Sexual feelings towards the therapist

Breuer’s difficult experiences with Anna O (1893–5) and Freud’s (1905b) summary dismissal, with two weeks notice, by Dora both had at their core sexual wishes by the patient towards their analyst. They set the scene for an analysis first of sexual wishes on the part of the patient towards the therapist and later for an analysis of sexual wishes on the part of therapist towards patient. At times these wishes lead to sexual activity. Several cardinal features of the field should be noted. First, the major commentators are psychoanalytic. No other school of psychotherapy appears yet to have produced an extended theory-driven meditation on sexuality in the consulting room. Second, it is assumed by almost all writers that sexual activity between patient and analyst is dangerous and harmful. In conformity with this, sexual relations in this setting are illegal in some countries and result in professional sanctions in almost all countries and settings. A third feature, which will become apparent, is the tension created by a desire to explore erotic feelings during therapy and the sanctions over their expression.

Freud (1915) set out the classic combination of neurotic female patients who fall in love with their male analyst. He argued that these feelings of love are displaced from elsewhere and transferred onto the analyst. As elsewhere in psychoanalytic theory his views were successively modified by later writers, often to conform them to the requirements of wider theoretical considerations. Public perceptions of analysis picked up on the erotic possibilities inherent in the activity and soon generated a stereotyped version of an aloof male analyst as the object of hopeless and somewhat demeaning love of an attractive blonde. Psychoanalysts subscribed
to very similar views. For example, Greenon (1967) thought all cases of eroticised transference were of women patients analysed by men, while Racker (1968) described transference ‘nymphomania’, with attempts to seduce by the patient.

Freud thought initially that all transference was an obstacle to analytic progress, and even after this view was revised the erotic transference remained highly suspect and continues to be so to the present day. Schafer (1977, in Person 1983) sees erotic transference as resistance. This view is echoed by analysts from the Kleinian school, such as Joseph (1993) and Doctor (1999). The degree of pathology thought to be represented by an erotic transference depends on the general view of pathology espoused by the analyst. Thus Kleinian analysts tend to regard an eroticised transference as involving a significant degree of disturbance.

More benign views of erotic transference can be developed. Kernberg (1995), starting from Freud’s formulation, sets out a fairly classic theory of transference love but usefully contrasts it with unrequited neurotic love. Ideally, he argues, transference love, which is refused direct expression by the analyst, is relinquished slowly, mourned and lessens with time, whereas neurotic love is increased by rejection. Furthermore, unlike the secret love of the oedipal scenario, transference love is (or should be) talked about and analysed. This analysis sets Kernberg amongst a group of analysts who regard erotic transference as dangerous but useful, manifest analytic material to be mined for latent content. Kernberg argues that the erotic transference can go wrong in a number of ways. An excessive or demanding quality to the transference love implies neurotic/masochistic problems in the patient while too little evidence of erotic transference implies sadomasochistic resistances or narcissistic transferences.

Schaverien (1995), who reviews the field, points out that post-Freudian theory increasingly relies on a distinction between erotic and eroticised transference, which are thought to be, respectively, neurotic and psychotic. Chiessa (1994) describes eroticised transference as the delusional manifestation of a pathological organisation. He subscribes to the idea of erotic (good) and eroticised (bad) transference, suggesting that the appearance of the analyst in a dream is a bad sign, presaging possible involvement of analyst. He also thinks that early overt expression of erotic transference in therapy, is likely to be seriously difficult and can be distinguished from benign episodes occurring later during therapy which are self-limiting (Chiessa 1999). Patients who experience this pathological reaction have, in his experience, a history of childhood seduction and a sexualised family story.

An even more permissive view sees the erotic transference as defensive but, if handled correctly, beneficent. Covington (1996, in Mann 1999) sees erotic longing by the patient as representing a desire to find nurturing parents and to internalise a new (presumably more benign) primal scene. Schaverien (1995) takes a broadly similar view and cites Blum (1973) and Rappaport (1956) who both argue that sexual urges may be covering up wishes for, but fears of, dependency on the analyst.

However, as Kernberg (1995) points out, love which was displaced once may be displaced again and if transference love is secondarily displaced onto others then the patient may ‘act out’.

John’s behaviour in therapy was experienced by his therapist as sexually provocative and threatening. She had already made sure to see him only at times when there were other people present in the therapy centre where she worked. The strangest thing was that nothing was stated openly and the therapist was sure that if she raised the issue of his behaviour he would laugh it off with scornful contempt accusing her of imagining things, and even possibly turn the remark into evidence that the therapist had sexual feelings about him. Matters intensified over a few sessions and the therapist’s paralysis and desperation increased. Then, suddenly, it went away. The sessions were no less strained or contemptuous but the sexual edge was gone. Later the therapist found out that John had started two new relationships with women he hardly knew, one of whom he insisted on seeing once a week, only at exactly the same time each week.

John’s behaviour in the later part of the sessions would certainly be seen by most analysts as ‘acting out’ and the feelings which were building up in the therapy, to the acute discomfort of the therapist, are latterly being discharged elsewhere. The therapist’s experience is well described by the term erotic horror. This was coined by Kumin (1985, in Mann 1999) to describe the impend-
Sexual feelings of therapists towards patients

Broadly speaking, those analytic writers who concern themselves at all with erotic feelings by therapists towards patients do so under the rubric of countertransference and tend to take a more benign view of erotic feeling in analysis generally. Mann (1999), reviewing the topic, cites Searles (1959) as taking a more progressive view than was usual at the time of both transference and countertransference. Some writers on the topic are preoccupied with creating a taxonomy of the types of patients who may elicit countertransference feelings. Goldberg (1986) lists four different kinds of characters who elicit erotic countertransference: the female masochist, the male sadistic and the phallic male or female. Kernberg also produces a classification system, arguing that erotic countertransference is most intense in male analysts analysing sadistic women whose erotic longings represent an impossible love for an unavailable oedipal object, and in male analysts with female narcissistic patients. For women analysts, he argues, their own masochistic traits may lead to erotic feelings towards the narcissistic men they are analysing. Kernberg's categories go beyond an anatomy of patient characteristics to suggest that features of the analyst may also be important in determining the play of erotic transference and countertransference.

