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# **The Therapist's Love**

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*This dissertation is submitted to Auckland University of Technology in partial fulfilment*

*of the degree of*

*Master of Health Science*

*Auckland University of Technology*

*2006*

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## **Attestation of Authorship**

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person nor material which to a substantial extent has been accepted for the qualification of any other degree or diploma of a university or other institution of higher learning, except where acknowledgement is made in the acknowledgements.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

## Acknowledgements

I would like to acknowledge the two patients who appear in this study and to thank them both for their considerable teachings.

My heartfelt thanks go to my supervisor Dr Kerry Gibson for her patience and helpful guidance throughout the formulation and writing of this dissertation. There were many times when I felt submerged within this topic and could not easily find a way forward. Kerry was always able to help me to find that way.

Many other people also helped me during the course of this dissertation in numerous ways - by listening, by being encouraging, engaging in discussion on this topic, and giving me ideas for further reading. I would like to thank in particular Associate Professor Stephen Appel, Dr Jonathan Fay, Tom Davey, Liadan Cotter and Sue Joyce.

My love and gratitude go to my husband Olli and my daughter Jaime, who put up with me in less than ideal circumstances during the writing of this dissertation. Olli listened to my endless talking and pondering; I thank him for his love, generosity and forbearance. Jaime had a mother who was too often reading or writing; I thank her for being the wonderful girl that she is.

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Ethics approval for this dissertation has been obtained from Auckland University of Technology Ethics Committee (AUTEC) on 27<sup>th</sup> April 2004, ethics approval no. 02/33.

## **Abstract**

This dissertation explores the ways in which the therapist's love is described in psychoanalytic literature and the value of this for clinical work. The methodology used is a modified systematic literature review with clinical illustrations. Whereas love in the therapy relationship initially tended to be described from the patient's perspective, that is, 'transference love', there has been a move towards also considering the phenomenon of the therapist's love. This has occurred within the context of increasing relationality and intersubjectivity, and includes but is not limited to issues of countertransference. The way that the therapist's love is described in the literature is shown to fall into three broad areas: 'parental love', sexual love and Eros, and a type of love that is particular to the therapy relationship (love as a "thing unto itself"). Each of these areas is described and discussed in relation to a clinical vignette. It is proposed that the therapist's love is essential in the therapy, and that, given the asymmetrical nature of the therapy relationship, the therapist has particular responsibilities to bear in mind.

## Chapter One: Introduction

*Today, having at our disposal a wide range of techniques, it is interesting to note that, whatever the other factors interfering with love may be, there is no view that denies its centrality in the cure, even if it is differently understood in the subgroups of contemporary psychoanalysts. (Green, 2005, p. 8)*

*When Elizabeth walked into my room for the first time about three years ago I instantly liked her and felt warm towards her. In fact she is a rather aggressive-looking woman, who has difficulties in relating to other people a lot of the time. She was chronically and also acutely depressed at the beginning of the therapy and barely functioning in her day-to-day life, although she was holding down a demanding job. This was all she had energy for, and it was a huge struggle for her to keep going. Our first step was to work together with a psychiatrist to find an antidepressant medication that worked for her, which we eventually did.*

*From the beginning Elizabeth decided that I was a 'safe' person, who was not trying to take anything from her, in contrast to how she felt about most others in her life. For my part, I responded positively to her childlike nature, her innocence and her trust in me. I felt tender towards her in the face of her sometimes self-destructive behaviours and felt privileged that she was able to talk very freely with me. I admire greatly her determination to work in therapy and in general I feel very alive in our sessions. At the same time there is an uncertainty about the 'loving' feelings I have towards Elizabeth.*

My experience with Elizabeth started a process for me in thinking about how we, as therapists<sup>1</sup>, love our patients, or not. I wondered what this feeling of love was that I was experiencing towards Elizabeth, and how it fitted in the therapy process. What could I call it? Was it real or not? Did I have to be careful of it? How much were my feelings of love towards Elizabeth crucial to her therapy, and how much did they hinder it? How much was this love a countertransference phenomenon, whereby I was responding to her desperate need for a good mother? Could I then call this love parental love, and what were the boundaries of it? How much did I need to be experienced as a good mother? Was there an erotic component to this love, and surely if so I would need to be careful of that? Or did I love her for her love of the therapy process, for our joint love of it, for her pursuit of her own truth, and her absolute determination in this and commitment to it?

Being with Elizabeth and asking myself all of these questions and more led me to this enquiry into love in the therapy relationship. I began to read the literature to find out what others have thought about the therapist's love.

Love is perhaps the most written about and thought about emotion. Bergman (1987), Mann (1997), and Green (2005) represent the common psychoanalytic view that there will never be one satisfactory definition of such a complex human emotion as love, and also that it is not the job of the psychoanalyst to define what love is, but rather that this domain belongs to the poet, and that there may be as many definitions of love as there are poets (Mann, 1997, p. 36). This dissertation does not therefore attempt to define love but is concerned with describing how psychoanalytic writers have written about the

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<sup>1</sup> The words 'therapist' and 'analyst' are used interchangeably in this study, as are the words 'patient', 'analysand' and 'client'. This reflects the different terminology used by different authors.



therapist's love in the therapy relationship. I will be questioning what the nature of this love is, how the description of it has evolved (or not) since Freud, and how an exploration of the therapist's love in the therapy relationship might inform clinical practice. I will be describing some of my own work with patients to illustrate the theoretical ideas contained within my review of the literature.

Freud placed love in a central position in psychoanalysis; he is purported to have said that the goal of analysis is to be able to work and to love (although Masson points out in the notes to a letter from Freud to Fliess (February 4, 1888) that no source can actually be found for this famous dictum). Perhaps Freud's most famous discovery in the area of love was that of 'transference love', the love of the patient for the analyst. He was clear about the role of that love in effecting a cure – "Essentially, one might say, the cure is effected by love", wrote Freud to Jung (1906, pp. 12-13). Freud's views on transference love will be explored in chapter 3 as a starting point in engaging in this topic.

Love may be at the centre of the psychoanalytic endeavour, and Green (2005) writes that there is no view that denies its centrality in the cure (p. 8). However, I have noticed in my reading of psychoanalytic writings that there seems to be some anxiety about using the word 'love' in psychotherapy, in particular when applied to the love that a therapist might have for his or her patient. Often 'love' has been written about in terms of when things go wrong, for example, when a therapist has loving or sexual feelings, or both, for his or her patient and abandons the therapeutic endeavour by acting out these feelings. 'Love' is a problematic word, and Green (ibid.) has asked the question as to

whether the reference to love is still accurate or whether there is a better word to describe the nature of the emotional links that are created in analytic relationships.

There are also contradictory views in the literature with regards to the therapist's love. Some authors have categorically stated that the love of the analyst is not the curative factor in the treatment, for example, Kohon (2005, p. 81), and others have just as categorically stated that it is. Ferenczi - an early explorer of and proponent for love in psychoanalysis places love in a central position – "Psycho-analysis works ultimately through the deepening and enlargement of knowledge; but...knowledge can be enlarged and deepened only through love" (1926, p. 17), and defines love as being "neither egoism nor altruism, but mutualism, an exchange of feelings" (1931, p. 248).

Writers who comment on the anxiety of writing about the therapist's love include Coltart (2000), who writes that the very use of the word 'love' in psychoanalysis is "often felt to be dangerous, or open to misconstruction" (p. 120). Bach (2006) writes that love in psychoanalysis is fraught with problems of transference and countertransference, the weight of social attitudes and collegial judgments, special ethical considerations, and even legal concerns (p. 126), and Lear (1990) notes that it is hard to take love seriously (p. 156) and that "love has become almost taboo within psychoanalysis", that as soon as anyone mentions love, from somewhere comes the response, yes but what about aggression? (p. 15). Siegelman (2002) posits that we assume that we are on safe ground with the negative emotions, because this means we are not "whitewashing the shadow" (p. 21).

This dissertation does not aim to deny the powerful forces and realities of aggression, hate, violence, death, and also their relationship with love (it is interesting

that the later accounts in Greek mythology state that while the mother of Eros was Aphrodite (Goddess of Love) his father was Ares (God of War)). As well, it hopefully does not make any naïve assertions along the lines that ‘all we need is love’, that love is in some way ‘absolute’ in the therapy process. Hillman (1989) rightly points out that “to take love as the principle of psychotherapy is again to find a monotheistic panacea for the imaginative complexity of our psychic life” (p. 289). However it does aim to focus on and to explore love in the therapy context, especially the therapist’s love, and to ascertain to what extent love is viewed as being intrinsic or not, valued or not, in the therapy relationship.

The methodology chapter describes in detail how I have researched, selected and synthesized the literature and the third chapter then goes back to the beginnings of psychoanalysis, and reviews the thinking about love in the therapy relationship at that time. It became obvious during my reading that in describing love in the therapy relationship, writers, particularly over the last about fifty years, have tended to write within three broad categories when writing of the therapist’s love – parental love (that is, the therapist in a quasi-parental role), sexual love or Eros, and love as a “thing unto itself” (Shaw, 2003). I have therefore devoted a chapter to each of these categories (chapters 4, 5 and 6) in order to explain them more fully, with a clinical illustration in each. In some ways it is artificial to separate them out and there is a good deal of cross-over. This will be addressed in the final section, the conclusion, as will an evaluation of the proposition that the therapist’s love for his or her patient is essential to the therapy process and that more awareness of its subtleties, pitfalls, dangers and pleasures will enhance the therapeutic relationship, and thereby benefit the patient.

## **Chapter Two: Methodology**

The methodology of this dissertation takes the form of a modified systematic literature review, with clinical illustrations. In this chapter I will briefly describe the nature of a systematic review and its location within evidence-based practice, as well as its relevance to the practice and theory of psychotherapy. I will then describe the question that has guided this dissertation and will outline how I went about searching the literature, the criteria I used to either include or exclude material, and my method of data analysis.

### ***The Systematic Review in Evidence-Based Practice***

The systematic review is described by Pai et al. (2004) as being a methodology that is widely considered the best evidence for evidence-based practice. They describe the systematic review as including a comprehensive exhaustive search for primary studies on a focused clinical question, using clear and reproducible eligibility criteria, critical appraisal of studies for quality, and synthesis of results according to a pre-determined and explicit method (p. 86). Evidence-based practice generally privileges quantitative research, and particularly the randomised controlled trial (RCT), which is considered to be the 'gold standard' (Gilgun, 2006). When 'evidence' is mentioned the RCT is generally what is meant. The material used in this dissertation, however, draws from a psychotherapy base which has tended to be qualitative rather than quantitative; it includes mainly clinical cases that have been written up by experienced clinicians, as well as psychoanalytic theory that has been formulated from clinical experience.

Much has been written about the value of qualitative research, particularly in the last decade. Jones (2004) points out that qualitative research is no longer the poor stepchild of quantitative inquiries and stresses that it is not useful to transpose methods best suited to systematic review of quantitative studies into qualitative ones (p. 96). His view is that the concerns of qualitative work are with issues such as meaning, truth, purpose and the significance of things (p. 108). Earlam, Brecker and Vaughan (2000) also point out that “while randomised controlled trials are the gold standard for assessing the efficacy of specific clinical interventions, qualitative research gives insight into why people behave as they do” (p. 7).

Starcevic (2003) states that there are many reasons why the “technology” of RCTs is not suitable for demonstrating the usefulness of psychotherapy, including the difficulty of obtaining a sample of people who are similar enough in, for example, their diagnoses, for the results to be meaningful, and also the impossibility of standardising the psychotherapy given to the subjects. He points out that “every encounter between the patient and the therapist has some unique features, with the potential of producing ‘something’ that cannot be predicted and entirely ‘standardized’” (p. 279). Fonagy (2001) also claims that RCTs are in general seen as inadequate in the field of psychotherapy due to their “low external validity and generalizability” (p.10). He makes a case for not only evidence-based practice but also practice-based evidence, and that in psychotherapy there needs to be a balance between the two (that is, gathering evidence from both external research and practice).

In terms of this balance, there are psychoanalytic writers who write of the need for empirical outcome research in psychodynamic and psychoanalytic therapy. Leichsenring

(2005), for example, has published a review of empirical data, a collection of twenty-two randomised controlled studies of short-term and moderate-length psychodynamic psychotherapy. However, the main thread in writings about psychotherapy research seems to suggest the need for psychotherapy not to try to bend itself out of shape attempting to fit a model for which it is poorly suited, but instead to move more towards exporting its own model to others who may be interested. Lees (2005) suggests this, as do Leuzinger-Bohleber and Fischmann (2006):

The richness of psychoanalytic research trying to capture the world of primary process, of unconscious fantasies and conflicts, a *Wissenschaft*, not a 'science' in a narrow and past sense of an *Einheitswissenschaft*, could then also gain a new attraction for other scientists, as well as for artists and the public. (p. 1380)

Although there are explicit guidelines available on the correct procedures and processes to be followed when conducting reviews based on quantitative methods, there is much less advice on how to conduct reviews incorporating qualitative approaches (Hawker, Payne, Kerr, Hardey & Powell, 2002). With regards to, for example, summarizing and synthesizing qualitative evidence Hawker et al. (ibid.) believe that suitable methods have yet to be agreed on (p. 1293). This seems to be a theme in other articles relating to systematic reviews of qualitative research (Popay, Rogers & Williams, 1998; Lemmer, Grellier & Steven, 1999; Booth, 2001; Jones, 2004; Gilgun, 2006). This dissertation does fit the criteria for a systematic review in that there is a focused clinical question, there are clear eligibility criteria, a critical appraisal of the studies and synthesis of the results. However, the qualitative nature of the material used has needed to be taken into account when considering the methodology.

In my reading in this area I have found the criteria of Hawker et al. (2002) to be the most useful, and have applied these to this review, with some modifications. Briefly, they suggest the following:

1. Tables that précis all “accepted” articles
2. Table that shows how empirical studies were graded for methodological rigor
3. Evaluation of literature in relation to the question
4. Reasons given for exclusion of rejected articles

Empirical studies have not been included in this review, therefore I have not included step 2, however I have included the other steps (although ‘accepted’ articles have been described in a form other than table form). In addition, Lemmer et al. (1999) cite Jensen and Allen (1996) who, they say, stress an interpretive, rather than an aggregative approach in qualitative research, and that the synthesis of the material takes the form of “translating the studies into one another until a synthesized description of the phenomenon is achieved” (p. 322). Lemmer et al. suggest that this does not address the issue of comparing a large number of documents or the need for a rapid system of overview of the review process (p. 322). Further, they point out that individual reviewers interpret qualitative articles and research designs in different ways (p. 323). Increasingly, however, the researcher’s influence has been acknowledged and this can be no different in relation to the literature review. The interpretation of the data is inevitably filtered through the observer’s understandings and experiences; Hollway and Jefferson (2000) refer to this in discussing “reflexivity”, the impossibility of staying outside of one’s subject matter while carrying out research.

It also needs to be said that there is much narrative discussion in this review.

Narrative discussion of large numbers of studies is critiqued by Hawker et al. (2002) and Lemmer et al. (1999), however, in this area I agree with Jones (2004) who makes a case for strengthening the narrative approach; he posits that although systematic review protocol now routinely states that the narrative approach is passé, dead and simplistic, that he believes that narrative is the “bread and butter” of qualitative work (p. 96). Narrative is, however, an aspect of this review rather than the entirety of it.

