



Should Analysts Love Their Patients?*

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In 1926, on the occasion of Freud's seventieth birthday, Ferenczi wrote that psychoanalysis works through the deepening and enlargement of our knowledge, a task accomplished only through love. Thus, it is the analyst's love that ultimately heals the patient. What is surprising, then, in the sixty years that have passed, is how little has been written about the central and complex nature of love as it enters the analytic process. Far more has been written on the therapeutic uses of hate, about the analyst's rage, greed, grandiosity, competitiveness, despair and hopelessness than about his love. Although we as analysts are supposed to be experts on love, and the subject certainly fascinates all of us, Tauber (1979) addresses the current dilemma well when he writes, "I have thought for a long time that what strongly blocks us is a profound unease in dealing with love, affection and tenderness in our work; we have acknowledged the need to deal with anxiety, hate, rage, etc. but are unclear about and evasive with love, affection and tenderness . . ." Is Tina Turner speaking to the therapeutic community when she says "What's love got to do with it? Who needs a heart when a heart can be broken?"

Yet we are all therapists with hearts, and none of us would disagree with the importance of such aspects of love as positive regard, empathy, or understanding. Freud, of course, did speak about love and recognized the power of love in the relation of

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physician to patient. In 1912 Freud wrote that the analyst "must turn his own unconscious like a receptive organ towards the transmitting unconscious of the patient" (in order to reconstruct the patient's unconscious); in a 1913 letter to Binswanger (1957) he said, "One must always recognize one's countertransference and rise above it. Only then is one free oneself. To give someone too little because one loves too much is being unjust to the patient and a technical error." Here we can see a loving and dedicated man concerned about how suppression of one's feelings can work against the interest of patients. Yet, Freud recognized that analysis could be carried away by their feelings and apparently felt that was often necessary to keep them at bay. Marie Bonaparte quoted Freud as saying "One must never love one's patients. Whenever I thought I did, the analysis suffered terribly from it. One ought to remain completely cool." This type of thinking led to the consequent idealization of the neutral, accepting and relatively unresponsive analyst. Tauber (1979) and others have pointed out that the classical position is itself a countertransference phenomenon. "It is the therapist's fear of using himself and is directed against the therapeutic transaction; it indirectly discourages the patient's confidence and daring in respect of his own contribution."

The systematic study of one's countertransference reactions is now seen as a necessary condition for analytic success and a number of theorists including Winnicott (1949), Searles (1959, 1969), Weigert (1954), Epstein (1979), and Spotnitz (1985), have written about this, particularly in relation to the pre-oedipal disturbed. Spotnitz (1985) tells us that to give too little of any kind of feeling because the analyst has too much is a technical error. He states, "The patient is entitled to whatever feelings—positive or negative—are needed to resolve his resistance to mature functioning. These feelings should be a source, and tool, of communication." Winnicott (1949) calls this "the truly objective countertransference . . . the analyst's love and hate in reaction to the actual person and behavior of the patient, based on objective observation; this he means that realistically induced emotions are to be distinguished from those reactions based on the analyst's idiosyncratic adjustment reactions."

Searles (1959) in his moving paper "Oedipal Love in the Countertransference" emphasizes that a successful analysis involves the analyst's deeply felt relinquishment of the patient both as a cherished infant and as a fellow adult who is responded to at the level of genital love. As he progressed in his work, Searles became

convinced that there is a direct correlation between the affective intensity with which the analyst experiences awareness of loving and erotic feeling, as well as the unrealizability of such feelings, and the depth of maturation the patient achieves in analysis.

In my own experience the more powerful the feelings I have toward a particular patient, the greater his or her involvement is in the treatment process and the more likelihood of therapeutic success. I am speaking now about inner awareness, and not the overt expression of such feelings. Inner awareness helps the therapist direct emotional communication toward the unconscious reciprocal emotional state in the patient, freeing the expression of repressed material. I hope to demonstrate here how the analyst's loving feelings can be used to resolve certain difficult transference resistances, thereby furthering progress in advanced stages of psychotherapy.

