractice by the patient's family after the patient committed suicide. In the ensuing discovery process, it was learned that the candidate had written numerous, encouraging, non-erotic 'love notes' to her patient in an attempt to support his shaky self-esteem and that the patient had broken into his therapist's office and stolen her personal diary, in which she had described in detail highly erotic dreams and fantasies concerning this patient. While all this was going on, the candidate was in analysis with a respected training analyst. Given the extremity of the situation – she once physically rescued her patient from a 4th floor window-ledge late at night, when he was intoxicated and threatening to commit suicide – it is reasonable to assume that her analyst knew about the treatment and the questionable turns it had taken, and yet there was no indication that he attempted to intervene or question his candidate's judgement. In addition, the candidate had obtained consultations about the case with highly respected senior clinicians known for their expertise in treating borderline and other primitive personality disorders and, as they testified in her behalf, these consultants supported her efforts and the direction of her treatment.

These were disquieting times for the general public, as well as the professional community. There were lurid headlines, allegations and exposés in our daily newspapers. Rumours of all sorts were rife. Patients and their families had been damaged. The public trust had been betrayed. Candidates and other patients who were, or who had been, in analysis or supervision with the offending analysts – indeed with *any* analysts – questioned the value of what they had experienced or learned. Psychoanalysts, already feeling marginalized and on the defensive, suffered a further loss of esteem, confidence and

credibility in the public eye. The psychoanalytic society affected by these events was deeply shaken. Of what use were extensive admission interviews and assessments throughout training or the carefully regulated and reviewed steps involved in progression, graduation and appointment to the faculty and position of training analyst, if these procedures were not adequate to the task of uncovering and addressing potential boundary violations and ethical problems? Why did the personal training analysis not offer sufficient protection against the forces that led to violations of professional ethics? What were the dynamics that produced such behaviours and how could we understand them? How could this have happened?

In response to this turmoil, a group of analysts began to meet to try to understand how and why such things could happen and what might be done to restore confidence, repair the damage and heal the wounds.[1] It became immediately clear to us that our city was not alone in this dilemma. Boundary problems and violations, especially sexual boundary problems and violations, had been – and continued to be – a part of the psychoanalytic landscape from the very inceptions of our profession. Recall Breuer's flight from the erotic transference of Anna O, the love affairs between Jung and Sabina Spielrein, Ferenczi and Elma and Gisella Palos, Ernest Jones and Loe Kahn, August Aichorn and Margaret Mahler . . .

The list of sexual liaisons, consummated and nearly consummated, between analysts, psychotherapists and patients seems to go on and on. The problem of boundary violations has not just proven to be an artefact of the early days of our profession, when personal analyses were relatively brief, professional ethical standards were being formulated and the risks inherent in this 'most dangerous method' (Kerr, 1994) were only beginning to be recognized. Nor could the problem be solely ascribed to the proverbial 'rotten apples' – predatory or psychopathic practitioners who become serial abusers. Although the latter do exist, many boundary violating analysts and therapists have been involved in only one such relationship and are found to be depressed, masochistic or lovesick individuals caught up in overpowering circumstances at particularly vulnerable points in their lives (Celenza, 2007; Gabbard & Lester, 1995).

There is an inevitable tendency to respond to sexual boundary violating therapists and analysts with moral outrage. When viewed through a psychoanalytic lens, however, the character pathologies, including psychopathic, predatory, perverse and narcissistic behaviours, of even predatory abusers have their determinants which, not infrequently, are organized around early traumatic circumstances. This origin does not imply that all conditions are therefore remediable by treatment, nor does it excuse or exonerate the transgressors. It does, however, emphasize the common humanity of the transgressors as well as the victims, and, in so doing, cries out for an attempt at understanding their behaviour rather than simply condemning it.

Recognizing that the psychoanalytic and psychotherapeutic situations are inherently designed to mobilize and intensify unconscious longings and desires emphasizes the extent to which each of us contains powerful forces that can drive any of us towards boundary crossings and violations.[2] The presence of these forces explains why inappropriate sexual contact between analysts and patients and other kinds of boundary problems were endemic for the founding generation of psychoanalysts and remain problematic for us today. A corollary is that every institute or society is at risk for problems of sexual boundary violations and probably none has been immune from their occurrence.