I have also found the recommendations of Popay et al. (1998) useful in guiding me in the methodology of this review, particularly with regards to their emphasis on variability rather than standardization, the importance of subjective perception and experiences, and the process of moving from a description of the data, through quotation or examples, to an analysis and interpretation of the meaning and significance of it (p. 348). Booth (2001) also makes a valuable point when he says that in qualitative research concordance between researchers is not the issue that it is in quantitative research, but rather what is ultimately of value is the content of the disagreements and the insights that discussion can provide (p. 6).

### ***Clinical Question***

My original enquiry for this dissertation was the area of ‘analytic love’. Broadly speaking I thought of this as the analyst’s or therapist’s ‘attitude’ in the therapy relationship, and how much this is or is not akin to love. One difficulty with this has been the different ways in which love is written about and also how love is understood and described. There is no neat and tidy definition of love. Given this difficulty I eventually formulated the following question:



*How is the therapist's love conceptualised in the literature, and what is the value of this conceptualisation for clinical work?*

I have selected mainly the writings of psychoanalytic writers on this subject. Practically every psychoanalytic author has said something or can be surmised to have said something about this subject, and it also goes very near to the topic of psychoanalytic technique, and the whole history of psychoanalysis and its development, an area obviously far too broad for the scope of this study. Therefore I have selected only those writers who have specifically written on this subject in a substantial way.

### ***Search Strategies***

I began my search for relevant articles and books in the electronic PsycINFO database, an abstract database of psychological literature from 1806 to the present. Currently it includes material from 2140 journals and also relevant books and book chapters. I began with the search term "love". This produced 2127 results, and as can be expected included material relating to all aspects of love. In order to narrow the field I searched under "love AND analyst" and "love AND therapist", which produced 359 and 457 results respectively. I also searched using the terms "erotic" (2501 results), "psychoanalytic love" (5 results), "sexuality AND psychoanalysis" (12 results), "Love AND therapist AND analyst" (47 results), "analytic love" (8 results), "loving the patient" (2 results), "love AND psychotherapy" (5 results).

Of these results, I excluded all those which were not written in English, and those which were not specifically related to the topic. In fact, out of interest, to reach a broader understanding and also at that time to better inform myself as to the exact topic of this

dissertation, I read a good deal of those I later excluded; however they are not included in my study. So, for example, my initial reading included a lot about the nature of love, both within and outside of the therapy context and tradition. Also, if there were relevant articles in French and German I read those, however I was not able to read articles in Spanish, Portuguese, Italian or any of the Scandinavian languages.

I also searched the Psychoanalytic Electronic Publishing database (PEP), which holds the material from 20 psychoanalytic journals from 1920 until 2002, with similar search terms as above. “Love” yielded 1000 results, “agape” 27, “love AND therapist” also 1000, “love AND analyst” 1000, “love AND patient” 1000, “analytic love” 929 results, “loving the patient” 706 results, “love AND hate” 1000, “eros AND analyst” 526, “sexual countertransference” 19, “erotic countertransference” 94, “parental love” 203, “parental love AND analyst” 132, “analyst as parent” 34, “erotic psychotherapy” 34, and “eros” 955. Again I excluded articles which were not in English and (eventually) those which did not specifically relate to the topic.

In addition I carried out an e-journals library search under the headings ‘Psychiatry’, ‘Psychoanalysis’, ‘Clinical Psychology’ and ‘Psychotherapy’. I searched relevant publications using similar search criteria as above, and found another fifteen articles that were relevant to the topic.

In order to ground myself I read some early writings, particularly those of Freud and Ferenczi; a synopsis of their ideas appears in chapter 3. This was to ascertain the original thinking in this area, and has helped to inform and place into context some of the later writings. I could have read and included other major early writers, however, as I have mentioned, the scope of this dissertation has necessitated me including only those

writers who have specifically written on this topic. For this reason, Freud and Ferenczi seemed to me to be writers who could not have been left out.

Possibly one of the most useful ways of collecting material for this dissertation was by collecting articles that were cited in the reference section of very recent relevant articles. If an article was written in 2005 or 2006 on the topic of the therapist's or analyst's love, and it claimed to review at least some of the relevant literature, I went through the references and obtained them, either through the electronic databases, through interloan borrowing or purchasing. As well, some recommendations were made directly to me from colleagues.

### ***Ethics***

Ethics approval for this dissertation was granted by the University of Technology Ethics Committee (see Appendix A). An invitation to participate in this research was given to two of my patients (see Appendix B) and permission was obtained from them to use the material in the clinical vignettes (see Appendix C). Their confidentiality has been protected by way of use of pseudonyms and also some disguise of the material.

### ***Summary***

This dissertation has at once been undertaken within the guidelines of evidence-based practice, but also acknowledges that the literature used is that which makes up the majority of psychotherapy literature, that is, theory and qualitative data, including case studies, and is therefore a modified systematic literature review. The purpose of a systematic literature review is to select the literature relevant to the topic, and to review it critically in order to inform clinical practice. In line with a qualitative research focus I

have used an interpretive approach with thematic analysis of the literature and have integrated that with my own clinical work with two patients. The clinical work is intended to illustrate rather than provide evidence for the ideas contained in this dissertation. It was my clinical work that first prompted the enquiry into the topic of the therapist's love; however I did not have a pre-conceived idea of the outcome of the research, and to some extent the research into the literature proceeded in a different stream for quite some time from my clinical work, before I was able to bring them together. This dissertation will identify the contributions from the research for clinical practice, and will also indicate areas for further research.

## **Chapter Three: Love at the Beginnings of Psychoanalysis**

In the introduction I alluded to the centrality of love in the therapy relationship and also the anxieties that arise when discussing it, as well as the contradictory views in the literature. By discussing both Freud's and Ferenczi's struggles in this territory, this chapter explores how these issues have been present since the beginnings of psychoanalysis, thus providing a context for the later writings.

### ***Freud***

There are conflicting accounts of how Freud described love in the analytic relationship. Weinstein (1989) quotes Marie Bonaparte who quotes 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" (p. 193). In 1912 Freud advises his colleagues to model themselves on the surgeon, who "puts aside all his feelings, even his human sympathy, and concentrates his mental forces on the single aim of performing the operation as skillfully as possible...this emotional coldness...creates...for the doctor a desirable protection for his own emotional life" (p. 115). He also writes that the analytic relationship is "one for which there is no model in real life" (1915, p. 166), and that it is "based on a love of truth...a recognition of reality – and...it precludes any kind of sham or deceit" (1937, p. 248). Love, then, belongs to the therapeutic process itself, embodied in the quest for the 'truth'. Freud did, however, talk about a 'substitute' for the analyst's love. In describing situations where female patients fall in love with the analyst, he says that this must be compensated for by some substitute for love – "The trouble taken by the

physician and his friendliness have to suffice for such a substitute” (1893-1895, p. 301). Gabbard (1995) suggests that the exact nature of that substitute remains difficult to define. Mann (1997) also cites LeShan (1989), who writes that when British psychoanalyst J. C. Flugel asked Freud why analysis cures that the reply was – “At one moment the analyst loves the patient and the patient knows it and the patient is cured” (p. 31).

On the one hand we have here the “coolness” of the analyst’s stance, on the other hand, a hint that the analyst’s love may in fact be curative. Mainly, however, Freud seems to have engaged with the issue of love in the therapy relationship in terms of *transference* love, and in 1915 wrote a paper on the topic (*Observations on Transference Love*). He acknowledges that the analyst is working with “highly explosive forces”, and that the lay public may seize upon the discussion of transference love as proof of the dangerous nature of the psychoanalytic method (1915, p. 170). Bergmann (1997) describes the position that Freud found himself in at that time:

...we will be struck by Freud’s audacity. The basic idea that Freud unfolded to an astonished world was novel and bold. He advocated that the sexual current appearing in the treatment should not be repressed, but instead of gratifying it, should channel its energy into curing the neurosis... [this]... had never been attempted before. (p. 90)

Transference love had a shaky start. Person (1993) relates the first story of transference love to come to Freud’s attention (in 1882), that of Joseph Breuer and his patient Anna O. Breuer became increasingly fascinated with Anna O. and her therapy, but when Anna O’s erotic transference to Breuer eventuated in a phantom pregnancy, Breuer became terrified and terminated Anna O’s treatment (p. 2). Person writes that it took Freud a long while to formulate his understandings about transference love, only

gradually coming to the understanding that Anna O's reaction to Breuer was more the rule than the exception (ibid., p. 3).

It seems that many early analysts found the territory difficult to negotiate. Baur (1997) describes the intimate relationship that developed between Jung and his first patient Sabina Spielrein, as well as that between Ferenczi and his patient (later his wife) Gizella, and another patient, Elma (later his step-daughter). She also details many other "romantic explosions", on the part of Otto Rank, Victor Tausk, Sándor Rado, Frieda Fromm-Reichmann, Karen Horney, René Allendy, Julius Spier and others. As Gabbard (1995) has pointed out, "Freud and his early disciples indulged in a good deal of trial and error as they evolved psychoanalytic technique" (p. 1115).

It has been conjectured (Eickhoff, 1993) that the impetus to write the 1915 paper came from Freud's concern over Jung's relationship with Spielrein, and also from Freud's correspondence with Ferenczi about Gizella and Elma. Eickhoff writes that Freud wrote to Ferenczi on 7 July 1909:

I myself have never been taken in quite so badly, but I have come very close to it a number of times and had a narrow escape. I believe that only the grim necessities of my work and the fact that I came to psycho-analysis a decade later than you have saved me from the same experiences. (p. 50)

Without summarizing Freud's paper in full, the main points are that the analyst must recognise that the patient's falling in love with him is induced by the analytic situation and "is not to be attributed to the charms of his own person" (1915, p. 161). He believes that any passionate demand for love is largely the work of resistance and is an impediment to therapy. He advises on the *danger* of returning tender feelings, writing that the analyst's control over himself may not be as great as he or she might imagine it to be, and that the patient who is craving for love must be denied it (pp. 164-165). Further, he

recommends treating the transference love as “unreal”, as a situation which has to be gone through in the treatment and traced back to its unconscious origins, and goes on to say that the work is to uncover the patient’s infantile object choice and the phantasies woven round it (p. 167). At the same time, Freud does not dispute the genuineness of the transference love, and concludes by saying that the only real difference is the analytic situation itself, and that the analyst has a responsibility to the patient to provide an analytic experience rather than any other type of experience, that however highly the analyst prizes love he must prize even more highly the opportunity of helping his patient.

Freud’s writing in this paper is not particularly decisive or consistent, in fact he questions what he says at the same time as he says it, and there is a sense that there is much left to discuss. It has also been suggested that Freud’s stress on repetition was in part a response to real and threatened public disapproval of the erotic transferences that female analysands developed in relation to their male analysts (Schafer, 1997, p. 340). In any case, it seems clear that his motivation for writing this paper was, at least in part, to assist analysts to find their way through this difficult terrain. While he does not explicitly write about the analyst’s love, apart from the analyst’s sexual love, which he proposes as being countertransferential in nature only, he emphasizes the analyst’s tasks as being to interpret the unconscious, to be ethical, to be dedicated to the task, to be neutral, to provide an analytic relationship rather than any other and to prize the opportunity of helping the patient above all else. We could surmise that this is where Freud saw the analyst’s love to lie; at the same time there can be no doubt that he regarded this area as a very difficult one, filled with potential dangers.



## ***Ferenczi***

Sándor Ferenczi was a favourite of Freud, who increasingly began to challenge Freud's 'abstinence' principle and to consider the impact of the *analyst* on the patient (Hoffer 1991, p. 467). His explorations took him to what Ferenczi described as his "relaxation technique", where he tried to gratify the patient's longings without making any demands, and where there was essentially an "implicit re-enactment of...the idealized early mother-infant bond, characterized by an ambience of total acceptance and indulgence of the help-seeking, traumatized child-within-the-analysand" (ibid.). Hoffer (1991) writes that this departure from Freud's techniques was prompted by Ferenczi's wish to create a more egalitarian atmosphere, as well as to include the "positives" such as tact, empathy, elasticity, indulgence, warmth, candour and responsiveness, which he felt Freud lacked (p. 467). If Sigmund Freud was the father of psychoanalysis, writes Hoffer, Sándor Ferenczi was the mother (p. 466).

In his clinical diary (Dupont, 1988), Ferenczi writes of his belief in the curative power of the analyst's love to heal the patient – "no analysis can succeed if we do not succeed in really loving the patient. Every patient has the right to be regarded and cared for as an ill-treated, unhappy child" (p. 130). He exhorted analysts to give up passivity and to place themselves at the patient's disposal in a passionately active manner (ibid.). Ferenczi's experiment in 1932 with mutual analysis, whereby he agreed to be analysed by his patient RN, at the same time as his analysis with her was proceeding, shows how seriously he took his enquiry into mutuality in the psychoanalytic relationship.

Ultimately Ferenczi renounced this method. Gabbard (1997) writes that Ferenczi's efforts to avoid becoming the abusive object for the patient in the transference by

fulfilling the patient's ardent wishes for a loving parent were contaminated by his growing awareness that he was desperately fending off hate, and quotes from Ferenczi's clinical diary –“the patient's demands to be loved corresponded to analogous demands on me by my mother. In actual fact and inwardly, therefore, I did hate the patient, in spite of all the friendliness I displayed” (p. 8). Ferenczi's desire to push the normal boundaries led him into unexpected territory, from which he ultimately learnt much. Maroda (1998) writes that he amended his original belief in the therapeutic benefit of disclosing love and affection to a belief in the therapeutic benefit of disclosing any emotion that the patient asks to have verified in one form or another (pp. 130-131).

Hirsch and Kessel (1985) note that Ferenczi's experiment “led, in orthodox circles, almost to a phobia about mentioning anything about the analyst's love and this remains today” (p. 74). Ferenczi's stance meant that he was rebuked by Freud for his technique of “motherly affection” and was ostracized from the mainstream of psychoanalysis (Glucksman, 1993, p. 166). The English-language publication of several of Ferenczi's contributions were suppressed for sixteen years by Ernest Jones because of Ferenczi's presumed mental “aberrations” (Hoffer, 1991, p. 466). In spite of this, it has been acknowledged (Hoffer, 1991) that Ferenczi and Freud constitute the two original and primary sources for psychoanalytic work and reflection, that Ferenczi created an increasingly two-person psychology, and that his influence is widespread, in particular among the British object-relations school of Balint, Winnicott, Khan and Guntrip, who focus primarily on parent-child configurations (p. 468).

### ***Freud and Ferenczi***

I am aware that in describing Freud's and Ferenczi's attitudes to love in the therapy setting that I have set up a type of dichotomy. On the one hand there is Freud's view that the analyst must remain neutral, and that loving feelings from the patient are largely the work of resistance, and must be traced back to their unconscious origins. Ferenczi, on the other hand, is shown to have experimented with analytic technique in a way which set the scene for more mutuality and also the notion of the analyst actively employing his or her love (mainly in the form of empathy) as a curative power in the treatment.

It has been suggested, however, that Freud became increasingly aware of the need for more activity on the part of the analyst and that he encouraged Ferenczi to develop this concept (Rachman, 1997, pp. 142-143). Rachman also writes that Freud was more active in his technique than many of his writings imply, and gives many examples of this (ibid., p. 132). Both Freud and Ferenczi were revolutionaries, suggests Rachman (p. 138), with Freud being attracted to Ferenczi's experimental and innovative spirit (ibid.), and needing Ferenczi to develop psychoanalytic technique further (p. 145). He adds that Freud continued to support Ferenczi's clinical experiments and that it was likely that Freud was connected to many of Ferenczi's innovations (p. 158). Thus, although it seems that Freud ultimately disapproved of the direction that Ferenczi went in, at the same time he was encouraging him to go in that very direction.

