Sexual Misconduct and Enactment
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Sexual misconduct remains a significant problem in the behavioral health professions. Although it is tempting to view sexual misconduct as perpetrated by “bad” clinicians against patients who are “victims,” this is an oversimplification of a complex problem. In this article, the author explores the psychoanalytic concept of enactment as a mechanism that can lead well-meaning clinicians to engage in sexual misconduct; defines enactment and differentiates it from near neighbor phenomena; uses case examples to illustrate how enactments may lead to sexual misconduct or may offer opportunities to deepen and enhance psychotherapeutic work; and offers recommendations for prevention of sexual misconduct.

supervising treatment, consulting intensively, or serving as a forensic psychiatric expert with patients whose previous clinicians engaged in sexual misconduct with them. Most of these patients were left devastated in their capacity for trust of another clinician. The patients treated by me had therapies that were difficult, complicated, and painful for both parties, though often quite rewarding. Some of these patients had long histories of repeated sexual abuse, in which therapist sexual misconduct was simply the latest manifestation, but others did not, and appeared too potentially competent and high functioning to be seen simply as victims. A minority worth mentioning felt the sexual relationship had been the best part of the previous therapy and were prepared to try it again with the current therapist, if the therapist were willing. How are we to understand all this and make sense of it?

**CATEGORIES OF THERAPISTS INVOLVED IN SEXUAL MISCONDUCT**

Glen Gabbard and Andrea Celenza are psychodynamically oriented clinicians who have written lucidly on the subject of sexual misconduct. Gabbard’s 1994 paper on psychotherapists who commit sexual misconduct is a helpful one that frames the complexity of the problem. He notes that frank discussion of the issues is not always politically correct, and that there is a real danger of reductionism in the wish to view perpetrators of misconduct as simply “bad” and different from the rest of us. Gabbard groups therapists who commit sexual misconduct into four broad categories: 1) those with psychotic disorders; 2) those who manifest predatory psychopathy in their disregard for their own behavior and lack of empathy for their victims; 3) those suffering from “lovesickness”; and 4) those he sees as fundamentally masochistic and self-destructive.

Citing a study by Gartrell et al., Gabbard reports that as many as 65% of those who have engaged in sexual relationships with patients describe themselves as “in love” with their patient, suggesting that this “lovesickness” category accounts for the majority of cases of therapist sexual misconduct. Gabbard goes on to describe 14 psychodynamic themes that may be involved in lovesickness as a precursor of sexual misconduct.

Celenza has published findings from her in-depth study of 17 therapists involved in heterosexual and homosexual sexual misconduct. Her study included interviews and test batteries of the therapists, and, whenever possible, consultation with their supervisors, colleagues, spouse, and therapist, as well as with the patient/victim. She describes six common findings, the most ubiquitous of which, found in all cases, was these therapists’ tendency in their work with many patients to be intolerant of the negative transference. Other findings included unresolved problems with self-esteem; sexualization of pregenital needs; histories of covert and sanctioned boundary transgression by parental figures; unresolved anger toward authority figures; and defensive transformation of countertransference hate into countertransference love. Celenza notes that the motivation for the misconduct “most often involved unconscious, denied, or compartmentalized conflicts about which the therapist had little insight.” As a result, she notes, the therapists were “vulnerable to enactments.” Gabbard, too, makes reference to the importance of the notion of “enactment” in cases of therapist sexual misconduct, but neither he nor Celenza systematically defines the concept of enactment or illustrates how it applies to sexual misconduct. Such a definition and illustration will follow.

**THE CONCEPT OF ENACTMENT**

Enactment as a psychoanalytic concept represents an elaboration and extension of terms that have become part of the everyday lexicon of most clinicians. This elaboration progressively moves away from conceptualization of the therapist as an uninvolved expert and toward recognition of the importance of the therapist’s participation in the phenomena unfolding in the therapeutic situation. Enactments are not limited to psychoanalysis or psychodynamic psychotherapy, any more than are transference or countertransference. These processes occur in all kinds of therapeutic settings, including individual, family, and group psychotherapies of every variety, in medical-model psychopharmacologic treatments, and in cognitive-behavioral therapies. They also occur in pastoral counseling and other professional relationships in which an element of transference may be assumed to exist.