From early on, Freud was aware that the intimacy of the analytic relationship presented a potential source of difficulty for the analyst and, paradoxically, as he was to describe in his papers on technique, an opportunity for the treatment, as well. In his paper 'Observations on transference love' (Freud, 1915), he drew the analogy between the analyst's handling of the transference and a chemist's handling highly explosive materials! In one of his earliest statements on the subject, a letter to Jung on 7 June 1909, in response to the latter's involvement with Sabina Spielrein, Freud wrote:

> Such experiences, though painful are necessary and hard to avoid. Without them we cannot really know life and what we are dealing with. I myself have come very close to it a number of times and had a narrow escape [English in original] . . . They help us to develop the thick skin we need and to dominate the 'countertransference', which is after all a permanent problem for us; they teach us to displace our own affects to best advantage. They are a blessing in disguise [English in original]. (McGuire, 1974, pp. 230–1)

Objectivity, Subjectivity and the Impossibility of Neutrality

Freud recognized that psychoanalysis – and today we would add psychoanalytic psychotherapy – has the potential to liberate and intensify the most powerful of human emotions in both participants and tried to address some of the problems this presents in his papers on technique. His solution to these problems, embodied in the recommendation that the analyst maintain a position of abstinence and neutrality in regard to the patient's desires, rested heavily, albeit reluctantly, upon the analyst's objectivity and rationality. I say reluctantly, because Freud never lost sight of the fact that the voice of reason was always in danger of being undermined or overwhelmed by the powerful forces of the unconscious.

In describing the complexity of the patient's position in his 1915 paper, Freud noted that transference love functioned as both resistance to and motor of the treatment. He therefore cautioned analysts always to bear in mind that, although transference love was 'real', especially to the patient who felt it, it was mobilized in the service of resistance. Thus the patient's declarations of love were to be analysed rather than reciprocated. And love,

which may appear in many different forms, some of them salutary, must be distinguished from actual sexual contact between analyst and patient, which is always redolent of incest (Ferenczi, 1932). To the extent that patients seek love and a new relationship as their cure, they often do so to avoid the pain and experience of loss, disappointment, vulnerability, conflict and mourning or to oppose, undermine or destroy the analytic situation. And as we shall see, for the analyst or therapist, the situation is much the same.

Freud's advice made good sense as a starting point for a theory of technique. But the problem remained that the analyst's objectivity and reason are fragile protections at best against becoming ensnared in the patient's – or analyst's own – desires and defensive needs. Even after the training requirement of a personal analysis was added as an additional safeguard,[3] Freud (1937) remained aware that even a well-analysed analyst could not be expected to eliminate the unruly and irrational desires inherent in the human psyche; that the 'rational' or 'objective' analyst or therapist represented an unattainable ideal.

In more contemporary views of the analytic and psychotherapeutic process, the analyst or therapist is no longer assumed to occupy a place of objectivity outside the field of the patient's involvement. Instead the analyst or therapist is seen as an 'irreducibly subjective' (Renik, 1993) participant in the treatment process. This change recognizes that the analyst or therapist is inevitably susceptible to all the expectable irrational forces to which the patient is subject. Thus, in addition to having a *counter*transference response to the patient's transference reactions, we would expect that the analyst or therapist would also develop his or her own transference to the patient based on his or her unrequited unconscious desires and needs. What makes the matter even more complicated is that the analyst's transference and countertransference are not only potential interferences in the treatment process, they are at the same time *vital elements of the analyst's emotional engagement with the patient* (Levine, 1994, 1997) and therefore necessary and expectable components of a successful analytic process. There are, however – or, at least, should be – important differences between the analyst's transferences and those of the patient.

While the analyst's transference is structurally and dynamically identical to that of the patient, we would expect that relative to the strength of the analyst's ego, it would be less peremptory and intense. That is, although the drives – and related wishes, fears, fantasies, needs, etc. – will be mobilized by the transferences of *both* participants, under ordinary circumstances, the analyst, through the advantage of having been previously trained and analysed, will be able to take an observational and internally analytic position about all that happens between them. Perhaps one set of contributions to situations where this expectation fails are conceptions of treatment that emphasize feelings, emotions and action (including forms of relationship, such as 're-parenting') to the detriment of language and the work of the

preconscious [what Green (2005) has called the 'transference onto language']. Such theories may predispose clinicians to the so-called 'slippery slope' towards boundary violations by encouraging action over reflection as a central therapeutic factor, thereby inadvertently promoting the potential for enactments (E. Séchaud, personal communication).