### ***Summary***

To summarise, this chapter has taken a brief look at how the therapist's love was viewed in the first few decades of psychoanalysis, through the seminal figures of Freud and Ferenczi. It appears at first glance that the views of Freud and Ferenczi may have

been at opposite ends of the spectrum, with Freud representing 'neutrality' - the withholding of love - and the asymmetrical nature of the therapy relationship, and Ferenczi representing mutuality, including empathy and a loving exchange of feelings. This chapter has shown the difficulties Freud and the early analysts encountered in the area of love, Freud's efforts to address these, and Ferenczi's explorations into developing analytical technique in a direction away from neutrality.

When considering both asymmetry and mutuality in the therapy relationship, and my work with 'Elizabeth', who I mentioned in the introduction, I think of my countertransference feelings of protectiveness and wanting to be a good mother to her, in the face of her traumatic childhood experiences, and that my feelings are also, in my opinion, based in the reality that Elizabeth does need to feel my love for her, at least for a period of time in the therapy, as Ferenczi may have suggested. I will explore this further in the next chapter. In any case, it seems that it is holding the balance of mutuality and also retaining the overview and being aware of what is happening in the therapy relationship that makes the encounter a therapeutic one rather than anything else. We could view this balance as being a synthesis of both the contributions of Freud and Ferenczi - asymmetry and mutuality - although attributing them according to each person would appear to deny the complexities of their relationship both with each other and with psychoanalysis.

## Chapter Four: 'Parental' Love

Many writers have compared the therapist's love to that of a parent, beginning with Ferenczi, who describes the analyst's love as being akin to that of the mother (Dupont, 1988). This chapter will describe how the therapist's 'parental love' in psychotherapy has been written about, the perceived value of parental love, and also a critique of the notion of parental love in therapy. The significance of this for clinical practice will then be explored.

### *Qualities of Parental Love*

#### *Tenderness, affection and the abiding presence*

Suttie (1963) aligns himself with Ferenczi, writing that it is "sympathetic understanding", "the capacity to put oneself in the patient's place", "affection", and "tenderness" that heals the patient (pp. 81-84). He defends tenderness, which he says is tabooed in our culture more than sex, because it is "childish" (p. 84), and that psychoanalysis is limited by this bias. He goes on to say that what we call tender feelings and affection is based not on sexual desire but upon the pre-oedipal emotional and fondling relationship with the mother (p. 91). From this he concludes that the nature of the analyst's love is understood as a feeling-interest responsiveness – not a goal-inhibited sexuality - and that the analyst re-plays the original role of the mother in becoming the starting point of a broadening circle of anxiety-free relationships (p. 200).

Winnicott (1949) also compares the love of the analyst to that of a parent - particularly that of the mother. The qualities he speaks of are patience, tolerance,

punctuality and reliability, as well as the ability to recognize the patient's wishes as needs (p. 74). Gerrard (1999) writes fifty years after Winnicott of her belief that in order for her patients to reach their capacity for loving and a sense of wholeness that they need to experience her as a loving mother (p. 30). She describes the qualities in this therapeutic love as including patience, endurance, humour, kindness and courage, as well as containment, reverie, tenderness and affection. She also points out that, unlike most mothers, she is unlikely to begin a new therapy 'loving' a patient, though she may like him or her.

Shaw (2003) identifies a lineage of psychoanalytic forebears who place love at the centre of their theories of development. With regards to 'parental love' he mentions Ferenczi, Suttie and Balint, saying that these three all believed that human beings are relationally oriented from the beginning (p. 262). Balint's view, according to Shaw, is that the analyst attempts to set his own needs and agendas aside, and provides the analysand a new beginning with his non-impinging, abiding presence. Balint's version of analytic love, writes Shaw, is intended to provide a new relational experience (p. 263).

### ***The Value of Parental Love***

#### ***Reparative parental love, attachment research and neurobiology***

Thinking of the therapist's love as being similar to parental love does have the advantage of safeguarding the patient against the analyst's exploitation and emphasizing the reparative nature of the analytic work. Money-Kyrle (1956) describes the analyst's "motive" as being a blend of "curiosity with parental and reparative drives" (p. 364), and further states that the analyst is mostly concerned with the unconscious child in the patient (p. 360). Racker (1968) argues that the analyst's love is needed to motivate the

patient and that the masochistic analyst tends to renounce parenthood, leaving the direction of the analysis overmuch to the patient. He adds that the analyst's love must be somehow detachable and more fluctuant than a parent's; the ability to observe the countertransference and to step out of it are intrinsic to the process. Harris (1960) makes a similar point. Mitchell (1984) cites Guntrip, who in 1969 wrote that parental love, or agape as distinct from eros, is the kind of love the psychotherapist must give his patient, because he did not get it adequately from his parents (p. 491). Natterson (2003) speaks of love as a fundamental creative and propulsive force in therapy, and that therapy is a mutually loving process. He describes the therapist's subjectivity as having the caring parental quality that is necessary for the establishment of the symbiotic arc of love that is essential for therapeutic action (p. 520).

Attachment theorists starting with Bowlby in the 1950s initially highlighted the crucial nature of the infant's attachment to his or her mother, in particular, for the infant's optimal development and later capacity to live a satisfying life with others. Later research has suggested that the infant's brain may actually develop differently if attachment needs are not met and if there is a surfeit of separations, losses, wounds and deprivations. Bach (2006) refers to recent research by Schore (1994) and Hoffer (2003) in cognitive neurobiology which shows that the mother's language and emotional reactions psychobiologically influence the production of hormones and neurotransmitters in the child's brain, so that the emotional interactions between mother and infant are configured into the developing nervous system. He believes that therapists need to be aware that their own words and actions also influence the production of hormones and neurotransmitters in the patient's brain, and so the power of paying a certain kind of attention can be very

great indeed (p. 134). Bach uses the analogy of the mother with her baby, although he does not emphasize being the patient's mother, but rather highlights the *motherly function* of paying very close attention and the benefits that can have for the patient (pp. 131-132).

Many others have written on the role of the psychotherapist in providing an environment which can help to alter the limbic processes in our brain, thus compensating for what may have been lacking earlier. Lewis, Amini and Lannon (2000) write that "psychotherapy alters the living brain" (p. 168) when the therapist is able to really listen and attune to the patient, that is, to provide a quasi-mothering function where the patient is nurtured emotionally and can rely and depend on the therapist. The longer a patient depends, they argue, the more stable they become, until they are able to gain their independence.

### ***Critiquing Parental Love***

#### ***No love without hate***

Winnicott (1949) discusses hate in the countertransference of a psychotic patient and speaks firstly about the analyst's devotion to the patient as being similar to that of a mother devoted to her infant:

I think that in the analysis of psychotics, and in the ultimate stages of the analysis, even of a normal person, the analyst must find himself in a position comparable to that of the mother of a newborn baby. When deeply regressed the patient cannot identify with the analyst or appreciate his point of view any more than the foetus or newly born infant can sympathize with the mother. (p. 74)

Winnicott points out that there can, however, be no love without hate, perhaps particularly for the parent/analyst - "However much he loves his patients he cannot avoid



hating them, and fearing them, and the better he knows this, the less will hate and fear be the motive determining what he does to his patients” (p. 69).

In referring to analysis during Freud’s time, Winnicott (1955) also mentions both the analyst’s love and hate - “The analyst expressed love by the positive interest taken, and hate in the strict start and finish and in the matter of fees. Love and hate were honestly expressed, that is to say not denied by the analyst” (p. 21). Winnicott’s important contribution to remembering that hate and love exist together is mentioned by Denzler (2000), who quotes Winnicott cautioning social workers and analysts who want to “love” patients that one should never forget that love and hate co-exist. He also strongly cautions against the danger of sentimentality (p. 233).

### ***Is parental love what is needed?***

Certainly the way that a therapist interacts with his or her patient will depend largely on what the patient brings and what they need. Some patients may need something that is more akin to parental love than to anything else. Hirsch (1994) suggests that analysts work within three different models of psychoanalysis and describes how the analyst’s countertransference feelings of love within these three models differ. The first, the ‘drive conflict model’, views the patient as dominated by infantile sexual and aggressive drive derivatives. He suggests that within this model, sexual material, for example, is interpreted as infantile sexuality and that this makes it easy for the analyst to dissociate from countertransference sexual responses as he can view the erotic material as “not real or not adult” (p. 176). The second model, the ‘developmental arrest model’, views the patient fundamentally as a child in an adult’s body suffering from a deficiency in poorly attuned parenting - “The analyst of the developmental arrest model...views the

patient as a not yet sexual child” (p. 180). Countertransference feelings are generally parental – “symbolic touch or love is in the form of the gentle parental kiss, the refusal to impinge. Sexual feelings in the transference are far overshadowed by longing for parental holding” (p. 178). As an example of this he describes Margaret Little’s account of her analysis with Winnicott, who, he says, essentially took care of her as a good parent would. In the third model, the ‘relational-conflict model’ he argues that the patient-analyst relationship more closely resembles other social relationships, but the frame is clearly set, with the analyst being the observer and the relationship being asymmetrical - “the patient’s sexual feelings toward the analyst may very well be those of a reasonably mature, sexual adult” (p. 190).

Hirsch applies some element of criticism to the parental model by arguing that the ‘relational-conflict model’ enables the analyst to be aware of and make use of the broadest range of countertransference enactments (ibid.). He does, however, point out that many people use all three models, or a combination of them, or operate outside of a model altogether.

### ***Parental love as a defense against erotic feelings***

Some writers describe the maternal or paternal paradigm as a possible defense against exploring erotic feelings in the relationship. Lester (1985) acknowledges that it is difficult to offer herself to a male patient as an object of sexual cathexis; she is more at ease in the role of ‘analyst as mother’. Baur (1997), points out that the “feminization” of psychotherapy is leading to a philosophy whereby the only permissible relationship is a nurturing one between therapist and client. She suggests that there is such fear that sexual attraction will lead to exploitation that many therapists retreat to the safety of the parental

framework (p. 222). She points out that although some therapy relationships need to be of a parental nature, not all therapy occurs in this paradigm (p. 223).

Mann (1997) cites Freud's view (1905) that the infant-mother bond is not only the prototype for the infant's sexual experiences, but that relating to the infant is also part of the sexual experience of the mother:

A child's intercourse with anyone responsible for his care affords him an unending source of sexual excitation and satisfaction from his erotogenic zones. This is especially so since the person in charge of him, who, after all, is as a rule his mother, herself regards him with feelings that are derived from her own sexual life: she strokes him, kisses him, rocks him and quite clearly treats him as a substitute for a complete sexual object. A mother would probably be horrified if she were made aware that all her marks of affection were rousing her child's sexual instinct and preparing for its later intensity. She regards what she does as asexual, 'pure' love, since, after all, she carefully avoids applying more excitations to the child's genitals than are unavoidable in nursery care... [but]...She is only fulfilling her task in teaching the child to love. (p. 223)

Stern (1993) also demonstrates how the behaviours and psychic processes of adult lovers find their prototypes in the infant-mother bond – “expressions of love begin strikingly early. The most basic language of affectionate love is both performed and learned by the fourth or fifth month of life” (p. 176).

Mann (1997) refers to Winnicott and Bion, who, he says, are the most important proponents of the mother-therapy analogy. Although he does not disagree with what Bion and Winnicott ascribe to the maternal-therapeutic process, that is, holding, containing, mirroring, primary maternal preoccupation and so on, he makes the point that the erotic component of the mother-infant couple is ignored (p. 122). He cites Wrye and Welles (1989), who have also noted the absence in the analytic literature of discussion concerning the erotic pre-Oedipal mother, and the dangers both to analyst and patient if early eroticism is not recognized (p. 123). Mann argues that if therapists are going to use

the mother-infant analogy in their work, and most do, he suggests, then they can no longer idealize out of existence the erotic nature of being a mother, and that there is no avoiding placing the erotic centre stage in the “therapeutic mothering” (p. 135).

It seems unlikely that Bion and Winnicott would have left out the erotic component of mothering altogether. Sandler (2005) notes that sex and sexuality are a central issue in Bion’s work but that many fail to perceive it, and that his theory of container and contained has a sexual ethos clearly indicated by the genetic symbols chosen to represent it: ♀♂ (p. 374). However, it does seem likely that at that time they chose to take the focus off the sexual aspects of early mothering and instead highlighted other aspects of the relating. Writers in the last ten to fifteen years (Wells and Wrye, 1991; Wrye, 1993; Hirsch, 1994; Mann, 1997 & 1999; Baur, 1997; Green, 2005) have been keen to ensure that pre-oedipal as well as oedipal sexuality is included in the consideration of the therapist’s role in the therapeutic process.

***The therapist’s love cannot be wholly compared to parental love***

Most authors do in fact acknowledge that although the psychoanalytic relationship can be likened to the mother-infant relationship there are also radical differences. Steingart (1995) alludes to Winnicott’s concept of ‘primary maternal preoccupation’, whereby the mother’s total psychic life, cognitive and emotional, is absorbed in a rapt, fascinated attention to her infant’s thriving. He likens this to the state of mind that Freud called the analyst’s “evenly suspended attention...without therapeutic ambition” (p. 122) and says that it is part and parcel of the loving idealization of the analysand’s psychic reality. Although he says that a transference experience could be facilitated in which the analyst becomes someone who is holding or containing, he disagrees that the analyst is

the “mother” as such, and that such a fantasy is an illustration of therapeutic ambition. The adult analysand is not a child, but an adult, he says. He concludes by reiterating that the psychoanalytic relationship is unlike any relationship in real life (pp. 122-123).

Loewald (1960) says something similar. On the one hand he describes how the parent-child relationship can serve as a model for the analytic relationship (pp. 20-21), and on the other hand, he also says that whereas the analytic relationship shares certain aspects with other kinds of relationships, for example, child and parent, patient and physician, student and teacher, friends, lovers; that it is quite different from all of them – “it seems to exist for its own sake and at the same time to be a rehearsal for real life” (1979, p. 156).

### ***Summary***

The therapist’s love is often described as being parental in nature. Natterson (2003) notes that the qualities of this love transcend issues of countertransference and are part of the therapist’s subjectivity. The qualities include attunement, patience, containment, caring, reliability and so on. The value of viewing the therapist’s love in this way is described, particularly the importance for the patient of a non-exploitative therapeutic relationship, and the reparative nature of the therapist’s love. The differences between writers on this subject seem to be related to the degree to which they compare the therapist’s love to parental love, and it is shown that the needs of different patients also have a bearing on this.

Writers have also pointed out the limitations of comparing the therapist’s love to that of a parent. These include forgetting that hate is also an important part of love, possible infantilisation of the patient, and using the parental role as a defense against the

exploration of erotic feelings. Most authors point out that whereas there are similarities to parental love, there are also major differences, and that the therapist has specific responsibilities in this area, particularly in the observing of their countertransference, the nature of the analytic frame, and also in responding to the patient as the adult they are.