Understanding enactment requires differentiating it from other near neighbor terms that have preceded it historically. Acting out is a familiar term even to nonclinicians; it signifies a defense employed by a patient who puts an affect or impulse into action rather than words in a way that assaults the boundaries of the therapeutic
alliance and/or is a resistance to the therapeutic task. Note that acting out is a label we give to the patient’s behavior. Although the act of labeling suggests that we remain objective and uninvolved, the term acting out has come to connote a behavior that we do not like. When a clinician applies the label “acting out” to a behavior, he or she is inevitably including an implicit but unacknowledged reaction to or judgment of the patient’s behavior. When we explicitly acknowledge our reaction to the patient’s behavior as therapists, we speak of our “countertransference.” The contributions of Heimann⁴ and Racker,⁵ among others, broadened Freud’s earliest notion of countertransference, as the analyst’s transfer-ence to the patient, into the current notion of countertransference, as the totality of the analyst’s response to the patient. This includes both the kind of response that any reasonable individual would have to the behavior (e.g., fear of a patient who threatens us) and the uniquely personal reaction that is reflective of our own neurotic conflicts (our own “transference” to the patient). In the first case, the countertransference is elicited in us as it would be in any other clinician in response to the patient’s action. In the second case, our own blind spots and areas of conflict are an essential component of the countertransference.

From time to time analysts speak of actualization of the transference, a term that refers to a coincidence in which the reality of the therapeutic relationship duplicates the transference. An example is a patient, struggling painfully with having been orphaned as a child when both parents died in a motor vehicle accident, whose therapist is coincidentally injured in a motor vehicle accident seriously enough to interrupt the therapy for several weeks.

The term projective identification has gone through an extension and elaboration similar to that described above for countertransference, to include both patient and therapist. Initially, psychoanalytic theorists⁵–⁸ used this term to signify a defense in which a patient disavows an intolerable self experience, instead projecting this self experience into a therapist, who is conceptual-ized as a neutral, passive, uninvolved antenna. A fa-miliar example is the borderline patient who misses a session and then accuses the therapist of abandonment. Over time, the term has been elaborated by theorists like Shapiro and Carr,⁹ whose eight components of projective identification (p. 24) include notions of the therapist having “an attribute that corresponds” to that disavowed by the patient, “an unconscious collusion” with the process that sustains the projection, and a “complementary of projections—both participants project.” The authors note the inevitability of characterologic “hooks” in both patient and therapist. This increasing recognition of the therapist’s participation is essential in the extension of the concept of projective identification into the concept of enactment and the key to its importance, therapeutic utility, and link to sexual misconduct.

In 1976 Sandler¹⁰ noted that the analyst came to the session not only with “free-floating attention,” but also, inevitably and ideally, with what he called “free-floating responsiveness” to the patient based on the analyst’s own conflicts and character. This notion is a central one in setting the stage for the concept of enactment. In the early 1990s, McLaughlin¹¹ and others¹² discussed experiences with patients that they described by using the ordinary English word enactment in a particular way: to delineate a pattern of nonverbal interactional behavior between the two parties in a therapeutic situation that has unconscious meaning for both parties.

One might think of enactment as a multistep pro cess in which, first, there is the usual “reenactment” in the transference relationship of part of the patient’s conflicted or traumatic past. This is the part of the process of enactment that Freud captured in the notion of the “repetition compulsion.” However, in an enactment, the patient’s associated unconscious self experience is next disavowed and projected into the therapist. Again, this is familiar terrain for dynamically oriented clini cians. Enactment begins to become a unique concept, though, when the therapist then participates unwittingly by projecting back into the patient reciprocal and complementary unconscious conflicted countertransference material from the therapist’s own life history. The ther -apist unwittingly colludes with the patient in a process of mutual and complementary projective identification organized around significant past events from the lives of both participants. Within such an enactment, the ther-apist is as much an active participant as the patient.

In attempting to understand the concept of enact ment, it is helpful to recall that the interpretive work of psychodynamic psychotherapy is carried out from a position of technical neutrality. For the current purpose, the relevant area of technical neutrality is the therapist’s comfortable and unflinching acceptance of the patient’s transferences. Although such technical neutrality is the ideal, psychotherapists know how hard it is to remain able to bear intense and often negative transferences from a patient. In enactments, the therapist may be
thought of as joining the patient in a process that moves the therapist away from neutral acceptance of the transference.

