

Running head: THE THERAPIST'S EXPERIENCE OF LOVE FOR PATIENTS

THE THERAPIST'S EXPERIENCE OF LOVE FOR PATIENTS

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Abstract

From the beginning of psychoanalysis, love has been recognized as a crucial and healing part of the therapeutic relationship. The literature, which has focused more on the experience of the patient than that of the therapist, suggests that while therapists do feel love for patients, they are uncomfortable with these feelings and reluctant to discuss them in a public forum. This qualitative study explores the experience of love from the therapist's point of view, bringing the topic more into the open. Semi-structured interviews were conducted with eight psychodynamically oriented psychotherapists. A modified grounded theory method (Corbin and Strauss, 2014; McCracken, 1988) was used to analyze the data. The following themes were identified: Love for patients can be parental and/or erotic; is characterized by warmth, care, and stretching the frame; is deepened by having survived struggle and even hatred together as well as by the passage of time; is characterized by careful listening and the dedication that goes with it; and is at times akin to spiritual love. Findings support, challenge, and expand on different aspects of previous discussions in the literature. Consistent with the literature, most participants reported experiencing a range of loving feelings for patients. In contrast to the literature, participants reported feeling comfortable both experiencing and discussing these feelings. Expanding on the literature, participants reported that the greatest influence on their attitudes towards love for patients was their own therapy. This study supports the importance of love in promoting healing in psychotherapy and suggests a need for greater awareness of loving feelings in training and supervision.

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Introduction

From the beginning of psychoanalysis, when Freud famously wrote in a letter to Jung, “Psychoanalysis is in essence a cure through love” (McGuire, 1974, pp.8–9), love has been recognized as a crucial and healing part of the therapeutic relationship. However, the love Freud referred to and the love that has been much discussed in the literature is the love of the patient for the analyst – “transference” love. It is generally taken as a given that many patients have strong feelings about their therapists. These feelings are all-inclusive, ranging from intense hatred to intense loving feelings, including romantic love. Part of the work of therapy is to allow these feelings to emerge and to explore, understand, accept, and work through them. Psychodynamic therapy privileges the emotional life of the patient and regards being able to experience intense emotion without being overwhelmed as a sign of psychological health.

The psychoanalytic literature shows that therapists also experience a range of emotions for their patients. However, discussions in the literature of therapists’ feelings towards patients typically focus on negative feelings – hate and rage – or on sexual feelings. Less attention has been paid to loving feelings that therapists have for their patients and how these feelings help or hinder the therapeutic process. Although anecdotal evidence suggests that therapists and analysts do, in fact, love their patients in various ways, it seems that most often these feelings are discussed in private settings such as the therapist’s own therapy or supervision rather than in public or in print as part of a professional conversation. This behind-closed-doors approach suggests that therapists feel uncomfortable when it comes to loving their patients. Furthermore, the fact that such love is sometimes referred to as the “L-word” in psychotherapy circles (McWilliams,

2004) suggests that it is taboo, while by contrast other intense feelings such as hatred have long been regarded as acceptable and useful (Winnicott, 1947). Recent events, however, suggest that attitudes may be changing. For example, in 2016, the New York University Postdoctoral Program in Psychotherapy and Psychoanalysis sponsored a one-day conference about love in the therapeutic relationship; in 2017, there was a panel on love at the Division 39 conference in New York; and in 2018, love was declared to be a core competency of relational psychoanalysis (Shaw, 2018).

This study explores the subject of love in the therapeutic relationship from the psychoanalytic therapist's point of view. It has three main purposes: to explore the experience of therapist–patient love in psychotherapy, to seek a new definition of therapeutic love, and to further the understanding of love as a healing force in therapy. The vast majority of authors who have written about the love of therapists for their patients have used the mode of inquiry typical of much psychoanalytic writing, which involves drawing on theory and clinical experience without conducting formal research. The unique contribution of this study is to take a more systematic approach to the topic by conducting semi-structured interviews. In exploring the therapists' experience of love for their patients, it brings into open professional dialogue a topic that has formerly been discussed mainly off-the-record. The study aims not only to discover what therapists have to say about their experiences of love for patients, but also to uncover their attitudes towards these feelings, and to investigate factors that influence those attitudes. It is hoped that in bringing to light what therapists think and feel about loving their patients the study will help to dispel the anxiety that is presently associated with having these feelings. Furthermore, there is a great deal of confusion about how to define love in the

context of psychotherapy in the existing literature, where it is often conflated with sexual feelings. The second purpose of this study, therefore, is to sort out *eros* from other loving feelings and work towards a redefinition of therapeutic love that is more nuanced, subtle, and inclusive of the rich spectrum of experience that is encompassed by the term “love.” The third aim of the study is to begin to explore the therapeutic action of therapist–patient love. According to McWilliams (2004), “Matter-of-fact acknowledgements in the psychoanalytic literature that we love our clients are rare, and even rarer are suggestions that love is the main therapeutic agent” (p.158). The importance of this project, then, is that it begins to offer a new perspective on the topic of love through open discussion and exploration of the experience and therapeutic action of loving feelings in the therapeutic relationship.

The starting point for my curiosity about the subject of therapeutic love was the disconnect between my own experience in therapy as a patient and the tone of discussions in my graduate school courses, in which the topic of love consistently elicited anxiety and embarrassment. My decision to pursue graduate training in clinical psychology followed the resolution of a midlife crisis that had prompted me to enter therapy two years earlier, with a psychoanalyst who saw me twice a week. At the beginning of the therapy I felt lost, depressed, and barely alive psychologically speaking, without hope or desire. My therapist brought me back to life, and the love between us was crucial in promoting healing and revitalization. (In case there is any question, there have been no sexual boundary violations here.) Mutual love and respect, open discussion, and honesty were the means by which healing was achieved. So when I arrived at school, and something I had experienced as the agent of my return to life made people deeply uncomfortable, I

asked myself why my fellow students were reluctant to confront this area. When I began to explore the topic in the psychoanalytic literature, I discovered a similar state of anxiety and confusion, and I felt compelled to carry out my own research.

Research Questions

The study will consider the following questions: 1) What is the nature of the loving feelings therapists experience towards patients? This question encompasses how therapists define and describe love in the therapeutic context. 2) What are therapists' attitudes towards loving feelings? 3) What factors influence therapists' attitudes towards these feelings? Areas to be explored include therapists' own therapy, training and supervision, and personal lives. 4) What are the therapeutic effects of therapists' loving feelings for the patient? That is, how does love promote or hinder the patient's healing? 5) Finally, if therapists do love their patients, would they disclose it, and why or why not?

Definitions of Love

Although it may be said that most people know love when they feel it, love is a multidimensional concept that eludes precise definition. Maroda (1998) put it well when she said: "The character of love is knowable on an intuitive level, yet impossible to gauge or define with any certainty" (p.39). The Greeks identified seven varieties of love: *eros*, or sexual attraction; *philia*, characterized by knowledge and friendship; *ludus*, or playful love; *storge*, or familial love; *philautia*, or self-love; *pragma*, or companionate love; and *agape*, characterized by empathy and altruism (Burton, 2016). Merriam-Webster (n.d.) offers several definitions of "love" as a noun, including: "strong affection for another arising out of kinship or personal ties," "attraction based on sexual desire: affection and tenderness felt by lovers," "affection based on admiration, benevolence, or

common interests,” “warm attachment, enthusiasm, or devotion,” and “unselfish loyal and benevolent concern for the good of another. As a verb, the meanings of “to love” include: “to hold dear: cherish,” “to feel a lover’s passion, devotion, or tenderness for,” “to like or desire actively: take pleasure in,” “to thrive in” (as in “the rose loves sunlight”) and “to feel affection or experience desire.” In *The Art of Loving* (1956), Erich Fromm emphasizes the active character of love and posits that it implies four basic elements, common to all forms of love: care, responsibility, respect, and knowledge. The types of love Fromm identifies are brotherly love, motherly love, erotic love, self-love, and love of God.

The seven varieties of love identified by the Greeks, the dictionary definitions of love, and the types of love singled out by Fromm are overlapping but do not map onto each other in a perfect way. Given the many and varied meanings of love, and the fact that one of the purposes of the study is to find out how therapists define love themselves, no definition was provided for participants ahead of time. However, the study assumes that love goes beyond or is something more than the professional care that is a minimum requirement of all therapist–patient relationships.

Literature Review

This chapter reviews what has already been written about love in psychotherapy, as well as considering the topic in the context of evolving understandings of countertransference and of what is “real” in the therapeutic relationship. It further provides an overview of the concept of countertransference and the controversy concerning countertransference disclosure.

A Brief History of the Concept of Countertransference

This study is intended to explore the lived experience of participants and thus for the most part uses experience-near language, such as “love for patients,” rather than theory-laden language, such as “countertransference love.” However, as the study focuses on psychodynamic clinicians, among whom the term “countertransference” is often used in an imprecise way to refer to all the feelings a therapist has for a patient, a brief overview of the concept is provided here, in order to place the topic of the therapist’s loving feelings for patients in the context of current thinking about countertransference. In the early days of psychoanalysis, the ideal of analytic neutrality was upheld, with the analyst functioning as a “blank screen” onto which the patient projected transference feelings (see Racker, 1957, 1968). According to this paradigm, any feelings on the part of the therapist for the patient were regarded as problematic, likely the result of “incomplete analysis,” and to be eradicated. Eventually the idea of countertransference feelings as a problem to be eliminated gave way to the view that feelings engendered in the therapist by the patient are helpful in understanding the patient; this view was still pre-relational (Gorkin, 1987; Tansy & Burke, 1989). With the advent of the two-person, relational paradigm, views of transference and

countertransference changed even more. Barsness and Strawn (2018, p.184), presenting the relational point of view, “contend that transference–countertransference theory should be repositioned from either/or and replaced with concepts such as ‘transferential experience’ (Fosshage, 2000), ‘intersubjectivity’ (Stolorow, Brandshcraft, & Atwood, 1987), or the ‘interpersonal’ (Mitchell, 1988). Transference–countertransference is then essentially perceived as an organism, as transactional, interactive, and perspectival – a relationship in which there is a ‘mutual, bi-directional, interactive influence’ (Fosshage, 2000, p.25).” By this definition, loving feelings exist in the therapeutic relationship or the relational dyad rather than separately in the patient and/or therapist.

Is countertransference love “real”? Some authors (Searles, 1959; Slavin, 1998; Fitzpatrick, 1999; Gerrard, 1999; Mann, 1999; Rabin, 2003) argue that love for patients is real, while others (notably Gabbard, 1994, 1996, 1998) maintain the position that if analysts feel real love for patients, boundary violations may follow. Celenza (2017) argues that the real–unreal polarity of transference–countertransference phenomena is a false dichotomy that can be used as a rationale for boundary violations. That is, if the therapist approaches the therapeutic encounter with the expectation that what is experienced will be “unreal,” and is unprepared for, say, the intensity of loving feelings for a patient, those feelings may then be mistaken as “real,” as exceptional, and used as a justification for sexual boundary violations. Maroda (2004) argues that it is impossible to distinguish between what is real and what is transference or countertransference, encouraging therapists “to be aware of the ways in which they are likely to manifest their own pathological tendencies in the treatment relationship – and to do so without shame or self-deprecation” (p.109).

The controversy regarding countertransference disclosure. Maroda (1998) provides a useful review of the controversy surrounding self-disclosure, from its early proponents (Ferenczi, 1932; Little, 1951) through the advocates of “occasional disclosure” (Bollas, 1987; Tansey & Burke, 1989; Aron, 1991, 1996; and Renik, 1995) to her own view of countertransference disclosure as a valuable technique in a two-person, relational paradigm. Barsness and Strawn (2018) go even further, asserting: “The relational analyst holds to the notion that a patient needs to hear what is on the therapist’s mind and how the therapist experiences the patient” (p.179). What others call self-disclosure, they term “courageous speech” or “disciplined spontaneity.” Such action is characterized by statements such as, “Says out loud what he/she is thinking and experiencing,” “Resists the urge for self-protection,” and “Offers his/her ideas from a non-authoritarian stance, with tentativeness, curiosity, and humility” (p.181).

Barsness and Strawn even support disclosure of erotic countertransference, which is arguably the most controversial area of self-disclosure. To summarize briefly, they argue that while having sex is taboo, talking “is not taboo within the analytic situation. *In fact, this is what we do. We talk about it!*” (p.186). They find fault with the reasoning behind Gabbard’s (1998) claims that the therapist’s disclosure of erotic feelings is “fundamentally different from disclosure of other countertransference affects” (p.783). They agree with Davies (1994) that the erotic energy in the relationship propels towards life, and if the analyst is unwilling to participate in a conversation with the patient about it, “whole areas of the patient’s unconscious experience may be kept out” (p.11), to the detriment of the therapeutic endeavor.

Characteristics of Love in the Therapeutic Relationship

Although much has been written about the nature and meaning of patients' love for their therapists (see especially Bergmann, 1987), relatively little has been written about therapists' loving feelings towards patients. Rabin (2003) points out that even in the context of discussions of therapists' sexual feelings toward patients (Gorkin, 1987; Benjamin, 1994; Coen, 1994; Davies, 1994, 1998; Gabbard, 1994, 1996, 1998; Cooper, 1998; Hoffman, 1998a; Slavin, Rahmani, & Pollock, 1998), little attention has been given to "loving feelings, including falling in love with our patients" (p.677). Rabin aimed to address this imbalance by "bring[ing] discussion of the analyst's loving feelings toward his or her patients into open professional dialogue" (p.677). However, it seems that few authors have followed his lead. Although McWilliams (2004) states: "I believe it is love that endows the therapist with the emotional power to foster change and love that gives the patient the courage to pursue it. It is not the only therapeutic factor, but love may be the one that allows the other curative processes to do their work" (p.150), she stops short of discussing specific loving feelings for patients.

General characteristics of the analyst's love. Authors who have written about the defining characteristics of love for patients each have their own perspective on it, illustrating the point that there are nearly as many versions of therapeutic love as there are therapists. In addition to general characteristics, which cluster around the Greek *agape*, themes of parental love and love equated with understanding have been prominent, as well as the idea that love is more than care. According to Sherby (2009): "Countertransference love exists along a continuum from the implicit analytic attitude of respect, concern, and empathy, through the love born of intense connection and

gratification of the work accomplished, to intense feelings of either maternal or sexual love” (p.77). Shaw (2003) says that analytic love is hard to define, “because it may at times resemble parental love, fraternal love, charitable love, friendly love, erotic love, and so forth, but is not simply or actually any of those things. It is a thing unto itself” (pp.267-268). He offers “faith and belief in human potential” and “the analyst’s commitment to the analysand’s safety” as defining principles of analytic love (p.268). Fox (1996) emphasizes “acceptance and caring” (p.1077) and elaborates by saying:

The loving countertransference is at the core of the analyst’s sublimated positive responses to patients ... Manifestations of this sublimation are to be found in ongoing efforts to maintain empathic contact; in the curtailment of judgmental responses; in sustained attempts to maintain compassionate neutrality; in efforts to suspend action, to understand, and to channel reactions into interpretation; and, most prominently, in the deferral of personal interests and desires. (p.1083)

All of these indicate a “mature and selfless kind of love” (p.1083). Mendelsohn (2007) includes “discernment, critical thought, committed challenge, generosity of spirit, and acceptance” among the therapist’s “loving capacities” (p.219).

These sound rather passionless in contrast to Cole’s (2007) conception of the analyst’s loving feelings as “a wide territory of affective experiences marked by the swooning crush to a melancholy, resigned constancy” (p.348). Friedman (2005) looks for “clues to the nature of the analyst’s love” in the work of Racker, Schafer, and Steingart, and finds: “(1) The analyst’s love may be induced by the analyst’s own activity. (2) The analyst’s love may be compared to the appreciation of art and literature. (3) Love may be generated by intimate acquaintance arising from the impact of

transference passion (and its interplay with countertransference)” (p.365). Finally, Weinstein (2007) returns to Fromm, saying, “The four components of love which Erich Fromm (1947) describes – care, respect, responsibility, and knowledge – are the heart of all successful analysis” (p.302). Themes of parental love, love equated with understanding, and love as something more than care are further elaborated below.

Parental love. One consequence of the relational turn has been the conceptualization of the therapeutic relationship as one of therapist–parent to patient–child or even infant. The “good enough mother” becomes the good enough therapist: “As an early contribution to an emergent relational and developmental perspective, Loewald (1960) likened the analyst’s position to a parental role in that the parent, out of ‘love and respect for the individual and for individual development’ (p.229), helps to foster the child’s growth” (Fosshage, 2007, p.332). Fox (1996) writes: “This view of the analyst at work is similar to an idealized version of parental love” (p.1083); and Hirsch (1994): “Love plays an enormous part in the developmental arrest model, but as described here, it is maternal love to a baby-patient” (p.180). Friedman (2005) identifies a specific component of maternal love that is active in therapy when he says: “Observations of mother-infant interactions have led some theorists ... to suggest that the analyst shares with the patient a kind of interpersonal joy in spontaneous discovery that previously had been an ingredient in maternal love” (p.372).

The model of the therapist-patient relationship as that of parent – in particular mother – and child has implications for what is and is not appropriate in that relationship. As Hirsch (1994) puts it: “In the world of the good-enough mother/analyst, there is little sexuality in either the transference or countertransference” (p.178). According to this

view, on the part of the patient, sexual feelings are “far overshadowed by longings for parental holding,” while the analyst, “in identifying with the patient’s basic needs and fulfilling them, does not tend to feel sexual or romantic” (p.178). Similarly, Little (1977), in speaking of her treatment with Winnicott, during which, as she understood it, she became quite regressed, noted that “sexuality has no meaning here” (p.89).

Love equated with understanding. Another theme in the literature is “the equation of love with understanding” (Friedman, 2005, p.353). However, as Friedman (2005) notes: “One fears that its ambiguity is just what is being traded on when love is equated with understanding: it ensures a safe union of warmth with distance” (p.356). He goes on to say that to think of the therapist’s love as nothing more than understanding is a safe and comfortable position:

The comfortable thesis that, yes, analysts do provide love, but (never fear) it is nothing else than their understanding – this is the ‘hidden attractor’ on which almost all definitions converge, as they progressively refine and sublimate and modify and control the more recognizable forms of love that are being mentioned. After various, specific feelings are discussed, author after author concludes that love is embodied in the analyst’s understanding, which in turn is embodied in interpretation. (p.356)

Understanding, although an important aspect of the therapeutic relationship, falls short of the potentially transformative impact of the kind of love that can be enlivening, disruptive, destabilizing, or inspirational: “Understanding seems a rather bloodless sort of love, and, as we have seen, analysts have now and then bravely ventured to put some juice in it” (Friedman, 2005, p.365). Hoffman (2009) is one writer who hints at the

potential for love to surpass understanding when he says: "The analytic process holds the promise, not only for a special degree and quality of understanding but also for a special degree and quality of love and reciprocal inspiration" (p.635).

