

Complex Sexualized Transferences When the Patient is Male and the Therapist Female

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The expression of sexual feelings toward the therapist is a common development in psychotherapy regardless of the gender constellation of the dyad. Much of the literature on this topic has been written about female patients by male therapists, though, and some authors (1, 2) have suggested that male patients either are too inhibited to express sexual feelings to a female therapist or tend to act out such transferences by involving themselves in outside sexual relationships. In the last 20 years or so, however, a growing literature written by women clinicians has suggested otherwise (3–7). In primitively organized male patients, sexualization may be deceptive since it often represents only the phenomenological surface of the transference, and female therapists need to be aware of underlying aggressive and dependency themes beneath such transferences (7, 8). Resident-therapists beginning to learn psychotherapy may be surprised by this inextricable connection between aggression, dependency, and sexuality in such patients, as the following case presentation will illustrate.

Case Presentation

Dr. Hobday

“Mr. A” was a 44-year-old college-educated white man who initially presented to psychotherapy at a low-fee training clinic. His chief complaints at that time were social anxiety and depression, which he reported had been present intermittently throughout his lifetime. He had significant trauma in adolescence when his mother, who was chronically suicidal, finally killed herself. He had attempted to prevent her from killing herself on numerous occasions.

Before presentation to the clinic he had never been in therapy, been hospitalized, attempted self-harm, or taken psychotropic medications. When he finally sought treatment, he was virtually housebound and had lost his job, had no friends, and would only go out for groceries in the middle of the night secondary to his social anxiety disorder. At intake, his diagnoses were social anxiety dis-

order, depression not otherwise specified, and alcohol dependence in early remission.

When we began our work together, he had already completed 1 year of cognitive-behavioral therapy (CBT) with Dr. S, who had transferred the patient to my care at the time of her graduation. Mr. A had shown an ability to use CBT techniques and had experienced improvements in his disabling anxiety. He had increasingly longer periods of sobriety, had returned to stable employment, and was reconnected with a small circle of family and friends. He had also been started on an antidepressant, duloxetine, 30 mg, for depressive symptoms and a low dose of an antipsychotic, risperidone, 1 mg, for intrusive and ruminating thoughts at night. Dr. S, however, detected no signs of psychosis. The addition of medications seemed to result in further improvement.

Upon mental status examination, he presented himself as a tall, thin man with long hair that was shoulder length and thick. He chewed on a coffee stirrer throughout our first meeting. He chose not to shake my hand when approached and appeared visibly anxious with a noticeable tremor in his hands and beads of sweat on his forehead. The volume of his voice was surprisingly loud for the small office where we met. Although his eye contact was fairly good, he appeared frightened despite maintaining a pleasant demeanor. He was in no way threatening and was immediately likable. His pain and anxiety were palpable, and I could sense a powerful feeling of wanting to rescue him as he spoke of it. He seemed able to talk with me fairly openly but voiced that he was afraid to meet with me. He carried a notebook with him and, minutes into the session, pulled pages of writing from this notebook and thrust them toward me.

I recalled from reviewing his chart that in his work with Dr. S, he had a practice of writing his “thought records” in a prose format between appointments. He and I discussed the best way to incorporate the content of these rather extensive writings into therapy sessions. He expressed concern about my “wasting time” in the session reading his writings. So to begin we agreed that I would look at them between sessions and comment on them at our next session. I felt this had the potential for supporting continuity between sessions. In addition, we discussed whether he desired to continue work with CBT, since it had proved helpful thus far. He said he felt some sense of mastery of those techniques and was ready to work on “deeper issues.” Hence we agreed to move into a dynamic therapy. The largest of these issues was his mother’s suicide. He wanted to “eventually get there” but felt he needed to develop trust in me and work on less intense material first. He

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continued to struggle with long-term abstinence from alcohol, continued to feel anxious and “judged” by people in public, and suffered from depressive episodes related to long-standing low self-esteem.

At our second session, Mr. A presented me with his first writings. There was nothing at all flirtatious or seductive in his manner during the first session, but in his writings that he brought to the second session, he made the following notation: “Dr. Hobday handled the session very well. I need to tell her that when I lose eye contact, it is generally because I’m thinking. I am considering what she said and what I think; there was two or three times when I felt she might have thought I was looking at her chest, when actually I was looking at her nametag and trying to think, in order to give her a rational response, but she probably thinks I’m just a pervert.”