The evolving mutual projective identification of an enactment becomes a slippery slope on which the therapist is in danger of sliding away from the component of the therapeutic role that requires accepting the patient’s transference. Enactments become a mechanism that may lead to sexual misconduct by professionals. The equation to be constructed, though, is not Enactment = Sexual Misconduct. Far from it. Enactments are not inherently “bad,” and they do not happen only to “bad” therapists. The ideal technique in therapy is not even to avoid enactments—as if one could. In an endeavor as complex as psychotherapy, enactments that put therapist and patient on a slippery slope are as inevitable a part of the work as a slippery snow-covered slope is to the endeavor of skiing. In fact, in both situations the trick is to learn to use the dynamics of the slippery slope to help get to the bottom of things.

Therefore, an enactment is neither tragedy nor cause for celebration, but an inevitable event and an opportunity to find meaning through a new way of looking at things. When recognized and then utilized by the therapist to enrich the grasp of the patient's inner world as it intersects the therapist’s own, enactments offer us an opportunity to deepen and enrich our work with patients. Left unrecognized, though, they can lead a therapist to become lost in the dyad with the patient, becoming unmoored from the larger task and the field’s ethical standards in a way that may lead to various problems—ranging from those that are within the bounds of good clinical practice and professional ethics, to impasses or negative therapeutic reactions, to those involving egregious professional acting out and such ethical violations as sexual misconduct.

Recognizing and making use of enactments requires a broader view than the traditional view of therapy as composed of two parties in a dyad, one of whom is an omniscient expert who competently applies technical knowledge. The concept of enactment is predicated on the notion that the therapy occurs within a supraordinate context or third space beyond the dyad. Becoming lost in the task of therapy is not simply a risk for the patient. The therapist’s task is not only to understand and interpret how the patient is engaging him or her in the dyadic relationship, but also to detect, understand, and interpret enactments involving both parties in the dyad from the perspective of a supraordinate third space. It is not the therapist’s task to prevent all enactments within the dyad, but rather to establish and maintain a reflective outside perspective on the dyad that can detect enactments quickly, then use them to deepen the therapeutic work. Maintenance of a perspective on the dyad may be enhanced through cultivation of a self-reflective capacity learned from one’s own analysis or psychotherapy, but it is often best provided through an actual concurrent outside perspective, such as consultation, supervision, or case discussions or presentations. It is through the use of this reflective space that a therapist can detect the presence of an enactment and translate its meaning into words.

**ENACTMENTS INVOLVING REFUSAL OF THE TRANSFERENCE**

Enactments generally occur when the therapist’s own blind spots and character lead him or her to drift away from technically neutral acceptance of the transference, toward either refusal or actualization of the patient’s transference. Refusal or actualization of the transference by the therapist is often an early manifestation of an enactment. Refusal of the transference, particularly of the negative transference, occurs when the therapist has trouble accepting the transference because of distaste for the one offered by the patient. A semi-fictionalized case example illustrates this point.

A 40-year-old woman entered therapy because of depression associated with recovery of a painful memory of adolescent sexual abuse after her own teenage son was accused of sexually inappropriate behavior with his cousin. The patient had been raised in a rigidly moralistic fundamentalist Christian home by her emotionally absent, depressed mother and her angry, disapproving, born-again preacher father. The patient rejected the stifling environment of the family and challenged her father’s authority, which led to severe physical punishments. Eventually she learned to keep her anger at him secret and developed a secret social life that involved sneaking out the window of her room at night. As a 14-year-old, the patient was sexually abused one night by a group of older boys she had befriended, but she felt unable to report this to anyone. The patient struggled to get on with her life and “forgot” this incident. She became “born again,” and formed a new idealization of her parents, especially her father, who responded with the first warmth she had experienced from him. In fact, she became his special confidante. The patient grew up to become a woman who alternated between idealization of men and anger at and mistrust of them. She had a strained marriage to a man who engaged in a series of extramarital affairs, but she managed well until
the accusations against her son emerged when he was the same age as her abusers. The patient’s marriage became further strained as she and her husband disagreed about how seriously to take the allegations about their son.

The patient’s psychiatrist was a man in his forties whose own marriage was strained by his long hours at work. The youngest child in his family and the only son, he had been adored as a child by his father and sisters, who saw him as special and brilliant. His mother, though, was demanding, critical, and prone to rages targeting her son. Father and sisters would let him “get away with murder” because of their idealization of him and guilt about his victimization by the mother, whom none of them dared challenge. In his training, the psychiatrist had been in therapy and had learned about his fragile self-esteem and fear of his rageful mother, from whom his father and sisters had protected him by concealing sometimes significant misbehavior.