Something more than understanding. According to Friedman (2005): "the something more that is meant by love is exactly the opposite of the analyst's desire for intermittency of contact (including vacations), his readiness to terminate, and his unwillingness to proceed without payment" (p.360). What *is* the something more? Friedman, again, says: "Analytic loving is a movement toward the patient" (p.360). Mendelsohn (2007) is another writer who has explored the question of therapists' love for patients beyond the concept of understanding. He says, "Along with its affirming, consoling and inspiring aspects, love can be a disruptive act and experience" (p.219). He alludes to the paradox inherent in the situation of therapy or analysis when he states:

On the one hand, it is a highly structured, ritualized collaboration between colleagues, each with a well-defined and distinct role, who meet together to discuss the patient's problems in living ... At the same time, the patient-therapist collaboration inevitably embodies virtually all the ambiguities and conflicts that arise in ordinary intimate relationships. (p.222)

He says that the "interplay of safety and danger, or containment and expressiveness" (p.224) is what characterizes the therapeutic relationship, which provides "a forum for the experience of different forms of loving connectedness while, at the same time, it functions to contain the passion and disruption that are part of loving" (p.224). When the concept of therapist/patient love begins to expand beyond the safety of understanding,

more therapists become unwilling to discuss it. The reluctance of therapists to engage in a public conversation about the topic of love has been often noted in the literature.

Silence about the Therapist's Loving Feelings for Patients

Many writers have noted the relative absence of discussion in the professional literature on the general topic of the therapist's feelings of love for patients. According to Davies (1994):

Love and passion, the favorite and timeless topics of poets and philosophers, have been subjects assiduously avoided in the psychoanalytic literature of the day.

Especially when such pressures begin to exert their influence on the countertransferential experience of the analyst, we become measured and cautious in our response to patients and in the openness of our dialogue with each other.

(p.154)

Weinstein (2007) agrees, saying, "until the last decade, the role of love in treatment had been largely ignored" (p.304), as does Gerrard (1999), who states, "'love' in our work as psychoanalytical psychotherapists has been much neglected" (p.29).

This silence on the topic of the therapist's feelings of love is in marked contrast with the vast literature on the topic of the patient's feelings for the therapist, often referred to as transference love. For example, Novick and Novick (2000) say, "In contrast to the volumes written about love and sexuality in the patient, there has been ... very little discussion of the analyst's love for the patient" (pp.189-190). And Rabin (2003) points out that "Bergman (1987), in his erudite and extensive treatise on love, explicates the multiple meanings of patients' falling in love with their analyst. Nevertheless, I could not find a single sentence describing the analyst's powerful loving

reactions towards his or her patient” (p.677). Some writers, while noting the lack of public discussion on the topic, group loving and sexual feelings together in the same category. Gabbard (1996), for example, says: “While all analysts must struggle with loving and sexual feelings toward patients, until recently the psychoanalytic literature was ... surprisingly silent on the subject” (p.67). Similarly, Hirsch (1994) writes: “There is relatively sparse psychoanalytic literature focused upon analysts’ sexual, romantic, and otherwise loving feelings toward patients” (p.171); and again: “The analyst’s countertransference feelings of love, particularly sexual love, have been subject to minimal examination in the literature” (p.171).

Other writers distinguish between sexual feelings and loving feelings, emphasizing the sexual ones, but still noting the lack of discussion. Davies is one such author. “The psychoanalytic exploration of the analyst’s erotic countertransference has remained a subject rarely discussed in open collegial dialogue” (1994, p.153), she says; and later: “If psychoanalysis is, as Freud suggests, ‘the impossible profession,’ then the topic of this discussion – ‘the analyst’s sexuality’ – is certainly the ‘impossible topic’ within that impossible profession” (1998, p.747). Mann (1999) points out the taboo nature of the topic, saying: “The veil that has been unconsciously drawn around the erotic transference and countertransference merely draws attention to its fantastical importance. The presence and influence of the erotic are felt by their lack of discussion and draw attention to themselves by being almost unspeakable” (p.3). Gabbard (1996) agrees and also suggests a reason for the taboo:

The paucity of reports in the literature on intense erotic countertransference reactions is undoubtedly related to the reticence of most analysts to expose such

feelings. While a wide range of other countertransference feelings have been shared in clinical reports by analysts of all persuasions, a taboo persists in the area of sexual feelings that is probably related to the incest taboo. (p.92)

According to Gabbard (1994), the veil may be lifting because, "The recent emphasis on transference-countertransference enactments in the analytic setting has resulted in increased openness about the development of such feelings" (p.1083).

Other authors suggest that loving feelings are even more difficult to discuss than sexual ones. Shaw (2003), for example, says:

We have long been free to discuss hating our analysands (Winnicott, 1947) and more recently to discuss having sexual feelings for them, including disclosing such feelings (Davies, 1998). 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. (p.253)

Fox (1996), whose "unobjectionable positive countertransference" connotes a kind of blandly loving attitude, says: "What is perhaps most surprising is that the 'unobjectionable' positive countertransference, the analyst's contribution, is rarely acknowledged openly and has not been the focus of attention and serious study. Even in this era of countertransference expositions, analysts remain reluctant to discuss their positive feelings for their patients" (p.1068). Rabin (2003), after reviewing articles by Davies and others about erotic countertransference, states: "In this context of rich and informative writing about the trials and tribulations of the analyst trying to understand and handle his or her powerful sexual feelings toward the patient, there has been little

attention to our – the analysts' – loving feelings, including falling in love with our patients" (p.677).

Evidently there is a consensus in the professional literature that analysts/therapists have not openly discussed, explored, and examined their own loving feelings towards their patients. As Shaw (2003) put it, "the *analyst's* impassioned connection to her patient became a love that dared not speak its name" (cited in Mendelsohn, 2007, p.228). However, according to McWilliams (2004), "there are signs that the L-word is coming out of the closet" (p.158). Gelso (2014) is not alone in his opinion that, "It is important *not* to avoid the topics of both love and sex as they relate to the patient-therapist relationship. Instead, it is of great importance to address these topics openly and thoughtfully, for they have the potential to greatly benefit, damage, or destroy the treatment relationship" (p.123).

Discomfort with Loving Feelings

Therapists' discomfort about their loving feelings for patients has been frequently noted. As Coen (1994) says: "we still do not easily admit to loving our patients" (p.1131). In fact, "analysts can feel uncomfortable with even more benign caring feelings, not only with intense passion and desire, toward our patients" (Coen, p.1109). Now that the profession has broached the subject, in Friedman's opinion: "It is especially impressive that analysts have been willing to contemplate general loving feelings, considering that the possibility of even random affective reactions made them squirm for many years" (Friedman, 2005, p.350). Discussions of discomfort concerning patient-therapist love have addressed level of professional experience as a factor as well as noting that it appears to be easier for therapists to talk about negative feelings for patients

than loving feelings. Authors have formed a number of theories about what makes love so threatening to discuss, notably vulnerability to loving and wanting to be loved, the tension inherent in feeling but not acting, and the lingering professional ego-ideal of neutrality.

The literature does not document evidence that level of professional experience determines level of comfort with countertransference feelings. It is no surprise that inexperienced clinicians are uncomfortable about the feelings they have towards patients, including love. As Maroda (2013) says: "Many neophyte therapists feel guilty if they are angry or resentful or have strong sexual feelings toward their patients. They know they are gratified not only by a job well done, but by the relationships they have with their patients. They love many of them and feel uncomfortable that they do" (p.182).

Speaking of her own experience as a beginning therapist, she said: "When I felt aroused by a client's expression of sexual interest in me, I felt guilt or even shame. As a young therapist, I'm not sure I knew the difference between feeling the pull to act on my feelings and actually acting on them. So I had to cut them off" (p.211). It is perhaps more surprising, however, that seasoned therapists also appear to feel uneasy about loving their patients. Coen (1994) writes:

Even in the work reported by skilled colleagues, there often tends to be evidence of discomfort with the analyst feeling caring and loving with patients. The analyst may tend to remain distant, critical, and rejecting, or collude with the patient in persistent sadomasochistic struggles ... The function of such behavior by the analyst seems to be to protect against mutual caring between the analytic

couple, when such caring appears to be dangerous and forbidden by the analyst's ego ideal. That is, antagonism and fighting remain safer than loving. (p.1127)

Many authors have noted that negative feelings are more easily addressed than loving feelings. According to Lear (1990):

love has become almost taboo within psychoanalysis. Analysts talk of sex and aggression with ease, but as soon as anyone starts to talk of love, from somewhere there instantly comes the response: But what about aggression? This would be reason enough for love to command our attention. (p.15)

Kernberg (1994) agrees, noting that: "far more has been written about aggressive countertransference than about erotic countertransference. The traditionally phobic attitude toward the countertransference ... still operates with regard to the analyst's erotic response to the erotic transference" (p.1143). Coen (1994), speaking in the context of preparing a paper for presentation at a conference, said, "What do we say about other, more passionate loving feelings, such as romantic and sexual desire? Another editorial reader suggested that even in my writing this paper I was holding back description of my loving feelings for both of my patients, that I was freer to report what I did not like about each patient" (p.1107).

Many reasons have been offered to explain what makes love so difficult to discuss. One is that therapists, like patients, are vulnerable to loving and wanting to be loved – so much so that they actively defend against it at times. As Coen (1994) puts it: "Barriers to love in the analytic setting protect against the varied dangers associated with allowing oneself to be vulnerable to loving and wanting to be loved" (p.1114). Gabbard (1994) goes further, saying: "countertransference love inevitably entails a measure of

torment for the analyst" (p.1102). Mendelsohn (2007) suggests that therapists both wish for and fear passion in the therapeutic relationship, saying:

These forms of expressive participation and self-recognition are most likely to be watered down when the analyst's depressive anxieties are engaged. Although therapists dread remaining isolated and failing to connect with their patients, they fear, as much or more, connecting and making a difference because, when they do, they must grapple with the disruptive and impassioned relatedness they can, and do, engender. (p.233)

Another explanation that has been offered for therapists' discomfort with loving feelings has to do with the tension inherent in feeling but not acting. As Searles (1959) puts it:

the nature of the analytic work presents to the analyst such a peculiarly powerful and conflictual feeling-experience in this regard – a fostering of his deepest love towards the fellow human being with whom he participates in such a prolonged and deeply personal work, and a simultaneous, unceasing, and rigorous taboo against his behavioral expression of any of the erotic or romantic components of this love – as to necessitate almost any analyst's tending to relegate the deepest intensities of these conflictual feelings to his own unconscious. (p.187)

In other words, it is easier to repress deeply loving and romantic feelings than to experience them fully but not to act on them.

A third reason therapists are discomfited by their loving feelings concerns their professional standards. Although most therapists these days are unlikely to embrace the model of the analyst as unfeeling blank slate on which the patient projects their own

experience, it has been suggested by some authors that this model is internalized in the professional psyche. According to Fox (1996): "From the very beginning the analyst's feelings of attraction for the analysand posed problems for the scientific status of psychoanalysis as a treatment modality and investigative tool" (p.1068). He goes on to say:

Our psychoanalytic ego ideal is still strongly influenced by our identification with Freud and his writings on technique. As a result ... the "unobjectionable" countertransference remains a potential source of guilt and shame. Avoidance of the topic helps mask the analyst's unacknowledged and inadequately analyzed motives and "ways of loving." (p.1077)

Coen (1994) puts it more simply, saying: "I contend that our analytic ego ideal tends to encourage restriction and discomfort with our loving feelings for analysands" (p.1107).

Friedman (2005) is another author who attributes discomfort with loving feelings to the model of what the analyst is supposed to be: "The reason for the discomfort is obvious.

The technical model of psychoanalysis is a paradox: the analyst is supposed to be an objective observer, but one whose inner responses are in important ways uncontrolled and freely moved by the patient's impact. Theory seems at once to forbid and require detachment" (p.350).

Coen (1996) suggests that the function of the model is in part defensive when he says: "Therapists' rigid therapeutic ego ideals may seek to protect

them from what they cannot tolerate feeling in themselves. My primary aim in

discussing problems of loving between patient and therapist is to assist clinicians in our

inevitable, interminable struggles to bear in ourselves what seem unbearable" (p.25). The

passage posits the assumption that feelings of love are “unbearable.” Coen goes on to say:

Therapists tend to avoid experiencing the full range of loving and hating feelings between themselves and their patients. They do so because such intense passions make them feel anxious and guilty. Therapists’ ego ideals still hold that therapists are not to feel such passions in the therapeutic setting. (pp.25-26)

These passages suggest that the analytic ego ideal finds some kinds of love more acceptable than others. As Coen (1994) writes: “Do we psychoanalysts similarly advise that the analyst in the analytic setting should *only* feel more modulated, sublimated, ‘purer’ forms of love such as concern, optimism, hope for change, even friendship? And how do we regard respect, admiration, affection, romantic and sexual desire, or ‘loving hate’ (Bollas, 1984-1985)?” (p.1108). Mendelsohn (2007) discusses the conflict such a professional standard poses for therapists:

Acting, reacting, enacting, acting out, interacting, participating, countertransferring, dreaming about one’s patient, crying, touching, or wittingly self-disclosing, demonstrate a failure of optimal analytic restraint. Because all these forms of involvement have *always* occurred, they have tended to be selectively inattended and, to the extent that they have been acknowledged and discussed, they have been imbued with shame, guilt, and the sense that the analyst needs more analysis. In the context of such an understanding of analytic participation, the involvement *between* analyst and patient has been understood primarily as an expression of the patient’s wishes and fantasy-based distortions. (pp.227-228)

Mendelsohn (2007) describes the impact of this rather cerebral professional ego ideal when he writes: "Yet insofar as consciousness and self-awareness are privileged in psychoanalysis, spontaneity and passion are likely to be attenuated and/or regarded with discomfort" (p.229). And Aron (1996) notes: "Ferenczi saw the polite aloofness of the analyst as a form of professional hypocrisy that kept both the patient's criticism of the analyst repressed and the analyst's true feelings toward the patient masked, although nevertheless felt by the patient" (p.163).

In summary, then, many authors have noted that openly talking about loving feelings for patients is threatening. The difficulty is not necessarily related to level of professional experience. Negative feelings such as anger and hatred are more easily discussed than love and tenderness. Authors have speculated that the reasons love is felt to be so difficult or threatening to discuss have to do with vulnerability to loving and wanting to be loved, the tension inherent in the position of feeling but not acting, and the lingering analytic ideal of neutrality.

Ways of Defending against Loving Feelings

Ehrenberg (1992) uses the term "countertransference resistance" to refer to the tendency of therapists to defend themselves against feelings that make them uncomfortable: "Countertransference resistance often arises when awareness of countertransference requires us to face aspects of ourselves and our feelings that may be threatening. In this regard it is interesting to note that positive emotions can be as threatening as negative ones" (p.80). This resistance can assume the form of assorted defensive maneuvers, including obsessional defenses, minimization, and intellectualization; blaming the patient for the therapist's feelings; and using sexual and

aggressive feelings, such as anger, hatred, and criticism, to defend against more vulnerable emotions such as love and tenderness.

For example, Gabbard (1996) argues: “Analysts today often share Freud’s discomfort with powerful feelings of transference love, and ... our excessive focus on distinctions between love in the transference and outside of it may serve as an obsessional defense against our own distress when feelings of love arise in treatment” (p.36). Davies (1998) says: “For a century now, psychoanalysts have contorted themselves, their patients, and their understanding of the psychoanalytic process in an attempt to minimize, disavow, project and pathologize the sexual feelings that emerge between the analytic couple in the course of their emotionally powerful and most intimate encounter with each other” (p.747). Similarly, Rabin (2003) points out the defensive function of using experience–distant terms to discuss the therapeutic relationship: “The use of abstractions and technical terms such as erotic and libidinal instead of experience–near terms such as loving feelings and falling in love defends against the discomfort and anxiety that many of us experience in feeling and/or publicly reporting that we feel deeply loving toward our patients” (p.678). Friedman (2005) suggests that even maternal feelings need taking apart in order to render them more acceptable when he says, “One can see the tendency in current thinking to make analytic love more acceptable by breaking mother love down into behavioral elements, such as mentalization, playful interaction, and the like” (p.372).

Blaming the patient for the analyst’s feelings – for example, through an overreliance on the concept of projective identification as a way of understanding interactions with patients – is another way analysts may protect themselves, as described by Sherby (2009):

Although all these terms speak to the inevitable interaction between the patient and analyst, the focus is usually on the patient as the projector and the analyst as the recipient. One problem that can then arise is a tendency to “blame” the patient for all the analyst’s feelings ... The tendency to blame can become a particular difficulty in the area of countertransference love, when the analyst’s discomfort with her own loving or sexual feelings makes it more likely that she will understand those feelings only as a response to what is projected by the patient. (p.66)

Additionally, authors have noted that sexual and aggressive feelings, including anger, hatred, and criticism, may be employed to defend against more vulnerable feelings such as tenderness and romantic love. For example, Gabbard (1996) states: “sexualization may also defend against feelings of love which are relatively more difficult for many analysts to acknowledge than lustful feelings” (p.91). In particular, Coen (1994) has written about barriers to love in the analytic relationship. Here are a few statements from his writing: “Chronic hatred is safer than the vulnerability and pain of risking loving and wanting to be loved” (p.1129); “how common are ... barriers of angry, critical feelings between the analytic couple as *joint* protection against feelings of love” (p.1113); and “persistent negative, critical feelings between the analytic couple, including sadomasochistic engagement, seek to block access to more intense passion, loving and hating” (p.1129).

Overall, it may be said that the literature presents a variety of ways analysts avoid experiencing loving feelings for patients. These include engaging in obsessional defenses, blaming the patient through an overreliance on conceptualizing

countertransference feelings as resulting from projective identification, and using sexual and aggressive feelings to defend against more vulnerable emotions.

Influences on Therapists' Attitudes towards Loving Feelings

Several factors have been proposed in the literature to account for therapists' discomfort with loving feelings, including the nature of their training, the existing literature, and fear of public censure. Searles (1959) noted the impact of his training on his attitudes towards loving his patients:

[W]ith the first few patients toward whom I found myself having such feelings, I reacted with much anxiety, embarrassment, and guilt. My training had been predominantly such as to make me hold rather suspect any strong feelings on the part of the analyst toward his patient, and these particular emotions seemed to be of an especially illegitimate nature. (p.180)

Searles (1959) also notes the influence of the professional literature on his attitudes, saying: "psycho-analytic literature is, in the main, such as to make one feel more, rather than less, troubled at finding in oneself such feelings toward one's patient" (p.180).