We spent several sessions simply building rapport to ease Mr. A into the transition. Loss of his prior therapist was anxiety provoking for him and contributed to withdrawal from others and feelings of distrust. At no time during his prior work with Dr. S or during our initial sessions did he reveal any signs of psychotic disturbance, and his distrust related to his social anxiety never shifted to frank paranoia or delusional thinking.

My countertransference to him during this time was maternal. I felt as though I could succeed with him if only I could make him feel calm, comfortable, and safe with me. I even verbally expressed to Mr. A that this room was meant to be one free of judgment. He contributed to this countertransference response by initially appearing meek and frightened, apologizing on multiple occasions, and at times actually providing me with the reassurance that I was probably looking for, i.e., that he felt comfortable with me, that I was “doing it right.” After all, he was my first long-term psychotherapy patient.

During this time he developed an idealized transference to me and engaged in splitting between myself and his prior therapist. I was the good object who could “finally really help him.”

After working together for several months, there was a striking shift in his transference to me. He became derogatory, interrupted me, and talked at an even greater volume. He would make statements such as “I do not mean to hurt your feelings, but I’m smarter than you are.” He also accused me of using him to meet the requirements of my residency. He was highly intelligent and well read, and at times I was intimidated by his knowledge base. However, I continued to enjoy working with him and found him to be interesting, engaged, and having potential to change.

During this period in which he became more contemptuous, he also started commenting on my high heels at every visit. I dismissed his comments as reflecting the fact that he only wore flip flops, rather than feeling it reflected a sexualized transference. I did not feel leered at or uncomfortable. However, when he continued to express his superiority over me while commenting on my shoes at each session, I began assuming that something else was going on. He had become defiant and critical rather than compliant and anxious. I pointed this out to him, and he responded by saying, “Yeah, I am in my rebellious phase.” He was unable to provide further clarification of this “rebellion.”

Several weeks later Mr. A arrived with four pages of writings. He continued to be rebellious and oppositional.

While I was flipping through the writings, he was speaking of being a “horrible person” because of the things he thinks. In the middle of a scribble on the last page was written “Die now.” I asked him what it was about. He minimized the significance of it, stating that he was very frustrated with Alcoholics Anonymous and particularly with his Alcoholics Anonymous sponsor. When I specifically asked him about why he wrote “Die now,” he innocently responded, “Oh...I did?” After assessing suicidality and risk for violence and finding no evidence of either, we moved on.

He noted that he was an awful person because he liked to look at women and should not do that. I attempted to reframe this “cognitive distortion” of himself by normalizing this behavior/desire to look at attractive females. I reviewed with him whether or not he had ever acted on any of the looks he gave women. He responded that he had never touched anyone inappropriately.

We ended the discussion on a good note, and as he left the clinic, I was standing by one of the clerks filling out his billing sheet, and he commented that I was “still wearing high heels.” For the first time I suddenly felt that I was being leered at. Indeed, when I returned to the office, I read the rest of the writing he had given me and was in a state of shock: “OK, I need to face this. I have to apologize to Dr. Hobday. Here is the problem. I do not know what I’m apologizing for. I am stupid. I do not know what I did wrong. I do not remember looking at Dr. Hobday. I do not fixate on her breasts, rear end, or legs. One thing I do not understand is her fixation with wearing high heels. They are uncomfortable and unwieldy. OK, they accent your legs, but Dr. Hobday does not need that. She has really nice legs as is. This is a body that most women would kill for. I cannot talk about this anymore. I have to view it as doctor and patient. Perhaps this is what I did wrong. Perhaps I looked at her like a sex object. Perhaps I imagined softly running my hands up her legs. Perhaps I should stop. Perhaps I should remember that Dr. Hobday is a professional. Perhaps I know what I should apologize for. I cannot even attempt to improve myself without wallowing in sexual desire. Why cannot I look at Dr. Hobday as a professional? Why must I look at her body? Because it is a really nice body to look at.

Do I compare Dr. Hobday to Dr. S? Yes, I do. I need to remember that Dr. S helped me through a tough time, but Dr. Hobday needs to work with me on a deeper level. Dr. S is no more. I need to quit comparing Dr. Hobday to Dr. S. They are two different doctors with different agendas. However, all things considered, Dr. S has nicer legs. Typical—men—all they think about is sex. If it makes you feel better, you have nicer boobs.”