In the therapy with this patient, there was an initial idealization of the therapist that shifted into an extended period of anger at him after his first vacation. At one point the patient, complaining about his abandonment of her during the vacation and on weekends, suggested that he was “abusive and getting away with murder” while she suffered. The therapist was quite rattled by her angry accusations that he was an abuser. He felt guilty about his vacation with his wife (which had gone badly), became quite solicitous, began to extend sessions, and then offered extra ones. The patient responded by becoming idealizing again, and the transference and countertransference developed an erotic tone. As the next interruption to therapy approached, the therapist became anxious about telling the patient and “forgot” to tell her until just before it. This time her rage on his return was more intense than the previous time.

At this point, for heuristic purposes, we need to engage in a bit of sleight of hand, cloning the patient and therapist at this moment in the work when they are poised together on the slippery slope of enactment, where both real skiing and tragic falls may result. The fate of each cloned pair (Dr. X. and Ms. X., Dr. Y. and Ms. Y.) will be explored.

In the first pair, in response to Ms. X.’s even more intense rage on his return from vacation, Dr. X. began to reveal bits of his personal life, explaining how hard it was for him at home in his own marriage, to which the patient responded with sympathy and renewed idealization, leading to further mutual self-revelation. Therapist and patient began to feel especially close and like kindred spirits. When Ms. X. revealed her love for the therapist, Dr. X. revealed his for her, and they entered a sexual relationship.

The patient’s rages and idealization were transference manifestations of her early family experiences and abuse. Using projective identification, she found in her therapist her abusers, her critical father and unavailable, emotionally absent mother, and the idealized father of her period of rapprochement with him after the abuse. The therapist was characterologically unable to tolerate rages in the transference and was struggling with his own marriage and self-esteem. His projective identification into the patient found in the relationship with her an angry and abusive mother whose rage he could not tolerate and a covert and sanctioned invitation to violate boundaries, like that his sister and father offered him, which became components of his sexual misconduct. The patient’s uniquely personal characterologic “hooks” hooked his own characterologic vulnerabilities, and they became lost in the dyad, with sexual misconduct the result.

The second cloned pair had a better outcome. Poised on the same slippery slope, Dr. Y. was troubled by forgetting to tell Ms. Y. about his vacation. When Dr. Y. returned, he consulted with a colleague before the first session with Ms. Y. and realized he was in an enactment in which he was in danger of losing his way. When Ms. Y. began to berate him angrily for forgetting to tell her about the vacation until the last session, and for abandoning her again, he found a way to sit still and listen. Ms. Y.’s rage escalated in response to his invitation to tell him more. After listening to her anger, Dr. Y. told Ms. Y. that she had a right to be angry with him for forgetting to tell her about his time away, and that he thought his error probably had to do with recalling how enraged she had been over his last absence. Dr. Y. said he was sorry about letting her know so late, but it wouldn’t help either of them to pretend he could or should avoid her rage. Since surviving absences and finding a way to deal with intolerable rage and abuse were important issues she had told him came from her past, he was determined not to shy away from these issues as they emerged in her therapy, and planned to survive her rages. Ms. Y. calmed, but she continued to be angry in some sessions, while in others she began to explore the link between her rages, her experience of Dr. Y., and her early family experiences. Since holding to his intention to accept Ms. Y.’s transferences still proved difficult, Dr. Y. entered supervision with a senior colleague, and the treatment progressed well.

Dr. Y. recovered from his enactment because he remained able to reflect on the dyad, stayed in his role as therapist, and kept within the standards of his profession. He was able to make use of his awareness of the unfolding transference and of his countertransference impulse to refuse the negative transference, first to discover in himself (with the help of a colleague) the way in which Ms. Y.’s anger at him, her father, and her abusers were connected, and then to bring this discovery—in words—into the work with his patient. He was able to use the enactment to deepen and enrich the therapeutic work. It is worth noting that Dr. Y.’s dealing with and using his understanding of his own participa-
tion in the enactment with Ms. Y. did not mean disclosing his personal history to her.

ENACTMENTS INVOLVING ACTUALIZATION OF THE TRANSFERENCE

Actualization rather than refusal of the transference can also lead to enactments. Actualization of the transference has been defined above as a coincidence, which is often the case. However, the actualization does not always take the form of the unmotivated, coincidental auto accident offered above as an illustration of the concept, but may be a behavior engaged in by the therapist that unwittingly actualizes the patient’s transference through acting out of the countertransference. This is illustrated in the following semi-fictionalized case vignette.

