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ORIGINAL PAPER

An Examination of the Historical and Current Perceptions of Love in the Psychotherapeutic Dyad

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Abstract Since the initial dialogues on the treatment relationship began, a hierarchical structure of our profession was set forth. This was largely created by Sigmund Freud, often considered the initiator of psychotherapy and psychoanalysis. Our profession was characterized by a neutral, distant practitioner who performed his work upon an unknowing patient. The reality of the multiple complexities of this relationship has become clearer over time. This paper seeks to examine the steps that have taken us from the initially distant and non-mutual psychotherapeutic relationship to the more egalitarian and co-created format that many clinicians are working in today. Love, in both its absence and presence, is examined as a central concept and tenet of psychotherapy.

Keywords Love · Countransference · Relational · Intersubjective · Hate · Ferenczi

Introduction

There are many reasons not to discuss or study the reality of non-erotic love in the psychotherapeutic relationship. These include conceptual struggles regarding the actual meaning of "non-erotic love;" linguistic difficulties that are byproducts of the evocative tenor of the word "love" itself; and the obstacles produced by researching a concept that is so largely defined by its subjective nature. But perhaps the most powerful reason to avoid the complicated presence of love in the therapeutic relationship is the very reason it must be deeply understood and scrutinized: It is an ethical minefield.

I first began studying love in psychotherapy as a direct response to recognizing what had felt unspeakable to me as a patient during my long-term psychotherapy treatment regimen. The same relationship that gave me *carte blanche* to speak openly about any and all of my feelings left the underlying emotional frame of the relationship between my therapist and myself unnamed. Eleven years into this transformative treatment, as a therapist in training myself, I was astonished by the unbelievable nimbleness with which my therapist and I danced around and avoided the word "love."

My initial work was driven by a wish to take this love out of hiding, both in my own therapy and in the treatment of others. Blind, perhaps, to the substantial risks associated with this goal, I initiated my research self-righteously; that is to say, I was certain I had the "answers." I believed that love had been unfairly and systematically erased from clinical discourse and therefore needed a fierce and powerful reintroduction. After practicing for several years as a therapist myself, I have backed down somewhat from my initial position, largely because I started to very much love a client.

My original conceptualization of love in psychotherapy was held together by fantastical scaffolding: the belief that love can be understood in discrete terms, specifically by categorizing it into either non-erotic or erotic. From my own work, I now realize that this scaffolding does not actually exist. Instead, love (on the part of the therapist) is not scaffolding at all; it is actually a deconstruction. It is a deconstruction of how we think of our professional, boundaried selves. In order to avoid falling apart completely in the face of love's deconstruction of identity, therapists must aspire to a lofty level of honesty and self-awareness.

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This must occur in order for love, in psychotherapy, to be managed healthfully rather than to the detriment of the client.

For me, loving a client was at once exhilarating and terrifying. That is because love often possesses both attributes in equal measure. However, admitting to the reality that a client had penetrated my psyche beyond my office, beyond my supervision, and beyond my psychological-professional frame created a tremendous disruption in my sense of self and balance. I dreamed of the client many times. My waking fantasies ranged from the monumental wish that she become a member of my immediate family to the banal hope that we might merely see a movie together. While these images might seem benign because of their overt absence of sexual content, the space they occupied in my mind caused me sincere discomfort.

Initially, my goal in studying the absence of love in the philosophical discourse was to encourage therapists not only to feel love permissively, but also to admit their feelings to clients who would be helped by this admission. At this point, I don't know whether such a goal is productive or not. I know that I have never said "I love you" to a client, and I am not sure if I ever will. This does not change my strong conviction that withholding such language is almost as complicated as not withholding it. Further, cloaking this reality in linguistic synonyms such as "care," "empathy," "the therapeutic alliance," or "countertransference" is a decision, while potentially wise, that must be carefully interrogated for its actual intent. Do we describe love instead of saying the word "love" to protect ourselves or our clients? And what about the clients who have never been told that they are loved? Is our withholding a reenactment of such abuse or an obvious attendance to the professional frame? Perhaps it is both.

Having taught hundreds of social work students and completed both my master's and doctoral degrees in social work education, I have arrived at some conclusions that do not necessarily support the admittance of love in the therapeutic relationship, but do necessitate researching it and tracing the treatment of this phenomenon throughout history. I cannot count the number of student papers I have read that mention "countertransferential feelings" and the students' "plans" to rid themselves of them. While in some echelons of our field, namely psychoanalytic communities, countertransference is increasingly welcomed, this phenomenon does not appear to have trickled down. Similarly, while the "real relationship" characterized by an intersubjective nature is currently being embraced by some journals and institutes, the notion of having a "real" and potentially loving relationship with a client instills terror in young clinicians who are taught to adhere to evidence-based and measurable technique.