A second way of viewing erotic countertransference is to highlight its function within the analytic situation. Kristeva (1983, quoted in Mann, 1999), for example, propounds a complex view of countertransference in which the analyst represents the 'father of prehistory', that is, the pre-oedipal father who is/stands for the mother's desire for the father's phallus. This leads Kristeva to argue that the experience of being acknowledged as an erotic object for the analyst helps the patient become a subject-in-process. The idea of a positive function both for erotic countertransference has been taken up strongly by a large number of modern writers, such as Mann (1999), Schaverien (1995), Covington (1996) and Samuels (1985a). The view they hold in common is that erotic feelings are in some way crucial to the very process of analysis and that inattention to them may be damaging to the patient's self-awareness and to the patient. Field (1999), who agrees with this position, also feels that the patient's experience of the therapist's self-aware desire for the patient is curative and might be lost if erotic countertransference is neglected. These writers and others permit disclosure of countertransference feelings by the analyst as a legitimate part of technique, once a range of otherwise anxious criteria have been met.

This view needs to be distinguished from that of a more traditional writer such as Chiesa (1994, 1999), who discusses the adverse consequences of inattention to erotic countertransference in a patient, who, as a result of this, subsequently acted out. Chiesa does not see in erotic countertransference the opportunity for the patient to experience validation as an erotic object. For Chiesa, the valuable thing that is lost as a result of failure to attend to the erotic countertransference is the capacity to make interpretations informed by the countertransference. In analytic practice Chiesa and also Kernberg are absolutely clear that no disclosure of the countertransference should occur.

Jung differed from Freud in matters of sexuality and developed his own perspective on erotic longing in the analytic relationship. Jung sees sexuality in the transference as a progressive force and as a symbol for various patterns of relatedness (Jung 1959 CW 8:74, 1956 CW 5:7–11). His most extended work on the subject is The Psychology of the Transference (Jung 1946 CW 16) combines an extended meditation on the symbolism of alchemical woodcuts and on the passionate involvement of patient and analyst in the mutual process of analysis. The work repays study but is often neglected for a range of reasons, not least because modern readers find Jung's theories about alchemy as a symbolic representation of psychological processes of growth difficult to swallow. A key
feature of the woodcuts is the intermingling of the bodies of the King and Queen, represented sometimes side by side sometimes in coitus and sometimes as a fused hermaphrodite. Jung thought that the goal of the psychological process was 'individuation' a term which refers to the development of the psyche into a more differentiated and integrated state. Since the woodcuts are a symbolic depiction of individuation they depict the passionate intermingling which will be needed in the analytic process for change to occur.

Wendy thought that her therapist was looking down her cleavage and said so. The therapist was mortified and chiefly felt guilty, unsure whether she had been looking down her patient’s cleavage or not. On a reflex she assured Wendy that she was not looking down her cleavage and the matter appeared to rest. Some sessions later Wendy repeated the accusation and the therapist, having discussed the matter in supervision, proceeded to try to explore Wendy’s ‘fantasy’ about her. There, overtly, matters rested again except that the therapist now had no idea where to put her hands. Should she look defiantly at Wendy’s cleavage, which was, as it happened, rather attractive now she came to think of it, or should she avoid it and look away? The problem was that each session Wendy’s cleavage became bigger and bigger. In her mind the therapist even called Wendy ‘the cleavage’. Pleasurable if guilty sexual fantasies alternated with a sense of disgust engendered by the notion of drowning in Wendy’s cleavage. Wendy took to describing her own sexual fantasies about the therapist, which grew juicier and spicier even as the therapist struggled to interpret them, often in terms of infantile material. Eventually Wendy said, ‘Come off it, you’re looking down my cleavage aren’t you? Cornered, the therapist had to admit that she was, but then added, ‘You started it!’ With tones of extreme satisfaction Wendy said: ‘They’re my one good feature. Sometimes I like to watch people look at them. I know I can push people around with them if I want to.’ More by luck than judgement on the therapist’s part Wendy’s pushy cleavage became a central image of work on someone who in other areas of life had a low opinion of herself and problems with assertion.

Wendy’s case underlines the experienced dangerousness of sexual material to the therapist. Sometimes one or both parties may conspire to avoid erotic material emerging, in order to remain in the comfortable area of dependency and childhood (Lester 1985). Schneider would agree, and adds that to do so and keep things infantile is a form of abuse of power, because while the analyst denies adult elements of sexuality in the transference he or she prevents the infantile and dependent from developing into the adult and independent.