A 19-year-old woman, Ms. A., began cognitive-behavioral treatment and pharmacotherapy with a psychiatrist through a college counseling service because of depression and symptoms of posttraumatic stress disorder after an experience of date rape. The youngest child and only daughter in her family of origin, Ms. A. had been the object of sexual teasing by her older brothers and father. The patient reported she always “felt funny and ashamed” about the language and the taking of liberties in touching her body that had been part of her childhood experiences. Ms. A.’s mother knew her daughter was troubled by the teasing from her older brothers and father. When Ms. A. con®ded in her mother some con®icted homosexual longings, the mother became anxious and withdrew from the previously close relationship with her daughter, whose homosexual longings subsided while she withdrew from involvement with the family and decided to attend college far from home.

At college, Ms. A. sometimes abused alcohol with a group of peers and, while intoxicated on one occasion, had an experience of date rape with a man at a fraternity party. Humiliated and confused, Ms. A. did not report the rape, but developed symptoms over several months and entered treatment with the psychiatrist through the college counseling service.

The psychiatrist was a woman of 30 who had just completed her residency. Unknown to the patient, the psychiatrist’s own lesbian relationship had just ended unhappily. The psychiatrist’s early experiences included an especially close relationship with her stepfather that eventually led to sexual overtures that she resisted, but she was unable to report his behavior to her mother despite realizing her younger sister might be his next target. When the stepfather did approach the younger sister sexually, the latter quickly revealed this to their mother, who sought a divorce. The psychiatrist-to-be (the older sister) was left with guilt about her silence in response to the stepfather’s sexually inappropriate overtures, but also with sadness about the loss of the special relationship with him. The psychiatrist-to-be was not sure she had done the right thing, but she found a way to forget about her guilt by compartmentalizing it and becoming an activist in rape prevention.

Early in the treatment the psychiatrist prescribed medications and helped Ms. A. come to grips with the experience of date rape. Unable to put aside her personal convictions, though, the psychiatrist advocated for Ms. A. to report the rape to campus authorities, despite Ms. A.’s own guilt about the incident and fears of being shamed and humiliated. Trusting her psychiatrist’s advice, though, Ms. A. reported the rape near the end of the 20 sessions permitted by the counseling service. Unfortunately, the campus authorities and police were less than supportive. Ms. A.’s shame and humiliation intensified and interfered with attending classes. Her grades slipped. Feeling guilty about Ms. A.’s unfortunate experience in following her advice, the psychiatrist became solicitous and especially tender toward Ms. A., offering additional free sessions beyond the number sanctioned by the college. Ms. A. responded with idealization of the psychiatrist, decreased shame, and improved academic performance, and she reported an erotically tinged dream of being comforted by an older woman who would not victimize, tease, or abuse her. The psychiatrist developed a special sense of fondness for the patient. The psychiatrist felt unclear in her own mind about whether the sessions still constituted treatment or a post-treatment relationship, eventually deciding it was the latter. She managed to compartmentalize and overlook the fact that she was still prescribing medication and recording the meetings in her treatment schedule. The psychiatrist began to hug Ms. A. at the end of their meetings, then began disclosing bits of her personal life, including her sexual orientation, to Ms. A., who responded with curiosity and admiration. Uncertain what to do, but worried about repeating the abandonment of her younger sister through her silence about sexual overtures from the stepfather, the psychiatrist continued to meet with Ms. A. in mutually self-revealing sessions that increased in frequency. Over time she came to feel she was in a special and unique relationship with Ms. A. that others could not possibly understand, then found herself increasingly sexually attracted to her. When Ms. A. openly asserted her love and sexual longings for the psychiatrist, the latter reciprocated and they became sexually involved. The psychiatrist explained to Ms. A. that this kind of relationship was acceptable because they were in a special situation and no longer in a treatment relationship.
In this vignette, Ms. A.’s idealization, sense of comfort and safety from abusers, and erotic longings for the psychiatrist were transference re-creations of her early family experiences. Through projective identification she found in the psychiatrist the safety and security, the sense of sanctuary from sexually abusive men, and the seductiveness of her recently lost intimate relationship with her mother. The psychiatrist was struggling with unconscious guilt about failing to speak up to protect her younger sister from abuse, coupled with unprocessed longing for the lost special relationship with the stepfather. Her projective identification into Ms. A. found another special relationship and, through it, another chance to protect her younger sister. Ms. A.’s erotic transference, with its origins in her longings to recover the intimate and sexualized connection to her mother, was not “refused” by the psychiatrist, but “actualized” with a reciprocal erotically tinged countertransference based on the latter’s own dynamics. The psychiatrist drifted toward action as she progressively created a special relationship with the patient, colored by her own family experiences, and lost sight of her therapeutic role. Advocating a particular course of action led to guilt and to a sense of responsibility for the unfortunate outcome when reporting the rape failed to help Ms. A. In an effort to compensate for her guilt, the therapist offered sessions beyond those sanctioned by the college counseling service and entered a “special” and intimate relationship with Ms. A., who responded with the irresistible seduction of idealization, improvement, erotic longings, and love. The psychiatrist saw this as a justification for her to increase her personal revelations and for the relationship to go further, rather than as a signal that she was lost, in trouble, and in need of consultation with colleagues.