Dr. Mellman

Many therapists are reluctant to expose their work in a more public setting, yet presentations like these are essential for learning, and we all are most appreciative for Dr. Hobday’s courage in this regard. Assessing the suitability of the patient for treatment and determining the treatment of choice are quite important. Did Mr. A benefit from CBT and could he make use of a psychodynamic approach? Many patients who are most suitable for CBT are also suitable for psychodynamic therapy. These are patients motivated for treatment, willing to look at themselves, and open to learning and working with a therapist. Assessing the level of the patient’s de-

fenses—primitive, intermediate, or high—will help the therapist assess the patient's ability to make use of psychodynamic psychotherapy. For example, evidence of a tendency toward severe splitting and paranoia may undermine dynamic therapy. The spectrum in dynamic therapy of supportive to expressive that is optimal for a patient depends on the patient's ability to tolerate uncomfortable affects without significant disorganization or paranoia, an ability to explore thoughts, feelings, and reactions in relationships including the transference, capacity to explore unconscious conflict, and ability to identify and explore patterns between current relationships, past relationships, including family relationships, and the transference relationship with the therapist.

In the case of Mr. A, his pattern of avoiding interpersonal interactions for many years, difficulty holding a job, and lack of progress in developing significant relationships likely made psychodynamic psychotherapy more challenging for him and suggested that he might respond with avoidance and anxiety, or at worst, disorganization or paranoia. His early comments on breasts and shoes suggest an early, primitive transference without a good filter, and his projected fear that he will be rejected as a pervert and feelings of shame and humiliation suggest more primitive defenses. His use of writings is interesting in that they were a way to express himself, keep him connected with the therapist in between sessions as a way to hold on to her, and yet avoid having to deal with these feelings in the sessions. They also allowed him to control Dr. Hobday by making her think of him between sessions by having to read them and to control the treatment by omitting any spontaneous thoughts, such as free association.

Dr. Gabbard

I share Dr. Mellman's admiration for Dr. Hobday, and her case allows us to examine the unique features of a particular sexualized transference when the therapist is female and the patient male. Female therapists may actually experience much more of a physical threat to their safety when the patient is a male, compared to the situation with a male therapist and female patient. Celenza (7) makes the point that in traditional gender stereotypes in the culture, hardness and the outward direction of aggression are associated with maleness, while passivity, softness, and inward direction of aggression are viewed as female. Moreover, men in general tend to be physically stronger than women, which may be the chief difference in sexualized transferences involving a female therapist.

Transferences that are characterized by sexual desire for the therapist reside on a rather extensive spectrum from those involving a shy, deeply conflicted and ashamed male patient, on the one hand, to those involving a threatening, antisocial male on the other. Female therapists must carefully assess this dimension of risk when undertaking the psychotherapeutic management of such patients. Does one explore the meanings of a transference? Or does one set firm limits on what is acceptable in treatment? Moreover, are there instances in which one must end the treatment? A related concern is how much latitude one gives a male patient to explicitly express sexual wishes and fantasies toward the female therapist. At what point do such expressions become verbally abusive and violating in their impact? And when

does a female therapist feel that she is being devalued and professionally deskilled by being transformed into a sex object? Female therapists facing this dilemma must decide whether their feeling of being demeaned is itself a countertransference problem that they must master or a realistic reaction to outrageous behavior by the patient. The point at which one sets limits and asks the patient to cease and desist is complicated because one risks conveying that sexual feelings are not acceptable in the therapy or that they can be expressed only in a narrow range within an unspoken set of rules of therapeutic discourse.

In the case of Mr. A, writing these sexual thoughts was a compromise between keeping the material in the session and excluding it from the therapy by writing about it between sessions. Some therapists may not have agreed to read the material between sessions, but I think Dr. Hobday pursued a more useful course by allowing the patient to proceed in the only way that he could proceed. As a result, she discovered productive content in the writing that may not have otherwise entered the verbal exchanges.