Three cases come to mind in which awareness of powerful stirrings within myself helped resolve a particular transference resistance and led to therapeutic progress. The first, a seemingly naive, passive, and moderately depressed young woman was without a defined sense of self. It soon became apparent that primal scene memories and fantasies set the stage for certain behaviors that were destructive for her. She actually remembered sleeping in the same room as her parents as a very young child, turning as close to the wall as possible and covering her ears not to hear the sounds of sex coming from her parents' bed. This, along with certain subsequent events, led to the development of a profound fear both of self-assertion and of intruding upon others. Now, after a deep and lengthy analysis, which included many professional and personal accomplishments, she can accept both her sexuality and her aggressive feelings and is no longer the timid, waif-like girl who first appeared in my office.

If asked, she might tell you that I deeply care about her and feelings of mutual love and respect have been very much alive in the treatment. Recently, some interesting developments have emerged. Having received her long-deserved Ph.D. and professorship, she began to actively look for a life partner based on realistic goals. Months passed. Not a satisfactory mate in sight, despite her devoting considerable energy to the search. All the men who became interested in her were found to be flawed—one too possessive and clinging, the other too childish, still another too self-abasing, and so on. The men she found compelling, special and fascinating, couldn't care less about her and were of course

ultimately disappointing. The analysis seemed stuck. I even found myself helping her write personal ads. She was becoming annoyed at the status quo and I, too, found myself irritated by what seemed at best a tenacious resistance, at worst very bad luck. Why wasn't I helping her to find a worthwhile guy whom she could care about?

Now, I am very fond of this woman. I have known her for a long time, watched her grow from a sweet girl to a developed and productive person as she shared intimate secrets and struggled hard to be honest with me and truthful to herself. Although she could be frustrating and irritating at times, it was generally in an atmosphere of warm regard that the sessions were conducted. She began to question why I was not aware of sexual feeling toward her at this stage of treatment and I realized we were colluding in mutual suppression; neither one of us was speaking of the love relationship between us, thereby keeping erotic fantasies at bay. With this in mind I told her she was not finding the right man because she had already met him. Who? Me, of course! I was the ideal she was seeking; no one else could ever come close. After she laughed heartily at this suggestion, associations followed which validated the interpretation and opened up a new area for discussion and confrontation. If she couldn't have me, she secretly hoped for a clone in the guise of my best friend to whom I would introduce her. Although in this case we were dealing in part with transference from father to me, more importantly the patient was highly reluctant to give up the partially gratifying but hidden relationship with me. This is what was keeping her from finding a full-time man in her real life. Once she began to see this and to openly with her feelings, new possibilities of relationships emerged. She no longer felt stuck in pursuing an unrealistic romantic ideal, began dating men seriously and now has more than a few possibilities to choose from.

We are all familiar with transference love but what I am illustrating here is how countertransference love and the acknowledgement of it in a particular context can free the analyst to do what may seem to be an outlandish confrontation-interpretation in order to resolve a difficult transference resistance. Of course, in all kinds of emotional reactions to patients it is necessary for the analyst to contain the feeling until it is appropriate to communicate it to serve the emotional growth of the patient.

Certain patients seem incapable of love; the abuse of the analyst engenders hate. This may well be stressful for the analyst; the feelings must be analyzed and contained until the patient

emotionally ready to be confronted. As Winnicott (1975) states, "If the patient seeks objective or justified hate, he must be able to reach it, else he cannot feel he can reach objective love. . . . There is a vast difference between those patients who have had satisfactory early experiences which can be discovered in the transference, and those whose very early experiences have been so deficient or distorted that the analyst has to be the first in the patient's life to supply certain environmental essentials."