Ironically, it is precisely our less seasoned clinicians who deserve to be educated about the often complex reality and nuanced experience that accompanies our work. We work, more often than not, in the murky realm that defies simple "right" or "wrong" answers. Manualized treatments seek to convince therapists otherwise, but the tolerance for ambiguity that practicing clinical social work requires, particularly when it is coupled with love, is a technique with which we must also equip members of our field.

In this article, I will examine the utterance of the truth of love and its pervasive presence in social work. It is my sincere belief that an in-depth dialogue about the presence of love in the therapeutic relationship ought to take place in the field of social work: A field founded on the dismantling of hierarchical power structures and the curative nature of human relationships must also examine the curative nature of every element of such relationships. Love is an essential element in human interaction. Further, social workers and therapists work with populations that are historically underserved, oppressed, and placed on the periphery of services that make living a sustainable and fulfilling life possible. What we avoid saying about the vulnerable members of our treatment populations is that they are frequently unloved. Indeed, many of our clients have gone most of their lives deprived of love. Recognizing this reality, as well as realizing that social work is the realm of paradigm shift and equality, renders this research all the more important.

Understanding how to master our loving feelings towards clients, developing theory that informs technique on how to manage love, and realizing its curative potential is the work of social work. According to Lear, "Freud's revolution contained three related elements whose significance we have only begun to understand: a science of subjectivity; the discovery of an archaic form of mental functioning; the positing of Love as a basic force in nature" (1990, p. 3). Freud did indeed recognize the centrality of love to the human existence; however, he sought to practice his work free of what he perceived as the dilutive nature of love in psychotherapy. When urged by Ferenczi, one of his analysands, to interrogate his beliefs regarding the role of love in treatment, Freud rejected Ferenczi. This rejection was followed by both a character and conceptual assassination of Ferenczi and relational love respectively—a rejection that still impacts our thinking today. While many of the nuances of the therapeutic relationship have been unveiled over time, the same cannot be said of love.

In this article I seek to cover the literature that currently exists on the issue of therapeutic love within psychodynamic theory. In using the word "love", I refer specifically to a non-erotic phenomenon, an affectional bond that forms alongside the similar yet distinct phenomenon of positive

countertransference or countertransferential love. The literature explored herein will consider varying theoretical understandings of therapeutic love, including differing views on its essential and pervasive nature. I will offer a description of the historical evolution of these various understandings and present the research currently available on this topic. The data on the topic of non-erotic love in the therapeutic relationship is, however, nominal at best. Further, this research is largely based on the personal cases of therapists performing analyses of their own clinical work. While these cases are certainly of value, the minute subject size offered by these studies limits their ability to be generalized. In order to compensate for the limited nature of the research performed on the topic of non-erotic therapeutic love, I will provide historical perspectives on the correlative issues of countertransferential erotic love and countertransferential hate, along with a more general historical understanding of countertransference and transference. I will, in addition, examine the research of contemporary relational theorists, who have only just begun to re-conceptualize the potential role and power of therapeutic love. These theorists collectively argue for a wider understanding of the strengths and weaknesses of this type of love (Baur 1997; Bernstein 2001; Schamess 1999; Shaw 2003). Finally, I will present a summary of the research supporting this shared argument.

A Paucity of Research

While Plato introduced the notion of non-erotic, or platonic, love in the fourth or fifth century BCE, the idea's acknowledgement as a powerful force within psychotherapy has been neglected. Plato asserted that platonic love is an abiding, deep, spiritual connection that evolves between two individuals. He argued that this love exists without any form of sexual connection. Given the seeming benignancy of this concept, it is surprising that a longstanding tradition of discouraging loving feelings within the therapeutic dyad has held sway. The discouragement of platonic love has resulted in a paucity of research on the topic. This is not to say that such love has not existed between therapists and their patients; on the contrary, for as long as such love has existed, so too has the fear of acknowledging it professionally, whether in research or in supervision. In fact, "over its 100-year history, the psychoanalytic literature has rarely considered therapists' loving feelings and fantasies in relation to their patients" (Schamess 1999, p. 9).

In order to demonstrate the true dearth of research on the issue of therapeutic love, it is useful first to trace some of the potential causes for its banishment. The inception of the psychotherapeutic profession can most surely be marked by the case of Anna O. With this inception, fears about the love between therapist and patient began to take root. This case suggested the need for panic over the possible feelings analysts could feel for their analysands. Springer (1995) reveals the intensity of this panic on the part of the clinician, Joseph Breuer:

> The first beginnings of our profession are marked by the alarm caused by the possibility of the eruption of emotions and feelings in the therapeutic relationship. In 1892, Breuer is appalled and breaks off the treatment of Bertha Pappenheim (Anna O.) when she reveals to him her fantasy of bearing his child—three months after Breuer's wife has given birth to a baby daughter. Breuer's wife rebels against this close relationship between the patient/rival and her husband. He sees his marriage in jeopardy and breaks off all contact with the patient, who is subsequently admitted to hospital and withdraws from psychoanalysis (p. 44).