Freud and the classical theorists counted on neutrality – which, in his 1915 paper he referred to with the word, *indifferenz* (Hoffer, 1985) – to keep the irrational forces of the analyst or therapist in check and to guarantee the patient's autonomy. But in more contemporary views, neutrality, at least in the classical sense, is seen to be impossible. The analyst's or therapist's needs and desires, transference and countertransference will always be irreducibly present, will always be expressed to at least some small, unconscious degree in both feeling and action and will have a significant and determinative impact upon the treatment relationship. Perhaps the most one can say about neutrality in this new context is that it is not a matter of 'fact' or a rational position, but the result of a constant analytic movement inside the analyst to become aware of what is at stake inside him/herself.

This contemporary description of the forces unleashed in the psychoanalytic process should alert us to the fact that boundary *crossings* will be ubiquitous and inevitable and can begin to offer us a tentative formulation of how and why the potential for boundary *violations* exists within us all. A personal analysis, no matter how thorough, does not guarantee freedom from irrational engagement with the patient or immunization against boundary crossings or violations. It only offers a potentially greater degree of acquaintance with one's desires and needs, a partial reduction of key personal conflicts and defences and a deeper capacity for tolerance, self-reflection and reverie, so that more of the analyst or therapist may be brought to bear upon the engagement with the patient. Considering the difficulties inherent in our profession, these are no small achievements. The protection provided, however, is neither absolute nor foolproof. There is an irreducible symmetry of susceptibility and emotional subjectivity that exists between patient and therapist, which Lawrence Friedman (1988) aptly described when he said: 'Human psychology must bear equally on all heads present' (p. 97).

Further light may be shed on the forces within the therapist and analyst that may move them towards boundary crossings and violations by examining the motivations behind and gratifications inherent in the very practice of analysis and psychotherapy. What does the analyst or therapist want? To answer this question, we could begin by rounding up the usual suspects. We want to help patients understand or get better; we want to earn a good income; to practise a profession that we spent many years training in; to emulate highly regarded teachers, supervisors or our own therapists or analysts; to advance professionally; to have experiences which will allow us to write papers and deliver lectures; and so forth.

But what if we look more deeply at our motivations? Money-Kyrle (1956) has persuasively argued that as analyst or therapist we, inevitably, unconsciously deal with each patient in regard to our own internal objects and guilt-laden reparative needs. Each time we treat a patient, that patient in some sense unconsciously comes to stand for at least two things: some (projected) aspect of our own past selves that we are forever saving and some significant object from our own internal world in relation to which we feel we owe a form of reparation, based on real or imagined past hurts that we have inflicted upon it.

In a similar vein, Gabbard and Lester (1995) commented that:

> Many individuals who choose careers as psychoanalysts or psychotherapists feel they were insufficiently loved as children, and they may unconsciously hope that providing love for their patients will result in their being idealized and loved in return. In this manner, analysts may regulate their self-esteem through their work with patients. (p. 87)

Others have noted that, in the early lives of analysts and therapists, there has been an important person whom they needed or felt they needed to care for. That is, the analyst or therapist's childhood role was that of a 'parentified child'.

Salvation and Reparation: Some Dynamics of Sexual Boundary Violations

The playwright, Sam Shepherd, once said that the problem with love was that people confused it with salvation. If we bear in mind the universality of the Oedipus complex, the fact that both members of the therapeutic dyad represent forbidden objects for each other, and if we add to these observations what Money-Kyrle (1956), Gabbard and Lester (1995) and others have described as the inevitable motivations behind the choice of a helping profession and the 'normal countertransferences' engaged to some degree in the treatment of every one of our patients, we can see how close in the unconscious mind of the analyst or therapist the matters of love and salvation may be.

In some sense, at some deeply unconscious but vital level, it is always our own salvation, self-esteem and the preservation and repair of our internal objects that are at stake in the treatment of our patients. This explains why we cannot simply ascribe sexual boundary violations to an 'outlaw' group of immoral, psychotic, addicted or otherwise impaired professionals. To do so would be misleading and would probably stand in the service of denying our own impulses and needs and relieving anxieties about our own susceptibilities. Nor can we only ascribe the motivations that lead to boundary violations to destructive or self-destructive ends. The question we must also ask of ourselves and of our colleagues is how (unconsciously) desperate at any

given moment does any therapist or analyst feel to preserve themselves or their internal objects in the guise of their patient? And to what means will they go to do so?