Two other points are worth noting. First, a treatment need not be defined as psychodynamic psychotherapy or psychoanalysis for enactments to occur and to be associated with a risk of sexual misconduct or other boundary violations. The psychiatrist in the above vignette saw herself as doing pharmacotherapy and cognitive-behavioral therapy. Second, much more is going on in the complex transference-countertransference enactments described in this and the preceding case than refusal or actualization of the transference alone. There is always the danger of oversimplifying these complexities; however, the notions of refusal and actualization of the transference help organize and frame a way of thinking about the problems in the treatments.

PREVENTION OF BOUNDARY VIOLATIONS

Prevention of boundary violations is a laudable goal, but attaining it is unfortunately about as likely as eliminating crime and poverty. The point of view described in this article leads to several suggestions, though. The prevention of boundary violations depends, in large measure, on education of therapists, clergy, and other professionals. It is important that training programs include peer discussions and readings orienting trainees to the field’s standards. There are numerous publications addressing the field’s standards and the boundaries of clinical work. Such readings and peer discussions not only educate trainees to the field’s standards, but also offer practical tips about warning signs of impending boundary violations. However, it is not enough to identify warning signs and teach that boundary violations are wrong because they violate our code of ethics. We would do well to educate therapists and other professionals to think of their dyadic work as located within their discipline’s larger, supraordinate context. The educational process should help individuals join the values of their field, not simply be trained in a discipline that they are then authorized to practice independently. It is the recognition that we carry out our work in a larger context, that we have joined a field and joined its values, and that we and our patients each have a role that is subordinate to the larger task of treatment, that stands to help therapists and other professionals learn to reorient themselves when they begin to become lost in the work.

One concrete way of helping professionals stay aware of the larger context is through supervision or other perspectives on the dyad from outside it. Prevention of sexual misconduct depends on making easily available to therapists, clergy, and other professionals the possibility of consultation with others in the field, particularly at times of impasse. Therapists who routinely present their work to others in consultation, supervision, peer discussion groups, or case presentations are probably at less risk of becoming isolated and lost in the dyad in their work. This is not a simple matter in the current clinical climate, where financial pressures have squeezed treatment settings and therapists in a way that leaves little room for clinical conferences or case discussion.

Educating practitioners and students about central psychodynamic notions like transference, countertransference, and enactment, and teaching them the impor-
tance of accepting and tolerating the transference offered by the patient, seems wise. In therapeutic work, if the transference fits, wear it—even if it hurts! Awareness of the concept of enactment, in particular, has a double benefit. First, it teaches therapists about an inevitable therapeutic phenomenon that places them at risk for sexual misconduct but that also offers an opportunity to deepen their work. Second, knowledge of the concept of enactment reminds therapists that we are all inevitably vulnerable human beings. This awareness serves to minimize the unhelpful we/they split that can provide a false sense of security to therapists who believe that sexual misconduct can’t happen to them. Unfortunately, in psychiatry today little is taught to residents about psychodynamics, much less about the complexity of tolerating intense transferences and the importance of enactment. These trends in training, coupled with the current focus on behavioral and symptom-focused treatment approaches that exclude attention to transference and countertransference, do not help. Despite all the good that comes from a focus on patient satisfaction, this trend may have the unfortunate effect of reinforcing therapists’ inclination to refuse negative transferences.

It seems wise to cultivate humility in ourselves as clinicians and teachers of younger professionals, emphasizing the inevitability of our own fallibility in this complex work. However great our expertise, we remain fallible human beings, doing our work along a fine and fragile boundary.

REFERENCES