Other authors have written about the fear of public censure concerning therapists' loving and erotic feelings for patients. According to Hirsch (1994):

Romantic and sexual countertransference feelings in particular are indeed a delicate theme, although such feelings in the transference have obviously been absolutely central since the first moments of psychoanalysis. Many analysts informally acknowledge such feelings to their friends and sometimes to their supervisors, yet formal discussion in the literature or at public meetings understandably creates considerable anxiety because of the incest taboo. (p.172)

Coen (1996) writes that when he was preparing to present a paper that included discussion of loving feelings between himself and a patient, a close friend “urged me not to present the paper ... What he objected to was my getting up in public and talking about loving feelings between us!” (pp.15–16). Similarly, Gelso (2014) writes about being discouraged from discussing loving feelings in public:

A few years ago, the first author participated in a round table discussion of factors involved in successful psychotherapy ... [He] brought up the concept of love as one that was rarely addressed but perhaps very important, particularly in longer term psychotherapy. He was quickly cautioned to avoid discussing love in psychotherapy. Because the topic so often seemed to stir thoughts of ethical violations around sex and sexual acting out in psychotherapy, it was best left out of the discussion. (p.123)

Shaw (2003) writes that the public disapproves even of non-erotic loving feelings, saying: “case presentations where feelings of tenderness, affection, and love for an analysand are openly expressed are often greeted with the suspicion that the analyst has ‘acted out’ his narcissistic need to cure by posing as an impossibly perfect parent to a perennially infantilized patient” (p.253). Such attitudes in the professional community discourage therapists from speaking openly. For example, Rabin (2003), in writing about experiences of romantic love for patients, said: “I struggled with what and how much of my own subjectivity I could reveal to the analytic public and still feel comfortable enough with my exposure” (Rabin, 2003, p.678).

Dangers of Love in the Therapeutic Relationship

According to Fosshage (2007), "Discussions about the cocreation and mutual expression of love in the analytic relationship typically evoke concern and anxiety about its dangers. In my view, the dangers are essentially twofold in nature: (a) the analyst's needs for love take priority over the patient's welfare; and (b) the analyst is unavailable for the cocreation of developmentally needed loving experiences" (p.344). One variant of the analyst's needs taking priority is captured in the idea of the "slippery slope," namely that feeling sexual attraction or romantic love will lead to sexual boundary violations, and the sense that there is a certain inevitability to this progression. Davies (1994) states that where loving and sexual feelings are concerned, "Patient and therapist together appear to lose sight of the distinction between thought and action" (p.154). Gabbard is the main proponent of this theory. For example, he says: "Sexual and loving feelings, in particular, are likely to impel us into action ... Such feelings are powerful, immediate, and compelling in their tendency to override the steady reflectiveness of the analyst" (1996, p.67). It is not clear what the evidence is for this assertion and why, for example, there is not a similar concern about therapists' anger leading to violent action toward patients. Gabbard (1994) further says: "longings for love and sexual gratification elicit enactments that occur along a continuum from overt sexual relations between patient and analyst at the one end, to subtle forms of enactment involving partial transference gratifications of a verbal or nonverbal nature within the boundaries of the analytic frame" (p.1085). He seems to imply here that even enactments within the analytic frame are to be avoided, and that it is possible to avoid them. However, he does allow for the therapeutic value of these feelings when he says: "Powerful sexual feelings

towards patients can compel us into action and bring us perilously close to the abyss of unethical transgressions. However, only by tiptoeing on the edge of the abyss can we fully appreciate the internal world of the patient and its impacts on us" (1994, p.1103).

Maroda (1998) points to a possible gender difference in emotional experience and the expression of it in words or actions. She says:

if a man feels strongly about something, he wants to act on that feeling in some way, while women are more content restricting themselves to verbal expression of emotion. As I read this I couldn't help but wonder if this helps to explain why the analytic literature (overwhelmingly dominated by male authors) historically reflects fear of analysts being out of control and acting out if they attempt to self-disclose their countertransference feelings. Could it be that these fears of acting out reflect a gender difference in emotional expression, since women typically violate the boundaries less often than men do, and do not seem to be as concerned about self-disclosure and the slippery slope? (p.80)

Another perspective on the dangers of love focuses on the consequences of therapists' discomfort with loving feelings for patients. These writers converge on one theme, which is that the discomfort can interfere with the therapist's access to a full range of feelings and therefore make them unavailable and put a damper on the patient's experience and the progress of therapy. For example, according to Hoffman (2009), the danger is more that the idea of the "slippery slope" leads therapists to remain too detached. He writes:

put the influence taboo associated with the power of "suggestion" together with the incest taboo and it's a lock that the analyst would stay relatively detached. No

matter that the needs that were considered primary were no longer narrowed to the Freudian preoccupations with incestuous desire ... Instead, increasingly in self-psychology and in relational theories ... developmental needs have been recognized that were insufficiently met in childhood and that may be partially, not only understood but also met in some form in the analysis. Despite these revolutionary changes ... we are still haunted by the specter of the “slippery slope” associated with incestuous wishes. So “touching” the patient figuratively, never mind in the literal sense, could be dangerous. (p.618)

Searles (1959) says: “our time-honored horror of such classical countertransference feelings has only served to increase the likelihood of their remaining in the analyst’s *unconscious*” (p.187), where they operate outside of awareness. Tauber (1979) also notes the obstacle presented by the profession’s discomfort with loving feelings: “I have thought for a long time that what blocks us is a profound unease in dealing with love, affection, and tenderness in our work; we have acknowledged the need to deal with anxiety, hate, rage, etc. but we are unclear about and evasive with love, affection, and tenderness” (cited in Mann, 1999, p.18). Decades later, analysts are still struggling with these feelings. Coen (1994) writes: “whatever tends to close off the analyst’s access to all of his feelings, wishes, perceptions, and expectations ... will interfere with [patients’] change and growth” (p.1131). In Shaw’s opinion, discomfort with loving feelings has inhibited the growth not only of individuals but also of the profession as a whole. He writes: “In my view, these suspicions against tenderness in our work have gone beyond their proper safeguarding function and have led instead to the

inhibition of the growth and development of our thinking about analytic love” (Shaw, 2003, p.253).

If there are dangers inherent in loving too intensely, there are also dangers in loving too little, and these have been explored most notably by Mendelsohn, Hoffman, and Ehrenberg. Mendelsohn (2007) considers “how the psychoanalytic situation functions to facilitate, but also inhibit, the intimate, loving connection that develops between analyst and patient” (p.219). In particular, he discusses how an emphasis on self-awareness may interfere with experience:

Historically, along with a privileging of reflective modes of participation and inattention to the analyst's passions and self-regulatory needs, there has been an emphasis on self-awareness. It has been assumed that, with self-monitoring, comes increased control and an enhanced capacity for choice. The idea is that the more we see and know, the more self-directed and less reactive we become. Although in many respects this is unarguable, there are realms of activity in which self-awareness, or even focused reflectiveness, *interferes* with the flow of experience and performance (Wilner, 1998; Levenson, 2001). As examples, athletics, dancing, and lovemaking come to mind ... A certain suspension of self-monitoring can be an important component of talking freely, and of emotional expressiveness. (p.229)

This bias in favor of self-awareness and control can have a deadening effect on the therapeutic process: “This bias, which reflects the fear that things will go too far in analysis, and in life outside the consulting room, often defines the limits and possibilities of therapy more decisively than does the complementary concern, that opportunities for

fuller participation will be missed. We tend to worry more that things will get out of hand than we do that life will not be lived" (p.230). Mendelsohn (2007) goes on to say: "If therapy lacks sufficient deconstructive thrust, we run the risk of engendering relatively denatured, decadent versions of love" (p.230).

Hoffman (2009) puts it even more starkly when he says:

The relationship between playing it safe and taking a risk in the analytic situation can be paradoxical in that the allegedly safe course may entail a danger of settling into something dead or deadening, possibly for years, with nothing short of slow motion tragic consequences, whereas venturing something that seems riskier can hold the promise of creating new possibilities, new vitality, and new hope. (p.619)

He advocates taking emotional risks, and being vulnerable with patients: "So what I am saying we are called upon to do is, in fact, to risk it, to put ourselves on the line in that respect and let ourselves be vulnerable to that degree. We cannot hide anymore" (p.623). Similarly, Ehrenberg (1992) says: "Where analyzing fears, anxieties, detachment, and resistance seem[s] to have no impact, the key to a viable process may be the analyst's willingness to take some kind of affective risk in order to reach the patient" (p.66). These risks include the therapist's willingness to disclose her feelings, be fully and immediately present with the patient, and not to hide behind analytic neutrality.

In conclusion, discussions of the dangers of therapist/patient love converge on two themes. First, the idea of the slippery slope states that loving or sexual feelings increase the risk of sexual boundary violations. Unfortunately concerns about the slippery slope have contributed to therapists' discomfort with loving feelings and a tendency to disavow them. Such disavowal may paradoxically increase the chances of

acting on feelings. The second theme concerns the danger of remaining too detached and emotionally unavailable to patients, which poses the danger of having a deadening effect on the therapy by depriving the patient of an essential, affectively alive and loving connection.

Love as a Normal and Necessary Part of Therapy

In contrast to the many authors who discuss discomfort with loving feelings or the dangers of love, there are those who claim that therapists' love for patients is a common, inevitable, and necessary part of the therapeutic relationship. Fosshage (2007) writes: "Analysts commonly report various experiences of love for their analysands" (p.332). Similarly Celenza (2017) says: "loving our patients and feeling sexually aroused is most certainly part of the psychoanalytic experience and context" (p.157), even if "the love the analyst may have for the patient has been more highly contested and even outright denied, in contrast to the love the analysand may or may not have for the analyst" (p.158). Sonne and Jochai (2014) found that "therapists across disciplines commonly experience romantic and/or sexual feelings (sexual attraction) and thoughts (sexual fantasies) about their patients" (p.192).

Sherby (2009) and others take matters further and argue for the "inevitability of love in the therapeutic setting" (p.66). Schafer (1983) suggests as much when he says: "It is within this mutual construction that personal experience can become possible that will at times transcend in richness and intensity what is ordinarily possible even in the most intimate of daily relationships" (p.292). Similarly Lear (1990) states: "Psychoanalysis is nothing if not a (special) emotional relationship between analyst and analysand" (p.5). According to Hirsch (1994): "mutual two-person enactments are

ubiquitous in psychoanalytic work ... and ... the spectrum of feelings of love [is] common among these” (p.173). Furthermore, he says: “To the extent that love in various forms, as well as lust, is part of everyone’s range of affect, it is difficult to conceive that such feelings are absent in the countertransference” (p.183). Gabbard (1996) implies that analysts love their patients by noting that feeling loved is an experience common among patients: “As any analysand in the process of terminating an effective analysis will tell you, a sense of being loved is an integral component of the analytic process” (p.39).

Others regard love as necessary for healing. Fox (1996) writes: “the analyst’s loving feelings for the analysand ... are not only inevitable but in fact may be essential for the analytic process to unfold. While we should not speak of a ‘cure by love,’ we should be equally cautious of suggesting that there can be an analytic cure without love” (p.1067). According to Shaw (2003): “love can be experienced ... as having greater vitalizing power than hate and fear” (p.273). Similarly, Fosshage (2007) says: “If to give and receive love, keeping in mind its various forms, is central to development and maintenance of vitality, then its emergence in the analytic relationship is hardly surprising and needs to be welcomed, understood, and utilized to foster growth” (p.333). Mendelsohn (2007) also connects love with vitality in saying: “to love more fully and, by extension, to enrich one’s participation in life itself, are among the most central goals of analytic therapy” (p.224). He writes that it is not enough to talk about love: “For love to enter the psychoanalytic setting it must be experienced, not just narrated” (p.225). He also emphasizes the importance of reciprocity in the therapeutic relationship, and by implication the need for self-disclosure on the part of the therapist, by saying:

When this part of the work goes well, an intimate and loving connection is engendered, insofar as the patient comes to be known, warts and all, and the analyst has the thrill and satisfaction of having achieved a special kind of loving acceptance of another person. However, if the therapy goes this far and no farther, if it omits the recognition and detailed exploration of the analyst's participation, the opportunity for a fuller, more reciprocal kind of loving is attenuated. After all, the patient needs to see as well as be seen. (p.231)

In his opinion, "Love, in its consoling, inspiring, and challenging forms, arises from the shared experiences of disruption, persistence, and repair that characterize analytic work. The fuller the involvement of each participant, the more likely will the other be emboldened" (p.233). Weinstein (2007) agrees that love is necessary for healing, saying: "love is a healing force that keeps us all connected to life and to health, and ... this is the critical ingredient of all successful analysis ... Love is the glue that cements the analytic work" (p.306). Finally, Slavin (2007) says: "in order to fully accomplish the task of freeing patients to be able to love more fully and authentically in their real lives, the analytic relationship must be able to contain and embrace both the imprisoning and the liberating potential of love as real possibilities in the analytic engagement" (p.197).

After decades of avoiding the topic of therapists' loving feelings for patients, attitudes are beginning to change. Maroda (2010) attributes this shift in part to changing views of the meaning of patients' loving feelings: "Now we are more willing to consider that erotic or loving interest has as much potential for being a healthy expression of the client's adult capacity for attachment as it does for being defensive or pathological. The therapist's role in creating an erotic or loving relationship has also been recognized"

(pp.205–206). Furthermore: “Now that love and desire are accepted in the therapeutic relationship, curiosity, rather than guilt or shame, has become the order of the day” (p.213). In fact, it has even been said that the absence of loving, erotic, or romantic feelings is problematic. For example, Cole (2007) says: “I remember a useful bit of supervision, from early in my training, the gist of which was, if you *never* imagine yourself in a sexual or romantic situation with every patient at some point in your work together, there is something wrong” (p.355).

The Therapeutic Action of Love in Psychotherapy

The role of the therapist's love in psychotherapy has long been the subject of controversy: “Beginning with Freud (1915) and Ferenczi, a long historical battle has been waged between those who have viewed the emergence of the analyst's love as a countertransferential encumbrance, indicative of a loss of objectivity and neutrality, and those who have emphasized the analyst's love for the patient as central to the therapeutic action” (Fosshage, 2007, p.332). However, one side of the controversy has been emphasized at the expense of the other. As Shaw notes: “Disclaimers and precautions concerning analytic love are ubiquitously emphasized in the literature, while the therapeutic action of analytic love, its power and value, is comparatively undertheorized” (p.254). McWilliams (2004) also notes the scarcity of discussion about the role of love as a therapeutic agent: “Matter-of-fact acknowledgements in the psychoanalytic literature that we love our clients are rare, and even rarer are suggestions that it is our love that is the main therapeutic agent” (p.158).

Authors who have written about the role of the therapist's love in healing the patient have taken a variety of approaches. Some are of the opinion that love is necessary

but not sufficient in the therapeutic relationship. For example, Fox (1996) writes: "The analyst's loving feelings for the patient, as reflected in acceptance and caring, are a necessary precondition for the development of this analytic bond" (p.1077). Similarly, Coen (1996) says: "I do not believe that love between patient and analyst is curative. Rather, it is necessary to facilitate analytic change" (pp.24–25). Others discuss the therapist's love as motivating and mobilizing for the patient. Fine (1971) writes:

The analytic honeymoon is in every sense of the word except the physical a love experience between analyst and patient. The patient not infrequently expresses it in so many words. While the therapist as a rule does not verbalize it, because such verbalization would be misunderstood at this stage, he often has the same strong love feelings for the patient. It is these love feelings, which the patient senses, that provide the drive behind the rapid improvement. (p.48)

Similarly, Rabin (2003) asks: "Could loving feelings, including the extreme of falling in love with one's patient, be significantly associated with encouraging therapeutic change?" (p.689). According to Friedman (2005): "Racker (1968) ... goes further in maintaining, along with Nacht (1962), that the analyst's love is needed not just to inform the analyst, but to motivate the patient" (p.354). Similarly, Natterson (2003) states: "Love is a fundamental creative and propulsive force in therapy" (p.509).

Another perspective on the role of the therapist's love regards it as aiding in development. For example, according to Fosshage (2007): "Fundamental experiences of love – to love and be loved – are central in development and maintenance of vitalized self-experience. Ferenczi was the first of many ... to believe that 'love is as essential to the child's healthy growth as food' (Thompson, 1988, p.187)" (p.330). Shaw (2003) sees

love not only as functioning to heal the patient (and therapist) but also as the main goal of therapy: “At the heart of this endeavor, I believe, for both patient and analyst, is a search for love, for the sense of being lovable, for the remobilization of thwarted capacities to give love and to receive love” (p.252).

Some go so far as to suggest that love is what cures. According to Friedman (2005), Nacht (1962) says that “it is the analyst’s unconscious love that is basically responsible for cure” (p.354). Likewise, “Young-Breuhl and Bethelard (2000) write about the importance of ‘cherishment,’ the sense of being affectionately and personally cared for by a devoted other, in creating the possibility and the will for change. Many psychoanalysts, starting with Freud, have credited love with the major role in therapeutic healing” (McWilliams, 2004, pp.40–41). If love is the major curative factor, “A vital question arises: Why might experiencing our love be so beneficial, even transformative, to patients?” (Rabin, 2003, p.689). Buechler (2019) offers one reason: “As far as I know, being mirrored by loving eyes softens shame, guilt, and humiliation more powerfully than any other force” (p.147). Fosshage (2007) suggests that it is not love alone, but the cycle of rupture and repair, facilitated by love, that is so beneficial:

Experience tells us that a patient and analyst are capable of cocreating deeply loving moments, not that love is always present or in the forefront, as in any relationship. Once these loving moments have emerged, however, the frequency of ruptures gradually diminishes over a period of time. Moreover, reparation of ruptures through understanding and regaining perspective accelerates over time. All of these processes contribute to a deepening sense for both parties of a sustained, reliable loving relationship. (p.339)

Method

Data

The data for this study are semi-structured interviews (McCracken, 1988), each lasting about ninety minutes, conducted in person with eight individuals from May 2018 to June 2019. There were several reasons behind the decision to conduct the interviews in person and to have the interviews be long. First, although some authors have written about their experiences of loving patients, the process of writing about one's experiences for the public record, name attached, is very different from speaking confidentially to another person. For one thing, the writer has more control over the content and many opportunities for self-censoring, and for another, published work is not anonymous. Second, the interviews were long in order to allow the participants to become comfortable enough with the interviewer to be candid in discussing a topic that can be anxiety provoking and exposing. Similarly, the interviews were conducted in person, rather than via telephone or videochat, and in locations where the participants would feel most comfortable, in order to promote a sense of safety and intimacy. Third, the interviews were semi-structured in order to provide some consistency while also allowing room for the participants to say whatever came to mind that might be relevant to the topic. A drawback to structured interviews or questionnaires is that they are too focused or narrow in scope and may therefore exclude relevant information because the interviewer fails to ask about it. Leaving room for participants to take the interview in unexpected directions was in keeping with the exploratory nature of this study and was

presumed to be more likely to elicit what each participant felt was most important and relevant.