**Gender and erotic transference/countertransference**

Once the idea of a reciprocal interaction in relation to erotic feelings in therapy is allowed, then a range of potential pairings are evident, each of which may interact differently. On the manifest level there are at least four pairings of analyst and patient gender. These become sixteen possible combinations if the sexual orientation of either partner is added in as a variable. Unsurprisingly, given the combinatorial complexity, the literature has not yet developed far enough to encompass accounts of, for example, gay men analysed by lesbians (or vice versa). These sixteen possible pairings become a minimum of thirty-two if the possibility that either partner may unconsciously be operating as a different sex to their overt one is admitted. It is perfectly possible to contemplate a situation in which a gay male therapist is related to sexually in the role of oedipal mother by a heterosexual woman who is exploring or fantasising, consciously or unconsciously, her inverted Oedipus complex. However, such situations have also yet to make it into the therapeutic literature and most commentators confine themselves to conscious heterosexual pairings.

Freud had little to say about analysing couples other than the female patient – male analyst pairing. Other Freudians have, however, taken up the challenge. Kernberg (1995), for example, begins to extend this range, distinguishing, as well, between neurotic and narcissistic patients. He argues therefore that a neurotic man analysed by a woman will inhibit transference love and displace it because of anxieties over sexual performance with a woman seen as the oedipal mother. Narcissistic patients fear humiliation and shaming. Thus narcissistic women do not experi-
ence sexual desires for their male analyst because this would be experienced by them as humiliating. However, narcissistic men may develop very aggressive sexualised transferences towards their female analyst as a way of defending against dependency, which is experienced as humiliating.

Apart from a gesture by Kernberg, the erotic transference and countertransference experiences of female analysts with male patients are often absent from the literature. Person (1985:163) suggests that women feel the touch of the erotic transference less. She argues that women use erotic transference in analysis as a vehicle of resistance whereas men resist the experience of the erotic because feeling erotically towards the female analyst would be experienced as undermining male autonomy. Lester (1982) agrees, arguing that cultural factors, amongst others, make male erotic transferences towards women analysts unlikely. Guttman (1984, in Schaverien 1995), argues similarly that men who want to say devaluing erotic things are not keen to tell female analysts because it is more socially acceptable to tell such things to men (locker-room talk). Chasseguet-Smirgel (1984a) suggests that a male patient who idealises the female analyst will keep sex out of the transference, presumably thereby maintaining the split between idealised mother and designated whore. Coming from a different tradition, Meltzer (1973) produces a different reason for the lack of erotic transferences, arguing that male analysts are drawn into an infantile form of sexual excitement in perverse patients whereas women analysts tend to idealise the patient within maternal transference.

Maguire (1995) disagrees and argues that sexualised male patient to female analyst transferences do occur. She suggests that female therapists may not discuss sexual transferences because of anxieties about being seen as provocative. She cites in evidence Gornick (1986) who points out the existence of a film theme of the woman analyst who restores her male patient by having sex with him. The suggestion is that women analysts are scared of being boxed into the role of therapeutic prostitute and therefore crush signs of erotic transference. Arguing from her own clinical experience, Maguire contends that sexual transferences tinged with aggression and contempt, born of fear and envy of a woman in a superior position, do occur. Her experience is echoed by Schaverien (1995), whose extended case reports involve a range of male patients who experienced erotic transferences towards her. She usefully argues that women analysts' erotic transference and countertransference experiences with male patients are structured by the ways women are viewed by men, pointing out that erotic or loving feelings towards female analysts are often treated as maternal rather than erotic. So, female clinicians do report experiences of heterosexual transference with men, but there are differences which reflect the relationship between sex and authority and sexuality.

Schaverien is also willing to admit the possibility of erotic feelings between female-female analysing pairs, and cites O'Connor and Ryan (1993), who discuss the lack of any extended discussion of lesbian transference and countertransference feelings in the literature but who also remedy this deficiency with case history material. Schaverien acknowledges sexual feeling towards her female patients but says these were not as strong as towards male patients and attributes this to her heterosexuality. Person (1999) will not even go this far and downplays the erotic element, even of erotic transference between heterosexual women, suggesting that feelings are affectionate and tender rather than sexual. By contrast she suggests that homosexual women develop very strong erotic transferences and that this situation is redoubled when the analyst is also homosexual. Person also discusses male patients analysing with male analysts and suggests that the erotic transference is muted largely because of taboos on homosexual expression in heterosexual men.

Where non-analytic literature discusses sexual feelings on the part of the patient towards the therapist the general tendency is either to borrow some of the simpler and more evidently rationally based formulations of psychoanalytic theory or to regard expressions of sexual attraction by the patient as carrying simply their manifest meaning. Scharff and Scharff (1991) summarise sex therapy attitudes to countertransference. Masters and Johnson (1970) thought it dangerous and tried to design it out of their treatments. Dicks and Strauss (1979) acknowledge its importance as a threat to treatment. Kaplan (1974) regards it as important but gives no guidance on its use. Scharff and Sharff, being analytic in orientation, use countertransference analytically as an explicit therapeutic tool within a mixed therapy involving both behavioural and analytic elements. There are extra difficulties with this
approach since the behavioural elements of treatment may be experienced as provocative within the transference, but clearly attempting to ignore transference elements, as Masters and Johnson do, is no solution.

Sexual orientation and erotic transference/countertransference

It is clear in all these discussions that psychoanalytic theorising about sexual transference and countertransference and gender is an area where social custom and cultural forces demand accommodation. Despite the relentless focus in psychoanalytic theory on the inner world, analysts considering the manifestations of the transference and countertransference have been forced to give the outside world’s social conventions pride of place in determining the nature, direction and strength of the erotic reactions which may occur in therapy. This makes accounts of the interaction of sexual orientation with erotic experiences in therapy particularly interesting as there is less (or at least a different) weight of social convention structuring gay relationships. Issues involving sexual orientation issues have until recently not been well discussed. Elise (1991), for example, has a go but her account both lacks detail and is rather denigratory. She discusses an intense lesbian transference on the part of a patient who idealised her. When the idealisation broke down threats of rape and murder followed, plus a confession that she had raped her last lover.