To this point, I have said little about the forces within the patients that may move them towards becoming caught up in situations of sexual boundary violations. In large part, they are the very same forces that operate in the transgressing analyst and therapists. Autistic defences, narcissistic needs, destructive envy, fantasies of omnipotence or entitlement to or salvation through love, unrequited incestuous longings, feelings that one is beyond the bounds of ordinary ethical behaviour, defences against loss, anger, and so on. In addition, some patients with sexually or masochistically traumatic histories may be almost hypnotically drawn towards repetitions of the past.

Each dyad is unique in terms of how much each participant contributes to the sexual boundary violation, in what ways and for what reasons. In regard to the *patient's* contribution, however, it is worth emphasizing that, although the patient always makes at least some contribution to the situation, the analyst or therapist bears the professional and ethical responsibility to ensure that such occurrences do not happen. It is the job of the analyst or therapist to provide the patient with a safe place in which the latter's fantasies, impulses and feelings can emerge. It is the patient's role to allow wishes for and even attempts to induce sexual boundary violations to emerge when they are present. The analyst's or therapist's proper response is to help the patient explore and understand such wishes, impulses, fantasies and fears, not to facilitate their expression in overt action.

Having said this, I would like to return to the question of why an analyst or therapist becomes involved with a *particular* patient. The situation may be likened to that of 'The Perfect Storm'. The patient arrives in a state of eroticized vulnerability, object hunger, aggression and/or unrequited wishes and needs. And something about the unique qualities, characteristics or needs of the patient fits a specific unconscious template within the analyst or therapist that further aggravates the situation. Once the feelings between the two begin to intensify – and even more so once actions such as some sort of physical contact have begun – the pair may then retreat to a position of insulated secrecy in order to escape discovery and avoid the potential disapproval of the outside world. This retreat into a '"hyper-confidentiality" or treatment bubble' (Celenza, 2007, p. 21) may further foster or reflect what I have termed a *claustrophilic collapse* into an isolated and idealized twosome. Once this collapse begins, outside contact – e.g. with colleagues, consultants, friends and family members – may be avoided and even disparaged, in a manic flight of gratification, fulfilment, well-being and self-sufficiency.

From the analyst or therapist's perspective, this means the weakening or loss of the internal 'third' position, which ordinarily acts as anchor or ballast in the face of the powerful and unruly unconscious forces to which the analyst or therapist is normally subjected. Britton (1998) has related this

third position, which he calls *triangular space*, to the mental freedom needed to see oneself simultaneously as subject and object, witness and participant, loving and hating. In his view, it 'provides us with a capacity for seeing ourselves in interaction with others and for entertaining another point of view while retaining our own – for observing ourselves while being ourselves' (Britton, 1998, p. 42). From another perspective, this position is part of each clinician's internal identification with idealized imagoes of analysts, supervisors, teachers, professional authors and other figures, who contribute to a loving and beloved internal object of analytic identity that serves as a guide and role model to which we aspire in our professional lives.

The structuring and organizing power of the third derives in part from the strength of the paternal position in the Oedipus complex and the positive role and action of the superego. It is connected to the incest taboo and, when the third is weakened, through destruction, loss or abandonment, an important barrier to indiscriminate and incestuous action is lost. When sexual boundary violations have occurred, the third often re-appears – or is evoked – from the outside in a violent, punitive, concrete and condemning form assumed by 'the authorities', who are then called in to judge or condemn the action.

In a well-functioning analytic treatment, the position of the analyst or therapist is akin to that of Odysseus and the Sirens. In order to hear their song, Odysseus knew that he must protect himself from acting on what he heard and felt by having himself restrained. He instructed his crew to plug their ears, leave his ears unplugged, tie him to the mast of the ship and not listen to any of his commands until they had sailed well clear of the Sirens. It is our professional identity and analytic attitude organized around and reinforced by the presence of the internal third, the ability to maintain an internal analytic frame and perspective about what happens in the treatment, that ties us to the mast of appropriate analytic functioning. This is our necessary rope, the strands of which consist of elements such as identifications with previous analysts and supervisors, colleagues, the profession and its ethics, etc. Without these, we are all susceptible to being lured upon the rocks to our destruction.

Gabbard and Lester (1995) have provided the standard analytic categorization of sexual transgressors, dividing them into four groups: (1) psychotics, which are rare; (2) predators and psychopaths; (3) lovesick analysts and (4) masochistics. Predators are distinguished by life-long patterns of psychopathy, sometimes perversions, severe narcissistic disturbances and a lack of empathy, remorse or concern for others. Their histories may include other forms of dishonest or unethical behaviour. Often, their previous behaviour has been noted in training programmes, but was ignored because of threats of litigation or because they were able to adroitly manipulate the system. Some predators have had profound childhood histories of abuse or neglect and so may be seen to be on a continuum with other transgressors. They can

be particularly difficult to treat and their prognosis for rehabilitation[4] may be uncertain.