Participants

Selection criteria. In order to take part in the study, participants were required to be licensed psychologists, licensed clinical social workers, and/or psychiatrists; to adhere to a psychoanalytic or psychodynamic theoretical orientation in working with patients; and to have been in therapy themselves for at least two consecutive years at some time in their careers. The selection criteria were set with the following factors in mind. First, participants were required to be licensed, as opposed to being students or therapists in training, because by the time of licensure a person has had significant training and experience. Arguably a greater level of experience provides more opportunity for feelings of all kinds, including love, to emerge in the work, as well as greater comfort in speaking about them. Second, the sample was restricted to psychodynamic therapists because discussion of the importance of the therapeutic relationship and emotions experienced in that relationship, including loving feelings, has traditionally been much more associated with psychoanalytic perspectives than other approaches to therapy, and therefore it seemed safe to assume that speaking with such therapists would yield more information about the phenomenon in question. And finally, participants were required to have been in therapy for at least two consecutive years at some time in their careers in order to leave open the possibility of exploring connections between their experiences as patients and as therapists. This proved to be a very modest requirement, as some participants had been in therapy for decades.

Recruitment. Participants were recruited through a process of network or snowball sampling, in which the researcher began by contacting known psychodynamic therapists and asking them for the names of other therapists they would recommend to participate in this study. In addition, an advertisement (Appendix A: Subject Recruitment Protocol) recruiting potential participants was posted on the electronic mailing list of a psychodynamic membership group and also sent to the alumni list of the Rutgers Graduate School of Applied and Professional Psychology. Interested participants contacted the researcher by e-mail, at which point they were provided with more information about the purpose and procedures of the study, had their eligibility for the study confirmed, and were scheduled for an interview. All respondents who met the inclusion criteria were interviewed, with the exception of one person who lived too far away to be interviewed in person and one whose schedule was incompatible with the writer's.

Procedure

Data collection. Interviews took place in person in the New York Metropolitan Area at locations chosen by participants. Participants were asked to choose settings that ensured comfort, privacy, and confidentiality, such as their offices or homes. At the beginning of the interview, participants signed informed consent forms (Appendix B: Informed Consent) and were provided copies for their records. Then the interviewer commenced recording.

Two instruments, a demographic questionnaire (Appendix C) and a semi-structured interview (Appendix D), were used in this study to generate data. Types of demographic data that were collected included age, gender, sexual orientation, ethnicity,

relationship status, years in practice, training, and theoretical orientation. The semi-structured interview protocol included a series of open-ended questions related to 1) the therapist's experiences of love in the therapeutic relationship, 2) the therapist's definition of love in a therapeutic context, 3) the therapist's perception of the impact of these feelings on the therapy, and 4) attitudes towards these feelings in the therapist's training, supervision, personal therapy, and personal history. Each interview lasted about 90 minutes. At the conclusion of each interview, the interviewer thanked the participant and invited him or her to call or email with any further thoughts. Participants appeared to enjoy the interview process and two sent follow-up comments and recommended readings by email. Participants received no remuneration for their services. The study was approved by the Rutgers University Institutional Review Board.

A number of procedures were followed throughout the data collection process to protect the privacy of participants and to safeguard materials. Consent forms and demographic questionnaires completed by participants were stored in a locked file cabinet to which only the interviewer had the key, and separately from transcripts of the interviews. Interviews were recorded using a small, digital recorder that was transported to and from interviews in a locked bank deposit bag, which was also used to store the recorder when it was not in use. The recordings of the interviews were stored on the interviewer's password protected MacBook Air laptop, using a numerical code for each participant rather than name or initials. Recordings were transcribed using Trint, an automated, confidential transcription service. Trint's security practices are certified by the International Organization for Standardization, which sets global standards for information security management systems. Transcripts of the interviews were edited to

remove identifying information before being stored in the above-mentioned password protected laptop using file names with numerical codes.

Data analysis. This is a qualitative exploratory study informed by a grounded theory method. The approach taken here could be described as modified grounded theory, or “grounded theory ‘lite’” (Braun & Clarke, 2006). Generally the purpose of studies conducted using grounded theory is to “move beyond description” and to “generate or discover a theory, an abstract analytical schema of a process” based on “data collected from individuals” (Creswell, 2007, p.63). However, the present study emphasizes exploration and description over explanation.

Grounded theory was developed by the sociologists Glaser and Strauss (1967) and modified by Strauss and Corbin (1990), who approach grounded theory using “systematic, analytic procedures” (Creswell, 2007, p.64). Grounded theory typically asks questions about “what’s going on here” (Richards & Morse, 2013, p.62) and has “gained popularity in fields such as sociology, nursing, education, and psychology” (Creswell, 2007, p.63). Charmaz (2006) and Clarke (2005) have written about a constructivist grounded theory that employs flexible guidelines and postmodern perspectives such as “reflexivity on the part of researchers and repositioning the researcher away from the ‘all knowing analyst’ to the acknowledged participant” (Clarke, 2005, p.xxviii; cited in Creswell, 2007, p.64). For Charmaz, “a grounded theory approach does not minimize the role of the researcher in the process. The researcher makes decisions about the categories throughout the process, brings questions to the data, and advances personal values, experiences, and priorities. Any conclusions developed by grounded theorists are ... suggestive, incomplete, and inconclusive” (Creswell, 2007, p.66).

In grounded theory, data are analyzed using the constant comparative method of qualitative data analysis, a process in which any newly collected data is compared with existing data in an ongoing way until a point of “saturation” is approached. Once the data are collected, they must be made into a usable form, which in this case means transcribing audio recordings of interviews. As mentioned above, the interviews were transcribed using an automated transcription service, Trint, which generated written versions of the recorded interviews. Transcripts varied in fidelity depending on factors such as the speaker's enunciation and rate of speech. The researcher listened to the recordings while reading the transcripts and edited any relevant passages to reproduce more exactly what participants said, a painstaking process requiring many hours in some cases. The process of transcribing the interviews is not neutral but interpretive, as there are many ambiguities in word choice and intended meaning. Furthermore, speech patterns and rhythms suggest but do not determine things like punctuation, which can change the meaning of sentences. For example, “I love her, you know I do,” has a different meaning from, “I love her, you know, I do.”

Grounded theory uses specific procedures for data analysis, consisting of “developing categories of information (open coding), interconnecting the categories (axial coding), building a ‘story’ that connects the categories (selective coding), and ending with a discursive set of theoretical propositions” (Creswell, 2007, p.160). However, this modified grounded theory study follows more the procedure described by Braun and Clarke (2006, p.87) in their article on thematic analysis, which is focused less on generation of theory as a goal. First, the researcher must become familiar with the data by reading and rereading it and noting initial ideas. For example, in this study, it

was noted that contrary to what the literature and anecdotal evidence suggested, clinicians did not find the experience or discussion of love for patients all that anxiety provoking. Features of the interviews that were coded included any examples provided by participants to illustrate what they mean when they talk about love for patients, such as helping an elderly patient drive up an icy driveway. Second, relevant features of the data are coded across the entire data set. Third, codes are collated into potential themes. For example, one theme that emerged in this study is that love for patients is characterized by warmth, caring, and stretching the usual frame of therapy. Fourth, themes are checked in relation to the coded extracts and the entire data set in order to generate a “thematic ‘map’ of the analysis.” Fifth, there is an “ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names for each theme.” And finally, there is the writing of the report, including the “relating back of the analysis to the research question and literature.”

Personal factors. Qualitative approaches to research regard the investigator as the key instrument for data generation and collection (Creswell, 2007, p.38). Researchers are not neutral, and “what we bring to the study ... influences what we can see” (Charmaz, 2014, p. 27). It is therefore important for researchers to cultivate awareness of the way our own experiences and background assumptions can influence the processes of data collection and analysis. In the case of this study, the author and principal investigator is a 58-year-old heterosexual white woman, married and the mother of two young adult children. I identify most closely with relational psychoanalysis, although I integrate aspects of other approaches into my work with many patients, and I intend to

pursue post-graduate training in psychoanalysis. Of particular relevance to this study are the following autobiographical details.

I was an English major in college and worked in publishing for a time before attending graduate school in clinical psychology in early adulthood. One reason for this choice was a common one among future therapists: People found me to be a good listener, and I wanted to develop my natural talent for listening into a capacity for helping others heal. During graduate school earlier in life, I had my first experience of therapy, and although it was helpful in some ways, in crucial respects I did not get what I needed. Looking back on it now, I would say that part of what was missing was feeling loved by my therapist, who was insightful and well-intentioned and doubtless cared about me. After the birth of my first child, several years into my graduate education, my heart was no longer in the work, and I left school, had another child, and devoted myself fully to family life.

While I cherish the time I spent with my children, throughout the years I was plagued by a sense of inadequacy and incompleteness. Facing the prospect of my younger child leaving home, and feeling depressed, confused, and unable to decide what to do with the rest of my life, I returned to therapy in search of help. What I found was a healing relationship. It was clear to me that love informed my relationship with my therapist and played an important role in healing. Among other things, the therapy revived my aspirations to become a therapist, and gave me the courage to start again from the beginning.

As I gained experience in providing therapy during my second time in graduate school, I found that I loved many of my patients, and I believe that love helped the

process of healing. And while it would be naïve to suggest that it is love that cures, I think it would be equally naïve to ignore the potential therapeutic effects of love. As previously stated in the introduction, it was these experiences in therapy as a patient as well as a therapist, in combination with my perception of what was missing from discussions of therapy in graduate school classes and supervision groups, that led me to investigate the topic of the therapist's experience of love for patients.

Results

Participants

There were eight participants in the study. Seven of the eight were licensed psychologists and one was a licensed clinical social worker. Four of the participants were male and four were female, ranging in age from 52 to 78, with a mean age of 68.5. Six of the eight identified as heterosexual, one as bisexual, and one as lesbian. Five of the eight were in their first marriages, which had lasted between 20 and 50 years. Two of the eight were divorced and remarried, and one was divorced and single. All identified as white and half as Jewish. Participants had between 14 and 46 years of clinical experience post licensure, with an average of 29 years. Not all were currently engaged in therapy themselves, but each far exceeded the inclusion criterion of having had two years of continuous therapy, with two participants having been in therapy for more than 30 years. Potential impact of lack of diversity in the sample will be addressed in the discussion section.

In the excerpts from interviews that are included here, the author made a number of editorial decisions in the interest of transforming speech into something readable. Speech includes many pauses, verbal tics (such as, “you know”), repetitions, and so forth which, when transcribed exactly onto the page, make for difficult reading. Because the study does not address speech patterns, in transcribing the participants’ contributions, I have chosen to sacrifice some fidelity in favor of concision and clarity, while remaining as close as possible to the style of each participant’s speech. Square brackets are used to editorialize where the meaning of a sentence is unclear and to interpolate the interviewer’s questions. In many cases, verbal habits such as “like” are omitted without

any indication. Other omissions are indicated through the use of ellipses, which are used solely for this purpose and not to indicate hesitation or a pause. Reported speech is distinguished by quotation marks only where they are essential to make clear the speaker's meaning. Another editorial decision concerned the length of the passages cited. One complaint about qualitative studies is that excerpts from interviews often fail to include enough surrounding context. In this study, the author aimed to address that problem by including more, rather than less.

A brief description of each participant follows, provided in the order in which the interviews were conducted. The names of the participants have been changed as well as any other information that could be used to identify them. Pseudonyms were assigned based on names that were popular in the United States during the year of each participant's birth.

1) "David" is a 59-year-old heterosexual man, who is married and a parent. He is a licensed psychologist who has completed postdoctoral training at an analytic institute. He identifies most closely with relational psychoanalysis, object-relations theory, and self-psychology.

2) "James" is a 76-year-old heterosexual man, who is married and a parent and grandparent. He is a licensed psychologist who has completed postdoctoral training at a psychoanalytic institute. He identifies most closely with existential psychoanalysis, relational psychoanalysis, object-relations theory, and ego psychology.

3) "Michael" is a 69-year-old bisexual man, who is married and a parent. He is a licensed psychologist who has completed postdoctoral training in both family therapy and

psychoanalysis. He identifies most closely with family systems, ego psychology, object relations theory, and self-psychology.

4) "Linda" is a 64-year-old lesbian woman, who is married and a parent and grandparent. She is a licensed psychologist who has completed postdoctoral training at a psychoanalytic institute. She identifies most closely with relational psychoanalysis, object relations theory, self-psychology, and ego psychology.

5) "Mary" is a 78-year-old heterosexual woman, who is single and a parent. She is a licensed psychologist who is in training at a psychoanalytic institute. She identifies most closely with relational psychoanalysis, attachment theory, and trauma theory.

6) "Robert" is a 74-year-old heterosexual man, who is married and a parent and grandparent. He is a licensed psychologist who has completed postdoctoral training at a psychoanalytic institute. He currently identifies most closely with relational psychoanalysis, although he originally identified with more traditional Freudian approaches, which then evolved.

7) "Lisa" is a 52-year-old heterosexual woman, who is married and a parent. She is a licensed clinical social worker who is in training at a psychoanalytic institute. She identifies most closely with object-relations theory, especially the work of Winnicott, and relational psychoanalysis.

8) "Susan" is a 76-year-old heterosexual woman, who is married and a parent. She is a licensed psychologist. She considers herself to be eclectic but identifies with interpersonal psychoanalysis.

The Nature of Loving Feelings that Therapists Experience towards Patients

Love is a complex emotion that resists definition. Attempts to define it feel reductive, as if in the act of pinning it down, something essential is lost. It seems that love has a whole family of overlapping meanings, as suggested by the responses of participants in this study. When asked to talk about therapist–patient love, each participant emphasized a different aspect of the experience; however, there were also commonalities across all participants and among them. The researcher identified the following themes in the interviews conducted for this study: Parental and erotic love were prominent among the varieties of love experienced for patients. Love in the context of therapy was often characterized by warmth, care, and stretching the frame. The love of therapists for patients is deepened by having survived struggle and even hatred together as well as by the passage of time. Love for patients is characterized by careful listening and the dedication that goes with it. And love for patients is at times akin to spiritual love.

Parental love. Every participant is a parent, and each one described feeling something like parental love for patients. The patients who elicited the most intense parental responses were alike in having experienced extreme abuse or neglect at the hands of their parents. For example, in talking about a patient he has worked with for 17 years, who suffered horrible abuse at the hands of her father, David said, “I love her. I think it’s mostly like a father. I feel like I’m her father.” The patient has a diagnosis of dissociative identity disorder, and one of her alter identities was a six-year-old child. In a quasi-parental, spontaneous, and loving gesture, David once asked her if she would like

to play a game and engaged her in playing the children's board game, Candyland, which he happened to have in his office.

A quality of parental love is helping the child or patient progress through stages of development, as can be seen in the next excerpt. David continues to speak about the same patient:

One of the things I love about her is that she's gotten better. It sure feels good to actually help someone because sometimes we don't feel that. So, for instance, she may not have been able to have a relationship, but when I first started working with her, she was living with roommates, and it was not going so well. One of her presenting problems in coming to me was that she felt like her friends were abandoning her ... She has a really great circle of friends now.

David went on to describe, with obvious pride and pleasure, how the patient also went back to school, got a much better job, moved up the career ladder, and improved her living situation.

Another example of parental love was provided by Linda, who talked about a patient she has seen for more than 20 years:

She was about 22 when she came to see me and is 45 now. Has never been able to establish a long-standing romantic relationship with anybody, although she very much wanted to be married to somebody she loved and to have children. And so it's been very painful over the course of the time we've known each other for her to appreciate the ways in which her psychological troubles really made it impossible for her to trust anybody that much ... from her own perspective, not ever having been loved by her mother, the fact that she felt that she'd been hated.

And learning more history about the family I came to believe, too, that the mom has certainly pockets of psychosis if she's not schizophrenic all the time. And this child's medical problems required so much worry and focus from her that she wanted the child to reward her by becoming the child she wanted it to be ... And the father, his primary attention was to the mother, so anything that made the mother unhappy made him unhappy. And so it's like I started to lactate, frankly, just like, oh you poor baby, you, here let me hold you.

The patient's medical problems were related to Linda's area of expertise, which also may have predisposed her to love this patient.

Similarly, Susan described maternal loving feelings for a patient who had been abused by a parent. The patient was also in a field that interested her, and she seemed to have deep admiration for him as well:

He was then a graduate student at [a university in the Northeast] and came into therapy because he was stuck on his dissertation and couldn't move forward. He was just lovely, interesting ... But as we started to work it became clear that he had been abused by his father ... He had never talked about that. Nobody else knew about it. So the trust was so key for me that somebody would take those kinds of risks and let me know them in that way. He was also just lovely and fascinating and smart and in a different field, in a field I'm interested in, and he would talk about it, and I knew who his professors were, and they were very famous, and he was one of the star students. So it was fun that way, intellectually very stimulating. And the age difference was just enough – I'd just had a child – that I could think of him as an older son and I did. I mean that was my feeling

toward him, he was an older son ... My grandiose fantasy could be that I could be a better parent to him. So every now and then he is in touch with me. It's such a treat. It's just blossomed. It's wonderful. It's very exciting. So he was my first experience of loving somebody [a patient].

Erotic and romantic feelings. All but one participant reported experiencing erotic and/or romantic feelings toward patients, but in contrast to parental love, which tended to be more enduring and ever present, erotic feelings were typically more fleeting. Arguably erotic feelings are distinct from loving feelings, but as they are not only discussed together in the literature but often conflated, they are included here. Overall, participants reported feeling unthreatened by these feelings, which were contained by the contexts of therapy or supervision. They noted the usefulness of such feelings as indications of what the patient might be experiencing, and the danger inherent in closing them off and not speaking about them.

Michael said, "Romantically, you know, I did have, was I physically attracted to my clients? I would say some more than others, and that's male and female, and that usually was momentary." James highlighted the ordinariness of sexual attraction, saying:

I just take it all in stride. There's some sexual feelings involved. I just take it all in stride ... There's something artificial about calling every hint of a sexual feeling that you're having toward a patient, calling it countertransference or calling it an erotic countertransference. Because as we go through life we find lots of people that we might have a fleeting sexual feeling about or a sexual fantasy or whatever. And that's just life ... So I just take it as simply part of living. You just simply

don't act. You don't make a big deal out of every little fleeting sexual fantasy or feeling you have.

For the most part, participants did not report feeling threatened by erotic or romantic feelings, either their own or the patient's. Speaking of erotic transference and countertransference, Linda said:

I think what's dangerous about erotic transference is if it can't be talked about, if it can't be experienced in a sort of appreciative but boundaried way. So, yeah, I've had patients be attracted to me, and although I haven't been attracted to them or at least hadn't thought about being attracted to them until they conveyed this, I sort of appreciated the gift it is when somebody falls in love with you. And my sense is that I want to be very gentle. And I liked Jody Davies' line about, it's not bad love it's just impossible love. That's the kind of framework I work from. So there's a poignancy in it.