While Freud and Breuer worked closely together, it was not until Freud experienced his own episode of countertransference that he began to issue stringent warnings against its potential dangers. In Freud's 1905 piece "Fragment of an Analysis of a Case of Hysteria," he explored the case of Ida Bauer, or "Dora." Dora was the 16-year-old daughter of one of Freud's medical patients. Freud worked with her in an effort to deconstruct her idealizing relationship with her father. This case lasted 11 weeks and during this time a very close relationship developed. Springer, who characterizes this relationship as a lengthy discussion about love, argues that the examination of Freud's experience of countertransference produced a "coming apart" on the part of the analyst. She asserts that Freud's response to his countertransferential feelings in this case "fell short of good analytical practice," and describes his behavior in the following passage:

> When one reads the Dora text again today, one is aware of how insistent Freud becomes, particularly in the last sessions before the analysis is broken off, and how vigorously he asserts the correctness of his interpretations. He desires acknowledgement; he wishes to be recognized as a researcher and therapist; and most probably as a man too (Springer, p. 45).

Freud's inappropriateness, or "coming apart," as Springer describes it, planted the seeds for Freud's eventual declaration of the destructiveness of countertransference.

The strength of Freud's convictions about countertransference becomes clearer upon his consultation on Carl Jung's work with the latter's patient Sabina Spielrein. Between 1908 and 1909 Jung began to develop romantic feelings for Spielrein. In writing to Freud for supervisory purposes, Jung identifies himself as the "seduced party" (Springer, p. 45). Freud's response follows:

> 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 grim necessities weighing on my world and the fact that I was ten years older than yourself… have saved me from similar experiences. But no lasting harm is done. They help us to develop the thick skin we need to dominate "countertransference," which is after all a permanent problem for us (Letters between Jung and Freud, written June 7, 1909, p. 111).

With Freud's demonization of countertransference, the fear of its comfortable recognition, as well as the effort toward its erasure, was born. This very fear has created a longstanding divergence between clinical theory and the exploration of therapeutic love. While Freud's experience of countertransference was first documented in 1908, tools for appropriately managing and making use of it have only recently been discussed. Coughlin (1998) explains that "despite the significance of the transference-countertransference dynamic, clinicians have only recently begun to explore and develop literature" on therapists' experiences and feelings towards their clients (p. 3). Coughlin warns that "academic and training programs disregard the significance of erotic transference in their curricula, potentially leaving clinicians without the skills and tools to effectively manage these issues within their therapeutic dyad" (p. 3). Schamess (1999) also points to significant holes in the research and training on this issue. He discovered, after polling classes of MSW students, that many had felt feelings of love toward clients, but did not feel comfortable addressing this phenomenon until Schamess (1999) modeled that it was acceptable. He hypothesizes that this dearth of research and material reflects several essential issues, and interprets them to be:

> 1) Concern that therapists will exploit patients by initiating sexual liaisons; 2) difficulties in managing the treatment process when the "frame" has been modified to encourage transmuting internalizations; and 3) the danger that needy or insecure therapists will unconsciously use patients to meet their own narcissistic needs….

He adds the following caveat: "Ignoring erotic enactment does not make it disappear, and paradoxically, markedly increases the likelihood of sexual acting-out or treatment failure" (p. 23).

Baur (1997) elaborates on the discomfort with, and scarcity of research and writing on, therapeutic love felt by the therapist. She initiated her exploration at a conference on the feelings that therapists develop for their patients, and offers the following anecdotal, yet powerful, observation:

> At a seminar on the feelings that clinicians have for their patients—a weeklong affair… I made marks in the left-hand margin of my notes every time the word "hate" was said and marks in the right-hand margin every time "love" was spoken. At the end of five days, [the ratio of hate to love was] forty to one… When love for a client was mentioned—not love *from* a client, but a question such as "How did you handle your love for this woman?"—there was silence (p. 221).

Baur goes onto hypothesize that the "illogical and deeply emotional forces that underlie the [therapeutic] relationship have seemed too close to romantic love to investigate safely" (p. 223). She explains that the exploration of these feelings is only sanctified if they are framed within the "safety of a parental framework" (p. 222). Once a therapist mentions feelings other than those that mimic a parent–child relationship, she notes, little support is available from the clinical community.

Stirzaker (2000) attempted to formalize Baur's findings. He sought to prove empirically, through the compilation of quantitative data, the discomfort that accompanies discussing feelings of therapeutic love. Stirzaker (2000) discovered that despite the common occurrence of erotic countertransference, "many therapists seemed to be reluctant to enter into discussion about both erotic transference and countertransference because of the emotive nature of the subject" (p. 198). Given the notion that one of the primary tenets of effective therapy is open and honest communication, this reluctance is notably counterintuitive. Cooper and Lesser (2005) describe the importance of this tenet. While they pay homage to theory, they point out that "theory builds knowledge, and it is this knowledge combined with relational authenticity that is the hallmark of clinical… practice" (p. 10). Given the seeming essentiality of authenticity and realness within the therapeutic dyad, which suggests the presence of *caring* feelings at the least, Stirzaker's difficulty in finding subjects to explore the issue is significant. He sent questionnaires to 107 therapists, "asking for comments upon their therapeutic orientation, level of experience, and the length of time they had been working with the client concerned" and what their experiences of loving countertransference had been with their particular clients (Stirzaker 2000, p. 198). The 107 subjects selected had varying counseling degrees and worked in both agencies and private practices. Only four surveys were returned to the author. He interpreted this to mean that the issue was controversial for clinicians, precluding their ability to respond comfortably.