The complicated and flawed account given by Elise of the analysis of Dale stands in sharp contrast. Elise (1991) develops a powerful erotic countertransference over an extended period of time and speaks personally about the difficulties of managing bodily expressions of attraction like blushing or a vulnerable smile. Despite acknowledging the importance of erotic transference and the need to take it at face value rather than analyse it away as a defence, Elise maintains a rigid boundary of concealment between herself and her patient in relation to countertransference. Part of her reason may lie in her view that: ‘the intensity of erotic transference and erotic countertransference can lead to the therapist feeling out of control. These feelings of vulnerability are out of character with our role. Direct discussion can even increase these feelings’ (Elise 1991:64). The strain of the effort on her part to conceal her feelings is terrible. ‘I was attempting to work through these issues with Dale, yet I felt terribly concerned even after months and years of treatment with an unfailing therapeutic demeanour on my part, that a fraction of a second of possibly perceived sexualised vulnerability on my part would undo my role and my power to be helpful to her’ (Elise 1991:62).

Elise suggests that lesbians who know of their sexual orientation very early (and presumably Dale is one) are ‘more masculine’ and avoid vulnerability or dependency. She argues that because of the difficulties of growing up as a lesbian they do not have anxiety-free experiences of platonic friendships and also that they defend against dependency with erotic feelings. This analysis, while welcome because detailed, threatens to turn Dale into a man manqué and by extension to suggest that passionate or difficult lesbian feelings result only from internalised masculinity. Furthermore it provides no justification for the way in which Elise manages her countertransference feelings.

More extended accounts of gay men as analysing couples are beginning to occur in the literature (Domenici and Lesser 1998), although the dead hand of the analytic past still hangs over these attempts. Occasional accounts can be found of sexual issues developing between gay men analysing straight men, where one difficult situation is accusations of attempted seduction made by a frightened patient as a way to avoid threatening dependency or attraction. Sexual contempt is also an issue which may threaten gay analysts working with straight men. Therapists can be torn between their political and personal commitment to their orientation and the patient’s overt or covert contempt for homosexual orientation. Such matters become particularly acute when the therapist feels the patient is probing to find out about the therapist’s sexuality. Negotiating this unknown territory can be a frightening and bewildering experience for a therapist. The danger is generally not ignorance, but rather practice based on the knowing assumptions of a standard model. The following case vignette illustrates the value of attending sequentially to a hierarchy of possible explanatory sources for a phenomenon; first real world explanations, then personal material from the therapist, then conscious elements in the patient and only last unconscious forces or defences.
Gudrun’s therapist knew he was in trouble as soon as she told him she was a lesbian. His immediate reaction was ‘what a waste’. She had been brought up in Germany but her father had been an American serviceman and had been absent rather a lot as his job took him here and there. The family had also moved frequently and Gudrun’s developing lesbian sexuality had combined with her mother’s language difficulties on American bases to make her always feel an outcast. As the therapy progressed the therapist fought to shake of his persistent sexual feelings for Gudrun, which were evidently not reciprocated. The therapist reckoned that anyone with half an eye for beauty would think Gudrun very attractive and felt confirmed in this view by a co-worker who had spotted her in the waiting room and remarked upon her spontaneously. He also knew of his own tendency based on a first love experience on a school trip to find unavailable German women attractive. He wondered whether his own mother’s frightening tendency to remark, when angry, that if they were lucky his father would have to go and fight the Germans again and leave them in peace, might be part of the equation. The therapist felt confident that consciously sex was not a feature of the therapy relationship as far as Gudrun was concerned, but unconsciously he felt that he might represent the absent father for his patient. Sadly, he never plucked up the courage to raise the issue with Gudrun because he was terrified of the resulting humiliation he might experience.

Further inspection of this case vignette reveals an array of possibilities almost as dizzying as that opened up by contemplating all the possible analysing pairs and their potential erotic experiences. The therapist’s use of the phrase ‘what a waste’ for example has links with the war and the Germans. Angry and dismissing mothers and fathers on the therapist’s side are linked in a delicate quadrille with mute or absent ones on the patient’s. But through it all the vulnerable nature of sexual feelings in a setting where they seem both permitted and forbidden runs like a constant thread.

The renunciation of sex in the consulting room and in the Oedipus complex

Of course even the most sex-positive writers on erotic countertransference are against enactment. Instead they advocate the advantages of a kind of sailing close to the wind. Wrye and Welles (1994), for example, develop the idea that the basis for eroticism is a body love print based on the way mother deals with infant’s body fluids. Maternal erotic transference and countertransference recreates the sensual erotic contact that the baby once had and is an important positive and necessary transforming process in treatment. If the therapist defends herself from experiencing countertransference feelings the therapy may stall. Instead the therapist must tolerate the feelings without fanning the flames.

Mann (1999), writing in his own edited volume, makes powerful claims for the value and power of the erotic in therapy. He argues that the purpose of the erotic bond is to deepen an individual’s capacity for connection and relatedness to others. Thus the therapist’s sexual feelings allow him or her to participate with the patient in an erotic manner in a way that is ‘supercharged with unconscious incestuous and murderous desires’. Supposedly the therapist then brings to the encounter ‘an erotic subjectivity that may be characterised as good enough, incestuous, and murderous desires’ (1999, 77). Mann sees both repression and license as bad but restraint as good and the motor for development. Something of the Christian horror of license also fills Schaverien (1995) as she describes the, fantasised as unsatisfying, sexual encounter of bodies alone which might have followed an enactment of her erotic countertransference towards her patient (Schaverien 1995).