The case of Mr. A reminds us that there is often an aggressive undercurrent to sexualized transferences (8, 9). Brenner (9) suggests that all transferences have multiple layers reflecting both sexuality and aggression. Focusing only on the phenomenological surface may be misleading. Mr. A's writings also show how sexualizing the transference can be a resistance. By fetishizing Dr. Hobday as body parts—feet, “boobs”, and legs—he sees her as only a part object, not as a human being that he must relate to in all its complexity. Similarly, he reduces himself to a voyeuristic observer rather than someone reflecting on his own problems and working on them in the treatment plan with Dr. Hobday. However, resistance does not connote the need to eradicate what gets in the way—resistance is the daily bread and butter of the psychotherapist. It should be understood as a revelation of an important internal object relationship as well as the patient's habitual mode of relating to women. In this case, we also see the primitive nature of Mr. A's internal world through a study of the transference, suggesting that despite his erudition, he may be more disturbed than Dr. S had suggested.

Dr. Hobday

I took the written material to Dr. Gabbard in supervision. His supervisory response began with concern for my level of discomfort and whether I felt threatened by the patient. Obviously, I was uncomfortable, as this was explicit sexual material that caught me off guard, and I was a novice as a therapist. However, fortunately I did not feel frightened or threatened by the patient and actually hadn't even considered that a fearful response was possibly an appropriate one. Hence his question was an important aspect of my supervision experience regarding this case.

Our supervision moved on to discussing how to bring these writings back into the session. While a part of me wanted to just let it go because that was the easiest thing to do, it clearly was not in the patient's best interest to do so. It was helpful to have an external “superego” figure to help me put my own anxiety aside and act in the way I knew I should. Dr. Gabbard's guidance also provided me with a bigger picture—namely, this was not

only about me—but also about how he relates to women in general.

Finally, we discussed the nuts and bolts of how to introduce the material at the next session. Do I wait to see if he brings it up? Do I actually read the explicit passages to him? These discussions allowed me to be ready to think on my feet and react with some rationality when in the moment of our next session. Dr. Gabbard and I discussed pros and cons of different approaches, in addition to the risks and benefits of bringing the material back into the session. Since the psychodynamic model the patient and I had been using was for me to read his writings and then discuss themes and points from them at our next session, it seemed appropriate to continue this, especially with such affect-laden material. He had never shown any sign of fragility or regression when this model had been used previously to discuss other highly personal and intense feelings regarding his mother and other ongoing struggles. Additionally, we were concerned that if this material was not brought back into session, it might feel to him that I was colluding with him in the concealment of these hidden transference feelings, or it might reinforce the notion that he was “bad or wrong” for having these feelings or expressing them. Finally, we used some role playing techniques to help prepare me, rather than deciding a definite response/script.

In the days preceding the appointment, I found myself thinking about little else but how I was going to handle the situation. It culminated on the morning of our next appointment, as I stood in my closet completely unable to pick out my clothes. Should I wear heels or not? What about the tightness of my pants, the length of my skirts, and the neckline of my clothes? I did not want his writings to change what I wore, but I felt like every choice would send a message one way or another. I even stood staring at my long, starched white coat, contemplating wearing it to reemphasize the professional nature of our relationship. In the end, I tried to wear “what I would have,” and settled on pants, heels, and a simple blouse—without the white coat.

As I walked out to get Mr. A, I was desperately searching in my head for any possible way to ignore this—was there any possibility that I could pretend this hadn't happened? What could I tell Dr. Gabbard and others? My heart was pounding in my ears. As he entered the room, I noticed him looking at his writings on my desk. I wondered if I had done this on purpose to shift the responsibility of broaching the subject to him. I opened our session as usual by asking how things had been going. He gave me a gift by immediately stating, “Not so good—it has been a bad week.” After he had mentioned some events from his week, I then inquired what he thought might happen when he arrived today. He said he had envisioned that he would come into the office and be greeted by the front office staff, who would proceed to tell him that he would no longer be able to get treatment here and that he would need to settle up his balance. I reacted by saying, “Wow. If that is what you thought, I'm surprised that you decided to come in today.” He responded by stating that he used CBT techniques and told himself that he was catastrophizing.

I realized that we were both talking around the issue, so I picked up the pages and said, “Is this why you thought things might not go well today?” He halfway nodded and then said, “I was being rebellious last week.

I knew I had to apologize for being rude and disrespectful.”