Shaw (2003) offers a more in-depth analysis of the absence of literature and research on therapeutic love. While arguing for further research regarding therapeutic

love, he points out the historical trajectory of the issue's absence from theoretical discourse. The evidence for this absence is provided by examining the writings of Kohut, Freud, Balint, and other pivotal clinicians in the history of psychodynamic theory. He writes that each of these theorists examined a considerable number of controversial issues and subsequently normalized them. Loving clients, however, was not one of these issues. He writes, "…My attempt is to facilitate the analytic exploration" of therapeutic, loving feelings (Shaw 2003, p. 267).

In 1996, Kantrowitz produced an in-depth body of research on the profound impact that the patient has upon the clinician. In her book *The Patient's Impact on the Analyst*, she demonstrates the very real possibility that clinicians' experiences can be studied and documented, complete with thoroughly honest self-reflection. In addition, these findings can indeed be deemed as scientific, reliable and valid. With a sample size of nearly 400, using in-depth questionnaires, Kantrowitz found that clinicians were aware of their own vulnerability and mutability in the psychotherapeutic setting. Their retelling of these experiences helped other clinicians to navigate their way through the murky mutuality of our work.

My goal, which is closely aligned with the attempts of Kantrowitz, Shaw and Baur, is to uncover and research the evolution of the theoretical understanding of therapeutic love. I hope this exploration will make clear that we are now in a time and place that allows us to look at therapeutic love more boldly than Freud and others imagined. Despite his brave exploration of transference, Freud is largely responsible for having silenced an important conversation that has only been resumed in the last decade.

Transference

It was Freud who first coined the definition of transference as he sought to make meaning of this therapeutic phenomenon. In his writings on the theory of psychoanalytic technique, Freud offers two different models of transference:

> According to one model, transference is seen primarily as resistance to the recovery of memory, and therapeutic gains result chiefly from the retrieval of these memories. In the other, transference is largely a result of unconscious infantile wishes, and success in therapy results mainly from a complex process in which the patient re-experiences these wishes in the transference and realizes that they are significantly determined by pre-existing desires and is then able to experience something new examining them together with the analyst—the one to whom these wishes are now directed (Kirkland-Handley, 1995, p. 49).

To make the definition more accessible, however, Cooper and Lesser (2005) define transference as "a displacement of reactions originating with significant persons of early childhood" (p. 6). To Freud, the presence of transference made good treatment possible. "Freud and his school of classical psychoanalysts began to view transference as a source of data, as resistance, and as a battleground for their therapeutic engagement. Transference phenomena became an avenue to deepen the therapeutic process and provided the therapist with an illustration of the inner workings of the client's psyche" (Coughlin, 1998, p. 5). Freud also sought to make particular sense of the importance of erotic transference or loving transference. He argued that the presence of erotic transference stems from the activation of past childhood conflicts and fantasies that are difficult to address sufficiently with words (Coughlin 1998, p. 7). Freud said that transference love

> represents a new edition of an old relationship that is superimposed on the therapist. While the patient's feelings of dependency and desire fuel the therapy, the neurotic form of the transference relationship itself—the insistence on obtaining gratification from the perfect comforter—is the problem that is holding the patient back and must be overcome. Good therapy, then, manages to keep the transference going to provide impetus for the work that eventually convinces the patient that it is useless to continue looking for perfect providers and protectors (Baur, p. 141).

While Freud believed strongly in the curative power of transference, he pleaded for the erasure of countertransference, eliminating the possibility of the exploration of mutual therapeutic experiences. It was not that Freud did not understand the complexity of countertransference; indeed, it was quite the opposite. Freud believed that our inner-child selves must accept the frustration linked to a therapist's attempts to keep the patient at arm's length. He felt that "if the transference [were] acted on, and the therapist tried to be the perfect partner that the patient hungers for, the patient [would be] likely to repeat all her old mistakes and learn nothing" (Baur p. 142). In other words, "if the transference is acted on," the clinician has failed to rid him- or herself of his or her countertransferential feelings. In a letter dated February 20, 1913, Freud offered the following:

> The problem of countertransference is one of the most difficult in psychoanalytic technique. What is offered to the patient must never be spontaneous affect; rather it must always be expressed consciously. In some circumstances, a lot should be offered, but never anything arising directly from the analyst's unconscious. The analyst must always be

> aware of and overcome the countertransference to be free. However, at the same time, to give too little to a patient because the analyst loves him too much is to confuse him, and is a technical error. It is not easy and practice is required (Freud–Jung letters, p. 189).