It is, therefore, an odd irony that this very Christian idea should be linked by writers to a tribal taboo on incest and a Greek myth. Schaverien, for example, links the theme of renunciation with the incest taboo and the growth potential it possesses. This view is a Jungian one and is echoed by Samuels (1995b) who argues that the purpose of incestuous desire within the family setting is to foster psychological growth and that this growth is destroyed by too much or too little ‘erotic playback’. Searles view (1959) is very similar, but differentiates the countertransference to a pre-oedipal patient from the countertransference to an oedipal one. He argues that, in a pre-oedipal patient, the countertransference
Transference, countertransference and the erotic imagination

The amazing thing about all these accounts is that none will credit the existence of a truly plastic and sexual realm of the unconscious or of the imagination. While Freud was able to suggest that humans are born constitutionally bisexual and polymorphously perverse, no analyst seems able to grapple fully with the notion that the unconscious structuring of desire may not run in accord with anatomy or overt sexual orientation, nor are they able to accept that desire for the analyst or their patient may be just that. This means that while writers can agree that social forces structure permissible expression, they are not able to discuss the ways in which the tensions between social and unconscious realms condition the erotic imagination or the ways in which the imagination might transcend either realm.

The development of the notion of the incest taboo as the model for renunciation in the analytic situation provides a convenient analogy by which therapists can legitimate their strictures on sexual expression in the consulting room and at the same time permit themselves the right to explore sexual feelings, while withholding or revealing their own, as their theoretical whimsy takes them.

Jungian writers who accede to the erotic imagination its own wayward spirit but this has, by and large, failed to occur. Instead, his concept of holding the tension has come to serve as the model for correct management of erotic feeling in the consulting room. While holding the tension does offer one aesthetic for the expression of the erotic imagination it should not be elevated above all other aesthetic options. If the difficulty with at least some patients is imaginative cramp born of anxiety over the unruly demands of partly liberated in therapy. Helping the patient to develop this new potential presents the patient with a better curative offer than transference interpretations or pale corrective sexual emotional experiences provided by an analyst, always constructed as in the powerful position of being more loved than loving.

Sexual relationships between therapist and patient

It is agreed by all that sex between therapist and patient breaks the fiduciary duty which the therapist owes the patient, damages the patient, and is unethical. Most professional organisations have severe penalties for breaches of sexual abstinence during treatment and often for a longer or shorter period of time afterwards. In some states in America sexual breaches have been made illegal and in England it is illegal to have a sexual relationship with someone who is detained under the provisions of the Mental Health Act. The basic argument behind these prohibitions is that patients are, for a range of reasons, not capable of valid consent to sex and therefore that the sex involved is always coercive.

Despite this, sexual activity does occur and recent interest has been stimulated by high-profile scandals and increasing evidence that sexual acting out is rather common. Gabbard (1995) and Gabbard and Lester (1995) announce that acting out of erotic feelings between therapist and patient is more common than acknowledged. Jehu (1994), whose book length treatment of the subject is authoritative, reports on a survey of American psychologists (Pope, Keith-Spiegel and Tabachnick 1986) in which 95 per cent of men and 76 per cent of women reported having been sexually attracted to patients on at least one occasion, 46 per cent reported engaging in sexual fantasies about patients rarely and 25 per cent more frequently, usually 9 per cent of men and 2 per cent of women had acted out these feelings in some way.

Who has sex with their patients and why do they do it?

The vast majority of therapists who become involved with their
is an infamous case, reported by McNamara (1994), of exploitation of a male patient by a female psychiatrist/psychoanalyst, ending in the patient’s suicide. The case involved intense sexual fantasies by the patient and sexually suggestive letters both ways resulting in a curious, eroticised regression. McNamara points out that, consistent with our tendency to view female transgression more seriously, this case produced outrage and national coverage but cases of male sexual exploitation, which were much worse, did not. There are accounts of sexual exploitation between homosexual analysing couples and sufficiently many accounts have accumulated in the literature for there to be suggestions that lesbians analysing lesbians may be at particular risk of sexual acting-out, although no reliable estimate of numbers has been produced.

Attitudes to and explanations for sexual activity during therapy depend largely on the extent to which the experience of sexual attraction is thought to need any independent explanation. Those therapists whose views about sexual expression are most normative tend to regard the desire to have sex outside of a standard relationship (however defined) as pathological and needing explanation. Those therapists whose views about sex are more permissive or less theorised see sexual attraction as, to an extent, inevitable and focus mainly on controlling sexual expression.

In the former group Thompson (1999) sees sexual acting out in the consulting room, for all its grown up appearance, as an example of regression to mother–baby dynamics. She suggests that the analytic couple have come to fantasise that all their needs will be met by sex. Lasky (1989) takes a different tack, arguing that male analysts identify with their female patient’s heterosexual desire and feel homosexual or feminine. This makes them anxious and leads to sexual abuse of patient by the therapist who is trying to prove he is masculine and actively sexual. Kernberg argues that, in general, narcissistic pathology is involved in analysts who sexually act out but admits oedipal dynamics, including a wish to be found out, may be involved.