Linda also spoke about the usefulness of her own erotic responses to patients:

You know I think the more ways in which you can be kind of tuned in to who somebody is and understand how they might be perceived in the world, I mean I've had sexual feelings towards a client that made me realize how seductive this person is in other places in their life. I've also had those feelings tell me what it is about this person that reminds me of somebody in my life I loved from afar or loved and did not have that love reciprocated. So I think there's all kinds of information that you can gain from that experience that I found useful.

In the context of talking about working with couples on the sexual aspects of relationships, she said, "You really need to be aware of what it is that turns somebody on

in the situation. And part of the way I know that I'm hitting pay dirt is when I start to feel turned on myself." She has done workshops about working with couples on sexuality and has picked up on the tendency of some therapists to shy away from the topic: "I think people were listening politely but I think they were sort of horrified by the idea that we would willingly pursue access to erotic feelings that matched our patients'." Nonetheless, she affirmed her belief in the usefulness and safety of her own erotic responses by saying, "I firmly believe that it's an important piece of information. And I will tell you that I've never had a sexual indiscretion. I never acted out on any of this."

David reflected on the change in his comfort level with his erotic feelings for patients over the course of his career, as well as the role of supervision in helping him to contain these feelings:

I struggled probably initially. One of the other persons that I'm just thinking about now was drop dead gorgeous. And I did worry about a slippery slope. But [my supervisor] helped me with that [laughs] ... He reminded me that she was young enough to be my daughter and that I may see her in a maybe sexual way but she probably doesn't, maybe she did, although she had some erotic dreams about me, and so that was like, whoa, that's right. She is 25 years younger than me. I have to remember that. Then also he normalized it by [reminding me that] this is just like any other feeling. And that's all grist for the mill, par for the course. But I think now I feel much more comfortable in my own skin with these feelings and not in danger of acting on them, so that's freeing really.

Lisa also talked about the importance of supervision in providing a place to process anxiety about erotic feelings or fantasies and a way of containing it:

There was one point. It was summertime, and she was wearing a shirt that was kind of low cut. And she has a mole on her chest ... And because of the shirt I could see the mole which I had never seen before and I could also see the fade of a tan you know different necklines in the sun. And I had this hallucination about taking her nipple in my mouth. And I was like, oh my god. That actually worried me. What is this? And I went to see my supervisor ... and he said [mimes holding phone to mouth], "Police?" [laughs].

Two participants noted that they felt more destabilized by erotic feelings at times when they were feeling otherwise lonely or vulnerable. Robert discussed an interaction with a patient he loves in which he came close to "making something different happen":

She came to me ... in 1980, and I still see her, 39 years. And I certainly know she loves me, and she knows I love her. [Interviewer: How do you know?] ... I was in a different office ... and she was looking for a studio ... and there's an attic office, and she -- among other things she's an artist -- and she was looking for a studio, and at just that point, the tenant who was in the studio abandoned it. And I said, not thinking, "There's a studio here. You want to see it?" And I took her. And as we were walking up the stairs I thought to myself, what the hell? Are you nuts? ... Oh, she loved it. And then the next week I came back and said, "So do you want to talk about what just happened?" We talked about, I mean we didn't say I love you, and I love you. But it was clear. You were on the verge of making something different happen. And that is, I forget the author now ... but his statement is, love is not salvation. She wasn't going to get cured because I loved her, but because we do the work. So it almost got said directly but pretty

much she would know that. [Interviewer: What do you think made you do it?] I loved her and perhaps I was vulnerable for some reason ... I wanted to help, wanted to be her hero.

Linda talked about the struggle to contain feelings when working with a patient who under other circumstances she could imagine as a partner. In this case it was her own therapy rather than supervision that helped her process these feelings. "So I had been single for five or six years at that point. I was feeling lonely." Linda listed qualities she values in a partner and then continued:

And this woman just checked all those boxes with me and I found it very difficult to concentrate with her. So I had to really learn to bracket that material as much as I could. I didn't bring it up with either supervisor because ... I wasn't certain that either of them wouldn't pathologize that in some way, or feel like that was a reason that I needed to end the therapy. I felt like we were doing effective work. It was just for me personally painful ... I started to feel like, wouldn't we be a great couple. And so it was hard not to bring that into the room ... I didn't ever get a sign from her that she was drawn to me in that way, which felt like a relief because I thought at least I'm not behaving in a seductive way. But it was also a little painful too. I was turned on by her, so I think I had to work through that stuff in analysis, rather than supervision.

Of course, it is somewhat reductive to put love in distinct categories. Lisa described a patient for whom she had maternal and also erotic feelings, and she discussed how she used those feelings to understand what might be happening for the patient:

Well there are some people that I really love. One person ... came in when he was 19 ... and I really loved him like a mother, and some erotic feelings also got stirred up ... He was quite skittish and I was really aware that if I were ... too admiring of him, if too much of this affection came out he would feel smothered. So I tried very hard to contain it. And I think I probably did an okay job with that and I probably was right because he did finish college. He did stop smoking so much marijuana ... So he did then towards the end of college get into a physical relationship with a woman, a young woman, and he would talk, he was wracked with angst that he would never have a relationship ... And I think my erotic feelings were an indication that he was getting to that. I remember one time, he was a big boy and not terribly attractive to me, he was wearing shorts and he's hairy and is fat, and I remember looking at his knees and wanting to caress them and I was like, oh dear, what is this? And I knew for sure that I didn't want to caress his knees and that I should not caress his knees and that those feelings were not about wanting really to do it. And at some point in the relationship I thought, I should just sleep with him. I should just fuck him. That was not scary to me either. I knew that's not what was going to happen. I knew I really didn't want to do it ... From the thought to the action ... it was such a long way.

In this example, Lisa seemed to feel completely comfortable with her erotic feelings and able to use them as useful information in the therapy, as well as secure in the knowledge that having the thoughts and feelings would not compel her to act on them.

Love is characterized by warmth, care, and stretching the frame. James emphasized being warm and natural as characteristic of love:

Warm, to me [is] simply that people aren't afraid to be connected, to show that they have an interest and a concern somehow. And I think it all gets conveyed very nonverbally. There's no technique you can use for somebody to know that you really enjoy working with them or that you have some kind of caring spirit.

James shared an anecdote dating back to Freudian days to illustrate his point:

Erick Erickson writes with fondness somewhere about his wife, and his wife was in treatment with one of the early Freudians, Ludwig Jekels. And he recounts with great warmth how one day his wife was leaving a session with Jekels and just happened to notice pretty flowers outside of his house. So Jekels went out there and picked a few flowers and gave her a bouquet. Now that was not done for any technical reason, it wasn't done to show Mrs. Erickson how warm and fuzzy he was. No, it was just simply human. He was a mensch. But that's something that you can't really describe or put it into words. But it's a quality that, if it's there, you know that it's there.

Additionally, James emphasized being natural or relatable as another aspect of love. He raises the issue of how some therapists train their patients not to ask questions that would be perfectly natural to ask in another context: "Even like someone saying, 'So you're going on vacation next week. Where're you going?' But you know, imagine what happens if [the therapist says] 'I can't really tell you that' or anything equivalent to that. Or whether you've already learned that these are questions you don't ask. It just makes things weird and different." Things being "weird and different" translates into distance, which can be viewed as the opposite of love.

James provided another example of the natural responsiveness that is part of love as he understands it. James has a home office with a steep driveway:

I remember once I was working with a Catholic nun and she was out here in the snow, and she was having trouble just getting up the hill, or she might have even said to me, "I'm a little afraid of driving up the hill." So I just say, "get in your driver's seat [*sic*], I'm not afraid, I'll just drive you up the hill." So I just got in and drove her up the hill, got out and walked back down and sent her on her way. Again, it's a no brainer.

David discussed how love involves gestures that stretch the frame of therapy. For example, in the context of his patient with dissociative identity disorder, he said, "One of the moments that I will remember in her treatment is there was an alter who was like five or six years old. And we played Candyland," which he experienced as "something so intimate ... pushing the boundary of what we usually do." Similarly, when asked if they felt loved by their own therapists, and if so what made them feel that way, participants often cited small gestures that had a big emotional impact, such as Lisa's therapist eating "with desire" the cookies she had baked.

Love is deepened by having survived struggle and even hatred together, as well as by the passage of time. Mary reported that having survived hatred in the relationship deepened her love for a patient, described in the following passage:

So the complex patients that I have ... we tend to stick to each other. We gravitate and kind of attach Velcro-like on the basis of, with several of them, a combination of intellectual respect slash competition. These have tended to be people who are high functioning in one area at least. Really high functioning. And there is one

that I've been working with for five years now ... who comes in very defensive and superior ... and for years was denigrating and like, your office is messy, I like a neat office ... What I hope is due to me is that in the last couple of years she's stopped baiting me ... She really says how much she needs to come. And that acknowledgment of dependency is so important, right? I mean that was a big turning point for me. So you know your topic is love, and ... when you mentioned it in your initial write-up ... I thought of her right away ... I really do love this woman ... I know I love her. And it's the kind of love that is immensely complicated, it's immensely complicated by hate, fear, anxiety, and rage ... I think if I didn't feel identified and compassionate towards her I wouldn't have been able to stand it ... I was so attached to her that, probably in the last two or three years I have been able to put the word love to it but that's what it was all along. Susan connected the passage of time with the deepening of love in the relationship. She said:

I think love takes a while. That kind of intimate depth, trust, history, risk-taking, and going through a whole bunch of life circumstances while you're working together. Someone comes to mind who I treated a while ago whose husband has very serious cancer. She came to talk to me about something. She texts me periodically about how he's doing, and I would say I care deeply for her but I'm not sure it is love.

In the context of love deepening over time, she raised the question of whether love and care are on the same continuum or are different things:

I'd have to think about this, whether it's on a continuum or whether it's more multi-dimensional. With love, for me, trust, intimacy, unconditional positive regard – all that, but there's shared life experience that seems really important. As I'm listening to myself talk about it, going from caring to love feels like more depth of sharing life experiences, crises, risk-taking. So I'm not sure whether that's just more of something or something different. I haven't thought about that, but I probably will, because I did think about the distinction, and I particularly thought about this person whose husband is sick, so I care about her, versus this other person who I would say I love her.

Although love includes the element of care, it is more than care. Susan described the distinction between love and care this way:

There's a commitment level maybe that's different than with people I care about. [With someone I care about, when they leave therapy I might feel] that was a wonderful piece of work, and I'm so glad we did that, and they can leave and there's a sadness but it's not like this huge sense of loss. But I think with a person where I would say I love the person, the loss would be very different. You integrate them into who you are so they become a part of you.

Linda described the love that comes from having spent so many years together and knowing each other so well, which can sometimes be uncomfortable:

The [university] directory included where you'd gone to college and your marital status and the number of kids you had and she found this. And so she's known about my kids and it's kind of uncanny ways of perceiving that I'd become a grandmother. My daughter lives in the neighborhood now, and she was driving

up the street and my daughter ran by with her baby in a racing stroller. So she saw them run by and she was able to recognize me in my daughter ... Talked about it as a source, I know you're gonna think this is a fantasy, but this is how it seemed to me. And I did not confirm for her that this was my daughter but I thought, oh man! ... It is I think possible for her to read the slightest alteration in my attention. She often picks up that I'm feeling, if I'm feeling ill. She occasionally picked it up before I knew. She's like one of those trained service animals. [Interviewer: And how are you with that?] I feel invaded, you know, I don't like it. I know I have to decide whether I'm going to acknowledge that something is going on, and generally if I think that's the case, I do. But if I've had a fight with [my wife] for example and I'm still brewing about it when she comes for her session, I don't especially want to talk about the circumstances. I'll say, in that case, "You're right, I'm distracted. What is that bringing up for you?" You know, we can work through it that way. But there's a part of me that's just feeling irritated that we have to do that.

Love is characterized by careful listening and the dedication that goes with it, including an attitude of creating safety and respect. Most participants spoke about careful listening and setting aside one's own needs as characteristic of love. Michael said:

It's central, absolutely central. You know what, love is the cure. And love is something you feel deeply. And the behaviors that go along with that are careful listening, setting yourself aside to understand the other person. I don't mean

setting yourself aside completely, but in a transference way not getting into your transference with the other person. Working that out with your supervisor.

Robert put it this way: "I would say it's feeling desirous of letting that person have precedence, giving over." And James suggested that "loving patients in a generic way" means "giving people the space to talk about themselves."

Robert emphasized safety, saying, "You know I was thinking about it before you came in and really my bottom line is, to have safety, providing safety. And say whatever you need to say. Talk about whatever you want to talk about. And feel that you're not going to be punished, criticized, any of those things. If we can provide someone with that environment, we've done our job."

Susan captured many aspects of love in talking about one of her long-term patients. Safety and respect, the way love deepens over time, and the growth of love as the result of going through life experiences together – all are suggested in the following excerpt:

You know I didn't think about the origin. How did that get started. Probably, kind of thinking that she's a gay woman who was totally closeted, in a loving relationship with a woman. But they were totally closeted, both professionals. I think both concerned that they would be at risk, but she didn't tell me that. And I'm listening to her and said, "Gee, are you and so 'n' so partners?" And she was taken aback. So step one I think for me was that she trusted me with something that she was so afraid to be open about with anybody else. That was the start maybe for me and probably for her. Then she had an abuse history. Her brother sexually abused her. And that was very hard work and the risks that she took to

open up to me, that also I think made me feel closer and so valued that she would trust me that much, because again that's something she has never discussed except with her partner. And she only discussed it with her partner after we had done some work. She did come out to her mother, maybe a few years into our work, and her mother called me and thanked me. And she was quite surprised at how well it went. She never expected to be accepted. So you know there were these wonderful life things and then there was the terrible life thing. Her partner got a cancer ... and she lived to six years post first diagnosis ... So her partner came in, so I knew them as a couple. That was another level. And ... her father had Alzheimer's. That was another tragedy. So you know all of these life experiences that she shared with me. And I felt that I was supportive and helpful and helped her get through, and then when her partner died – oh my gosh, 41 years they were together. And the only woman she had ever been with. The only sexual partner she ever had and the only person she had ever loved in that way. So she was desperate, and said things like she would want to join her. I didn't think that she was a suicide risk but she was so, so unhappy. And over these six years post I've seen her on and off. She's happy again. You know, she has a life, she feels fulfilled. She's even considering the possibility of meeting someone else, which is a really big deal. So you know we shared so much. It's so intimate. And there's so much trust involved and so many life, you know, highs and lows.

Love for patients is akin to spiritual love. Two participants described love in spiritual terms. For example, Michael said, “My overall feeling toward my clients was profound respect, love in the sense of unconditional acceptance. Awe. I think there’s a

certain kind of love involved when people are in awe of God. Awe, this same kind of feeling about how my clients lived through their lives, I was like, oh, God.” McWilliams (2004) includes the sense of awe as part of a “psychoanalytic sensibility,” saying: “The sense of awe is usually associated with religious themes, with the numinous realm, the place of the spirit. It is intrinsically connected with humility... It is receptive, open to being moved. It bears witness” (p.32). James also described therapy in terms that are usually associated with spirituality:

[Therapy] is a sacred space ... because a person is entrusting you with their life.

And you don't really know what direction therapy will go in. You don't even know when they come to you where they've come from. You will learn more over the course of years where they have walked. So the fact that that space exists and you exist within that space, you exist for them. They don't exist for you at all.

You exist for them. That makes it also kind of sacred and special too ... It's sacred because it belongs to him. It's his time and he won't find any place else on earth, a place where 45 minutes is all yours, all yours. That's what makes it very sacred.

Therapists' Attitudes towards Loving Feelings

Participants in the study reported that while they themselves were not uneasy about the topic of love for patients, they could understand why others might be. Their understanding of why the topic elicits anxiety had to do with fear of boundary violations and vulnerability. Participants consistently reported that their own therapy had the biggest impact on their development as therapists, as well as their attitudes about loving feelings for patients. Seven out of eight participants reported loving and feeling loved by

their own therapists. Supervision and private life were also explored as possible influences on participants' attitudes towards loving feelings.

Understanding of why the topic elicits anxiety. David cited fear of boundary violations as well as fear of intimacy among the reasons why therapists might be nervous about having loving feelings towards patients: "I think they're afraid of the slippery slope. They're afraid of their own impulses. They're afraid of breaking some rule ... So I think ... there's this feeling, like, you're just not supposed to do that. But I think it's ... also maybe just a general fear of intimacy." Similarly Robert said: "My guess is they're afraid of crossing the boundary, that they can feel a place inside that would be willing to cross the boundary." Michael notes that it is easier to talk about anger and hate than love. In reflecting on his training, he said:

As I'm thinking back on it, people talked mainly about anger. And love. And more about anger ... than love ... It's scary to talk about love. It's not scary to talk about hate. It's not scary to talk about anger. [Interviewer: What makes it scary?] For me it goes back to Catholic school ... Love, any kind of love, comes with sensual feelings, not necessarily sexual ... Love is fine ... as long as there was nothing sexual or sensual.

Many find it not so scary. Although the literature and anecdotal evidence suggested that love for patients is an anxiety-provoking topic, participants in this study did not feel that way. When asked what he thought when he first learned of this project, James said, "My mind automatically said, that's cool, I'm eager for this 'cause she's right on target with wanting to study that ... It's natural. Like a chance to talk about something that is very natural and should be talked about." He further expressed his opinion about

his colleagues: “I don’t know anybody that I consider a close colleague ... – I don’t know of anybody – that would freak out. They would just frankly say I really enjoy that referral you sent me. I mean that’s just the way we talk.” Similarly, Michael said:

I think love is central to good relationships, and therapy is a model for good relationships, and love is a central factor in allowing both the therapist and the client, you know, to work together and to grow together ... I haven’t seen much about it, and what I have seen it’s always about the boundary breaking, but nothing about the positive aspects ... the centrality of love.

Linda alluded to the sustaining function of love in saying:

I think it’s an aspect of what happens in psychoanalysis that people don’t talk about. They talk about it as a kind of inhibiting or dangerous part of countertransference. And it certainly can be. But I don’t think it has to be. And there needs to be some love in analysis to help fuel each other through that long, difficult process.

Ways that love in therapy differs from love in other relationships.

Participants who distinguished between love in therapy and love in “real life” talked about the capacity for delight and the circumscribed nature of therapeutic love. For example, Mary said:

I look at love as such a complicated thing. The love within a boundaried relationship such as therapy or supervision ... is a different animal from the intimacy of real-world relationships that are not bounded, that are much more risky. I see why writers would refer to the therapy room as a kind of lab or microcosm or specialized environment that hopefully gives us the courage to try

to take our discoveries into real-world relationships. So as I think about myself then, I would have to say that my working on my relationship with my former supervisor as the boundaries have been relaxed and softened and sort of gone away has been my first exercise in allowing a mutually penetrative experience and not be afraid of it, but to be open to being delighted by it. So that openness to being delighted by being with another person is a part of love that I don't know that I can identify in my patient world.