Lovesickness among transgressing analysts and therapists is a more frequent occurrence and a potentially more rehabilitable condition. Characteristically, an infatuation, often with a younger patient, develops in the context of extreme stress in the life of the analyst. This may include divorce, separation, illness in a child or spouse, mid-life depression, death or decline of a family member or disillusionment with marriage or career. While the typical constellation of the lovesick therapist is that of the older male therapist with the younger female patient, homosexual dyads or instances where the therapist is female and the patient is male can also occur. In the latter case, the patient is often a 'wild' young man, whose personality is characterized by impulsivity, action orientation and substance abuse and whom his therapist hopes to heal and 'tame' with her love.

What often provides fuel to the fire of the lovesick dyads is the shared unconscious fantasy that each participant has failed to receive sufficient love in their lives – often, parental love during childhood – and that it is only through the therapeutic relationship that this 'deficit' will be (mutually) repaired. Our culture, which emphasizes sexuality, entitlement to personal gratification and recompense for past harms done at the expense of the necessity to mourn what is lost, may tend to reinforce such beliefs. Some boundary violating analysts and therapists have explained to their patients or offered the claim in their own defence that they believed sexual activity with their patients would prove to be therapeutic.

Masochistic therapists often have problems with their own aggression, limit setting and in asserting their own rights with patients. Tormented by the rage and controlling demands of difficult patients, they may find themselves intimidated into escalating boundary crossings and violations in an attempt to deny their own mounting anger or to prevent the patient's threatened or impending suicide. Celenza (1991, 2007) has described how the analyst's or therapist's professions of love and caring may unconsciously mask feelings of hopelessness, helplessness, resentment and rage. These declarations may occur in the face of the patient's angry transference feelings, which the therapist is trying to buy off with love or submission or they may occur at moments of impasse in response to a refractory patient, who refuses to idealize the therapist or satisfy the therapist's needs to be seen as a healer. The patient may accuse the therapist of 'not caring' just when the therapist's unbearable anger is at its height. It is under such conditions that boundary violations may occur as a form of appeasement, masochistic surrender or retaliation.

Two features that are shared by almost all of these transgressing therapists are: (1) serious disturbances in their narcissistic equilibrium and (2) a tendency to act on rather than be reflective about what they are experiencing. Gabbard and Lester (1995) suggest that it is useful to think about the

characters of sexually violating therapists as lying along a spectrum of disturbances of narcissism with greater and lesser admixtures of superego pathology, sadomasochism, impulsivity, action orientation and perverse trends. I would add that it is worth remembering that our own character types also lie along this very spectrum!

Responses to Sexual Boundary Violations: Personal and Institutional

The violation of sexual boundaries constitutes a destructive act not only for the patient and therapist, but for the community, the institution and the profession, as well. For the patient, trust in authorities may be severely compromised and doubts may be reinforced about impulse control. These patients may have difficulties feeling safe with subsequent analysts and therapists, forming a therapeutic alliance or refraining from unconsciously and repeatedly testing the boundaries of a new treatment relationship. They may suffer from intense shame, mood swings, punitive guilt, self-blame and/or the reinforcement of grandiose and entitled fantasies. Subsequent treatment may have to include the recognition and validation of the patient's positive feelings for the transgressor, along with the sense of all that was lost. Most important of all, however, any subsequent healing process may require that the patient achieve 'a forgiveness of self, an understanding of how the events . . . came about and a release from shame' (Wohlberg, 1997, p. 345).

When boundary violations occur in institutional settings – e.g. the therapist may be affiliated with a clinic, an analytic or psychotherapeutic society or training programme – it may be incumbent upon the institution to provide assistance to the patient. This may take the form of administrative or emotional support in ethics hearings, legal actions or subsequent treatment. Patients may require consultations, referrals for subsequent treatment, mediation (Margolis, 1997), reduced fee treatment, as some patients may have exhausted their financial resources in a transgressive therapy, or even reimbursement of past fees. An apology to the patient on behalf of the institution or professional group, along with the acknowledgement that what the therapist did was wrong, may also be called for. In Boston, such an institutional response was initially lacking, causing a severe rift in public and community relations, which, for a while, discouraged patients from seeking analytic treatment and worked to the detriment of both the analytic society and the general public.