Amongst those in the more permissive group, a number of writers have tried to anatomise the risk factors which predispose a therapist to begin a sexual relationship with a patient. Jehu (1994) lists personal distress, isolation, grandiosity, dominating character and antisocial traits as vulnerability factors. Schoener and Gonsiorek (1989) identify impulsive and sociopathic character disorders in abusive therapists. The former have longstanding problems with impulse control and have poorly controlled sexual behaviour in their personal lives. Sociopathic abusers tend to be more deliberate and cunning; they may abuse sexually and see the therapy situation as one in which they can procure sexual experiences. Typically they are cool and calculating and detached. POPAN (Prevention of Professional Abuse Network: www.popan.org.uk – an organisation to help people who have been abused in therapy) stresses isolation and turmoil in the therapist’s personal life as risk factors. They mention the more serious sexual and calculating abuser but stress that such individuals are rare. Finkelhor (1987) has written generally about sexual transgressions and deviant sexual behaviour and suggests a range of different factors, including wishes for sex and love or for the patient to assure the therapist’s distress. Against such factors may be reasons for restraint which include internal inhibitions, external constraints, and resistance by the patient. Jehu says that therapists who have sexual contact with one patient are at a high risk of re-offending and remarks that 80 per cent of offenders had had sexual contact with more than one patient.

Who is abused?

Many of the individuals exploited by therapists appear to have a pre-existing psychological vulnerability to abuse and can therefore seek, to a suitably predisposed therapist, to be asking for it. Patients reporting abuse experiences show a tendency to develop erotic transferences to therapists and to reverse roles with the therapist and start caring for them. Some patients also lack sufficient and accurate knowledge about the inappropriateness of sexual relationships with their therapists or may need to achieve power over the therapist by developing a sexual relationship. At the more extreme end of psychopathology some patients with borderline personality disorder, dissociative identity disorder or complex post-traumatic stress disorder may have a range of symptoms including dissociative reactions, sexualised behaviour, confusion over boundaries, or extreme dependency. These symptoms both offer an exploitative therapist excuses for breaking boundaries and initiating sex and also may reduce inhibitions on sexual activity by increasing the therapist’s evaluation of the chances for successful compliance.
Jehu (1994), Gardner (1999) and POPAN (www.popan.org.uk) all remark that as many as 80 per cent of cases reported to them involve patients sexually abused in childhood. The mechanisms by which sexual abuse experiences in childhood ultimately result in sexual exploitation in therapy are probably various. Some people who are sexually abused in childhood appear not to be seriously damaged by it but a large proportion of patients with personality difficulties, depression, and major psychotic disorder are found to have had unwanted sexual experiences in childhood. Patients with these conditions are likely to be vulnerable to sexual abuse in therapy. The prevalence of childhood sexual abuse is so high in cases of sexual exploitation in therapy that a history of it can serve as a useful warning marker to guide extra caution in managing such patients. A past history of sexualisation is reported by 51 per cent of patients, (Jehu 1994), who say that they have had sexualised relationships. The reasons for this may include difficulty in distinguishing sex and affection, having a compulsive need for sex as proof of being loved, and using sexuality to serve as a self-punitive function.

The process of sexual boundary violation is reported by most patients in therapy settings as involving a gradual erosion of customary boundaries. These commonly include unorthodox therapeutic arrangements, suggestive talk, physical contact, extra therapeutic relationships and excessive self-disclosure by the therapist. However, a softly softly approach is not invariably and severe psychological pressure may be applied, or therapists may physically intimidate or assault their victims. Sexual experiences in therapy often continue for a while. Jehu’s survey showed that therapy ended immediately after the first sexual contact in 34 per cent of cases and, of these, in over half the immediate ending of therapy also ended sexual contact. For the remainder sexual relations and therapy continued. This is important for the psychology of the patient. Someone who returns to a sexual situation which is transgressive, for whatever reason, potentially lays themselves open to internal and external accusations of complicity.

Harriet was a highly damaged woman whose early promise as a brilliant academic had given way to a life of obsessive cleaning and self-recrimination for reasons which remained stubbornly obscure even after twenty years of psychiatric treatment.

By the time she was referred to her present therapist she was on her fifth psychiatrist and seventh psychotherapist. In therapy she soon revealed that her previous therapist had sexually abused her and that she felt guilty and upset about this. The story, as gathered both from her and from others involved at the time, was that she had been referred to her previous therapist at a time when his stock was high and he was thought both a brilliant teacher and clinician. Sessions had been initially formal and restrained but had then been moved to an evening slot. As winter drew in the therapist often let the room grow dark. The patient grew increasingly dependent on the therapist and felt she had been reassured that she would stick with her whatever it took. One day when the patient was in deep distress she asked to hold the therapist’s hand and he let her do so and let her put her head on his lap. This established a pattern of encounters which she found beneficial and supportive. Then, one day the therapist under the guise of helping her to stand placed his hand on her breast. She was shocked and upset but said nothing. At the next session she placed the therapist’s hand on her breast. Again nothing was said. Now a new pattern had been established in every session there was some ambiguously sexual element. Some months later the therapist announced his retirement. Harriet was furious and threatened to disclose the sexual element to the sessions if he did not go on seeing her. The therapist denied the existence of any sexual element to the sessions.

This account of a sexually exploitative experience in therapy illustrates many of the complexities which often arise. The therapist’s behaviour is clearly on the wrong side of the line and yet it is not the kind of outrageous barn door transgression which usually comes to mind when sexual transgression is discussed. Classic vulnerability features are present in the patient, in the therapist and in the setting, all of which promoted regressive dependency which could have been picked up by someone with sufficient expertise. In this case the local expert was the abuser. The patient, because of her pathology, does much to worsen the situation but deserves to be protected not exploited. It is not clear whether the broken promises, leading to abandonment, or the sexualisation of the relationship was the more harmful or the most unprofessional.
Opinion is divided about the probity of sexual relationships once therapy has ended. Some people and organisations feel that a fiduciary duty continues in perpetuity (Gonisorek and Brown 1989, in Jehu 1994) while others set down a range of strictures and limitations which amount to a cooling-off period. Most commentators (see www.popsan.org.uk) would agree that there remains a power differential between therapists and patients even after termination, so that coercive influence may still be exerted after the end of treatment. Broadly, those patients who were vulnerable to sexual exploitation in therapy remain vulnerable to exploitation in post-therapy sexual relationships.