### ***Clinical Vignette***

*In an early session Elizabeth shyly said to me that she wanted me to be her mother. She needed, she said, a good mother in her life, someone who did not think she was crazy and who would be interested in her. She had been observing me, she said, and thought that I was 'stable', 'balanced', and 'understanding', and that I could be that mother.*

*In fact, I had already begun to respond to her desire for me to be a mother. I thought it was a shame that her finances meant that she could only come to therapy once a week; I thought every day would be better. She seemed to me to be so frail and so young (in fact she is not much younger than me) and needing a lot of care that I was not sure how she operated in the world from week to week. I wondered if she was eating enough and I felt outraged if she was treated by others with less sensitivity than I thought she needed. "Can you not see that she is only a little girl?" I would think, in silent conversation with the people in her world.*

*Of course I knew that I was not and could not be her mother and that we would need to talk about that. But in the meantime I felt that I certainly had some mothering functions to carry out with Elizabeth, in particular, being attuned to her,*

*providing her with a measure of the emotional environment that she had missed out on early on and in fact throughout her childhood.*

Much of the literature I have discussed in this chapter is relevant to my work with Elizabeth. I do not think that all patients need a predominantly ‘parental’ approach from their therapist; however Elizabeth is one who in my opinion does. Being a type of mother to Elizabeth has been part of her therapy, in a way that might not be appropriate for someone else. Here I am thinking of attachment and neurobiology research in particular, and how being attuned to Elizabeth has been very important, and has made up a lot of the work so far. Many of the ‘maternal’ qualities that some writers describe, for example, tenderness, affection, kindness, patience, humour, taking an interest, being reliable, and so on, have been my predominant way of being with Elizabeth.

I keep in mind the criticisms that have been made in this area. The comments made by Baur (1997) and Mann (1997) have prompted me to think about whether I hide too much behind the nurturing style that comes quite easily to me, and to be more aware of eroticism and sexuality in the relationship. This will be explored further in the next chapter. Also there is Steingart’s (1995) warning that trying to be a ‘mother’ to a patient can indicate therapeutic ambition. Elizabeth is also an adult woman who needs to be responded to as an adult. For me, that means continuing to talk with her about what we are doing in the therapy, so that, although I am on one level responding to the needs of her ‘child’, I am at the same time treating her as an adult. I am aware that her idealized observations of me are in part a wish that she herself had the qualities that she sees in me and I keep that in mind during our work, moving towards her being able to develop and recognize these qualities in herself. Observing my countertransference in our therapy is

crucial, as I watch my 'motherly' functions and gauge their effectiveness or otherwise in a way that I would find very difficult if I was actually Elizabeth's mother.

Lastly, Winnicott's (1949) exhortation not to forget hate is important. In my initial meeting with Elizabeth her aggression was palpable, although not directed towards me. It would be tempting to be such a good 'mother' that this aggression would never show itself to me. However, even if I did manage that, there is the therapy frame itself, which means that the sessions are fifty minutes, that I have holidays and so on, all of which proves to Elizabeth that I am not solely a wonderful and giving person. Her hate and mine are in our therapy as emotions to be worked with, just as much as our love.



## **Chapter Five: Sexual Love and Eros**

Sexual attraction and sexual feelings have long been considered problematic within the context of the therapy setting. Samuels (1999) points out that whereas analysts have different opinions on almost all aspects of analysis, there is almost unanimous agreement that sexual behaviour in analysis and therapy is damaging to the patient (p. 150). As I have already noted in chapter 3, Freud recognised the difficulties and the temptations inherent in this area - and indeed the very real threat to psychoanalysis as an emerging discipline. In this chapter I will explore what has been written about the therapist's sexual love, what it means, the value of it, and also its dangers.

This area, more than others on the subject of the therapist's love, is complex to research, and part of this is due to writers using different terms seemingly interchangeably. So, for example, one writer will talk about romantic and erotic desires, another about the therapist's erotic responses to patients, another about loving and sexual feelings, and another about the therapist engaging with the patient's erotic transference. And then we have 'the passion of the coital couple' (meaning the therapy couple), intimacy between analyst and analysand, mutually-enhancing love, reality-attuned respect, therapy as an erotic encounter, the erotic pleasure of doing therapy, and many more. What is meant by all of these terms is often not immediately apparent, and some writers will, for example, use 'sex' in a way that another will discuss 'Eros'. For this reason I have had to sift through the material for what is useful for this topic.

What I have found is that there has been much written about sexual and erotic countertransference (including the different types, Bonasia, 2001) and sexual enactments.

I would like to propose that sexual enactments in therapy do not have very much to do with the therapist's love, although there may be intense *feelings* of love. For this reason I intend in the main to exclude discussions concerning sexual countertransference that are related to sexual enactments in therapy and to focus on two areas only. These are:

1. Where sexual or erotic feelings are thought about by the therapist and used to enhance the therapy;
2. 'Eros' as being more than simply countertransference and existing as a loving force in the therapy.

### ***Qualities of Sexual Love***

#### ***Sensual love***

It is not difficult to see why sexual feelings can arise between the therapy couple. Although the therapist's love is often referred to as 'aim-inhibited', Freud noted (1930) that love with an inhibited aim was in fact originally fully sensual love, "and it is so still in man's unconscious" (p. 103). If we follow Freud's line of thought then we would have to say that if the therapist is operating largely in the realm of the unconscious, then he or she would also be operating largely within the realm of sensual love. It is only the analytic task of stepping back, creating distance, and observing, that rescues the enterprise from being a fully sensual experience, with possible sexual enactments.

Samuels (1999) alludes to this when he writes that when there is a universal moral taboo (for example, also with incest) there is also probably a universal impulse that is in the background. In this case, he says, there is a universal impulse and desire in therapists and analysts to engage in sexual behaviour in the session (p. 150). He argues for understanding the problem rather than seeking to merely suppress or eliminate it. Tansey

(1994) makes the same point, as does Field (1989), who adds that this can hardly be surprising “when psycho-analysis itself acknowledges the primacy of sexual impulses” (p. 516).

### *Normalising the therapist’s erotic responses*

Searles’ (1959) paper has been described by many authors as being a seminal paper. In it Searles explores his feelings of romantic and erotic desires towards his patients, which he says that his training had led him to feel were very suspect (p. 180). He says that at that time it was very rare for colleagues to acknowledge such feelings and cites Tower (1956) who noted that “Virtually every writer on the subject of countertransference...states unequivocally that no form of erotic reaction to the patient is to be tolerated” (ibid.). Searles’ main argument is the importance for the patient in sensing that he or she is capable of arousing such feelings/responses in the analyst. As well, he suggests that there is a direct correlation between the affective intensity with which the analyst experiences an awareness of the feelings and the depth of maturation which the patient achieves in analysis (p. 183). Searles normalizes the erotic reaction to the patient, and in fact describes it as a crucial part of the therapy. He likens it to the importance of the daughter knowing that her father finds her attractive (p. 184).

Erotic responses to the patient have been more openly written about since Searles’ article, and particularly from the early to middle 1990s<sup>2</sup>. Mann (1997), however, notes that there is still relatively little written on the subject, and that writers fear being misunderstood, and being overly exposed if they discuss this subject. He writes that

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<sup>2</sup> Gabbard (1994a) and Solomon (1997) attribute this to an American Psychoanalytic Association conference in 1992, which focused on ‘Love in the Analytic Setting’, and where clinical vignettes were presented involving love and erotic feelings in the therapeutic relationship.

discussing the erotic often leads to defensiveness. The underlying anxiety, he says, is that if you talk about the erotic that other therapists will think you act on your feelings – “to think about it is to do it” (p. 193). Green (2005) thinks that this has partly been brought about by a growing de-sexualisation and a return to puritanism in psycho-analysis and believes that “there is a general undervaluation of sexuality. It is our way of prohibiting a real questioning of the topic” (p. 22).

### ***Similarities between sex and therapy***

Some writers have likened the therapy situation to coitus, which does include the notion of sex but does it at one remove, that is, by taking the focus off the therapy couple and onto the therapeutic process. Examples of this are cited by Mann (1997), and include McDougall (1978) – “the psychoanalytic adventure, like a love affair, requires two people” (p. 129), and Meltzer (1973), who suggests that the psychoanalytic process needs (amongst other things) “the passion of the coital couple” (ibid.), and Jung (1946), who describes the transference in terms of the royal or divine marriage, the “higher copulation” or “psychic pregnancy” (ibid.). Mann himself also writes that analysis is clearly not an exact metaphor for sexual intercourse but that the analogy between analysis and coitus holds good, and that in many ways, the intimacy between the analyst and analysand is often greater than between sexual partners (p. 128).

He cites Stern (1993), who showed that the early sensual experience is the precursor of the later adult sexual experience, and then stresses the importance of the sensual-sexual in the therapy relationship. Holmes (2006) makes a similar point in likening “good sex” to “good therapy”, and that learning to associate freely in therapy might also enhance sexual capacity (p. 7).

## ***The Value of Sexual Love***

### ***Eros***

Some of the most pertinent writers on this topic are writing from the perspective of ‘Eros’, a wider area than sexuality, which I will explain briefly, firstly looking at the Greek mythical figure of Eros, then at Freud’s Eros theory, and lastly how writers use both of these to argue that psychotherapy is an erotic encounter.

### ***Eros, god of love***

There are various and conflicting accounts of the origins of Eros. Very early images of Eros show him as a beautifully-formed, full-grown young man, one of the oldest Greek gods, the cause of the birth of the race of immortal gods and goddesses. Later images show him as a small naked winged boy, a sometimes mischief-maker, and he is placed as the son of Aphrodite, Goddess of Love (later called Venus) and Ares (later called Mars), God of War (March, 1998).

Although Eros is often thought of as denoting sexual love, the quality of love described in the Greek myth is spiritual as well as physical, and includes the love of beauty, healing, and freedom, as well as the love between people. His name evokes passion, vitality and life-force. Eros is at once the creator of his parents as well as being descended from them and his lineage is both love and war/hatred (ibid.). Zuckerberg (1995) notes Eros’s paradoxical nature; on the one hand provocateur, dangerous ‘mischief-maker’, and on the other hand the cohesive force (p. 231). She argues that this paradoxical nature – cohesive, healing, generative at one time, at another destructive, chaotic, tantalizing - contributes to our fascination with the erotic as well as our reluctance to know it fully (ibid.).

Freud (1940) refers to Eros in terms of the libido, the libidinal energy or love, the life instinct innate in all humans, the desire to create life, to be productive and to construct. He describes Eros as battling against the destructive death instinct of Thanatos (pp. 149-150) and is clear in not equating Eros with sexuality alone (p.151). Rechart and Ikonen (1993) also emphasize that Eros and Thanatos, while being psychic tendencies independent of each other, also work together – “Eros and the death drive together form a peculiar binary system, where the one never exists, and cannot exist, without the other. They are together able to create infinite forms of love and death” (p. 97).

### ***Psychotherapy and Eros***

There are some authors (Haule, 1996; Mann, 1997 & 1999; Baur, 1997) who describe psychotherapy as an erotic encounter and who go to some lengths to describe why they think that is so. Haule (1996) highlights the passionate and creative aspects of Eros, and speaks of a “general interpersonal vitality” (p. 22), a lively sense of “we-ness” (p. 86), and also “chaotic passion” as opposed to “philia” (the Greek term denoting friendly affection) and “agape” (denoting Christian charity) (p. 24). Similarly to Freud, he stresses that sex is, or may be, a part of Eros rather than its entirety.

He describes the compelling nature of the work when Eros is present (p. 62) and likens the process of intimacy in therapy to the “letting in” and to the privacy that attend the sexual realm (p. 14). Throughout his discussion Haule remains an advocate for the transformative nature of Eros, while accentuating the importance of maintenance of boundaries in the therapy relationship, as well as the necessity for the therapist always to be consciously aware of the process. He also argues that every occasion of effective love involves both union (the erotic foundation and life-giving spirit), and distance (the careful

observer and clear elucidator) (p. 97), and points out that there is a danger when the therapist is inclined towards too much union and not enough distance; he suggests that this is where the therapy can become a narcissistic and grandiose endeavour. Love, he says, is the basis of the work, but it is not the work. Zuckerman (1995) also writes that the impact of Eros on the therapy situation is that a dynamic relational interplay is created. She believes that erotic transference-countertransference phenomena are, with few exceptions, not something “to get rid of” (p. 232).

Novick and Novick (2000) refer to Freud’s Eros theory and point out that until recently the analyst’s love has tended to be relegated to the area of countertransference, to be mastered but kept out of the analysis (p. 214). They argue for the possibility of mutually enhancing love in which self-esteem is regulated by reality-attuned respect between patient and analyst (p. 214). Love, they say, is part of an “open” system that includes more than sex alone, whereas a “closed” system is one in which sex, disguised as love, aims to exert hostile control and dominance over the other (p. 206).

Although Lear (1990) does not use the word ‘Eros’, he uses the word ‘Love’ in a very similar way in which Haule uses the word ‘Eros’, that is, love as the “basic natural force” (p. 181), and as an inner force for development (p. 155). He further says that psychoanalysis is a manifestation of man’s erotic attachment to the world (p. 181). Love, says Lear, is active, and is about accepting responsibility, even for the impulses in our dreams (p. 172). This then suggests that the active process of psychoanalysis is based on love.

### *The therapist's erotic subjectivity and pleasure*

Mann (1997) agrees that love in the therapy relationship needs to be sublimated, however that the erotic should be neither sexually acted out nor simply frustrated, as the latter may lead to a hostile negative transference “largely of the therapist’s making” (p. 43). He challenges the classical view that transference love is a resistance, and instead points out that when authors try to designate a difference between normal love and transference love, that it cannot be done (p. 37). This leads him to say that while transference love may sometimes be a resistance, it is clearly not so all the time (p. 40). He argues for the erotic to be welcomed by the therapist as an opportunity rather than as a problem of resistance, thereby greatly increasing the potential to expand the range of the patient’s emotional repertoire (p. 43).

Mann emphasizes the therapist’s own erotic subjectivity, which he says is neither neurotic nor solely a response to the patient – “we need to go beyond the term ‘countertransference’ in describing the therapist’s feelings” (p. 59), and argues that erotic fantasies and desires need be no more detrimental to the analytic process than any other feelings and that rather than being repressed or denied, they need to be subjected to the “rigours of analytic thought... [and] utilized to the patient’s advantage” (p. 71). He concludes by saying that “the erotic is the most powerful transformational force of all” (p. 195).

On a slightly different but related tangent, Bollas (1995) acknowledges the deep pleasure that analysts receive from their work with their patients. Like other pleasures of giving and receiving he feels it is an erotic one – “the aim of sexual urges is not simply



bodily gratification...the desire to populate the inner world with excitements and objects of desire is important” (p. 43). However he says that analysts hesitate to talk about this:

Better to emphasize the abstinence, the frustration, the pain, the travails, the pathologies, the resistances, the negative transferences, than to reveal the pleasure that is the source, the aim, and the gratified object of psychoanalysis. And as to cure? That pleasure should be a means to cure...that the analyst’s technique should be his pleasure in the handling of the patient, that two people in such a place should acknowledge such a pleasure: this seems as yet an impossibility. (p. 46)

Bollas suggests that this impossibility stems largely from Freud having exiled the idea that analysis could be sexually gratifying in any way, but that whereas the idea was exiled the pleasure was not. He contends that Freud did the same thing to the sexually pleasurable aspects of the technique he invented that most people in modern societies do with their sexuality, that is, repress and displace it rather than acknowledge it – “That psychoanalysis should be so gratifying is not a surprise...that its theoreticians should shudder from this fact is a curious oblation of the pleasures of unconscious communication” (p. 47).