While we may recognize that the limits of human nature make boundary violations inevitable, as educators, we must work to institute specific educational measures to help prevent their occurrence. These may include ethics courses, integrating the teaching of ethics into our clinical seminars and

supervision and training our students to anticipate and deal responsibly with the full range of feelings, defences, impulses, fantasies and desires that may be activated in them and their patients in the course of treatment. Articles such as this attempt to alert colleagues and students to the complexities and dangers of boundary crossings and violations and may work to help prepare them for the difficulties they may encounter. However, as I have noted, while education and reason are necessary ingredients, they are not sufficient and cannot be relied upon alone. Awareness that this is an endemic problem and universal challenge for our profession, continual analytic and self-analytic scrutiny, routine reliance upon individual and group, formal and peer consultations in the course of at least difficult, if not all, treatments, and any and all measures that support one's internal positive identification with the field and its practices will prove to be of value.

Serious boundary violations damage the reputation of our field and discourage access to the important help that we can offer by disillusioning some patients and frightening others away. When these incidents occur, we have an obligation to our patients and our profession to try to repair the damage that has been done to the public trust. Open discussions of the subject in various public and professional forums are also of value. We must better learn how to help our students, our colleagues and ourselves talk openly and appropriately about these problems and the full range of feelings that can be generated in our work with patients. As teachers and supervisors, we must also learn how to function as role models for these discussions and conduct them in an atmosphere of empathy and respect.

In the expectable climate of outrage at the betrayal of trust and concern for the patient that follows a boundary violation, we may emotionally distance ourselves from the transgressors. It is important for us not to overlook the fact that transgressing analysts and therapists are also human and that their actions, too, have been motivated by powerful, internal dynamic forces. In addition to the unconscious self-destructive and 'other-destructive' nature of some transgressive acts, boundary violators may be living out unconscious identifications with narcissistically impaired, psychopathic or boundary violating parents or suffering the consequences of their own childhood trauma or abuse. An attitude of empathy and compassion on the part of friends and colleagues for the frailty of these therapists may be important for their rehabilitation and must be maintained without mitigating punishment or denying, excusing or condoning the violation of boundaries and damage that has occurred.

Notes

1. In our initial discussions, the Boston group soon discovered that our explorations were limited by the bounds of confidentiality. We had in our group officers of the Society, members of the investigating ethics committee, consultants to the victims

and offenders, perhaps therapists, as well. What could be discussed or even heard in the discussions of others was often limited by professional and legal strictures. Our own scrupulousness and professional concerns with appropriate confidentiality kept us from gathering the data that we needed to study the problem in depth. So we decided to organize a broader, unofficial working group made up of colleagues from around the US, drawn from different societies and institutes, to try to study the problem.

This wider group had the advantage of being a place where discussions could more easily take place. If analyst A was discussing a case that had occurred in city X, then there was a reasonable chance that the rest of the group would be sufficiently removed from the situation so that in depth discussion would be possible and confidentiality could still be preserved. Later, this group was reconstituted, further enlarged and sanctioned as an official study group of the American Psychoanalytic Association under the auspices of the Committee on Psychoanalytic Education (COPE). We met for almost 10 years, studied cases of sexual boundary violations from societies around the world, published two papers (Gabbard, Peltz *et al.*, 2001; Levine & Yanoff, 2004) and tried to convey some of what we learned and concluded to our colleagues.

2. The idea of universal vulnerability is further supported by the high incidence of sexual boundary violations. In the US, Pope *et al.* (1995) surveyed mental health professionals and reported that 5–17% of respondents admitted to having had 'sexual intimacies' with their patients. In a series of 2,000 cases of therapist–patient sexual contact, Schoener *et al.* (1989) reported that approximately 80% of the 2000 were male therapists and that 20% of the total were same sex dyads (reported in Gabbard & Lester, 1995, p. 92). The prevalence of sexual boundary violations among female therapists is reported to be about 4% (Celenza, 2007).

3. This was proposed at the Nuremberg Congress (1910), which took place one year after the Jung–Spielrein affair.

4. By rehabilitation, I do not mean a particular or unique form of treatment. Rather, I refer to the possibility of the transgressing analyst or therapist being able to undertake a psychoanalysis or analytic psychotherapy that will prove successful in helping them to achieve a better and more secure internal psychic balance.

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