I was hesitant to get right into the sexual material, so I opted to start with a comparison between myself and his prior therapist. I said, “Mr. A, you have told me on several occasions that Dr. S was very helpful. You seemed to work really well with her on the CBT techniques she taught you. I wonder if you were hoping that we could move back to that kind of structure in our sessions.” After he had equivocated in his response, I became more forthright and I said, “Let us look at the writing.” I showed it to him without making reference or reading from it verbatim because I thought it might be too titillating. He responded, “I wrote that?” He actually sounded stunned and surprised. He then said, “Oh. Sorry.” I asked if he thought it was possible that I would read this and he would come in today and I would suggest that we have a relationship outside this room. He looked shocked, laughed, and said, “You would never do that—you are married.” That was actually not the response I expected, since I thought he would say that he did not think that would happen, but I thought it would be because I was his therapist. Hence I responded that while it is true that I'm married, I wonder what he thought about that happening between a therapist and a patient. His terse response was “I do not know.” I explained that it would be unethical for me as a therapist, regardless of my marital status. He looked thoughtful and indicated that he was not aware of that. Then he said, “But you would not with a guy like me anyway.” Clearly he was not getting it.

I looked at him and told him, “Mr. A, the important thing here is that it is OK to say anything you want, then we can discuss it and see how it can be helpful to you, but not act on it.”

After the session, I walked him out. He made no comments about my shoes, and I went back into my office and closed the door. I sighed. I had done it. I thought it went well. However, the next week he did not show and did not call—the first time this had occurred.

The following week he arrived and acted like there had not been a missed session. He commented about my pink shirt and how nice I looked in pink the whole way back to the room. I felt like I had been to hell and back for naught.

We had several productive sessions where this content was largely not brought back into session but further work was able to be completed.

However, he then became noncompliant with his risperidol and duloxetine. Following this he began to drink more and, while seemingly intoxicated, left aggressive and threatening messages on my voicemail. On one occasion when he missed a scheduled appointment he called and accused me of “setting him up to be laughed at by the office staff.” However, this message was in keeping with the general theme in his social anxiety that others would ridicule him rather than frank paranoia. He later left a message ranting about how screwed up he was and that he hoped I was happy with myself for doing this to him. Again, he was angry rather than delusional.

It was difficult to determine what led to Mr. A's angry accusations. I sensed that it was less the discussion of what he had written than it was his feeling that I did not or could not reciprocate his sexualized feelings.

This college-educated, articulate, and well-read individual was able at times to be sophisticated, reflective, and expressive in sessions. However, from the evolution of our therapy it appears that he may have been more schizoid and less object related than initially anticipated. I suspect that his narcissistic traits contributed to both his ability to present in such a confident manner at times, and to his tendency to respond more primitively to narcissistic injury in the transference.

I took this concern to supervision with Dr. Gabbard. Where I had never previously felt threatened by Mr. A, I was starting to at this time. We discussed how important it is to listen to gut feelings of discomfort, and how if the therapist is feeling frightened in the room, no work can be accomplished. We developed a plan to make me feel safe at the next appointment—this included having a security guard present in the clinic. I also left the door cracked open and pointed this out to the patient, relating it to his threatening comments on my voice mail. He was incredulous and responded in an indignant and surprised manner. He stated, “I would never do anything to intentionally frighten you, and beyond that I would never hurt anyone.” He stopped short of making a direct statement that his feelings were hurt that I would think that of him, but he sent that message in a subtle manner.

He went on to have two more sessions that returned to his usual, less angry mode of interacting. He then stopped showing for his appointments, and he did not answer the phone, nor return my voicemail messages, when I called to inquire what had happened. Eventually a termination letter was sent.

Dr. Mellman

As Dr. Gabbard noted, transferences involving sexual desire toward female therapists are less frequently reported, possibly because of some discomfort women have in discussing these issues. Women therapists may be more comfortable with underlying dependency longings (such as those in Mr. A) than those involving sexual love. Moreover, women, who as a gender have struggled to be seen as competent professionals rather than erotic sex objects, may feel trivialized, demeaned, or conflicted by expressions of sexual desire. Comments about their bodies may make them feel objectified, and the therapist may wish to avoid these feelings in the therapy. As Dr. Gabbard notes, there are multiple layers of meaning in sexualized transferences. The patient who comments on the therapist’s large breasts may really want to be taken care of and suck breast milk, or may actually be attracted to the therapist’s body as an expression of a desire for a sexual, loving relationship. In my own experience, especially as a new therapist, these transferences could be scintillating, scary, insulting, and incredibly intimate. The challenge of maintaining a steady analytic function while making room for and recognizing countertransference can be substantial, as with the patient I saw early in practice who ambivalently brought in the sexual nature of the transference as he exited a session, asking, “Was it good for you?” Women should also keep in mind that men are more visual in their sexual excitement and more oriented to body parts than women, so that looking at breasts, legs, and other body parts is arousing and normal.