### ***The Dangers of Sexual Love***

#### ***Sexual enactments***

As I have noted, this is not an area that I intend to go to in detail, however it is worth pointing out that Gabbard has written extensively on the countertransferential aspects of sexual and or erotic love, and the attendant dangers. Bonasia (2001) quotes Gabbard’s 1989 survey of a large sample of psychotherapists; 86% of the men and 52% of the women stated that they had felt, or were, sexually attracted to patients. In much of Gabbard’s writings on this topic (1994a, 1994b, 1994c, 1995, 1996a), his focus is on enactments in the therapy. He thoroughly explores the dangers of sexual and erotic love

in the therapy setting, and points to the way in which “sexual and loving feelings are powerful, immediate, and compelling in their tendency to override the steady reflectiveness of the analyst” (1994a, p. 1085), and also how an infatuation with the patient can lead the analyst to view their ‘in love’ state as transcending transference and countertransference considerations. As well, he suggests that sexualisation may defend against feelings of love, or alternatively may be prompted by a hostile wish by the more powerful analyst to humiliate a helpless patient (ibid.). Elsewhere, Gabbard (1996b) also explores the influence of the analyst's contribution to the erotic transference.

Baur (1997) writes about the therapist’s sexual desire and acknowledges that in the present climate - where there are very strict guidelines or rules around sexual contact with clients - therapists are often afraid to talk about their attractions to patients, which, she thinks, makes them more at risk of acting something out. She ponders on how to be open to love and at the same time vigilant against acting on sexual attraction. As well, she notes the difficulty experienced by therapists in thinking about love in the therapy relationship and concludes that love and possibly sexual attraction are *supposed* to be part of serious therapy and are *supposed* to remain unfulfilled, and acknowledges that this places psychotherapy in dangerous waters.

Berzoff (1998) criticizes Baur by saying that her argument fails by confusing love with sexual acting out and countertransference love with erotic love. However, Baur’s willingness to discuss the grey areas - while at the same time defining the needed boundaries around sexual enactments - is unusual compared to many other writers, who often have a somewhat censorious tone to much of their writing on this subject. I think this reflects the difficulty in writing about this area, as Mann (1997) has pointed out.

### ***Too distant approach***

In this difficult area, where it is emphasized that great care needs to be taken, some writers have suggested that therapy can suffer from the therapist's too *distant* approach. This can happen in different ways; one way is that the therapist ascribes all of the drives experienced by the patient to the desires of infancy, which Schavarien (1995) suggests may be a form of abuse of power (p. 26). Another way is described by Lester (1985) (mentioned in the previous chapter), who acknowledges that she more at ease with the role of 'mother' as opposed to being an object of sexual cathexis. Related to this, Kumin (1985) suggests that erotic countertransference in the analyst can lead to feelings of guilt, shame, disgust and horror (p. 15), and links these feelings to the incest taboo. He believes that they inhibit the development and elaboration of the erotic transference.

Davies (1994) acknowledges the reticence to discuss erotic countertransference. Like Kumin, she suggests that there is an unwillingness to view the parent/analyst as a full participant in the child's romantic oedipal struggles, and cites Wrye and Welles (1989), Welles and Wrye (1991), and Wrye (1993), who argue that the countertransference problem may be less of behaving oneself than allowing oneself to participate. Davies (1994) writes that there is a need for the analyst to work through her own countertransference resistances and illustrates this with a quote from Wrye (1993):

...what is longed for is contact with the analyst's body or with bodily products; both participants may face the longing or and terror of the wish to be one being in the same skin. Not only the patient but also the analyst will have to recognise and deal with this wish. (p. 243)

Davies (2003) further describes the difficulties that an analyst faces when the patient develops an intense erotic transference, and suggests that it is the realization that there is no clinically reliable "way out" that often makes an analyst reluctant to engage

fully with their patients' erotic transferences (p. 4). She argues that rather than considering the process to fully reside within the patient, that the oedipal love affair between parent and child - and therefore its enactment between analyst and patient - is a "deeply mutual, intensely romantic, cocreated process" (p. 5). She holds that the "love affair" must be entered into and lived out by both participants, and relinquished and mourned in equal measure by each participant as well (p. 9). She gives reasons as to why this joint enterprise can go wrong, not the least of which is the analyst's fear of the process (p. 14).

Solomon (1997) similarly describes the importance of the therapist's participation and that his or her immersion into the countertransference provides the path to change (p. 89). She highlights the potential difficulties for the therapist in managing loving and sexual feelings, that on the one hand the therapist needs to be able to recover his or her bearings after feeling pulled towards a variety of enactments, and on the other hand, the therapist must not take an overly cautious stance, as then the therapy remains superficial (ibid.). Tansey (1994) also writes of this dilemma, that is, that if sexual feelings towards the patient are not explored then they will go underground, and manifest in either sexual acting out or compensatory distancing (p. 142).

### ***Summary***

In this chapter I have reviewed literature discussing the therapist's sexual love as well as Eros. From the earliest days of psychoanalysis, this has been a fraught area, and much of the early writing is concerned to point out that the therapist must view the erotic transference as being always the patient's resistance to the therapy. Erotic or sexual feelings towards the patient seemed not to have been written about in an accepting way

until the late 1950s. Since then the subject has been dealt with in various ways. I have pointed out that this is a complex area to research, partly due to the terminology that is used, with writers using different terms seemingly interchangeably.

One theme that emerges is that there has been a growing acceptance and understanding of the therapist's erotic responses and how to work with these in the therapy for the patient's benefit. As well, there is discussion as to the extent to which the sexual or erotic love felt by the therapist towards the patient is countertransferential in nature or not. The literature seems to be pointing to the fact that we can sometimes talk about countertransference and other times not. Mann (1997 & 1999) in particular is adept in arguing that it is important to go beyond the term 'countertransference' in describing the therapist's feelings, and that erotic fantasies and desires can be well thought about and used to the patient's advantage, rather than being an indicator of pathology in the therapist. There is a distinction being made here between countertransferential feelings and the therapist's own erotic subjectivity, and a growing acceptance of the latter.

Another theme is that in the last decade, in particular, some writers are writing more about Eros than sex. These writers describe the paradoxical, passionate and creative aspects of Eros, as well as its transformative nature in the therapy. The benefits to the patient include opportunities to progress their development, to expand their emotional repertoire, and to have a therapy that is alive and meaningful. Thanatos and its interplay with Eros is explored. Eros becomes what Lear (1990) describes as the "basic natural force" in the therapy. In this paradigm, notions of the 'erotic transference' being always a resistance to the therapy are reviewed; there is room for this transference also to be viewed as a desire for aliveness and meeting in the therapy.

To conclude, although sexual enactments do not belong in the therapy situation and are harmful for the patient, many writers have noted that the repression and denial of the powerful forces of sexuality and Eros do not bode well either for a patient's treatment. Arguments are made to include thinking about sex and Eros as part of the therapy, and as part of the therapist's love, and the benefits to the patient of doing so. The dangers of not doing so are pointed out.

### ***Clinical Vignette***

*As Benjamin walked into the room for the first time I noticed his confident gait, his elegant clothes and his slightly drawn face. There was no doubt that this was an attractive man but there was something not alive in him that made me curious.*

*Benjamin is a very successful and senior practitioner in his field, who in conversation easily engages the other with an intensity that seems to contradict my initial impression of a lack of aliveness. Many women find Benjamin attractive and I am no exception. I would not say that I have a strong sexual attraction to him, however I do have an erotic response at times and I often think of him outside of our session time. A few days after our first meeting I dreamt of a weary mother, with an aggressive toddler at her breast, pulling at her and sucking and sucking. The mother was unable to pull herself away from him. When I woke up I felt that this dream related in some way to Benjamin.*

*My erotic response to Benjamin tells me something about the feelings he engenders in others, and that other women also have those responses to him. It*

*also tells me that this may be a familiar way for him to relate to women, and that there is a reason for this. Some questions then arise, such as, how much do I see this as a defense against honest intimacy on his part, or on the other hand, is there a desire for an aliveness in our relationship, for something real? How important is it for him to feel that he is successful in eliciting an erotic response from me? Would it be right to interpret my erotic response to Benjamin as signifying an infantile desire on his part? Or would this be wide of the mark? Benjamin is also an adult, with adult desires. And so am I.*

I have mentioned my sense of Benjamin's lack of aliveness and his seeming need for an erotic connection with the other, including me. Reading about sex and Eros in the therapy situation has been helpful for me in considering a number of dilemmas. One of these is how to think about a situation where an erotic transference is forming. One way is to notice and, at the right time, to interpret his infantile desires, where I am unconsciously being related to as the sexual mother. I think in Benjamin's case, from what I know of him, that this is valid. I also think that this formulation at this stage would be completely unthinkable for him. With regards to the erotic transference in particular, like Lester (1985), I am more familiar with the maternal role than being an object of sexual cathexis, and the writings of Davies (1994 & 2003), Wrye and Welles (1989), Welles and Wrye (1991) and Wrye (1993) are helpful in thinking about combining the maternal and the sexual. When Welles and Wrye emphasize that the difficulty is less in behaving than in allowing oneself to participate fully (1991, p.104), I agree, and hope that my thoughts on all of this will make it possible for me to respond to Benjamin in a way that honours what he needs, rather than prioritizing my fear.

I have found Mann's writing to be useful; particularly his challenging the view that transference love is always a resistance, as well as his writing that the erotic in the relationship is to be welcomed. Schavarien (1995) also writes of this, and warns against the therapist abusing his or her power in this regard. I have also enjoyed Haule's description of Eros in the therapy as being passionate and tempestuous, alive and transformative. With Benjamin, and any other patient, I hope that Eros and Thanatos will work together in such a way that there is room for plenty of disturbance and life, thus leading to alive and transformative therapy.



## **Chapter Six: Love as a “Thing unto Itself”**

The last two chapters have focused on the way in which the therapist’s love can be compared in some way to parental or sexual love. At the same time there is a recognition that the therapeutic task means that the comparisons cannot be wholly made. This chapter moves more into this territory and explores the writing of those who, like Shaw (2003), suggest that analytic love is hard to define, is often left undefined, that it may at times resemble parental love, fraternal love, erotic love and so on, but that it is not actually any of these things; it is a “thing unto itself” (p. 268). Most, although not all, of these writings have occurred within the last decade; the different ways that this love is described will be outlined here, including the implications for clinical practice.

### ***Qualities and Value of Love as a “Thing unto Itself”***

#### ***Loving attitude versus the interpretation***

Traditionally, the analyst’s interpretations have been seen as the analyst’s ‘love in action’. Nacht (1962a) questioned this by saying that the analyst’s attitude is a decisive factor in what is curative, and that this attitude includes loving the patient and is more important than interpretations (p. 210). The replies to his paper mainly defended the traditional view. So, for example, King (1962) disagreed with him and defended neutrality and interpretation, as did Segal (1962a), although Segal agreed with Nacht that a good therapeutic setting must include unconscious love in the analyst for the patient (she did not, however, agree that a mediocre interpretation is helpful if given with love, saying that mediocre interpretations are more likely to be due to an inhibition of love)

(1962b). When Nacht was questioned as to the nature of the love he is talking about, he replied that it is difficult to describe in common language “although I had to try to do so. It is a kind of openness that one can understand only if he has already experienced it” (1962b, p. 233).

Nacht’s suggestion that the therapist’s love is more important than the interpretations is taken up by some writers, however most stress that both are necessary (Natterson, 2003; Mann, 1997; Field, 1999; Steingart, 1995; Symington, 2006). An illustration of this is Symington describing his analyst clarifying the meaning of the “transference interpretation” – “It is to remove an obstacle that exists between the analyst and the patient” (2006, p. 1). At that moment, Symington reports, he realized that the transference interpretation is a means and not an end, that the goal of psychoanalysis is to bring two persons into relation with one another and that the function of the transference interpretation is to “dissolve the blur, to banish the delusion which prevents the opening of one person to another” (p. 2). Symington’s description of “the opening of one person to another” resonates with Nacht’s (1962b) “kind of openness”.

### ***Love as the “moral infrastructure” of psychoanalysis***

Coltart (2000) writes a list of the qualities which she feels are essential in order to practise as an analyst, and sums these up by saying that they can all be subsumed under the name of love. It is useful to list at least some of these qualities here, as it is one of the most comprehensive lists in the literature and is representative of what many others have written. Coltart’s love includes ‘being with’ patients, and being on their side (as opposed to taking their side) in the search for truth and health. She writes of an attitude which

makes the patient feel important in the relationship, and of the necessity of the analyst being both open to herself and unafraid to love (p. 90).

The qualities include: endurance, understanding, not using transference or countertransference destructively but only to create greater insight between the patient and ourselves, not exploiting his or her dependence on us emotionally, intellectually, sexually or financially, patience, single-minded attention to what is happening while at the same time allowing the inner flow of free-associative thoughts and images, a detachment rooted in thorough self-knowledge to experience and examine the countertransference and our own feelings, as well as scrutinizing the transference, sharply focusing, and scanning, complex involvement in feelings, and cool observation of them, close attention to the patient and to ourselves, distinguishing our own true feelings from subtle projections into us, communicating insight clearly, yet not imposing it, willing the best for our patients and ourselves, yet abandoning memory and desire, steering clear of being judgmental...sense of humour, toughness, courage, kindness, enjoyment (pp. 116-118). She describes the analyst's love as being "the only trustworthy container" in which to feel the full spectrum of feelings, including hatred, rage and so on (p. 121), and adds that love is the "moral infrastructure of our job" (p. 122).

### ***Loving the patient's psychic reality***

Steingart (1995) points out that Loewald was the first person who took Freud's position that linked the truth of psychic reality to the love and care for the patient. Loewald (1970) writes that "Scientific detachment in its genuine form, far from excluding love, is based on it.... It is impossible to love the truth of psychic reality...and not to love and care for the object whose truth we want to discover" (p. 65). Loewald

(1960) also writes that for things to go well the analyst must have “love and respect for the individual and for individual development” (p. 229). Steingart (1995) calls this “scholarly analyst love” (p. 118) and is concerned to convey that he is not talking about an intellectual experience but a “full loving sensibility, which includes, but is not only the equivalent of, a deep sense of intellectual comprehension” (ibid.). He believes that interpretations can only be a “loving response” within the matrix of an overall analytic relationship that is lovingly and responsibly devoted to knowing the analysand’s psychic reality (p. 118). He maintains that Freud created in his analytic technique a new type of human relationship and that the analyst possesses a real and extraordinary love for the analysand that follows directly and naturally from this relationship (p. 106).

#### ***“Falling in love” with the patient***

Bach (2006) agrees with Steingart regarding loving the patient’s psychic reality and also adds that the patient also comes to understand and love the analyst’s psychic reality including her whole embodied reality (p. 129). He describes his “personal prescription for love” as paying very close attention (p. 133). He speaks of this as being the “moral equivalent of a prayer” (ibid.) and that what is needed is to have a basic trust in the patient, a sympathetic resonance with him, and to be able to hold him in your mind so that he becomes a “living presence” (ibid.). The effect of this, he says, is that the patient begins to feel held together by the attention and to feel that more and more parts of him are becoming meaningfully interconnected (pp. 132-133). He goes on to say that paying this kind of attention, while maintaining one’s narcissistic balance, leads to being totally involved in the process, which leads to a “falling in love” with the patient, although he says it is dangerous to say so (p. 133). Gerrard (1999) writes in a similar vein and

describes this as “extreme tenderness” (p. 30) towards the patient, and that the patient cannot reach their capacity for loving without the analyst becoming involved in a passionate way. She stresses that the “tender loving feelings must emanate from one’s most authentic place – there is no place for sentimentality here” (ibid.).