The outcome of sexual relationships in therapy

Survey data (Jehu 1994) reports that predominantly adverse psychological consequences for patients follow therapy abuse. Negative effects on personality occurred in 34 per cent of the patients, including depression, loss of motivation, impaired social adjustment, significant emotional disturbance and suicidal feelings. Hospitalisation was necessary in 11 per cent of the cases, 14 per cent of patients attempted suicide and 1 per cent were successful in committing suicide. The problem with interpreting these figures lies in deciding how much of the pathology to attribute to pre-existing conditions. In contrast to these adverse effects, 16 per cent of the patients were reported to have become healthier and in 9 per cent of cases no effect was found. Therapists who were sexually intimate with patients tended to report positive effects. These were also more likely if the patient initiated the sex or if the initiation of sex was mutual. Obvious biases in reporting make the interpretation of this data difficult. It is a simple matter to spot the likely effects of self-justification bias in those therapists who report the value of their erotic attentions to patients. However, successful sexual outcomes may be underreported by patients who, well aware of the consequences of reported transgressions by their therapists, keep the matter secret. Some unsuccessful outcomes may never be revealed by patients who are too traumatised to complain.

Those psychological factors which predispose patients to a likelihood of sexual exploitation also predispose them to a more severe outcome. Labelling the psychological consequences of adverse events depends, to an extent, on diagnostic debates over the use of the term post-traumatic stress disorder (PTSD). Jehu (1994) freely uses this diagnostic category and finds it to be a frequent outcome in patients. A huge range of symptoms, including loss of sexual interest, many forms of addiction, self-damaging behaviour, and denying, minimising, playing down or rationalising the abuse, or feeling emotionally dead, numb, being unable to recall their abuse experiences in some degree, and dissociative reactions including 'spacing out' and depersonalisation, all fall under the rubric of PTSD. Reactions are grouped into blocks which involve intrusive thoughts, phobic avoidance, chronic arousal and emotional numbing. At the severe end of the spectrum PTSD shades into dissociative identity disorder. Patients can experience a PTSD diagnosis as helpful because it co-ordinates a wide range of symptoms into a coherent whole. However, a major disadvantage of the diagnosis lies in the way that it ignores the specific interpersonal complexities of the trauma of sexual exploitation by a therapist having been fashioned with reference to major catastrophe. Treatments based on the condition often fail to analyse feelings of complicity sensitively enough. Worries about complicity may occur in any trauma but have added force in interpersonal traumata.

Treating patients who have been sexually exploited

The first major problem with all accounts of treatment for patients who have had sexual relationships with therapists is that they fail to allow for the possibility that no treatment may be needed or wanted. Jehu, for example, stresses the need to facilitate disclosure and suggests that if abuse is not disclosed then the therapist may gently probe the patient. His argument is probably based on the use of exposure to the avoided stimulus in the cognitive-behavioural treatment of PTSD, and for many patients facilitating disclosure will be valuable. In other situations the fact of abuse may not be the primary thing the patient needs to deal with and it may even be the case that preoccupation with it is impeding progress.
A third area of special difficulty lies in the subsequent transference and countertransference difficulties that bedevil a new therapy. Patients who feel exploited and abused are likely either to lack trust in their subsequent carers or to idealise them as rescuers. Therapists are likely to have their own emotionally laden views about the topic under discussion. Some react with denial and try to move the patient off the topic. Others experience excitement and a morbid pleasure at the possession of secret knowledge about another therapist’s downfall. Perhaps therapists are the wrong people to be treating patients who have suffered at the hands of their colleagues. POPAN (www.popan.org.uk) does help patients to get into therapy if they wish it but also runs self-help groups which bring together patients who have been abused in a setting which is egalitarian and open.

**Primary prevention of abuse**

This may be difficult. Provocatively, Jenu (1994) reports that in a survey of psychiatrists in the USA it was found that offenders were more likely than non-offenders to have completed an accredited residency and to have undergone personal psychoanalysis or psychotherapy. A survey of social workers (Jenu 1994) also showed that personal therapy was not associated with lower rates of abuse by therapists. It is not clear why more highly qualified therapists may be more likely to abuse patients but it is possible that their professional status and prestige could help them to avoid detection. Jenu also reports that education does not seem to deter people from abuse and helpfully adds that factors like personal distress, tendencies towards professional isolation, grandiosity or domination, or an antisocial personality disorder, are likely to be relatively impervious to educational influences.

Regulation of psychological treatment from professionals seems a sensible step and ensures that patients have a properly constituted organisation that can hear complaints. The absence of such an organisation represents a considerable difficulty for patients who are complaining about an unregistered practitioner. However, there are disadvantages to regulation in some areas when professionals have a range of affiliations each of which takes independent disciplinary action and where each such procedure
requires evidence from the patient. The repetitive and drawn-out nature of the proceedings does not help the patient to move on.