Perhaps useful to note is the fact that Freud was trained as a physician. Most likely, this background supported his "antiseptic" attitude toward the management of countertransference (Rachman 1998, p. 263). Freud called for the analyst's role to mirror that of a surgeon: "An analyst as surgeon suggests expertise, detachment, and emotional control… Analysts used his technical guidelines to designate non-interpretative behavior as violating analytic doctrine" (Rachman p. 263). Likening the analyst to a surgeon makes clear the message about countertransference. In theory, the more emotionally involved a surgeon becomes with a patient, the more at risk that patient's surgery is for failure (Rachman 1998). Freud believed the same was true of the relationship between an analyst's emotions and the process of analysis.

Countertransference

Freud first mentioned the term "countertransference" in 1910, and subsequently deemed it to be a clinical obstacle that needed to be harnessed through careful self-analysis (Rachman 1998). It was not until 1950 that the term reappeared in the writings of Winnicott, Racker, and Heimann (Berman 1997). These theorists, four decades later, were able to endorse the importance of an internal, private recognition of countertransference as important clinical data (Berman 1997). While countertransference was slowly being deemed useful, limitations existed regarding the forms of countertransference that could and could not be discussed. Feelings of hate and disdain for clients were more readily acknowledged than loving feelings. This is most evident in the far-reaching impact of Winnicott 1949 paper "Hate in the Countertransference". This paper quickly legitimized the powerful experience of hating clients, as well as the multiple ways in which this data could become useful in the clinical relationship. Winnicott examined the experience of hating psychotic patients. He writes, "If we are to become able to be the analysts of psychotic patients, we must have reached down to very primitive things in ourselves" (Winnicott 1949, p. 69). He goes onto assert that a central primitive force is hate. This hate is normalized by his understanding of the mother–child relationship. "I suggest that the mother hates the baby before the baby hates the mother, and before the baby can know his mother hates him" (Winnicott 1949, p. 72). Through this normalization of hateful feelings in the sacred mother–child dyad, Winnicott legitimized the recognition of a form of countertransference. He believed that the feelings between mother and child were mirrored within the therapeutic dyad. If a mother can hate her child, a therapist can most certainly hate his or her clients.

Baur (1997) reveals the present-day impact of Winnicott's work. Elaborating upon her own aforementioned findings derived from the conference on therapists' feelings towards patients, Baur writes that "when 'hateful,' 'loathsome,' and 'detestable' came up, they triggered a comment or a question roughly three quarters of the time" (Baur, 221). This inquisitiveness contrasted greatly with the silence she encountered in response to discussing love in the context of countertransference.

While there is a diverse literature exploring the experience of countertransferential hate (Berman 1997), countertransferential love is not given equal or even minimal recognition. Shaw (2003) seeks to explain this phenomenon:

> We have long been free to discuss hating our analysands and more recently to discuss having sexual feelings for them, including disclosing such feelings. But it is less often that we discuss our feelings of tenderness and loving affection for our analysands, not with the kind of thoughtfulness and seriousness of many of our other discussions. Erotic or aggressive countertransferences are now widely conferred the status of therapeutic agents… Yet case presentations where feelings of tenderness and love for an analysand are openly expressed are often greeted with suspicion (p. 253).

It is not that efforts have not been made to fight the pervasive "suspicion" associated with countertransferential love. In fact, Ferenczi introduced the first mention of therapeutic love and mutuality in the 1920s (Martin 1998). Ferenczi was a student of Freud's for 25 years. From 1908 (the day they met) through 1933 (when Ferenczi died) the two maintained an intense correspondence. This correspondence was an impassioned debate about the efficacy of different analytic stances, specifically the engaged versus the withholding stance. Freud called for sterility, self-discipline, and a therapeutic dyad defined by the clear hierarchy of analyst over analysand. Ferenczi, conversely, encouraged "enthusiasm about equality, openness, and mutuality, about blurring boundaries, transcending hierarchies, and sharing knowledge freely" (Berman, p. 185). Ferenczi did not necessarily agree with Freud's ideals; instead, he found them unrealistic and designed his technique to respond to the realities of the analytic context. As the father of relational therapy, Ferenczi considered treatment a form of mutual analysis. He describes this analysis as follows: "The tears of doctor and patient mingle in a sublimated communion, which perhaps finds its

analogy only in the mother–child relationship" (Cabre (taken from Ferenczi), 1998, p. 252). Ferenczi is considered to have offered major contributions to this notion of communion:

> The first was that the analytic situation human situation [is one] in which two human beings attempt a sincere relationship. The second was that "one must give the love the patient needs." Two human beings who attempt a sincere relationship in the name of love is what characterized Ferenczi's technique of self-disclosing his feelings (Rachman, p. 264).