### ***The therapist’s “non-erotic” love***

Cohen (2006) writes that the confusion felt by analysts concerning love in therapy, is because many analysts consistently identify love with sexuality. This, he says, is owing to the “doctrine of the libido, which links all forms of love with sexuality” (p. 145). He suggests that a successful treatment is based on feelings of love, and that there is a difference between love that is based on biological erotic-sexual drives, which he calls ‘drive energy’, and emotional love without biological drive, which he calls psychic-mental energy. In describing the latter he says it is a non-erotic and nonreconstructed love, directed towards the object and not for the sake of the loving subject, as opposed to erotic-driven love, which arises from the wish that the object gratify a certain need felt by the subject (pp. 141-142). In support of his argument, he cites Doi (1993) who writes of the Japanese word ‘amae’, translated as ‘indulgent dependency’, characteristic of the child’s relationship with the mother (p. 142) and says that he also sees it as arising in relationships between adults and that he considers it a “universal non-sexualised drive for close dependent affiliation” (ibid.)<sup>3</sup>.

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<sup>3</sup> Doi (1989) describes Amai as “the behaviour and its accompanying affect of a child seeking his mother or any caring person, but it may refer to the similar situations that occur between adults. Amai in its most primitive form is equal to the concept of primary love defined by Michael Balint” (p. 354). Scheidlinger (1999) writes that where Amai appears in adult relationships it appears as a “wished-for emotional closeness to another” (p. 91).

He makes a case for the love between therapist and patient as having a ‘real’ component as opposed to being countertransferential only and suggests that many writers prefer to hide behind the issue of the analyst’s love with terms such as the ‘positive countertransference’. He contends that whereas the literature about countertransference has developed, that the literature relating to ‘real’ feelings experienced toward the patient has not, and is full of many contradictions.

Cohen makes some good points, particularly those relating to the squeamishness of therapists talking about their love for their patients, the hiding behind such terms as the ‘positive countertransference’ when sometimes ‘love’ might be a better word to describe the therapist’s feelings, and the real need of some patients for a ‘parental’ type of love from the therapist, which is caring, understanding, and belonging more to reparative and attachment models than to drive models. However, as discussed in the previous chapter, attempting to separate out ‘real’ love from sexual love seems to be a wish to deny the unconscious, rather than stressing the therapist’s responsibilities in this area.

***Love is not curative but is necessary***

Coen (1994) writes about the barriers that are often in place that serve to prevent loving feelings in the analytic setting, and that these are mutually constructed. He points out that “our analytic ego ideal tends to encourage constriction and discomfort with our loving feelings for analysands” (p. 1107), and states that his intention is not to advise analysts to love their patients, but to focus carefully on these barriers, whereby both patient and analyst try to destroy possibilities for loving feelings, especially by wishing to preserve a negative relationship, often sadomasochistic, which emphasizes the impossibility of loving and being loved. He mentions that he was taught in the 1960s a

dispassionate mode of analyzing – “it has tended to interfere with my freedom to enjoy a variety of passions with my analysands” (p.1108), and talks of a shift in which there is now an acceptance and welcoming of a full range of feelings, and then to subject them to self-analysis to inform analytic work (ibid.). His view is that persistent negative, critical feelings between the analytic couple, including sadomasochistic engagement, seek to block access to more intense passion, loving and hating (p. 1129), and concludes that it is not that love between patient and analyst is curative, but that it is necessary to facilitate analytic change, and adds that he would say the same about hatred (p. 1131).

***Both immersion and distance are needed***

Those who write about the therapist’s love often stress that the analytic relationship is a special one, which cannot be compared to any other, because even when the relationship is understood in a more egalitarian way, the analyst is still both participating and monitoring conscious and unconscious meanings (Loewald, 1979; Lear, 1990; Siegelman, 2002; Modell, 1989; Hoffer, 1993; Kernberg, 1994; Gabbard, 1996b). The combination of distance and closeness is seen as being unique to the analytic situation.

Friedman (2005) writes about the analyst’s focused attention and how patients naturally understand it as a sign of ordinary love. He argues that it is a kind of love, but that it is different from other kinds (otherwise it would be ordinary social love). Like others, he acknowledges that this ‘different’ kind of love is not easy to describe, that it is not just ‘understanding’, which he takes to be a rather bloodless sort of love, that although analysts are inclined to identify their love with powerful and fundamental growth endorsement, it is not ‘parental’, since analysts are not supposed to infantilise their patients, that it resembles the understanding involved in reading, the appreciation of

art and literature, but that it is more responsible, personal, alive and unsettled. A reason for this, he says, is that analysts feel personally addressed by their patients, both in speech and in silence and so he posits that analytic love is the personal, first-hand experience of the patient's appeal solely in terms of its value for the patient and its place in the patient's drama. He summarises by saying that an actual loving feeling is generated by the union of two analytic features – the taking of distance and immersion in the patient's experience.

This notion of immersion and distance is echoed by some others, for example, Lear (1990) - "Analytic therapy demands that the analyst embody a unique blend of empathy, sympathy, and distance" (p. 5), and Ogden (1989), who describes the analytic situation as one of "intimacy in the context of formality" (p. 175). Kohon (2005) also stresses the detachment that is necessary for an analyst to do his or her job and cites Winnicott (1960), who wrote of the importance of the "distance between analyst and patient". This detached love, Kohon writes, will allow the analyst to manage the patient's persecutory anxieties and reactions of hate (p. 81). Siegelman (2002) writes of this immersion and distance by describing the psychoanalytic relationship as a both real and 'as if' relationship (pp. 32-33).

Mitchell (2000) also describes the analyst's responsibility to at once be involved with the patient but also to provide an analytic experience. He suggests that we can move beyond the debate about whether love in the therapy relationship is real or unreal:

...we are at the point in thinking about complex emotions in the analytic relationship where we can move beyond polarized positions about analytic love as either real or unreal, and analytic feelings as to be either carefully restrained or loosely expressed. Love and hate within the analytic relationship are very real, but are also contextual. The asymmetrical structure of the analytic situation is a powerful shaper of the feelings that emerge within it, making certain kinds of



feelings possible and precluding others. It is precisely because these feelings, as real as they are, are so context-dependent that they are not easily translatable into either extra- or postanalysis relationships. (p. 146)

### ***The subjectivity of the therapist***

Most of the writers discussed thus far describe the analyst's love as being at times more than just countertransference; this has occurred with a shift to considering the analyst's subjectivity. Aron (1991), for example, argues that the analyst's total responsiveness cannot be referred to as countertransference, and that the analyst has too often been viewed as the mother is viewed in relation to her child, that is, as an object for the child - "We have been slow to recognise or acknowledge the mother as a subject in her own right" (p. 30). Shaw (2003) agrees - "Analytic love is not necessarily evoked by the analysand's transference, although it will undoubtedly be mixed in with the analyst's concordant and complementary countertransferences" (p. 256). Schafer (1983) describes his concept of the "analyst's second self". His belief is that analysts in their work are not quite the same as they are in their ordinary lives, that in their work a special kind of love can develop in relation to the analysand "which would be a mistake to identify with disruptive countertransference" (p. 291).

Symington (2005) laments the lack of words in the English language to describe love and talks about passion, delight, regard and contemplation with regards to the therapist's love. He describes it further as having wonder in it, metaphysical passion and scientific attention - "In this act the person marvels at the other. It is this act, the act of *contemplation*, there is a focused wonder at the quality of the other..." (p. 14).

There are many ways in which the patient may evoke feelings of love in the analyst, which may not have to do with the countertransference. Shaw (2003) and Kohon (2005)

both mention the importance for the therapist in being part of a mutual process, where both analyst and analysand feel valued, and recognized, for what they have to give, and that this is both vitalizing for the analyst, and therapeutic for the analysand.

### ***Some Difficulties in Loving***

#### ***Love under suspicion***

Shaw (2003) highlights the suspicion that often accompanies the analyst declaring feelings of tenderness, affection and love towards the patient. He writes that this is often seen as the analyst “acting out” his narcissistic need to cure by posing as an impossibly perfect parent to a perennially infantilised patient. Suspicions against tenderness have gone beyond their proper safeguarding function, he argues (this was also Suttie’s (1963) argument seventy years ago), and have led instead to the inhibition of the growth and development of our thinking about analytic love. He adds that seduction for the purpose of attaining control and domination over another might often happen in the name of love, but is not actually what love is meant to be, and on the other hand, professional neutrality, abstinence, and deliberate withholding of gratification can be equally manipulative means of maintaining domination and control over others.

#### ***Are there some patients who it is better not to love?***

Main (1989) describes a type of patient who, he says, does not get better but who has a talent for becoming ‘special’ to the therapist. The feelings aroused in the therapist include wanting to make a special effort to help, feeling that the patient had previously got a bad deal from all the other figures in his or her life, and that the therapist could be the one to break this pattern and really help, if only he or she tried hard enough. With

these patients, Main suggests, the stress of treating them means that the therapist can give “unusual services, different from that of other patients, more devotion, greater effort, with desperate attempts to be good and tolerant and to interpret the deeper meaning of the patient’s needs” (p. 24). Main notes that it is necessary to be aware of the insatiability and ruthlessness, aggression and hatred in these cases. He cites Klein’s work as being helpful in understanding the dynamics involved. By denying the hatred, and showing further good, he argues that the patient deteriorates further.

I think this brings us back to the question of what we call the therapist’s love. Main has his own definition of the therapist’s love for the patients he describes; it is “sincerity...about what can and what cannot be given...careful understanding, it is the only way in which these patients can be provided with a reliable modicum of the kind of love they need” (pp. 34-35). He further adds that therapists should not be more loving than they can truly be.

### ***Summary***

Whereas traditionally, and still, interpretations have been viewed as the manifestation of the therapist’s love, this chapter has also described other ways of viewing the therapist’s love and how it differs from love in other settings. Coltart’s (2000) list of adjectives describing the therapist’s love is more comprehensive than others but is essentially representative of what others have written. A shift towards more relationality and intersubjectivity in the therapy relationship is demonstrated, also that there is more to the therapist’s love than what he or she says, and that it is not all countertransference. There is the suggestion that the therapist is freer now than earlier to work with a full range of feelings rather than feeling uncomfortable about having loving

feelings for the patient, and that there is a connection between loving the truth of psychic reality and the ‘object’ (patient) whose truth is to be discovered. Steingart (1995), in particular, emphasizes a love of the patient’s mind, and all that it produces. Bach (2006) goes further and describes a “falling in love” process when the therapist pays the type of attention that he calls the “moral equivalent of a prayer”.

While there seem to have been changes in the way therapists practise, and some inroads made into a more widespread acceptance of the concept of the therapist’s love, at the same time, most writers are saying that we can compare the therapist’s love with the love of a parent, a lover, a sibling or friend, but in the end the asymmetrical nature of the therapy relationship means that it is none of these and the comparisons do not hold in a satisfying way. The most convincing contemporary description, for me, in reading about the therapist’s love, and the one that speaks to me the most in terms of my experience with patients, is Friedman’s (2005) concept of being immersed in and at the same time distant from the patient’s experience, and how this creates a feeling of love in the therapist which is particular to the analytic situation. This description seems to include the possibility of all the types of love being present in both patient and therapist, depending on what both are bringing to the experience (and this may differ from session to session), and reflects the asymmetrical nature of the enterprise, where the therapist participates fully, and observes at the same time, in order to ensure the safety of the patient. The benefits for the patient in experiencing the therapist’s love are described.

It is unlikely that this activity has in fact changed much since the beginnings of psychoanalysis. By its nature psychoanalysis has always been concerned with unconscious processes and the relationship has always been an intrinsic part of that.

Many have pointed out that the so-called ‘blank-screen’ model was probably never practised by Freud himself, and Lewis, Amini and Lannon (2000) note that one of Freud’s strong points was never to take his own advice<sup>4</sup>. Others may have taken it more seriously, and this will account for a lot of variation in the practise of psychotherapy.

The therapist’s love can easily be viewed in a suspicious light, as Shaw (2003) points out. Equally, however, it is important to consider what type of love is appropriate for a particular patient. Main (1989), like Winnicott (1949)<sup>5</sup>, points this out, including the need to acknowledge aggression and hate, and the need for the love to be genuine.

### ***Clinical Vignette***

*Benjamin talks to me about a dream he has had the previous night. As he talks to me I notice the following things happening inside my mind: I notice his body, how is he sitting, does he look relaxed or tense? What sort of response to his way of being with me do I find inside my body, what is my own body telling me about the relationship that is going on between us just now?*

*I am also looking at my own thoughts and feelings in relation to him. This slightly anxious feeling I have; does it belong to me or to him, or to both of us? What might it mean?*

*Already I know a lot about Benjamin and his life. As I listen to the content of his dream my mind cannot help itself going to my own associations. I wait and then ask*

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<sup>4</sup> See also chapter 3, page 21.

<sup>5</sup> See chapter 4, page 26.

*him to begin associating to parts of the dream. I help him with this as he is not familiar with thinking about how dreams might have something important to say. I feel affectionate towards him as he quickly applies himself to the task. He catches on fast, I think, he's clever. And then I realise that he is being a very good patient, a 'good boy', and I feel loving towards him and moved by his trusting attitude and the way he throws, almost leaps, himself into working with the dream. I begin to ponder his goodness, how his being a 'good boy' also creates problems in his life, and forces him into needing to balance that, to be a 'naughty boy', just to give himself some breathing space where he can feel alive. I feel fondness and a sort of awe for him in spite of his often harmful ways of asserting his freedom. I shelve those thoughts for now and return to his dream, which he is, also, keen to discuss.*

There have been a number of contributions in the literature that have been valuable for me in my clinical work, including with Benjamin. The above vignette is intended to illustrate the tension between being at once involved in the relationship and also sitting slightly outside of it. I have no doubt that Benjamin is involved in a similar process, but that it is my task to bring that into the room and talk about it. Steingart (1995) describes this as “loving responsibility”. Steingart’s concept of loving the patient’s mind and all that it produces is also useful. Benjamin has a mind that is for me very admirable, and it is not difficult for me to be very interested in it and in the various directions in which it goes. I enjoy paying him the very close attention that Bach (2006) mentions, and I wondered in the beginning stages of the therapy if I had in fact fallen in love with him. In examining possible countertransferential dynamics I had to conclude that these feelings were partly but not entirely due to countertransference. Yes, he is used to women falling

in love with him, and I could choose to see my response solely in those terms. However, I also choose to be passionately involved with Benjamin, as with other patients, and I think that this produces a loving feeling that needs to be considered just as much as countertransferential implications. In other words, both need to be considered.

I think it is easier to be passionately involved with some patients than others, and this is where an awareness of countertransference plays a part; the necessity to look at those things in myself (as well as in the patient) which hinder my involvement. Coen's (1994) discussion on barriers to loving is useful in this area. Related to this, I also think it is easier to love some patients than it is to love others; however when I think about what might make one person more 'lovable' than another, it is difficult to arrive at any common factors that lie within the patient themselves. Here, Friedman's (2005) notion of the analytic love as being the taking of distance on the one hand, and the immersion in the patient's experience on the other is useful. The questions that arise from this include, what would hinder me in carrying out either of these functions? What disturbances would make it difficult for me to both be distant and involved? Thinking about this has helped me in my work with Benjamin and with other patients, particularly with the necessarily asymmetrical nature of the therapeutic endeavour and my responsibilities within it.