Robert discussed the circumscribed nature of love in the therapeutic relationship.

He said:

It's a real feeling, and in that sense is real. But does it touch as many parts of us, as many parts of our lives? No, obviously. It's in this special place, and that's what makes it so wonderful is this special place where we could love each other and not have all the other baggage that goes with it, an expectation and all that other stuff. It's circumscribed, within limits. And even, I'm thinking even real love has limits, but these are more circumscribed, known and agreed upon. And it speaks to what the patient needs, and we need to put the patient's needs first to be able to have this kind of love.

Thus the love in this relationship is enhanced but also diminished by the special circumstance, to which both parties have signed up.

Factors that Influence Therapists' Attitudes towards Love

This study explored the participants' relationships with their own therapists, supervisory relationships, and private life as influences on their attitudes towards loving patients. Most participants reported loving and feeling loved by their own therapists.

Many also reported feeling safe in supervision to discuss such feelings. And some discussed the benefit of having satisfying intimate relationships in their private lives.

Most participants reported loving and feeling loved by their own therapists.

James, who drove his patient's car up his steep, snow-covered driveway, also used a car-related example to illustrate what made him feel loved by his own therapist:

Yeah, I felt loved ... I remember one time I came out of a session and the battery of my car was dead. So my analyst said, "Here's the car keys," and "You go out and jumpstart it from my car." Which I did and then somehow I brought it back either to his receptionist or left his car keys somewhere. But you know it was ... no big deal. You could sense with him, it wasn't, oh my god am I supposed to do this, or should I let him just call AAA. No I had jumper cables so I just said hey, I could jump it from your car. Easy easy easy.

Michael, who described love as involving careful listening, said he knows his own therapist loves him because:

He listens. He listens to the point that he knows me very very deeply. And I never feel judgment. Although I do feel, he says to me, "Are you going against your own judgment, your own best interests," not "Are you doing something I disagree with." So that listening, that understanding, and talking. Beyond therapy, you know, he's talking about himself, his sons ... you know, like talking father-to-father, talking sports. Also, he really stepped in and said to me, in 2013, "You are really sick. I don't care what your doctors are saying" ... He said to me ... "Why do you continue to work? You know it's doing damage, I can see that it's doing damage" ... I mean that was like, man, you got my back ... He just

clearly said ... “You must listen to what you’ve been telling me ... you’ve been telling me and not listening deeply enough to yourself.” You know, that, to me, was an act of love. “Save yourself,” he was saying. “Save yourself, you’re in trouble here.”

When asked if the topic of love had been openly discussed with his therapist, Michael said:

He has said, “Yes, I do care deeply about you.” He doesn’t say “love,” he says “care deeply.” But I never said to him “Do you love me.” [Interviewer: Yeah. Because you know it already.] I do. I mean even if he says, “care deeply,” it’s okay. Well, I mean that’s his way of saying this, just putting words to all these interactions in this relationship that is filled with mutual love and respect.

Linda also reported feeling loved by both her therapists:

You know I did feel that [my first therapist] loved me but not at the beginning. It took several years before I started to feel that way. And I think it took her saying ... “Why would I not love you, after all that I know about you, about the connection that we have here?” So it really challenged me to think, well, why would I be unlovable? But then I did feel it.

In identifying what made her feel loved, Linda recalled admiration, respect, and the therapist’s willingness to make herself more available in times of trouble:

I think she appreciated my intellect and my sense of humor. She admired or respected my mothering of my children and my work as a clinician. I felt admiration and acceptance about the parts of me that I felt shitty about. She really countered a lot of my most negative self-images. And there were times when she

took a great deal of care with me. Like when the relationship with [romantic partner] broke up, I saw her four days a week for a while, at her offer. Because I couldn't hold on to a connection for longer than a day. So I felt like she was attuned to me.

Mary did not expect her early therapists to love her and was taken by surprise when confronted by evidence of caring:

A married couple were my first people that I saw and I first saw him and then her and then I left after a while and went away. And then I just happened to call her up and listened to her berate me because I had left her hanging ... I didn't realize that she cared about me ... It was done in a not vindictive way but very matter of fact: "Where have you been lady?" Kind of informing me that I mattered to her. And ... it had never dawned on me that I would matter to her and it blew me away ... Me as a patient recognizing that a therapist really cared about me and I didn't experience it as [long pause] well I did. It felt like a parental love and became, that just became part of my world-view about therapy. It left me puzzled. I didn't think I was a lovable person but it certainly opened my eyes that I had been quite blind to somebody's experience of me. So, and a relationship that was a two-way relationship that I had assumed was quote professional.

Mary feels loved by her current therapist, and when asked what makes her feel loved, she talked about the way the therapist accepted a gift:

All of the usual analytic boundaries are observed, so it isn't as though I feel loved because someone is breaking boundaries and going out of their way to do things for me. I made a pillow for her that I spent a lot of time on. And because we had

talked about the crafts that I do, and made, I really wanted to make this for her. And it was very beautiful of her ... there was no fake niggling about it, oh that's too much. I mean there was ... I did it, she found it beautiful. She sent me a picture of it in her bedroom ... it almost took my breath away that that picture was in her bedroom. Oh ... that's a little sexual.

Robert, whose definition of love focused on safety, also felt loved by his therapist, because, "He let me hate him. A lot of the treatment was my busting his balls, telling him he dressed funny, and was stupid ... I just ripped the shit out of him. I was my mother to my father. And he let me do that ... And he survived and I love him for that and he didn't make me pay."

Lisa discussed the differences between her three therapists, who were progressively warmer and more relational:

So this first woman was really very absent in the relationship. And it infuriated me, it hurt me deeply. I have difficulty with sadness, so it's often anger. So it infuriated me and it really infuriated me in the same way that I was infuriated with my mother. And you know you can call it transference, but if you're going to talk about the real relationship which was really there it really hurt me ... Her theory got in the way actually of creating a relationship that I could use ... That I couldn't feel her warmth was just impossible for me, so hurtful that I really just couldn't have gone on, and I wouldn't have known how to articulate that to her.

Maybe now I could, but there was just no way then.

Her second therapist was much warmer. "Something at one summer vacation. She shook my hand at the door, to say goodbye, and that was the first time that ... she touched me.

But I think she might have done the double handshake. And I just remember that was such a significant expression of her affection.”

Lisa and her third therapist openly discuss their feelings for each other:

I've been seeing him for five or six years, mostly three times a week. And we do talk about the transference and we do talk about our mutual admiration and we do talk about love as, you know, love in so many words. Yes. And then all along that continuum ... And then love into eroticism. And actually I think something that was very helpful for me, pretty early on, and probably through a dream entered some eroticism. And he said, well of course there's gonna be some eroticism because this is, you know, an intimate relationship ... He can say something like ten paragraphs in ten words ... But he made it okay to also have that, you know, to move over into eroticism ... in the course of our working together. He's had surgery and I've had surgery, both of my parents have died, both of my boys have been Bar Mitzvahed ... There have been stops and starts and concerns and, I'm getting tearful. He's also retiring in June.

Lisa spoke about the experience of bringing her analyst gifts of food that she has made:

I bring in these little gifts. And he never interprets it, he never, he is always eager to eat it ... I remember as a girl buying gifts for my father ... and he would take the gift and he would go, oh very nice. And he would put it aside and that was it. That was it. So when he eats the food and looks at the thing, you know, it is being accepted and admired and adored ... He never interpreted it. He would just eat it with desire. And through his accepting it and enjoying it the meaning emerged without words and without interpretation, which would have been shaming. If he

had said, “Oh I’ll have it but first tell me what does it mean.” Well it’s a fucking cookie ... I’m sure I could have withstood that but this way was just so much gentler and kinder and allowed it to be a lot of things. It could be a cookie and love. And, you know, transference object and mutative and all of these things. It’s also a cookie.

Susan summed up her experience of love in therapy very succinctly, saying, “I thought of him as my emotionally corrective parent, as a part of my family development. He parented me in a way that I really value, and appreciate. So I loved him like a parent.”

The influence of supervision on therapists’ attitudes towards love.

Participants also discussed the importance of supervision in shaping their attitudes towards loving their patients. As in their own therapies, the influence could be positive or negative. James said:

Besides these positive experiences, what also had a profound influence was taking classes with some very uptight, rigid analysts and saying, I don’t want to be like that. And some of us even in class who weren’t in treatment with any of these people having the freedom to say, I don’t know how anyone could get better working with them. So I’ve had my positive models but the negative ones I think are equally powerful.

In contrast to the model of how not to be, James also had positive role models:

“Sam” [a pseudonym], who was one of my supervisors early on, Sam was somebody who studied analysis and was a full credentialed analyst but he had also studied under Martin Buber. So he was also very much philosophically in

the I-thou relationship kind of mode with people. So Sam is somebody, too, who you could really engage in an authentic conversation within a supervisory session about anything, anything at all. Sam was just there. So I think Sam also played an important role as somebody who is a full human being ... So I'm very grateful that I had an influence like that as a human being and as a model for doing therapy.

Linda remembered a supervisor who taught her that if she didn't like a patient, then maybe it wasn't a good idea for her to work with them. Also:

Conversely, if you like a patient, to really be open to understanding what that's about for you so you can start to distinguish between the kind of want and acceptance that everybody needs in therapy that I think leads to a conflict-free sort of love, and the kind of love that may be defensive on your part or on the patient's that needs to be examined over the process of the treatment.

Linda said this supervisor provided the experience of "feeling loved in supervision," which was very reminiscent of what made her feel loved in therapy:

I felt that I could say anything to her, and she wasn't going to reprimand me ...

And this is part of what I think the love was, that I felt from her, is that I always felt like she had respect for my efforts. She saw that I had the eyes and talent for doing this and acknowledged that this gave me advantages in the work that I was doing and she expressed her appreciation that I was so willing to talk about my countertransference towards my patients, because it just added a level of transparency to the work that made it much easier for her to supervise me.

The same supervisor provided a safe space to talk about love for patients. The supervisor “had had experiences of her own and was able to really empathize with how hard it is to keep your eye on the ball when there is part of you that wants to go sit in someone’s lap or breastfeed them or have sex with them, all those kinds of desires for a merged experience.” And now Linda, as a supervisor herself, helps her own supervisees understand their loving responses to patients:

I very much appreciate it when a supervisee is able to describe their feelings as love, whether it’s erotic or not erotic. Sometimes it’s even filial. It reminds me of my elder brother. So, you know, I think [I’ve] described how I work with people who are close to or have crossed that line, [which] is with alarm about the effect that this is going to have on the patient. But when people have a non-erotic love towards the patient, I encourage them to explore that for everything it’s worth. Certainly if they are in therapy I want them to explore it there, but I really ask about what that love is like and where they felt that love ... And I look for the parts of it that feel like they’re really fueling the treatment, and I’d point out the positive effects of that. And if there are ways in which it seems like it might be getting in the way, for example the urge to tell a patient to cut off contact with a parent, or to leave a relationship, those are always things I feel you have to proceed very carefully. If you’re feeling that you have a stronger love for this patient than anybody else in their life.

Mary discussed how supervision helped her with her own problems with intimacy:

My background is kind of cut off, emotionally cut off, that sort of stiff upper lip, northern European, don't show your feelings, don't know your feelings, actually don't get curious about your feelings in particular. And so it's been a steep learning curve for me, but I've been lucky enough to have supervisors who really pressed me to engage with them more intimately than – I mean that kind of scared me professionally. But I mean there was nothing ever unprofessional about that. But that sense of closeness, it was so –, so that also helps me to be tuned into what most patients from my ethnic background are dealing with as well. So yes the supervision ... is just very simply beautiful at articulating and helping [me figure] out what's going on between me and the patient in the room and inviting me more and more to be engaged in the room. So I'm still struggling with working with the countertransference.

Relationship of private life to work as a therapist. The relationship of personal and professional life is seldom mentioned in the literature. Participants noted the complicated ways one's private life interconnects with life as a therapist, including whether personal limitations on the capacity to love limit one's ability to experience love for patients. According to James, having a satisfying intimate relationship is essential to being an effective therapist because,

It does get you used to intimacy and a quiet kind of comfort in intimacy of the full range of human feelings that you also somehow bring down here [to the consulting room] so you're equally comfortable with the full range of feelings here also. And I also wonder really how people who, forget about even where there's a bad marriage or a good marriage but when they just don't have an alive

marriage or much intimacy or something. I don't know which comes first, whether if you can't really have that breed of relationship there you're not going to have it in your treatment room either. You know if it's just something you bring to both relationships where it just has a certain level but you can't get anything further.

James goes on to say that it is not just marriages or romantic partnerships that matter:

I think the same applies even to quality of friendships, also. I mean I think at some level if you have really quality friendships you choose them also on the basis of being as true and authentic self as you can, that you're not just cultivating friendships for political reasons or to be self-objects or whatever, and I think you also bring that into your world in here.

James also noted the danger of trying to get what is missing in one's personal life from one's patients: "Well how about this one therapist I told you about where something's missing in the marriage so ... they proactively tell a patient that they're able to get more from that patient than they are from their wife. I mean that's a horrible thing to actually tell a patient, it's a horrible thing. That's something you resolve outside."

Michael talked about the sadness and the difficult balancing act of feeling that he can have more intimate conversations with patients than he can have with his wife. In his opinion, the impact on his clinical work of the loneliness in his marriage is as follows:

It sure made me a hell of a lot more available to my clients. There were plenty of times in therapy when I would talk about this struggle to be close in an appropriate way, while having these unmet needs. You know, it made it all the more difficult. Like, I would talk to [my therapist], am I being appropriate? ... It

just made it, made the boundaries more difficult to expand, you know what I mean? It was just the opposite of, instead of falling in love with all my clients and acting out, all that shit, it took a lot of work to be able to have more intimate relationships with my clients than I have with my wife.

And then, the transition from work to home life was also difficult and painful: "It's such a struggle, because then I'd come home and that would make the loneliness even greater. How was it I could talk to everybody else, even people who were really stuck in kind of young states developmentally," in a more intimate way than he could talk to his wife. As a senior person in the field, he found the problem was compounded by the lack of spaces, apart from his own therapy, to talk about his struggles:

I was getting lonelier and lonelier ... To me if I wasn't in group supervision or in an institute then I didn't have people to talk to about that, the stresses of being intimate [at work] and being lonely at home ... And the older you get, the more you have to become the supervisor instead of ... I couldn't find a group of people that I could work together with to talk [about it]. So that's again where my own therapy really did help.

Mary, who was the only single participant, shared that her professional relationships with patients, colleagues, supervisors, and her own therapist, are the most intimate relationships she has, and the way that makes her vulnerable to the potential loss of those relationships, say, in retirement:

I'm very conscious of how much I depend, for my relational excitement and feeding, the intensity, on the relationships with my patients, and my analyst, and a few friends that are in the therapy community here. It is a danger ... and this is

something my former supervisor who is now in a nursing home says, it is really dangerous. You need to get out sooner than you think because of the danger of relying so much on your patients. And I'm sure he was very guarded and very aware of it and kept the boundaries and all. But it's, you know, leaving, even thinking about moving into short-term work is, you know it's going to be the next challenge ... I'm not finding ways to express it, qualitatively, what the issues really are. How to find something that's going to replace the intensity and challenge and excitement of these relationships in the rest of the world.

Robert, who emphasized safety as the most important meaning of love, had this to say about the relationship of personal and professional life:

I don't think you can do this work if you don't have a loving private life. This is hard work and I don't think you can do it unless you go home to a safe, to me safe is number one ... It means that people are not going to abandon you out of a whim. They're not gonna attack you, they're not gonna demean you, they're not gonna threaten. You see even if you've done a terribly stupid thing, they're really going to be forgiving, they're not going to hold a grudge and they're not going to be mean. And feeling that, in your private life, lets you absolutely be that for other people ... Because if I don't have my own safety at home I'm trying to get it here by seducing you into thinking I'm a great shrink ... Well if you're looking for love, to be loved, in the office, because you're not getting it at home, you're not gonna get it. And you're making it your therapy not their therapy. So you want to be secure enough that, I can let you hate me, and love me. You know either way and not take it seriously and not be reactive.

Susan, who described a patient she loved like a son, talked about her relationship with her real-life son: "We're very close, from the get-go. It's really special. I'm sure having that experience is relevant also. Because that is loving in a different kind of intimacy. You know all of that helps me to be available to those kinds of experiences."

How Therapists Work with Love in the Therapeutic Relationship

Downside to loving patients. Participants noted that there were potential pitfalls involved with feeling love for patients. David said:

One of the painful things about that love is I have aspirations for her that she's really probably not going to be able to achieve. This is one of the things I talk a lot about with [my supervisor] is accepting her limitations ... And that's the downside, is that it hurts, it hurts more. It's harder for me to separate it. And then again, like that issue about what's my needs versus her need, like how much to push versus how much to accept, that it's hard to know. So ... she doesn't know how to swim. And she has kind of a phobia of swimming. She's tried and hasn't had good experiences. And I think that from my need, my omniscience, is that if she could do that that would really have a carryover effect into other things. It's also a physical thing, a sensual thing. I mean, there's a lot to it that I think would be great. And I've pushed her but how much to push?

Linda noted another possible downside to feeling love for patients: "So the one way in which I worry about how I've loved her is that I've wondered if it's kept her in therapy for longer, to feel loved by me."

Disclosure. Participants varied in their willingness to openly discuss their loving feelings for their patients with those patients. And their willingness appeared to be

related to the way loving feelings were dealt with in their own therapy or supervision. For example, James, who had had explicit conversations with his own therapist about their feelings for each other, said that he had the impression he was more willing than other therapists to discuss his own feelings with clients:

I got the feeling more than other people that I worked with in terms of talking about and sharing, yes, I am attracted to you. And in terms of discussing their fantasies, and their wishes ... that I explore everything with them. There were times when they would say to me, well, don't you feel any of this? And if it were true I would say, yes, I do ... How comfortable was I? I would say until I got into the analytic community, not comfortable at all. And the more supervision I got, the more [I worked in] my own therapy ... exploring that, the more complete I would think our discussion ... I mean I wouldn't be ashamed to feel aroused. You know, growing up Catholic, I mean jeez that's a sin, that's a sin right there. But until I got into the analytic community, very uncomfortable ... And the more experienced I got, the more I came to see it as just an essential part of, why can you talk about everything else?

James asks the logical question that follows, which is to ask why, when we encourage openness and honesty and talking, we as a profession would make an exception for feelings of love and sexual attraction:

Why can I say to my clients, yes, you're pissing me off. Yes. You're doing it on purpose. And it sounds like the same thing you're doing with your boyfriend or your other friends or whatever ... It just became more and more appropriate as an

experience in therapy. And again that's because of my own therapy. My own maturity as a therapist. My own experience and being with other people who were saying, yeah, sure, of course ... Oh really? It's not a sin? It's not only not a sin, it's essential to explore that in myself, not totally with the other person of course.