Ferenczi's attempts to humanize the therapeutic relationship, through the use of countertransference, led Freud to shun him. This rejection, according to Cabre (1998), led to "one of the most remarkable processes of censorship in the history of psychoanalysis; Ferenczi's ideas were *forgotten* and condemned to silence" (p. 247). Thus, the issue of therapeutic love disappeared from the theoretical discourse for decades.

In 2000, Stirzaker sought to make sense of this disappearance. Stirzaker (2000) argues that Freud's endorsement of viewing erotic transference but not erotic countertransference as valuable clinical data created a sense of anxiety for clinicians regarding loving countertransference. He argues that Freud's attitude made "it harder for therapists to acknowledge their feelings," and that countertransference "was more likely to be seen as therapeutic error than a potential therapeutic research tool" (Stirzaker 2000, p. 202). In an effort to reverse this perceived trend, or at least to demonstrate Freud's impact, Stirzaker (2000) uses case studies from his own practice to question Freud's assertions about the inherently flawed presence of countertransference in therapy. He argues that Freud's beliefs underestimate the help countertransference can often provide in enhancing the therapeutic bond. Stirzaker (2000) offers examples that point to the benefits provided by introducing countertransference into the relationship. He asserts that acknowledging erotic love helps therapists to "understand [clients] in the context of the client's early relationships in order to help them develop and make sense of their present ways of relating" (Stirzaker 2000, p. 207). He supports his argument through the use of a case example offered to him by his supervisor, a man in his early sixties. A female client in her early twenties was experiencing difficulties in her relationship with her husband. According to his supervisor, the client acted and dressed in sexually provocative ways. The therapist began to experience erotic, countertransferential feelings towards this young woman. He explains:

> Through the erotic countertransference, Oedipal issues were being re-enacted in the therapy and these proved to be essential in understanding and resolving her difficulties in her relationship with her partner. Appropriate interpretation of these dynamics enabled [the client] to see her relationship with her partner in a different way. (Stirzaker 2000, p. 204).

In opposition to Stirzaker's (2000) *positive* findings, Gabbard (2001) presents a clinical vignette of a male therapist whose revelation of erotic countertransference was therapeutically destructive. The examined case was selected from an article written by a peer, Lester, in 1995. The vignette examines a female client who responds negatively to her male therapist's admittance of erotic feelings for her. She states, "Knowing that you have sexual feelings for me makes me feel unsafe here. This is just like what happened with my dad. He was always wanting to hug me and touch me, and I always had to be the one to set limits" (Gabbard 2001, p. 990). This negative outcome illustrates the precariousness inherent in choosing to address sexual feelings in the therapeutic relationship. This is one of the few vignettes offered by a theoretician about a more distant case that offers the potential for greater objectivity. From this vantage point, Gabbard (2001) argues for thorough consideration before disclosing feelings of countertransference, particularly erotic countertransference. It is important to note, though, that despite his cautious findings, he does not negate the inherent clinical value of countertransference. Rather, it is how countertransference is used that begs for meticulous scrutiny.

Schamess (1999) argued for the importance of the study of loving countertransferential feelings, not just transference feelings. Schamess (1999) uses anecdotal data to endorse his thesis that "patients benefit when therapists recognize the sensual components in transference-countertransference interactions and use them to inform therapeutic interventions" (p. 9). Schamess (1999) agrees strongly with Freud's assertion that transferential love should not be physically enacted. But, he writes, "my purpose is to encourage therapists to begin discussing the erotic and sensual substrata of wishes and fantasies that evolve reciprocally in treatment (even with 'preoedipal' patients), at the level of fantasy and/or symbolic enactment" (Schamess 1999, p. 10). He posits that erotic feelings typically evolve in relationships with large power differentials and suggests that contemporary clinicians must be mindful of this phenomenon. Schamess (1999) also states that the "healing action of psychotherapy is facilitated when therapists recognize their own as well as their patients' contribution to what often becomes… a more or less secret dance of mutual desire" (Schamess 1999, p. 11). The recognition of this mutuality by a few researchers has enabled other theorists to examine

countertransference, not just in terms of the erotic or hate, but in a complex and in-depth manner.

Moving Beyond Countertransference into Authentic Love

In the discussion of countertransference above, I mentioned the work of Ferenczi in the context of his mentor-student relationship with and subsequent shunning by Freud, as well as his contributions regarding the usefulness of countertransference. His contributions regarding the importance of therapeutic love have also been invaluable. In an address given at The Hague in 1920, Ferenczi expressed his belief that "the progress of the cure bears no relation to the depth of the patient's theoretical insight, nor to the memories laid bare" (Stanton 1991, p. 133). Instead, his method was "developed to the fullest when he recognized that genuine sincerity and empathic attunement were the essential ingredients to reach a traumatized individual" (Rachman 1998, p. 265). In a further elaboration on Ferenczi's beliefs, Stanton (1991) writes that the analyst "maintained that no progress whatsoever is likely to be made in psychoanalysis unless [we surrender] defense through distance" (p. 136). While Freud considered distance to be a necessary therapeutic technique, Ferenczi called it a defense. In fact, Ferenczi encouraged the clinical surrendering of blind obedience, asserting that this obedience was what had oppressed patients as children; consequently, these patients required tenderness. Ferenczi argued that patients sought something else—love. He felt that treatment outcomes were directly correlated with the amount of love given by the analyst to the patient.