## Conclusion

This dissertation began with a question forming in my mind – sparked by clinical work with a patient – about how therapists might love their patients. In this section I will summarise what I have found in the literature concerning the therapist's love and also the implications of this for clinical work. As well, I will point to further areas for research and the strengths and limitations of this study.

### *Summary of Findings*

I began by looking at how love was written about in the first decades of psychoanalysis as I felt this would lend context to later writings. I chose Freud and Ferenczi as two figures who wrote much about love and seemingly from quite different perspectives. Freud (1915) mainly addresses the issue of 'transference love', recognizing its explosive potential, and urges the analyst not to return the love. There are conflicting accounts as to whether Freud thought of the analyst's love as an important ingredient in the therapy, however in general he seems to have stressed the importance of holding to the analytical task, and love being expressed in this way. Ferenczi (1926, 1931; in Dupont, 1988) made forays into a more active therapy, exploring the use of empathy and mutuality. I have pointed out that Freud seems to have encouraged him in this direction, while also being disapproving of the results. In any case, both Freud's asymmetrical approach and Ferenczi's emphasis on mutuality have much relevance to clinical work today. Being able to hold the balance of mutuality and also retaining the overview in the therapy setting is, I think, evidence of the therapist's love in action.



From here I have suggested that writings on the therapist's love fall mainly into three different categories. Firstly there is 'parental' love, where the therapist's love is described as being similar to that of a parent, secondly the area of sexual love and Eros, and thirdly, explorations into how the therapist's love cannot be likened to any other type of love, a "thing unto itself", particular to the therapy setting. I will not repeat here my summary of findings with regards to each of these (they can be found in the summary section at the end of each chapter), but will focus on the way in which it is somewhat artificial to separate them out.

Throughout the writings, whether the emphasis is on parental love, Eros, or a "thing unto itself" there are constant references to the fact that whereas comparisons can be made to this or that type of love, in reality the therapist's love contains elements of each, depending on what the patient brings and that this can shift from minute to minute. In other words, in any one session the therapist can move from parent to lover to sibling and back again. The writings suggest that the therapist 'makes use' of different forms of loving (and hating) in the therapy hour without becoming attached to any of them in particular. The therapist being aware of his or her countertransference and also his or her subjectivity allows this process to take place. It has been pointed out that the difficulties and complexities of engaging in this way make it a loving act in itself and this is perhaps where we could say that the love actually lies.

It may be that this sounds as if there is no loving affect in the therapist, only a rather sterile 'use' of a type of loving. Some authors might suggest this, however there are many who describe feelings of love for their patients, and that this is necessary for the therapy. This is generally, but not always, described as taking place over a period of time, as the

therapist gets to know the patient, to understand who they are, and why they are the way they are. The benefits to the patient of feeling the therapist's love are described.

In addition, I would like to point to Freud's argument, outlined in chapter 3, that there is a very good reason for there being only one word (at least in German, and coincidentally also in English) for love. His argument is that all forms of 'love' are a sublimation of fully sensual love. In this respect, the writers who write about Eros and therapy being an 'erotic encounter' have something profound to say about the passion, aliveness and vitality of the therapy process, where love is a basic natural force (the importance of Eros's counterbalance Thanatos should not be forgotten here). As well, this points to a commonality between the different forms of love, with Eros as the source.

It is interesting that the notion of the therapy relationship being an asymmetrical one has survived since Freud's time until today, despite explorations into mutuality. These explorations have, however, necessarily moved the territory from one where the therapist was seen as being objective, to an environment of more relationality and acknowledging the therapist's subjectivity. This is mentioned by many writers and has had consequences on how the therapist's love is viewed.

### ***Limitations and Strengths of this Study***

As noted in the introduction virtually every writer has written something about this subject and I have chosen only those who have written substantially on the topic. At the same time, I am mindful of those I have left out; their views may have changed or added to some of the conclusions.

Another limitation that needs to be mentioned is that some writers have explored in depth the boundaries of the therapist's love to include sexual enactments. I have chosen

to say that this is not love and I think this is congruent with the topic of this dissertation. However, more exploration of this area would no doubt be useful, and contribute to learnings about the dangers of the therapist's 'love'.

In this study I have undertaken a very thorough search of the literature relating to the therapist's love and have related it to my clinical work. I think it is a useful contribution for therapists in thinking about the difficult area of love in the therapy setting, and the role that the therapist plays in this, as well as the benefits for the patient in thinking about the therapist's love. Based on what has been written I have broadly described three different types of the therapist's love, which I think facilitates a better understanding of this area. In addition, my exploration of Eros integrates original research carried out by Freud together with very recent research, with the aim of demystifying an area that is often viewed both with trepidation as well as more simplistically than is warranted.

### ***Further Areas for Research***

On page 67 I mentioned 'sibling' in relation to a type of therapist's love. I am aware that this could possibly be another category of love to add to the other three. In fact, in my literature search I have found only a few articles that discuss sibling transference and countertransference issues, and this may be an area that has been neglected in psychoanalytic literature at least, where the asymmetry of the therapy relationship is emphasized. My suspicion is that this type of love will be discussed in other therapy paradigms, for example, co-counselling and so on. This lies outside of the brief of this dissertation, however it does point to an area for further research.

Many writers suggest that writing about the therapist's love is particularly difficult. There are a few reasons for this. One is that the writers who attempt it feel that there is suspicion held against those who speak of the therapist's love and tenderness; this produces a need to be very careful, perhaps overly careful and defensive. Another is that, like Eros, this topic is paradoxical and rejects being neatly defined. It seems that sometimes the differences between writers are sometimes not so much differences as misunderstandings, and that the use of terms that look different might mean similar things. This area would benefit from clarification through further research, which might lead to a wider acceptance of the concept and value of the therapist's love.

### ***Implications for Clinical Work***

Learnings from this research for my clinical work are contained at the end of chapters 4, 5 and 6 in the discussions of the clinical vignettes. As well I would like to add that this research has clarified a number of areas for me. One is whether the therapist's love is or is not curative. Writers are divided on this issue; I agree with those who say that it is not the love itself that is curative but rather the way that the therapist uses their love in the therapy. This implies an awareness on the therapist's part; the immersion and also distance that Friedman (2005) speaks of. The therapist's love seems to shape up to be a willingness to submit oneself to the forces of Eros, to be cognizant of the forces of Thanatos, and to be able to think about these for the benefit of the patient.

All of this is not a simple task and there has also been value to me in considering the dangers that lie within this territory. It is not surprising that some writers privilege interpretation as the main manifestation of the therapist's love; understanding and transmitting understanding is without doubt a loving act, but it cannot represent all that is

loving in the therapy relationship. Being willing to be immersed in the other's experience seems to carry a certain amount of danger with it; thinking about how it is to be immersed and what occurs is likely to be the only way of mitigating against the danger, holding the tension, and thus being useful to the patient.

Finally, Bollas's (1995) exhortation to acknowledge the pleasure in working in the therapeutic realm of the unconscious (which he relates to an erotic pleasure) seems significant. Concentrating on the complexities is one thing but not to forget the pleasure seems to be the ultimate service to the patient, as well as to oneself.

## References

- Aron, L. (1991). The patient's experience of the analyst's subjectivity. *Psychoanalytic Dialogues*, 1, 29-51.
- Bach, S. (2006). *Getting from here to there: Analytic love, analytic process*. London: The Analytic Press.
- Baur, S. (1997). *The intimate hour: Love and sex in psychotherapy*. New York: Houghton Mifflin.
- Bergmann, M.S. (1987). *The anatomy of loving – The story of man's quest to know what love is*. New York: Fawcett Columbine.
- Bergmann, M. S. (1997). Passions in the therapeutic relationship. *Canadian Journal of Psychoanalysis*, 5, 73-94.
- Berzoff, J. (1998). The intimate hour: Love and sex in psychotherapy [Review of the book *The intimate hour: love and sex in psychotherapy*, by Susan Baur, New York, Houghton Mifflin, 1997]. *Psychiatric Services*, 49, 1627-1628.
- Bollas, C. (1995). *Cracking up: The work of unconscious experience*. New York: Hill and Wang.
- Bonasia, E. (2001). The countertransference. *International Journal of Psycho-Analysis*, 82, 249-262.
- Booth, A. (2001). *Cochrane or cock-eyed? How should we conduct systematic reviews of qualitative research?* Paper presented at the Qualitative Evidence-Based Practice Conference, Taking a Critical Stance. Coventry University, May 14-16, 2001. Retrieved October 31, 2006, from <http://www.lleds.ac.uk/educol/documents/00001724.htm>
- Coen, S. J. (1994). Barriers to love between patient and analyst. *Journal of the American Psychoanalytic Association*, 42, 1107-1135.
- Cohen, Y. (2006). Loving the patient as the basis for treatment. *The American Journal of Psychoanalysis*, 66(2). Retrieved 2 October, 2006, from <http://www.springerlink.com.ezproxy.aut.ac.nz/content/7u9573370wpn0832/fulltext.html>
- Coltart, N (2000). *Slouching towards Bethlehem*. New York: Other Press.

- Davies, J. M. (1994). Love in the afternoon: A relational reconsideration of desire and dread in the countertransference. *Psychoanalytic Dialogues*, 4, 153-170.
- Davies, J. M. (2003). Falling in love with love – oedipal and postoeidipal manifestations of idealization, mourning and erotic masochism. *Psychoanalytic Dialogues*, 13(1), 1-27.
- Denzler, B. (2001). Empathy: Love or skill? In M. Bertolini, A. Giannakoulos & M. Hernandez (Eds.), *Squiggles and Spaces: Revisiting the Work of D. W. Winnicott* (pp. 232-235). London: Philadelphia.
- Doi, T. (1989). The concept of amae. *International Review of Psychoanalysis*, 16, 349-354.
- Dupont, J. (Ed.). (1988). *The clinical diary of Sándor Ferenczi*, Cambridge, MA: Harvard University Press.
- Earlam, S., Brecker, N., & Vaughan, B. (2000). *Cascading evidence*. London: Adis International Ltd.
- Eickhoff, F-W. (1993). A rereading of Freud's "Observations on Transference Love". In E.S. Person, A. Hagelin & P. Fonagy (Eds.), *On Freud's "Observations on Transference Love"* (pp. 33-56). London: Yale University Press.
- Ferenczi, S. (1926). To Sigmund Freud on his seventieth birthday. In M. Balint (Ed.). *Final contributions to the problems and methods of psycho-analysis*, 1955 (Reprinted 2002). London: Karnac.
- Ferenczi, S. (1931). Notes and fragments. In M. Balint (Ed.), *Final contributions to the problems and methods of psycho-analysis*, 1955 (Reprinted 2002). London: Karnac.
- Field, N. (1989). Listening with the body: An exploration in the countertransference. *British Journal of Psychotherapy*, 5(4), 512-521.
- Field, N. (1999). 'O tell me the truth about love'. In: D. Mann (Ed.), *Erotic Transference and Countertransference: Clinical Practice in Psychotherapy* (pp. 99-110). New York: Bruner-Routledge.
- Fonagy, P. (2001, July). *Evidence based practice or practice based evidence. The controversies that surround the empirically informed selection of psychological treatments or 'Nobody has won and all their prizes are going to be taken away'*. Paper presented at the UKCP NHS Forum, Regents College, London. Psychotherapy and Evidence Based Practice for the NHS. Retrieved March 11, 2004 from [www.psychotherapy.org.UK/downloads/Fonagy.pdf](http://www.psychotherapy.org.UK/downloads/Fonagy.pdf)

- Freud, S. (1888). Letter from Freud to Fliess, February 4, 1888. *The complete letters of Sigmund Freud to Wilhelm Fliess, 1887-1904*, 18-21.
- Freud, S. (1893-1895). The psychotherapy of hysteria. In *The standard edition of the complete psychological works of Sigmund Freud*, 2, 255-305 (London: Hogarth Press, 1971).
- Freud, S. (1906). Letter from Sigmund Freud to C. G. Jung, December 6, 1906. *The Freud/Jung Letters: the correspondence between Sigmund Freud and C. G. Jung*, 11-13.
- Freud, S. (1912). Recommendations for physicians practising psychoanalysis. In *The standard edition of the complete psychological works of Sigmund Freud*, 12, 111-120 (London: Hogarth Press, 1971).
- Freud, S. (1915). Further recommendations in the technique of psycho-analysis: observations on transference-love. In *The standard edition of the complete psychological works of Sigmund Freud*, 12, 157-171 (London: Hogarth Press, 1971).
- Freud, S. (1930). Civilization and its discontents. In *The standard edition of the complete psychological works of Sigmund Freud*, 21, 64-145 (London: Hogarth Press, 1971).
- Freud, S. (1937). Analysis terminable and interminable. In *The standard edition of the complete psychological works of Sigmund Freud*, 23, 216-253 (London: Hogarth Press, 1971).
- Freud, S. (1940). An outline of psycho-analysis. In *The standard edition of the complete psychological works of Sigmund Freud*, 23, 144-207 (London: Hogarth Press, 1971).
- Friedman, L. (2005). Is there a special psychoanalytic love? *Journal of the American Psychoanalytic Association*, 53(2), 349-375.
- Gabbard, G. O. (1994a). Sexual excitement and countertransference love in the analyst. *Journal of the American Psychoanalytic Association*, 42, 1083-1106.
- Gabbard, G. O. (1994b). On love and lust in erotic transference. *Journal of the American Psychoanalytic Association*, 42, 385-403.
- Gabbard, G. O. (1994c). Psychotherapists who transgress sexual boundaries with patients. *Bulletin of the Menninger Clinic*, 58, 124-135.
- Gabbard, G. O. (1995). The early history of boundary violations in psychoanalysis. *Journal of the American Psychoanalytic Association*, 43, 1115-1136.



- Gabbard, G.O. (1996a). *Love and hate in the analytic setting*. New York: Jason Aronson.
- Gabbard, G. O. (1996b). The analyst's contribution to the erotic transference. *Contemporary Psychoanalysis*, 32, 249-273.
- Gabbard, G. O. (1997). Challenges in the analysis of adult patients with histories of childhood sexual abuse. *Canadian Journal of Psychoanalysis*, 5, 1-25.
- Gerrard, J. (1999). Love in the time of psychotherapy. In: D. Mann (Ed.), *Erotic transference and countertransference: Clinical practice in psychotherapy* (pp. 29-41). New York: Bruner-Routledge.
- Gilgun, J. (2006). The four cornerstones of qualitative research. *Qualitative Health Research*, 16 (3), 436-443.
- Glucksman, M.L. (1993). Insight, empathy and internalization. *Journal of the American Academy of Psychoanalysis*, 21, 163-181.
- Green, A. (2005). To love or not to love: Eros and Eris. In A. Green & G. Kohon (Eds.), *Love and its vicissitudes* (pp. 1-39). London: Routledge.
- Harris, I.D. (1960). Unconscious factors common to parents and analysts. *International Journal of Psycho-Analysis*, 41, 123-129.
- Haule, J. R. (1996). *The love cure: Therapy erotic and sexual*. Connecticut: Spring Publications.
- Hawker, S., Payne, S., Kerr, C., Hardey, M., & Powell, J. (2002). Appraising the evidence: Reviewing disparate data systematically. *Qualitative Health Research*, 12(9), 1284-1299.
- Hillman, J. (1989). *A blue fire*. New York: Harper & Row.
- Hirsch, I. (1994). Countertransference love and theoretical model. *Psychoanalytic Dialogues*, 4, 171-192.
- Hirsch, I., & Kessel, P. (1985). Reflections on mature love and transference. *Free Associations*, 12, 60-83.
- Hoffer, A. (1991). The Freud-Ferenczi controversy—a living legacy. *International Review of Psycho-Analysis*, 18, 465-472.
- Hoffer, A. (1993). Is love in the analytic relationship “real”? *Psychoanalytic Inquiry*, 13, 343-356.