He told the story of how, even when we try to suppress feelings, they find a way to declare themselves:

One time I can remember I called one of my clients a different name, the name of a woman that when I was a teacher in high school I kind of had a crush on. And she said to me, "Where did that come from?" 'Cause she was talking to me about how much she loved me. And I flat out told her, I said, "I think I'm just struggling with saying to you, yes, I do have those feelings too, about you. And so I brought in this other person." So she thought that was fabulous, and I did too. I felt really relieved ... These people, who think of themselves as unlovable, and you say in a genuine way, yes, I do love you. And yes, you can make me aroused or desire you. That's potent for them and it's a relief and honestly, it's potent for me, too. That would have come in the last ten years of my being a therapist ... Earlier there would be a half a conversation there we'd be talking about, that person's experience without my saying the same, without reviewing in any way on a conscious level.

David, on the other hand, talked about how little he knows about his therapist and how that may have served a defensive function in the relationship, which has been going on for thirty years:

Maybe we'll talk about how little I know of my therapist. It's maybe partly because of her, how she is, and partly because maybe I don't want to know. Like I don't know if she's married ... I think if I asked, eventually she might answer after exploring. For a long time I have harbored the belief that she's a lesbian, but I don't know that. I have really no basis for that at all ... Just about last week or two weeks ago, we were talking about that and that it has prevented me from having too much love transference or sexual fantasies or desire. It keeps it safe somehow.

David feels sure that the fact that his therapist has not disclosed very much about herself has had an influence on how he is with his patients, but he thinks that the influence may be oppositional. He has also been influenced by his supervisor and his supervision group, who are much more transparent.

In the case of the patient he discussed, he said, "I told her a few times that I love her." When asked about this, the circumstances, the timing, whether it was spontaneous or planned, David replied:

I think it was deliberate because I think before I did it, I talked to my supervisor about it and he was sort of encouraging. If you're feeling it and it's in the room and it's real, then it may be really healing ... I remember feeling anxious about it even while I was saying it, or as I was contemplating saying it. It's not like she came in and I said, "Oh by the way, [patient's name], I love you" ... I'm thinking

it may have been around this question of her safety with me, because some of what would go on with the multiple alters is that some of them would tell her, don't trust him. You shouldn't be telling him that because he's going to want to rape you or something like that. And I think maybe in that context I said, "Look, I'm not going to hurt you. I love you. I'm not going to hurt you."

David explained the clinical rationale behind telling the patient he loved her:

At some point I told her ... "I have loving feelings for you ... but I'm staying here. I'm not going to get out of this chair." And so to learn about that, that you can have feelings without acting on them, without violating boundaries. So ... that's why it was indicated, as a technical point, I think that's why it was indicated, because it was really an experiential learning about boundaries and the difference between feelings and actions.

On the other hand, James is willing to respond to but not to initiate expressions of love. His understanding of the situation is that his patients already know how he feels, and there is no need to say it:

I remember sometimes where a patient would say to me that they love me, and there I'm not afraid to say "I love you" back. "I'm really just considering it an honor to work with you." Something along those lines but more in response to them saying it. I feel [it would be] an intrusion, oh I'm just gonna tell you, by the way, I really love you. That's hyperbole in my example, but that's an intrusion. It's doing something they didn't particularly invite so that's why I'm leery.

[Interviewer: Okay, so if patients invite you to share how you feel in any way, what do you do then?] Well what do you mean by inviting? [Interviewer: You

know, ask what are you feeling right now, or how do you feel about me?] You mean they're asking me ... Quite frankly, I can't remember any patient ever asking me that. Because you know why I think? Because I think it's obvious. I think they know what I'm feeling.

Linda is willing to engage in conversations with patients about mutual feelings of attraction as well as grief about lost opportunities for friendship. She described her experience with one patient as follows:

At some point he said, if we met 40 years ago, I think we would have been a great couple. And I agreed with him. Because I think that was true. We had lots of interests in common and similar senses of humor. I found him attractive, he was clearly finding me attractive. I said, yeah, so I'm glad we have the relationship we have now, but I think I would have really enjoyed a relationship with you back then. And he was able to accept that and we played with it for a few sessions, just in terms of his fleshing out that fantasy and working with what that said about this transference to me. But then, I think within six months, he worked his way out of feeling much of any connection to me ... So I don't know whether it was my self-possession or whether what I felt was useful play around this topic started to feel like teasing to him. And he didn't give me any indication that was going on, he just slowly stopped talking about it ... It's possible that ... these feelings were powerful and complex enough that my having just shared my regret didn't feel like it gave him what he really was looking for.

A therapeutic rupture followed, not obviously connected in any way to Linda's self-disclosure, but possibly leading to a premature termination:

I think it [ending therapy abruptly] was about the injury but I'm not entirely sure. And did my sharing that yes, I think we would have had a lovely ... sexual interlude with each other and enjoyed each other's company, maybe become friends. But maybe having acknowledged that ... I regret it too that we haven't had that opportunity increased his idealization ... he knows enough about therapy ... to know that mostly therapists aren't open to discussing this kind of thing in that way. He may have felt it as seductive. There's any number of possibilities. Maybe he was scared by what that brought out ... but maybe he was just doubly disappointed when I dropped the ball in that session. I think all of them are possible.

Mary distinguished between disclosing feelings and saying, "I love you." She juxtaposed her struggle with her own patients and her experience with her analyst:

Disclosing feelings is different from saying I love you. The risk of saying I love you is handling the interpretation of it. Because obviously if the person feels invaded somehow, this is too penetrating, this is too much of a directed, personal expression of feeling ... too personalized and too penetrating, it would be scary. So that would be the limiting factor ... Well I have said to my analyst that I loved her and she replied that she loved me. And I believe it. And that's, you know, that's lovely.

Robert was trained in the Freudian model, and his own analyst was "very hidden, very opaque." He does not tell his patients he loves them, even in response to expressions of love:

I'm thinking of one particular guy who ... talks about, I love you, and I have another guy who is Serbian, a big giant guy, could be very gruff, but for some reason after every session he says, "I love you." This big hulking guy.

[Interviewer: So what do you say?] I don't say, "I love you too." I say ... "Thank you." [Interviewer: Do you love him?] Yes.

Robert, who has a serious illness, said of his own therapist, "Even though he was so loving to me and wonderful, when I got sick, he couldn't come out of his shell. When I call him and tell him what's going on, he's always my therapist. He never called me and said, how are you? And that broke my heart. Actually I could kill him for it."

Susan talked about whether or not to tell a patient she loves them: "With the woman who wrote the note, she'll sometimes say 'I love you' and we hug when she leaves. And occasionally I'll say 'I love you too.' I think she knows that but sometimes it just feels like the right thing to say and I can't tell you exactly why." Just as other participants said they thought their patients knew how they felt without being told in so many words, Susan said, of the patient she loved like a son:

I don't know that I would have said that exactly. But one day I had an hour free and I walked down into the waiting room and there he was. And it was easily ten years after we had worked together. And he happened to be in town and he just took a chance. So we spoke for an hour just catching up and whatever. And I think in that interaction it was very clear from how I was reacting to him and whatever that I was thrilled to see him and I was so caring and interested and whatever. I think he got it.

In conclusion, the results of the study showed that parental and erotic love were prominent among the varieties of love experienced for patients. Love in the context of therapy was often characterized by warmth, care, and stretching the frame. The love of therapists for patients is deepened by having survived struggle and even hatred together as well as by the passage of time. Love for patients is characterized by careful listening and the dedication that goes with it. And love for patients is at times similar to spiritual love. While participants understood why the topic of love might elicit anxiety among therapists in general, they themselves do not find it so scary. On the contrary, they were eager to discuss it and acknowledged its importance in their work. This study explored the participants' relationships with their own therapists, supervisory relationships, and private life as influences on their attitudes towards loving patients and found that most participants reported loving and feeling loved by their own therapists. Many also reported feeling safe in supervision to discuss such feelings. And some discussed the benefit of having satisfying intimate relationships in their private lives. Participants noted that the possible risks of love include that feeling loved by the therapist feels so good that it keeps the patient in treatment too long. Benefits of love include fueling a treatment that would otherwise be too painful or exhausting. Participants varied in the degree to which they were willing to disclose their loving feelings to patients, ranging from freely discussing them and even initiating the conversation, to never explicitly discussing them. Their willingness seems loosely correlated with how the issue was handled in their own therapy.

Discussion

Summary

This study explored the experience of love for patients from the psychoanalytic therapist's point of view. The three main purposes of the study were to explore the experience of therapist–patient love in psychotherapy, to seek a new definition of therapeutic love, and to further the understanding of love as a healing force in therapy. The unique contribution of the study was to take a systematic approach to the topic by conducting semi-structured interviews. The importance of the study was to begin to offer a new perspective on the topic through open professional dialogue. The study considered the following questions: 1) What is the nature of the loving feelings therapists experience towards patients? 2) What are therapists' attitudes towards loving feelings? 3) What factors influence therapists' attitudes towards these feelings? 4) What is the therapeutic effect of loving feelings for the patient? 5) Finally, if therapists do love their patients, do they disclose it, and why or why not?

The data for this study were semi-structured interviews lasting approximately ninety minutes each, conducted in person from May 2018 through June 2019 in the New York Metropolitan Area. Participants were recruited through a network sample and through notices posted on the electronic mailing lists of various professional organizations. Participants were seven licensed psychologists and one licensed clinical social worker in private practice, all but one with postgraduate training in psychoanalysis, including their own therapy or analysis. Participants ranged in age from 52 to 78, with a mean age of 68.5. Four of the participants were male and four were female. Six of the eight identified as heterosexual, one as bisexual, and one as lesbian. All identified as

white and half as Jewish. Participants had between 14 and 46 years of clinical experience post licensure, with an average of 29 years. The interviews were conducted in person and in the participants' own offices or homes in order to promote a sense of trust and safety, which presumably facilitated greater openness and honesty. The interviews were semi-structured in order to provide some consistency while also allowing room for the participants to say whatever they felt was most important and relevant to the topic. Interviews were recorded using a small digital recorder and transcribed by a secure automated transcription service, Trint, which yielded transcripts of varying fidelity. The researcher then edited the transcripts while listening to the recordings to improve accuracy and render the data more usable.

This study employed a modified grounded theory method (Corbin and Strauss, 2014) to analyze the data. In grounded theory, data are analyzed using the constant comparative method, a process in which newly collected data are compared with existing data in an ongoing way until nothing new seems to be emerging. After the comparative method had been exhausted, relevant features of the interviews, or data, were coded across the entire data set, codes were collated into potential themes, and themes were used to generate a narrative description of the data. For example, in this study the code, "ate the cookie with desire," was collated into the theme, "went beyond the usual frame of therapy."

The study found that each participant had a slightly different perspective on love for patients. Love for patients can be parental and/or erotic; is characterized by warmth, care, and stretching the frame; is deepened by having survived struggle and even hatred together as well as by the passage of time; is characterized by careful listening and the

dedication that goes with it; and is at times comparable to spiritual love. Although love includes the element of care, it is more than care, including setting aside one's own needs in order to give priority to the needs of the patient; knowledge of the patient; empathy with the patient; sensitive and imaginative listening; and commitment to the patient's safety, well-being, and recovery. Participants offered fear of boundary violations and fear of the vulnerability that can accompany love as reasons why the topic of love may elicit anxiety in the larger community of psychoanalytic clinicians, although they themselves denied feeling anxious about it. They distinguished love in therapy from love in other contexts by saying that love in therapy, while just as "real," is more circumscribed. Participants cited their own therapies as having had the greatest influence on their attitudes towards loving patients. In some cases participants felt loved in their own experience of therapy, and therefore tacitly granted permission to love their patients, while in other cases negative experiences of therapy were influential on their practice and approach. Relationships with supervisors and the quality of intimate relationships in their private lives also influenced therapists' attitudes towards loving patients. Participants varied in how they worked with therapist-patient love, including in their willingness to disclose it.

Interpretation of Findings

In everyday life, the word "interpretation" means the act of explaining the meaning of something. In the context of psychoanalysis, however, it connotes going beyond the obvious in order to clarify hidden meanings – in other words, making the unconscious, conscious. However, this study has taken what participants said at face value, as it is neither the task nor the intention of the researcher to speculate about

unconscious meanings. Instead, the purpose of this section is to delineate how the findings of this study relate to the existing literature. The findings of this study relate to the existing literature in a number of ways. Some of the findings confirm what we already know; some of the findings suggest that what we already know is incomplete or wrong and therefore conflict with the existing literature; and some of the findings represent new ideas. Often all three relationships exist within the same area.

Characteristics of the therapist's love for patients. Participants in this study described love for patients in ways that both confirmed and went beyond what has already been said in the literature. Parental love, warmth, care, dedication, safety, respect, putting the other first, romantic or erotic feelings, even awe – all these are characteristics of the love therapists feel for patients that have already been discussed in the literature and were confirmed by the participants in this study. Parental love was prominent among the varieties of love that participants experienced for patients. Parental love was experienced by all participants and is often cited in the literature as a common and relatively uncontroversial version of therapist-for-patient love. For example, Loewald (1960), Hirsch (1994), Fox (1996), and Friedman (2005), to name just a few, have all compared the therapeutic relationship to that of parent and child. It was noteworthy that the patients who elicited the strongest parental feelings had suffered severe abuse or neglect at the hands of their parents. Participants did not explicitly connect their feelings of parental love with their patients' need for it, but the data do suggest that, consciously or not, they were providing a corrective emotional experience.

Participants also described erotic feelings for patients. Discussions of erotic feelings and/or sexual attraction in the literature have at times put them together in the

same category with loving feelings and at other times distinguished between the two, a particularly conspicuous example of the largely unacknowledged confusion in the literature about what “love” is (for example, see Hirsch, 1994, and Gabbard, 1996). Some of the erotic phenomena that participants talked about, such as the passing thought, “I should just fuck him,” seemed outside the realm of love; while others, such as feeling aroused by a patient’s desire for physical intimacy commensurate with the emotional intimacy of the relationship, appeared more loving. For the most part, participants did not indicate that they felt threatened by erotic feelings, either their own or the patient’s, although they conceded that those feelings could be unsettling. Participants felt secure in the knowledge that they would not act on sexual feelings, which they felt free to discuss in supervision or their own therapy, and noted that acting on these feelings would not be consistent with a loving attitude. Furthermore, participants described feelings of sexual attraction as more short-lived and less important than other forms of love such as concern for the well-being of the other and commitment to therapeutic goals.

The study also supported the literature in confirming “the equation of love with understanding” (Friedman, 2005, p.353), expanded to include careful listening. For example, Michael said that he felt loved by his therapist because “he listens. He listens to the point that he knows me very very deeply.” Friedman noted that equating love with understanding is problematic because “it ensures a safe union of warmth with distance” (p.356). According to Friedman, something more than understanding is meant by love: “Analytic loving is a movement toward the patient” (p.360). In their descriptions of gestures that stretch the usual frame of therapy, participants in this study illustrated what movement towards the patient might look like.

Participants' characterizations of love for patients diverged from the literature in at least two ways. One was in how often, in providing an illustration of what love for a patient looked like, or what made them feel loved by their own therapists, they provided examples of small gestures that stretch the usual frame of therapy and were understood as demonstrations of love. Playing a game, picking a bouquet of flowers, driving a car up a snowy hill for an elderly patient, providing a jump start for a car, eating a cookie, accepting a gift with grace, giving a hug – these are the seemingly small things that can have a big impact in the context of therapy. These are also gestures that enact “movement toward the patient.” And these kinds of things, especially touching a patient, have been controversial in the profession (see Casement, 1985; Toronto, 2001; McWilliams, 2004) and therefore are likely to be under-reported in case studies and articles.

In the sources reviewed for this article, there was minimal exploration of the way love for patients endures and deepens over time. Every participant discussed therapeutic relationships that had spanned not years but decades, and these were often the patients singled out by participants as having been loved. The level of commitment involved and the terms used to describe what contributes to the growth of love – “that kind of intimate depth, trust, history, risk-taking, and going through a whole bunch of life circumstances” together – are reminiscent of other long-term, intimate relationships. And while much has been written about the patient internalizing the therapist, it is not often that you hear a therapist say of a patient, “You integrate them into who you are so they become a part of you.” Yet this, according to Susan, was a defining feature of love.

Participants' attitudes towards loving feelings for patients. Many authors, including Lear (1990), Coen (1994), Friedman (2005), Maroda (2013), have written about therapists' discomfort with feelings of love for patients. A few dissenting voices, such as Fosshage (2007), Sherby (2009), and Celenza (2017), have written that love is a normal and necessary part of therapy. Participants in this study agreed with the second group and denied that the experience or discussion of love for patients made them uncomfortable. There are several reasons why this might be the case. For one thing, participants in the study were self-selected. Either they were approached directly by this writer and invited to participate, or they saw the recruitment email on a listserv and volunteered. In all probability people who felt uncomfortable about the topic declined the invitation or deleted the email. It is noteworthy that the recruitment email was distributed to hundreds of people and only a handful replied. Although nothing can be said with any degree of certainty about the characteristics of people who did not respond to the recruitment letter, it is tempting to speculate that opting out may have been motivated by discomfort with the topic. (Another possibility for not responding was the significant time commitment involved. It was a lot to ask busy professionals to devote an hour and a half to being interviewed by a stranger, no matter the topic.)

Another reason the participants may have differed from the majority opinion in the literature is that they were highly experienced clinicians who in some cases were nearing the end of their careers, and their responses may not have been representative of less experienced clinicians or younger clinicians. Michael remarked that it was only in the last ten years of his career as a therapist that he became comfortable having mutual conversations with patients about love. Additionally, some of the therapy relationships

discussed by participants had lasted for many years, providing ample time to develop close familiarity and comfort. As Susan said, "Love takes a while."

Influences on therapists' attitudes towards loving feelings. Participants in the study discussed influences on their attitudes towards loving feelings in a new way relative to what exists in the literature, which focuses on intrapsychic influences such as vulnerability and anxiety (see Coen, 1994; Gabbard, 1994; Mendelsohn, 2007), external influences such as professional standards (see Fox, 1996; Friedman, 2005) and fear of public censure (see Hisch, 1994; Coen, 1996; and Gelso, 2014), and concerns about the dangers of love (see Shaw, 2003; Fosshage, 2007). In contrast, study participants focused on the influence of relationships with their own therapists and supervisors. Therapy has been compared to parenting in that, just as one learns to be a parent from one's own parents, one learns to be a therapist from one's own therapist. Participants in this study consistently cited their own therapy as having had the greatest influence on their development as therapists, including on their attitudes towards love for patients. Another aspect of the maturity of the cohort of participants is that they have been observing and processing therapy as recipients for a long time – thirty years in some cases. Loving and feeling loved by their own therapist(s) seemed to normalize love in the setting of therapy and give permission for participants to feel it for their own patients in turn. Conversely, Lisa's experience with a therapist who was "very absent in the relationship" provided her with a model of how not to be.