The question of “Why now?” is always worth asking in dynamic therapy. It would be useful to hear some mate-

rial from the sessions that just preceded Mr. A’s tendency to become more demeaning, and then later from sessions just before he expressed more sexualized feelings in his writings. In the early phase of alliance-building, was he simply keeping thoughts and feelings about her out of the room? Or was he suppressing his sexual feelings and then at other times being so flooded by them that he lost his filter, hence flip-flopping not so much in the content of what he experienced as in what he expressed? The sequence of demeaning and attacking Dr. Hobday after the humiliation of exposing his sexual preoccupations and idealization of her suggests a need to regain control in the relationship and regulate his diminished sense of self. Training clinics are sometimes compromise formations that work for a patient who is quite afraid of intimacy. Being handed over each year fulfills the wish to remain distant while also feeling superior about “training” the trainees. These adaptive aspects of training clinics for some patients are often forgotten in the face of discussions around loss and abandonment. The patient’s preoccupation with missing Dr. S in the structure of their work is interesting and suggests he may have been bringing her back in to defuse his intense feelings toward Dr. Hobday. It is unclear how much of his unraveling was due to going off his medications and how much of it was a response to an intensified transference and the exposure of feelings of shame and humiliation. Mr. A feared rejection and punishment yet provoked it through his writings. Dr. Hobday ended up experiencing the fear that he projected on her as she tried to address the threatening behavior he exhibited.

Dr. Gabbard

Psychotherapy occurs in a cultural context. In American films, from Ingrid Bergman’s 1945 *Spellbound* all the way to the present, there are recurrent cinematic narratives in which a female therapist succumbs to the charms of a male patient and crosses boundaries to embark on a love affair with him (10). One can only imagine how popular culture might influence Mr. A’s expectation that he might have a chance with Dr. Hobday if she were not married. He clearly did not understand the nature of the ethics code under which we conduct therapy, and Dr. Hobday helpfully clarified this for him.

Discussion

Since, as stated above, it is true that men are generally stronger than women, the safety of the female therapist must be of paramount importance before any therapeutic issues can be considered. The threatening voicemails made Dr. Hobday feel unsafe, so she rightly took steps to make therapy possible. The therapist’s chair must be more comfortable than the patient’s chair. Hence, the presence of security in the clinic and leaving the door open a crack were ways to make Dr. Hobday comfortable and able to think. Moreover, such measures often activate the patient’s conviction to prove a therapist wrong by being perfectly behaved. As Dr. Mellman notes, it is possible that Mr. A departed from the therapy because talking about the sexual material evoked overwhelming affects that he tried to contain and gratify by giving Dr. Hobday writings instead. Had she ignored his writings, of course, she would

have been colluding with his wish to keep sexual feelings out of the verbal discourse of the therapy, and it may have become even more threatening for Mr. A.

We do not know for sure why Mr. A became angry. Were these feelings directed at the therapist's wearing of high heels because they symbolized her status as a woman who was out of reach for him? Was the lack of reciprocity humiliating and reminiscent of experiences with his mother? One of the most striking things about the transference is not its sexualized nature but its primitivity—it has a schizoid/borderline quality that was not apparent at the beginning of the treatment. It is characterized by being unrealistic, devoid of empathy for the therapist, and unwittingly self-defeating since it portrays the therapist in a demeaning way. In any case, Dr. Hobday did manage to keep him in therapy for over a year.

Finally, we can speculate that much of Mr. A's anger that emerged may have related to his rage at his mother for killing herself. He had spent his childhood and adolescence trying to keep his mother from committing suicide, and he may have felt at some level that he had "killed" his mother by not being a good enough son and by not watching her more carefully. In any case, his childhood experience was that his mother had abandoned him. His departure from therapy could also be viewed as active mastery over passively experienced trauma. This time, he abandoned his therapist rather than waiting for her to abandon him.

We do not know if he will return to the training clinic or not. There is often a cumulative impact of a series of therapists that allows the patient to make substantial gains over time. In any case, Dr. Hobday compellingly conveyed the challenges faced when one confronts love and lust in the psychotherapeutic setting.

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