Ferenczi's unorthodox clinical discourse helped to set the stage for the development of relational psychoanalysis. It is within the relational model that conversations about authentic therapeutic love have finally begun to reemerge. According to Baur (1997), relational therapy can be defined as "the attempt to place therapist and patient on far more equal footing than conventional therapies… it emphasizes the curative power of the relationship that develops between them" (p. 222). Baur suggests that Ferenczi's notions are the inspiration for what we now call relational therapy, stating that his "ideas on mutual analysis and on the real relationship that develops in spite of a clinician's professional stance are more in vogue now than in his lifetime" (p. 222).

Research on this mutuality has proceeded rapidly since the onset of relational thinking, and relational practice, itself, has bred a range of theories and schools. In 2001, Gabbard led a panel at the biannual meeting of the American Psychoanalytic Association. Vida (2002), a panelist, answered Gabbard's (2001) question, "Do you think there is any type of love felt by the analyst toward the patient that contributes to the therapeutic action of psychoanalysis?" (Vida 2002, p. 437). Her response was as follows:

> It is not even possible for me even to enter my office in the morning of a clinical day without the hope and the possibility of love… How can I say what it contributes when it is not an option or a conscious choice whether it is there or not? This is like saying, "Does it contribute to the therapeutic action that the analyst draws breath, has a blood pressure and a pulse?" (p. 437).

Elaborating on Vida's observations, Shaw (2003), also a relationalist, speaks to the importance of using precise language to describe the love that occurs in therapy beyond countertransference and transference. He points to the contradiction between the therapeutic goal of enabling love and the failure to recognize the love that actually exists between therapist and client. Shaw (2003) performed a historical analysis of the understanding of analytic love. In his view, the results of this study contradicted the historical endorsement of professional neutrality. Instead, Shaw came to believe that theoretical "knowledge, rather than leading us to ignore, omit, or cancel our love, seems instead a call to persist in loving, as authentically, deeply, and respectfully and responsibly as we can" (Shaw 2003, p. 275). Shaw (2003), in accordance with many of his contemporaries (Gabbard 2001; Rabin 2003; Schamess 1999), argues for a normalization of these loving feelings through research and, ultimately, principles for practice. Shaw posits that this love should be managed meticulously, but still recognized. He writes, "I am saying that analytic love is indeed complicated and dangerous, and like all loving, carries the potential for devastating disappointment… [But] at the heart of this endeavor, I believe, for both analyst and analysand, is a search for love, for the sense of being lovable, for the remobilization of thwarted capacities to give love and to receive love" (2003, pp. 252, 275).

Bernstein also encourages deliberateness in managing loving feelings within the therapeutic frame. In order to dismantle the therapeutic fumbling Freud created surrounding the management of emotive countertransference, Bernstein (2001) attempts to formulate a definition of love that invites analysts to explore the possibility of its presence. He argues that the lack of agreement about the definition of therapeutic love precludes a broader discussion of the phenomenon. His definition evolves from the following line of thought:

> [The analyst] is able to set aside her own needs in favor of those of [of the client]. A renunciation of this sort is generally recognized as an act of love; and of the more than twenty varieties of love described in

> the dictionary, it certainly conforms to the one variety most clearly applicable to the therapeutic encounter, i.e., "benevolent concern for the good of another." (p. 252).

Gargiuolo (1999), Natterson (2003), and Shaw (2003) speak to the importance of identifying useful language to describe the love that occurs in therapy, beyond what feels transferred onto the relationship from a client's history. Natterson (2003), who makes use of one of his own case studies, suggests that the presence of love has been perceived solely as a therapeutic problem. As an alternative, he suggests that "therapy can be viewed as a specialized mutually loving relationship" (Natterson 2003, p. 510). Gargiuolo concludes that therapy is most effective when "we are alive, when we can interact with those whom we love, not as salves for our injuries, but as possibilities for experiences. To be able to use ourselves, to be able to use our world by recognizing relationships, is to feel effective and related" (Gargiuolo 1999, p. 342).

Rabin (2003), echoing these arguments, suggests that overtly discussing therapeutic love, rather than frustrating it, is curative. He asserts that loving feelings are an essential part of the therapeutic process. Further, he concurs that the efficacy of therapy and true change cannot occur without these feelings. He writes that the aim of his work is to "bring the loving feelings of the analyst into open professional dialogue" (Rabin 2003, p. 2). He states that without this inclusion, a central healing force is neither addressed nor understood. He arrives at these findings by researching three of his own cases. Each clinical vignette concerns a female client between the ages of 50 and 65. He found, in all three clinical vignettes, that his female clients felt empowered by the self-disclosure of his loving feelings towards them. Rabin (2003) summarizes these findings by concluding that "our love is… beneficial, even transformative, to patients" (p. 11). While his cases are embedded in a gendered power dynamic, perhaps the revelation of his loving feelings was a rebalancing act, an effort to gain equal footing through the exposure of mutual vulnerability.