Because re-offending rates are appreciable, wherever therapists are employed it is sensible to have checks to ensure that previous disciplinary procedures have not been initiated in this area and also clear written policies on standards of conduct. Jahu and POPAN both recommend supervision as another means of prevention. However, while supervision can be valuable, it should not be thought a sufficient guard against the professional isolation which may accompany and predispose to sexual boundary violations. Single-handed practitioners in private practice are evidently at risk but isolation amounting to single-handed practice within organisations also occurs. Both kinds of situation should be rigorously avoided:

Laura supervised Andrew, a psychiatric nurse with a second qualification in psychotherapy. His special qualification and position in a local community team had led to his being referred a portfolio of women with borderline personality disorder with whom he had built up a reputation for working well, even charismatically. Although Laura did not like Andrew much she had little to say faulting his work, as reported to her by him, but she had no contact with the clinical team and no independent check on what he did. When a patient made a very serious and well founded allegation of sexual misconduct against Andrew Laura was ‘both surprised and not surprised’. This was a general reaction throughout the service as people slowly realised that no one knew what Andrew was doing most of his working week. While the organisation was able to respond, slowly, to the allegation which had been made it was still not entirely able to acknowledge the challenge of this incident for organisational practice. It did not, for example, consider contacting any of Andrew’s other patients as it would have done if Andrew had been a surgeon with an infectious condition. It also did not find time or energy to review its working practices in relation to professional isolation.

The organisation’s response to the allegations of abuse bears the marks of fear which is fostering avoidance. Obviously complacency is equally worrying and can be found even in professional publications.

My patients may have eroticised fantasies about me from time to time, but they are in no way disturbing or uncomfortable for them or me, nor is there any expressed wish to act them out. (Gordon 1999:50)

Discussing the taboo

One topic is almost never discussed in the current literature on sexual misconduct or experience in the consulting room, and that is the reason for the taboo nature of the subject. At times the way the topic is discussed amounts to a sex panic. Granted that the outcomes for patients may be poor for some but it remains unclear that the results of sexual encounters between patient and therapist are much more seriously damaging than other, less investigated, technical errors in therapy. Furthermore, it is often the taboo nature of the sex which both excites and upsets the patient, who becomes complicit in the transgression of a social taboo and is therefore to an extent damaged by sex in the consulting room more because it is taboo than for any other reason.

Analysts have, to an extent, adopted the notion of taboo in relation to this phenomenon by relating the incest taboo to the taboo on sex in the consulting room. Yet they cannot say convincingly why a taboo on sex in one area (incest) should translate other than by analogy to a taboo on sex in another area (therapy). Admittedly they can draw on parallels between the analytic relationship and parent–child relationships but the therapeutic relationship also has many dissimilarities from early relationships. For example, money changes hands. Because commentators always start by assuming that the taboo on sex in the consulting room must exist they are handicapped in any effort to understand its origins. Even seriously considering the value and nature of the prohibition is itself taboo and can provoke public censure because questioning the taboo raises the possibility that the questioner may have broken it or be about to break it.

Samuels (1999) does take up some of these issues. He notices the harmful effects of sex panic on analysis, arguing that the effect is to promote the analysis of all erotic feeling as rooted in early mother–baby dynamics and thereby to do ‘safe analysis’. However, he too rapidly returns to a safe zone by arguing for an
eroticism that is experienced but not enacted in therapy. He also
fails to acknowledge an important undertone in his metaphor of
safe analysis which alludes to the idea that conducting a danger-
ous analysis would lead to the spread of a deadly virus through
the profession. Some of the ways in which the taboo on sexual expres-
sion in analysis is enforced, including the way some patients who
have experienced it are treated with exaggerated caution, do carry
the imprint of a fear of infection and contamination. This is
consistent with Battaille’s (1987) idea that the threat fought off
by a taboo is one of contamination of the ordered world of work
by a sexuality that is too sticky, confused, dangerous and related
to death, to be easily contained by the world of work. Analytic
dissection into oedipal versus pre-oedipal urges or reflective
discussion in supervision might prove equally inadequate.
Battaille’s analysis of taboo provokes the sobering thought that a
necessary prohibition on sexual exploitation in the consult-
ing room may also serve to civilise psychotherapy, fitting it and
helping it to fit others for the work of ordered production and
drawing them away from the dark excitations of the underworld.

The taboo on sex in the consulting room is therefore not, as
Samuels sees it, a necessary good which if managed right may be
productive for the patient. Instead, it is probably a necessary evil
which protects the patient from coercion and exploitation while
chaining aspects of the erotic imaginations of both parties. The
necessity for the taboo is partly driven by the need of our culture
to restrain sexual forces in order to maintain social control. The
other restraining force is the constitution of social space for
therapy in our culture, which demands sharp demarcation from
prostitution or courtanship, both of which might have been
seen as having had therapeutic functions in other cultural settings.
Erotic imagination, while shaped by culture is often able to tran-
scend it, and so it frequently threatens to escape from the confines
of the permissible, even in therapy.

The therapeutic implications of seeing the restraints on sexual
expression in therapy as a necessary evil rather than as a difficult
good are important. It means that the the restraint on the
freedom of the erotic imagination in therapy can be genuinely
mourned because it is genuinely being acknowledged as a loss.
This mourning does not necessarily have some ultimately thera-
piesically beneficial outcome for the patient but it is preferable to
the currently practised options. Feverish transference analysis in
an attempt to transmute sexual desire into baby longing may well
be an exercise in bad faith. The apparent acceptance of loss but
with the offer of the redemptive value of renunciation is a bit
better and might be helpful for some, possibly those whose erotic
imaginations take a Judaeo-Christian turn, but it runs the risk of
being a straitjacket in that there is no necessary advantage (for the
patient) in the renunciation of sex.