One narcissistic patient, who came into treatment with me at the age of 22, overweight, angry and self-destructive, became in the course of analysis a financial and social success but still could be easily wounded in his self-regard. He set out to hurt me when he felt attacked by my not taking his side; he was being uncompromisingly selfish on an issue and I told him so. He threatened to quit therapy so as to show me what a rotten guy I was, hoping that I would feel as impotent, powerless, and humiliated as he did in my treatment of him. He was too sane to kill me; leaving me to eat crow appeared to him the only option, knowing that I was both attached to him and interested in his emotional development (how patients can play on our tenderest feelings!). Of course, I hated him for this ploy, knowing that there was still analytic work to do, but he was not yet ready, nor did it seem therapeutically useful at the time for me to give him a full dose of my negative feeling. Instead, I made a decision to use both my love and vulnerability in relation to this patient. I told him that, of course, I would be hurt if he left treatment this suddenly; we had been together a long time and I did not yet have a sense of the completion of our work. It was not my intention to hurt him and he was using what I had said to him to attack both himself and me. I understood, too, that leaving treatment to hurt me was something he felt compelled to do. I then brought the session to a close, giving myself some discharge of the hatred I felt during the hour by heartily and lovingly greeting my next patient.

The next week he came to our scheduled appointment furious with me, letting me know what an uncaring son-of-a-bitch I was. No matter how he tried to hurt me, I would still go on, still live my life, still have other patients. He had heard me speak to my next patient as he had left the previous session. Now, he would have to acknowledge his competitive fury and his own sense of worthlessness, work on himself rather than put me out of order. So, now we are in love again and the beat goes on.

Hate is a powerful complex emotion. Some patients may seem

to truly hate us, yet we feel no similar emotion. One session comes readily to mind where a patient's explosive hatred paradoxically elicited warm and tender feelings. This countertransference reaction clued me into the patient's frustrated love and need for my understanding beneath the surface of her anger. This is the case of Susan, a young woman just barely out of a suicidal depression after an unhappy love affair. I had been treating her nearly two years when, after a seemingly innocuously supportive comment of mine, she burst into a tirade of hopelessness and hate. Exploding, she stated "I really feel I hate you. I don't want to be around you, just being around you makes me feel revolted. I really hate you. Don't take it personally. I don't know why but I don't like you either. I don't understand you. I hate you for not being happier, why after all this time I have to be the only different person in this world. Your other patients get better but I have to keep proving to myself I am not happy." Although hate from me has often elicited vastly different feelings, the kind of hate Susan exploded with became more transparent when I understood why I still felt tenderness and compassion. It was her love and longing that she was speaking about and what I really felt was that I should love her more than I did, guilty that my love went only so far. It was with this understanding that I told her if only I loved her more, there would be a chance for her happiness, but without it she was doomed to hopelessness and despair. With this I sighed and said "You love Joanna (her sister who was previously in treatment with me) better anyway and Michael (a patient I know) better than I do. . . . I have to keep an angry barrier even with people I am afraid of losing I have to have an angry barrier. It's pathetic. I'm not functioning like a full human being, it's starting from scratch. I don't want to make my mother happy, I don't want to make you happy either." This session was a turning point in Susan's treatment. With the revelation that she still wanted to be loved despite her feeling of losing her siblings and my other patients, Susan could begin to feel less despairing. She began to reach out toward others once again towards a different kind of working alliance with me. She became less interested in having me fail out of vengeance and more concerned with her own self-regard.

In conclusion, the more feelings that can be experienced and integrated into the analysis both from analyst and patient, the deeper the experience will be and the more the potential for

constructive change to occur. If the analyst changes too, then the therapy has been truly successful. For no human connection involving knowledge and love can occur without influencing all concerned. Erich Fromm (1947) writes that "the essence of love is to 'labor' for something and 'to make something grow'. . . . To love a person productively implies to care and to feel responsible for his life, not only for his physical existence but for the growth and development of all his human powers. Without respect for and knowledge of the beloved person, love deteriorates into domination and possessiveness."

We as analysts function with respect and knowledge. No longer do we need to be afraid of our love and passion, but instead use the intensity of our feelings as emotional fuel to ignite the dormant powers of our patients, kindling their spiritual growth with our love and hope.

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