In contrast to Rabin's cases, Rosiello (2003) examines loving feelings within a same-sex relational dynamic, seeking to unmask the pervasiveness of ignorance about and denial of same-sex transference and countertransference. She states that there are "few papers on erotic longings between female analysts with lesbian patients or heterosexual women patients, and there is an unfortunate lack of analytic literature on homoerotic transference and countertransference when both patient and analyst are heterosexual" (p. 90). Weinstein (2003) begins to unravel this problematic pattern in his piece "On Love, AIDS, and Emotional Contact in Psychotherapy." In this article, he reflects upon a long-term case involving a patient named Bruce. Bruce and Dr. Weinstein met for ten years before Bruce was diagnosed with HIV. In this article Weinstein contemplates the worth of visiting his client in the hospital. He offers the following vignette, which took place during this visit, to support his subsequent argument for the power of therapeutic love. He describes a conversation between him and his patient, a conversation filled with stories of love, family, and friendship, describing the dialogue as "an intense, loving interchange." He goes onto explain the depth of the emotions between them. "As I leave to go, feeling closer to him in this moment than ever before, he holds me and cries into my shirt, 'I don't want to die, I don't want to die.' I stroke his hair and say, 'Get better; let's continue our work together.'" As the therapist looks back, he witnesses an affective transformation. "His color is okay, and I feel right then that he will get better, which he does within a few days. This incident, which touched me deeply, convinced me of the therapeutic power of love as never before" (p. 214).

Weinstein (2003) offers this reflection in the hopes of convincing clinicians to use "sensitive and caring flexibility." This love and flexibility, while absent from documented historical clinical work, may in fact set the tone for the profession's future.

Conclusion

Applegate effectively synthesizes and distills the trajectory of the story that psychodynamic theory has told about love:

> No longer was the clinician to be objective and neutral, but he was given latitude to attend to, accept, and express his own affective responses. Countertransference, once seen as an impediment to objectivity that must be analyzed away, was in the object relations story an aspect of the clinician's personhood that should be embraced and employed in trying to understand the client's story. The moral of this story: The id may be fun, and the ego is useful; but objects that love you are better. (p. 116).

If the maxim "the more love, the better" is indeed true, as many theorists are collectively beginning to argue, then research and theory around this idea must evolve. There is not yet clear discussion on how love in the therapeutic relationship should be transmitted, if at all. Should it be overtly discussed linguistically? Should we be telling our patients "I love you"? If not, are there other means by which this powerful emotion can be communicated within the framework of our profession?

Rorty (1989) dissects the etiology of theory as a process of language development requiring "new vocabularies and metaphors" (Applegate, p. 112). Without this new language, we are left with the unwieldy power of love,

unaware of how to harness it and cure with it. Open to the possibilities of love and the varying modes by which we can communicate it, our peripheral professional role might just become irresistible to the mainstream.

In 1990, Lear wrote: "The idea of a science of subjectivity seems at first paradoxical: how could there be an objective study of subjectivity? And yet, Freud realized, there had to be such a study if we were to understand human existence" (Lear, p. 4). Freud's words ring ironically true in the effort to excavate the history of psychotherapeutic love in the treatment relationship. While he honored the essential value of researching the subjective, he also played a central role in the historical paucity of research on the very subjective nature of psychotherapeutic love.

Many pitfalls exist in the scientific nature of this discussion; however, tolerating the opaque nature of love as a research topic makes the idea of studying it possible. In this article I have framed the original erasure of love from the psychological canon as a byproduct of a singular relational failing between Freud and Ferenczi. This failing provides a metaphor for the formative power of relational failures and the long-lasting effects of these failures. It also explicates the reality that theory is often linked to personality, and personality to culture and moments in time. Further, to examine the absence of love from our shared literature is to uncover the inextricable link between theory and culture. This article seeks to lay the groundwork for future research and the clear lines that this research ought to take. An exploration of both therapist and patient perceptions of the role and management of love in the psychotherapeutic relationship should occur. Such an exploration would ideally inspire further research into how this love can be discussed in supervisory relationships, academic settings, and training institutes.

The effort to take love out of hiding, particularly in the framework of social work, is also a revelation about this moment in time. It is almost impossible to make sense of what precisely that revelation is, but I would speculate that it means something about the cutting-edge nature of social work. Moreover, though, it is evidence of a pendulum swing. While evidenced-based research and empirically informed technique are invaluable, the pervasive nature of their presence must be countered with an equally important dialogue about the art of social work, an art perhaps inspired by love.

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