- Hollway, W., & Jefferson, T. (2000). *Doing qualitative research differently*. London: Sage.
- Holmes, J. (2006). *Sense and sensuality: Hedonic intersubjectivity and the erotic imagination*. Paper presented in Auckland, May 2006.
- Jones, K. (2004). Mission drift in qualitative research, or moving toward a systematic review of qualitative studies, moving back to a more systematic narrative review. *The Qualitative Report*, 9(1), 95-112.
- Kernberg, O. F. (1994). Love in the analytic setting. *Journal of the American Psychoanalytic Association*, 42, 1137-1157.
- King, P. (1962). The curative factors in psycho-analysis—contributions to discussion. *International Journal of Psycho-Analysis*, 43, 225-227.
- Kohon, G. (2005). Love in a time of madness. In A. Green & G. Kohon (Eds.), *Love and its vicissitudes* (pp. 41-100). London: Routledge.
- Kumin, I. (1985). Erotic horror: Desire and resistance in the psychoanalytic situation. *International Journal of Psychoanalytic Psychotherapy*, 11, 3-20.
- Lear, J. (1990). *Love and its place in nature: A philosophical interpretation of Freudian psychoanalysis*. London: Yale University Press.
- Lees, J. (2005). A history of psychoanalytic research. *Psychodynamic Practice*, 11(2), 117-131.
- Leichsenring, F. (2005). Are psychodynamic and psychoanalytic therapies effective? A review of empirical data. *International Journal of Psycho-Analysis*, 86, 841-68.
- Lemmer, B., Grellier, R., & Steven, J. (1999). Systematic review of nonrandom and qualitative research literature: exploring and uncovering an evidence base for health visiting and decision making. *Qualitative Health Research*, 9(3), 315-328.
- Lester, E. P. (1985). The female analyst and the erotized transference. *International Journal of Psycho-Analysis*, 66, 283-293.
- Leuzinger-Bohleber, M., & Fischmann, T. (2006). What is conceptual research in psychoanalysis? *International Journal of Psycho-Analysis*, 87, 1355-86.
- Lewis, T., Amini, F., & Lannon, R. (2000). *A general theory of love*. New York: Vintage Books.
- Loewald, H. W. (1960). On the therapeutic action of psycho-analysis. *International Journal of Psycho-Analysis*, 41, 16-33.

- Loewald, H. W. (1970). Psychoanalytic theory and the psychoanalytic process. *Psychoanalytic Study of the Child*, 25, 45-68.
- Loewald, H. W. (1979). Reflections on the psychoanalytic process and its therapeutic potential. *Psychoanalytic Study of the Child*, 34, 155-167.
- Main, T. (1989). The ailment. In J. Johns (Ed.). *The ailment and other psychoanalytic essays* (pp. 12-35). London: Free Association Books.
- Mann, D. (1997). *Psychotherapy: An erotic relationship*. New York: Brunner-Routledge.
- Mann, D. (Ed.). (1999). *Erotic transference and countertransference: Clinical practice in psychotherapy*. New York: Brunner-Routledge.
- March, J. (1998). *Cassell's Dictionary of Classical Mythology*. London: Cassell & Co.
- Maroda, K. (1998). Why mutual analysis failed: The case of Ferenczi and RN. *Contemporary Psychoanalysis*, 34, 115-132.
- Mitchell, S.A. (1984). Object relations theories and the developmental tilt. *Contemporary Psychoanalysis*, 20, 473-499.
- Mitchell, S. (2000). *Relationality*. Hillsdale, NJ & London: The Analytic Press.
- Modell, A. H. (1989). The psychoanalytic setting as a container of multiple levels of reality: A perspective on the theory of psychoanalytic treatment. *Psychoanalytic Inquiry*, 9, 67-87.
- Money-Kyrle, R. E. (1956). Normal counter-transference and some of its deviations. *International Journal of Psycho-Analysis*, 37, 360-366.
- Nacht, S. (1962a). The curative factors in psycho-analysis. *International Journal of Psycho-Analysis*, 43, 206-211.
- Nacht, S. (1962b). The curative factors in psycho-analysis—Contributions to discussion. *International Journal of Psycho-Analysis*, 43, 233.
- Natterson, J. M. (2003). Love in psychotherapy. *Psychoanalytic Psychology*, 20(3), 509-521.
- Novick, J. & Novick, K. K. (2000). Love in the therapeutic alliance. *Journal of the American Psychoanalytic Association*, 48, 189-218.
- Ogden, T. (1989). *The primitive edge of experience*. Northvale, NJ: Aronson.

- Pai, M., McCulloch, M., Gorman, J., Pai, N., Enanoria, W., Kennedy, G., Tharyan, P., & Colford, Jr, J. (2004). Systematic reviews and meta-analyses: An illustrated, step-by-step guide. *The National Medical Journal of India*, 17(2), 86-95.
- Person, E.S. (1993). Introduction to "Observations in Transference-Love". In E.S. Person, A. Hagelin, & P. Fonagy (Eds.), *On Freud's "Observations on Transference-Love"* (pp. 1-14). London: Yale University Press.
- Popay, J., Rogers, A., & Williams, G. (1998). Rationale and standards for the systematic review of qualitative literature in health services research. *Qualitative Health Research*, 8(3), 341-351.
- Rachman, A. (1997). *Sándor Ferenczi: The psychotherapist of tenderness and passion*. London: Jason Aronson.
- Racker, H. (1968). *Transference and countertransference*. New York: The Guilford Press.
- Rechardt, E., & Ikonen, P. (1993). How to interpret the death drive? *Scandinavian Psychoanalytic Review*, 16, 84-99.
- Samuels, A. (1999). From sexual misconduct to social justice. In: D. Mann (Ed.), *Erotic transference and countertransference: Clinical practice in psychotherapy* (pp. 150-171). New York: Bruner-Routledge.
- Sandler, P.C. (2005). *The language of Bion: A dictionary of concepts*. London: Karnac.
- Schafer, R. (1977). The interpretation of transference and the conditions for loving. *Journal of the American Psychoanalytic Association*, 25, 335-362.
- Schafer, R. (1983). *The analytic attitude*. New York: Basic Books.
- Schavarién, J. (1995). *Desire and the female therapist*. New York: Routledge.
- Scheidlinger, S. (1999). On the concepts of amae. *Journal of the American Psychoanalytic Association*, 27, 91-100.
- Searles, H. F. (1959). Oedipal love in the countertransference. *International Journal of Psycho-Analysis*, 40, 180-190.
- Segal, H. (1962a). The curative factors in psycho-analysis. *International Journal of Psycho-Analysis*, 43, 212-217.
- Segal, H. (1962b). The curative factors in psycho-analysis—contributions to discussion. *International Journal of Psycho-Analysis*, 43, 232-233.

- Shaw, D. (2003). On the therapeutic action of therapeutic love. *Contemporary Psychoanalysis*, 39(2), 251-278.
- Siegelman, E. (2002). The analyst's love: An exploration. *Journal of Jungian Theory and Practice*, 4(1), 19-34.
- Solomon, M. F. (1997). On love and lust in the countertransference. *Journal of the American Academy of Psychoanalysis*, 25, 71-90.
- Starcevic, V. (2003). Psychotherapy in the era of evidence-based medicine. *Australian Psychiatry*, 119(3), 278-280.
- Steingart, I. (1995). *A thing apart: Love and reality in the therapeutic relationship*. London: Jason Aronson.
- Stern, D.N. (1993). Acting versus remembering in transference love and infantile love. In Person, E.S., Hagelin, A., & Fonagy, P. (Eds.), *On Freud's "Observations on Transference Love"*. London: Yale University Press.
- Suttie, I. (1963). *The origins of love and hate*. London: Penguin. (Original book published by Kegan Paul, 1935).
- Symington, N. (2005). *A technique for the creation of mind*. Paper given at the second annual conference of the Tel Aviv institute for Contemporary Psychoanalysis, Tel Aviv, 27-28 October, 2005. Retrieved September 30, 2006, from [http://www.taicp.org.il/page/conferences\\_en.asp](http://www.taicp.org.il/page/conferences_en.asp)
- Symington, N. (2006). *Transference interpretation as a cataract interpretation*. Paper presented at the Australia Psychoanalytical Society Conference, July 2006.
- Tansey, M.J. (1994). Sexual attraction and phobic dread in the countertransference. *Psychoanalytic Dialogues*, 4, 139-152.
- Weinstein, R.S. (1989). Should analysts love their patients? The resolution of transference resistance through countertransferential explorations. In J.F. Lasky & H.W. Silverman (Eds.), *Love: Psychoanalytic perspectives* (pp. 192-199). London: New York University Press.
- Welles, J. K. & Wrye, H. K. (1991). The maternal erotic countertransference. *International Journal of Psycho-Analysis*, 72, 93-106.
- Winnicott, D. W. (1949). Hate in the counter-transference. *International Journal of Psycho-Analysis*, 30, 69-74.

- Winnicott, D.W. (1955). Metapsychological and clinical aspects of regression within the psycho-analytical set-up. *International Journal of Psycho-Analysis*, 36, 16-26.
- Wrye, H. K. (1993). Erotic terror: Male patients' horror of the early maternal erotic transference. *Psychoanalytic Inquiry*, 13, 240-257.
- Wrye, H. K. & Welles, J. K. (1989). The maternal erotic transference. *International Journal of Psycho-Analysis*, 70, 673-684.
- Zuckerberg, J.O. (1995). Eros. *International Forum of Psychoanalysis*, 4, 231-237.

## M E M O R A N D U M

**Student Services Group – Academic Services**


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To: Andrew Duncan  
 From: Madeline Banda  
 Date: 28 April 2004  
 Subject: 02/33 Disseration 588869: The therapeutic relationship: A literature review with clinical illustrations

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Dear Andrew

Your application for an extension to your ethics approval for paper “588869, Dissertation” was considered by AUTEK at their meeting on 27/04/04.

Your application was approved for a further period of three years until 27/04/07.

You are required to submit the following to AUTEK:

- A brief annual progress report (using Form EA7) indicating compliance with the ethical approval given, providing details of names of students, titles of projects undertaken, nature of projects, noting any issues that arose during the research.
- A brief statement on the status of the project at the end of the period of approval or on completion of the project, whichever comes sooner.
- A request for renewal of approval if the project has not been completed by the end of the period of approval.

Please note that the Committee grants ethical approval only. If management approval from an institution/organisation is required, it is your responsibility to obtain this.

The Committee wishes you well with your research.

Please include the application number and study title in all correspondence and telephone queries.

Yours sincerely

Madeline Banda

**Executive Secretary**

**AUTEK**

CC:

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From the desk of ...  
**Madeline Banda**  
 Academic Services  
 Student Services Group

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 New Zealand  
 E-mail: madeline.banda@aut.ac.nz

Tel: 64 9 917 9999  
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## **A Literature Review with Clinical Illustrations**

### **Participant Information Sheet**

Principal Supervisor: Andrew Duncan, PhD.

Dissertation Supervisor: Kerry Gibson, PhD.

Student Name: Kerry Thomas-Anttila

School of Psychotherapy, AUT,  
Private Bag 92006, Auckland 1020

#### **Invitation**

I would like to invite you to participate in my dissertation research. I will be studying the therapeutic relationship in order to understand the process and facilitate more effective psychotherapy. Participation is entirely voluntary and your free choice. If you do agree to take part you are free to withdraw from the study at any time, without having to give a reason and you may withdraw any information you have provided up until the completion of data collection. Non-participation will not affect any future care or treatment you currently receive. There will be no costs to you for taking part in this study. There are also no financial benefits for you by taking part in this study. Please sign the consent form if you are interested in being a participant.

#### **What is the purpose of the study?**

The research is part of my studies for a Master of Health Science in Psychotherapy. Its purpose is to improve understanding of the therapeutic relationship, to further my education and training as a psychotherapist and to improve our psychotherapeutic relationship.

#### **How was a person chosen to be asked to be part of the study?**

All of my clients are being asked if they are willing to participate. If you consent then you may be in the study. Participation will involve use of excerpts from our psychotherapy in my dissertation.

#### **What happens in the study?**

I will be reading about and analysing an issue related to the therapeutic relationship and using illustrations from my work with clients in my research. The illustrations will be descriptions of interactions between us. These descriptions will come from tapes of our sessions and my notes. My understandings about these interactions and perhaps our conversations about them will be used to help explain the issue under discussion. I will use the concepts and theories of psychotherapy to further this understanding. This work



will be supervised by senior staff in the School of Psychotherapy and discussed with my fellow students in order to improve my understanding and our psychotherapy. The study will not change the focus of our work or where we meet. The tapes and notes will be held securely for six years according to AUT regulations and then destroyed (except parts which are considered part of your health record which according to health regulations must be kept for 10 years). The study will not affect the length of your psychotherapy.

### **What are the discomforts and risks?**

There are no risks.

### **What are the benefits?**

The research will contribute to the value of your psychotherapy by looking carefully at the process of your psychotherapy.

### **What compensation is available for injury or negligence?**

In the unlikely event of a physical injury as a result of your participation in this study, you will be covered by the accident compensation legislation with its limitations.

### **How is my privacy protected?**

Your name will not be used in the research. Any information gathered will be strictly confidential and seen only by fellow students and supervisors. No material which could personally identify you will be used in any reports on this study. If necessary descriptions may be changed to protect your anonymity.

### **Costs of Participating**

None

### **Participant Concerns –**

Please ask me any questions you have about the project and take any time you need to consider this invitation.

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor. Concerns regarding the conduct of the research should be notified to the Executive Secretary, AUTECH, Madeline Banda, [madeline.banda@aut.ac.nz](mailto:madeline.banda@aut.ac.nz), 921 9999 ext 8044.

### **Consumer Advocate:**

If you wish to talk to a consumer advocate for any reason you may contact the Health Advocates Trust, Ph 0800 20 55 55.

Re-Approved by the Auckland University of Technology Ethics Committee on 27<sup>th</sup> April, 2004 for three years, AUTECH Reference number 02/33.



## Consent to Participation in Research

Title of Project: A Literature Review with Clinical Illustrations

Principal Project Supervisor: Andrew Duncan, PhD

Supervisor: Kerry Gibson, PhD

Researcher: Kerry Thomas-Anttila

- 
- I have read and understood the information provided about this research project.
  - I have had an opportunity to ask questions and to have them answered. I know whom to contact if I have any questions about the study.
  - I understand that my sessions will be audiotaped or videotaped and parts may be transcribed.
  - I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way and withdrawing will in no way affect my future health care. If I withdraw, I understand that all relevant tapes and transcripts, or parts thereof, will be destroyed except those required to be kept as part of my health record.
  - I understand that my participation in this study is confidential and that no material which could identify me will be used in any reports on this study.
  - I agree to take part in this research.

Participant signature: .....

Participant name: .....

Date: .....

(A copy of this form to be retained by the participant)

Project Supervisor Contact Details: Andrew J. Duncan, PhD. 917-9999 ext 7744

**Re-Approved by the Auckland University of Technology Ethics Committee on 27<sup>th</sup> April, 2004**  
**AUTEC Reference number 02/33**