Participants also said relationships with supervisors had influenced their attitudes about love for patients. For example, Linda said a supervisor "was able to really empathize with how hard it is to keep your eye on the ball when there is a part of you that

wants to go sit in someone's lap or breastfeed them or have sex with them." And in her own work with supervisees, Linda passes acceptance for love down through the therapeutic generations: "When people have a ... love towards the patient, I encourage them to explore that for everything it's worth ... And I look for the parts of it that feel like they're really fueling the treatment, and I'd point out the positive effects of that. And if there are ways in which it seems like it might be getting in the way," Linda would point that out as well.

The influence of therapists' personal lives on their ability to do therapy is rarely discussed in any context. Study participants who addressed this topic spoke about the importance of intimate relationships in private life in supporting and nourishing them in the work of therapy. Participants also discussed whether limitations to love in private life would carry over to therapy. According to James, "if you can't have that breed of relationship there [in your marriage] you're not going to have it in your treatment room either. You know, if it's just something you bring to both relationships where it just has a certain level but you can't get any further."

How therapists work with love in the therapeutic relationship. Although the participants in this study did not explicate the relationship between love for patients and efficacy of therapy, it was clear that they believed love to be a crucial factor in promoting the patient's growth and healing. In this way the data support the literature that values love as a healing force (see Shaw, 2003). One of the most controversial aspects of the topic of love for patients concerns whether or not to disclose it to the patient (see Ferenczi, 1932; Little, 1951; Bollas, 1987; Aron, 1991, 1996; Maroda, 1998; Barsness & Strawn, 2018). The debate in the literature – to disclose or not to disclose – was reflected

in the participants' responses: Some participants had openly discussed their feelings with patients, and some had not. Acknowledgements in the literature of disclosing feelings of love and sexual attraction to a patient are extremely rare (see Davies, 1994, 1998; Rabin, 2003). Given that context, it was notable that some participants openly discussed instances in which they had done so and what the therapeutic impact was. More commonly, however, participants expressed the assumption that their patients sense what they feel even if it is not verbalized.

Implications

The primary implications of the study are the following four points: 1) Love for patients is much more common, less feared, and safer than the literature would have us believe. 2) Love is often conflated in the literature with sexual attraction, contributing to the confusion on the topic. 3) Small, human gestures are experienced as loving and have a big impact. 4) Training programs should better prepare students for the full range of emotions they may expect to feel for patients. These four points are expanded below.

Love for patients is more common, less feared, and safer than the literature would have us believe. Every participant in the study expressed having experienced a range of loving feelings for patients, was apparently at ease with these feelings, and denied that any ethical breaches occurred as a result. Moreover, the acceptance of loving feelings seems to have existed in prior generations. It was shared in many cases by these senior therapists' own analysts and supervisors, casting doubt on the idea that love of therapists for patients is a phenomenon associated with the relational turn in psychoanalysis. Regarding the range of feelings experienced, arguably this is attributable to individual differences in the way each participant experiences and processes emotions

– their intensity and duration, preferred and avoided emotions, and so on – which was beyond the scope of this study to explore. Concerning being at ease with one's feelings, David stated that early in his career he feared the “slippery slope” on occasion but a supervisor helped keep him on safe ground. This point raises the obvious possibility that the comfort of participants with their own feelings had to do with their maturity and experience – in life, in therapy on both sides of the relationship, and in supervision – and may not be typical of therapists overall. That is, younger and/or less experienced therapists might still feel very anxious about loving feelings for patients. David's comment also draws attention to the importance of supervision, especially early in professional life, but not exclusively then. For example, Lisa highlighted the importance of ongoing supervision in talking about taking her concerns about an erotic “hallucination” to her supervisor, who put it in perspective with humor.

The experience of participants did not support the majority of the literature reviewed for this study, in which the experience of love for patients was more commonly portrayed as anxiety provoking and fraught with danger. Participants instead supported the minority opinion (see Shaw, 2003; Fosshage, 2007; Mendelsohn, 2007; Sherby, 2009), which regards love for patients as normal, necessary, and in the service of therapeutic efficacy.

Love is often conflated in the literature with sexual attraction. The perceived danger of loving feelings may have arisen in part from the confusion in the literature about loving and sexual feelings and the fear that these feelings will lead to sexual boundary violations. Again and again in the literature, the broad and subtle variety of loving feelings is reduced to sexual feelings. There are plenty of token mentions of

“loving feelings” but always in conjunction with “sexual feelings,” which are apparently the sole focus of the comments (see Hirsch, 1994; Gabbard, 1996). This confusion may be embedded in the psychoanalytic tradition, given its historical emphasis on *eros* and libido and its equation of those with life itself.

Although analytically trained, the participants in this study did not appear to suffer from the same confusion as the literature. They expressed awareness of parental versus erotic feelings, for example, and described how the quality of these feelings is not static but fluctuates over time. Their openness and honesty about their feelings was earned through a lifetime of clinical practice, therapy, and supervision, and it speaks to the need for all clinicians to work toward having the same access to and understanding of their feelings as they arise in the course of treatment. Not only will this enrich the experience of therapy for both participants, but also it offers protection from suffering from or acting on unconscious or unexplored motivations.

Small, human gestures are experienced as loving and have a big impact.

Participants often provided examples of small human gestures that softened the frame of therapy when asked to say what made them feel loved by their own therapists. There is evidence of conflicting feelings within the psychodynamic community about these kinds of gestures. On the one hand, there is professional disapproval of such acts of acceptance and kindness that promote trust and liking and may support the process of healing by making the therapy more pleasurable to both parties. On the other hand, the relational literature and anecdotal evidence provide many examples of pivotal moments in treatment that turned on such gestures (see Greenberg, 1998, 2001). Perhaps the profession should consider redrawing the frame to accommodate these.

Training programs should better prepare students for the range of emotions they may expect to feel for patients. At the beginning of the semi-structured interview, participants were asked to describe their training, and it is noteworthy that none of them recalled that the topic of love for patients had been addressed before the level of post-graduate training. Because the majority of therapists do not pursue post-graduate training, it is very important that graduate training programs take steps to address loving feelings at an earlier stage of professional development. If talk about loving feelings is shunned, students may not have the scaffolding to recognize and process their feelings, and may either suffer from or act on unconscious or unexplored motivations. This is more important now than ever before, because anecdotal evidence suggests that therapists in training face more obstacles to access to therapy themselves and are therefore deprived of that space to cultivate self-awareness and process emotions.

Limitations

There were a number of limitations to the study, most importantly lack of diversity in the sample and a small sample size. Additionally, even “long” semi-structured interviews were short given the nature of the topic. Lack of diversity in the sample seriously limits the generalizability of the findings beyond very experienced, white, middle-aged and older psychodynamic therapists. Greater racial and ethnic diversity in the sample would be difficult to engineer, given the lack of diversity in the overall psychology workforce. According to the American Psychological Association, as of 2014 the psychology workforce was 86% white, 5% Asian, 5% Hispanic, 4% black/African-American, and 1% mixed race or other, which is less diverse than the population of the United States as a whole (Lin, Stamm, and Cristidis, 2018). The small

sample size is another limitation. The time commitment involved in participating in the study may have been a disincentive for many therapists. And yet, to shorten the interview would likely render it less revealing.

Reflecting on the interview guide, although the semi-structured interview in theory allowed participants to take the interview in unexpected directions, in actuality it did contain questions that led the interview in certain ways – towards an exploration of the relationship between therapists' own therapies and their attitudes towards loving feelings for their own patients, for example. Once they started talking, participants tended to anticipate and answer the interview questions spontaneously, without being asked, but the researcher was an active participant in the interviews and would occasionally redirect the participant. In this way the design of study may have led to eliciting information that confirmed what writer already knew or surmised. Concerning the questions themselves, in hindsight, the interviewer would have gathered information about graduate training ahead of time and not used precious interview time asking about it. This had been done originally to provide a gentle introduction to a potentially difficult subject, but participants were ready to talk and did not appear to need a warm-up. The interviewer would have asked more directly and consistently, at the beginning of the interview, how participants define love in the context of therapy rather than relying on descriptions of loving feelings to deduce their definitions. It also would have been useful to spend more time pursuing participants' views of the role of love in promoting healing, as in many cases this was implicit rather than explicit. A line of questioning that was relatively unproductive and would be abandoned if the researcher were doing the study

over again concerned what aspects of any kind of feelings participants had had for patients that had been troubling or problematic and how they dealt with them.

Additionally, in listening to and rereading the interviews the researcher was struck many times by moments where pausing and digging deeper might have elicited more complete answers. Although participants said they were comfortable discussing the topic, in many cases they seemed almost too comfortable; that is, there was a suspicious absence of conflict or struggle in some cases. It is possible that a certain degree of filtering had taken place prior to the interview and conflict laden material was kept out. Participants after all did know ahead of time what the interview would be about, and although there were advantages to their having had a chance to reflect in advance, there was also the opportunity to make choices about what to include and what to leave out. The interviewer felt grateful to participants for their time and willingness to talk and felt reluctant to press for more information at times out of respect for participants' privacy.

Suggestions for Future Research

There are many possibilities for future research on the topic of the therapist's love for patients, including looking at cultural differences in therapists' attitudes to loving feelings and gender differences in therapists' experiences of love and their handling of them. In spite of the fact that the field of psychotherapy is dominated by women – according to the APA, women make up 74% of early career psychologists and 53% of the psychology workforce – women are underrepresented in the academic sciences and publications, and therefore what has been written about love has come more from a male perspective.

However, the results of this study most strongly suggest that stage of professional development is an important factor in therapist comfort with loving feelings. Therefore, it would make sense to design a study comparing early-career therapists with senior therapists and see whether their feelings and approaches differ. A quantitative study using a larger sample size could provide information about such differences as well as interactions between stage of professional development and theoretical orientation or discipline. For example, would senior cognitive behavioral therapists also feel more comfortable with loving feelings? Such a study might use a survey that asks categorical questions about experiences of and opinions of love, and also captures demographics as well as information about years of experience and approach to therapy.

Finally, time after time, participants in this study stated their belief that patients know how they feel whether or not they verbalize their feelings. It would be interesting to put this to the test by asking patients about their awareness and experience of feeling loved by their therapists.

Appendix A

Subject Recruitment Email

My name is Laura McCann and I am a doctoral student at the Graduate School for Applied and Professional Psychology at Rutgers, the State University of New Jersey. For my dissertation I would like to interview psychoanalysts or therapists who practice from a psychoanalytic or psychodynamic perspective about their experiences of love in the therapeutic relationship, especially loving feelings they have had for patients.

The study will explore the range of loving feelings experienced by therapists, the impact of these feelings on the patient and therapist, and therapists' opinions about the role of love in psychotherapeutic healing. The study will also address how the topic of love was handled in training and supervision, whether therapists feel it is acceptable to love their patients, and the influence of the therapist's own therapy and life experience on their attitudes towards loving their patients. In addition, the study will look at whether therapists would ever disclose their loving feelings to patients, why or why not, and what factors are considered in making that decision. It is important to investigate this topic because although love has been recognized as a core competency of relational psychoanalysis, discussions of therapists' love for patients are relatively rare in the literature. More research and awareness of this issue may help therapists understand love for patients as acceptable and expectable and to be better prepared to use these feelings in the service of psychotherapeutic healing when they arise.

Three screening questions will determine if you [the reader] would be suitable to participate in the study:

1. Are you a licensed psychologist, a licensed clinical social worker, or a psychiatrist?
2. Do you adhere to a psychoanalytic or psychodynamic theoretical orientation with regard to working with patients?
3. Have you been a patient in therapy yourself for a period of at least two years?

If you have answered yes to the three screening questions and you are interested in participating in this study, then please contact me, Laura McCann, at LJM7@gsapp.rutgers.edu. Interviews are expected to take from 90 to 120 minutes. Although in-person interviews are preferred, telephone interviews may be arranged as an alternative. If the interview is not completed within the allotted time of 120 minutes, you have the option of completing the remaining questions in writing. If you have any questions about this study, please do not hesitate to ask. Thank you for your time and attention.

Appendix B

Informed Consent Form

You are invited to participate in a research study that is being conducted by Laura McCann, who is a doctoral student in the clinical psychology department of the Graduate School of Applied and Professional Psychology at Rutgers University. The purpose of this research is to explore psychodynamic therapists' experiences of love in the therapeutic relationship and what effect these feelings have on the therapy.

Approximately 12 subjects will participate in the study, and each individual's participation will last approximately one and a half to two hours.

The study procedure involves a semi-structured interview designed to last approximately an hour and a half. During the interview you will be asked questions about loving feelings you may have had for patients, how you define love in the therapeutic context, your perceptions of what impact these feelings have on the therapy, and attitudes towards these feelings in your training, supervision, personal therapy, and personal history. Please feel free to expand on the topic or talk about related ideas. If there are any questions you would rather not answer or that you do not feel comfortable answering, please say so and we will stop the interview or move on to the next question, whichever you prefer. If we do not finish the interview in the allotted time, you may have the option of answering any remaining questions in writing at your leisure. Audio recording is mandatory for participation in the study. Recordings will be transcribed either by the researcher or by an automated transcription service.

This research is confidential. Confidential means that the research records will include some information about you and this information will be stored in such a manner that some linkage between your identity and the response in the research exists. Some of the information collected about you includes your age, gender, sexual orientation, relationship status, educational history, years in practice, and theoretical orientation. You will also be asked to disclose feelings you have experienced in your work as a therapist and how you have handled them. Although you will be asked to talk about patients as part of this interview, you will not be asked to disclose any confidential information about patients. Any information that you provide which may be used to identify a patient will be removed from the transcript. Names of people and places will be replaced with pseudonyms. Please note that we will keep this information confidential by limiting access to the research data and keeping it in a secure location. Hard copies of data will be stored in a locked filing cabinet to which only I will have the key. Audio recordings will be stored in a password protected digital recording device that will be transported and stored in a locked bag, and transcriptions will be kept in password-protected files in my password-protected and encrypted personal computer. The data gathered in this study are confidential with respect to your personal identity unless you specify otherwise. The recording(s) will be stored electronically in password protected files within the principal investigator's password protected and encrypted laptop device. These files will be linked with a code to your identity, and the key to the code will be stored separately in a locked

filing cabinet. The recordings will be kept for three years after the date of completion of the research study and then erased/deleted. Transcripts of the interviews will be retained indefinitely.

The research team and the Institutional Review Board at Rutgers University are the only parties that will be allowed to see the data, except as may be required by law. If a report of this study is published, or the results are presented at a professional conference, excerpts of interviews may be quoted. In that case, all identifying information will be removed.

The risks of participation include anxiety or other emotional discomfort arising from talking about your loving feelings toward patients. However, it is expected that this discomfort will be similar to the level experienced when discussing such feelings with supervisors, personal therapists, colleagues, and/or patients. If at any time you feel overwhelmed or highly uncomfortable during the interview process it is advised that you discontinue your participation. There is also risk of breach of confidentiality; however, steps to be taken to safeguard confidentiality are described above.

You may receive no direct benefit from taking part in this study. However, the present research will contribute to the literature on therapists' experiences of love in the therapeutic relationship. Participants will play a role in helping researchers, graduate programs in mental health, social workers, psychologists, and others understand the experience and function of love in the therapeutic relationship.

Participation in this study is voluntary. You may choose not to participate, and you may withdraw at any time during the study procedures without any penalty to you. In addition, you may choose not to answer any questions with which you are not comfortable.

If you have any questions about the study or study procedures, you may contact me at:

Laura McCann
[address]
[cell phone number]
[email address]

You may also contact my faculty advisor:

Karen Riggs Skea, PsyD
Graduate School of Applied and Professional Psychology
152 Frelinghuysen Road
Piscataway, NJ 08854
[telephone number]
[email address]

If you have any questions about your rights as a research subject, please contact an IRB Administrator at the Rutgers University, Arts and Sciences IRB:

Institutional Review Board
Rutgers University, the State University of New Jersey
Liberty Plaza / Suite 3200
335 George Street, 3rd Floor
New Brunswick, NJ 08901
Phone: 732-235-2866
Email: humansubjects@orsp.rutgers.edu

You will be given a copy of this consent form for your records.

Sign below if you agree to participate in this research study:

Subject (Print) _____

Subject Signature _____ Date _____

Principal Investigator Signature _____ Date _____

Appendix C

Demographic Questionnaire

What is your age?

What is your gender?

What is your sexual orientation?

What is your ethnicity?

What is your relationship status? Include all that apply.

Examples:

- Single
 - Committed relationship for X years
 - Married for X years
 - Divorced
 - Widowed; partner died X years ago
 - Remarried
 - Polyamorous
-

How many children do you have and what are their ages? Stepchildren? Grandchildren?

How many years have you been in practice?

What level and type of training did you receive and where? Include all that apply.

Examples:

- MSW, NYU
- Clinical PsyD, GSAPP
- School PsyD, GSAPP
- PhD in psychology, Adelphi University

- EdD, Rutgers
 - MD
-

Where and when did you pursue postdoctoral/post-degree training, if at all? Include all that apply.

Examples:

- Center for Psychotherapy and Psychoanalysis of New Jersey, 1990-1995
 - NPAP, 1980s
 - William Alanson White Institute, completed training in 2008
 - NYU Postdoctoral program in psychotherapy and psychoanalysis, 2010 to the present
-

What are the theoretical orientations that have had the greatest influence on how you conduct psychotherapy? List all that apply.

Examples:

- Drive theory
 - Ego psychology
 - Object-relations theory
 - Self-psychology
 - Relational psychoanalysis
 - Integrative – CBT & Psychoanalytic or Existential & Psychoanalytic, and so on
-

Appendix D

Semi-structured Interview

1) Please describe your training as a psychotherapist.

- Graduate school
- Post-degree training
- Supervision
- Training analysis or personal therapy

2) What experiences have had the greatest influence on you in your development as a therapist?

- Certain professors/courses in graduate school
- Most influential supervisors – what were their theoretical orientations?
- Patients
- Therapists
- Experience as a supervisor
- Life experiences – family of origin, life partner, parenthood, traumatic experiences

3) What aspects of feelings that you have had for patients have been troubling or problematic?

- How did you deal with it?
 - Kept it to self

- Discussed in supervision – individual or group
- Processed with therapist/analyst
- Discussed with someone else

4) Do you feel it is permissible to love your patients?

- Do you feel threatened by these feelings? Why or why not?
- Do you see them as useful? How?
- How have you formed your opinions about this?

5) Have you experienced loving feelings for patients?

- Why have certain patient elicited this response?
- Are some forms of love more acceptable than others?

For example, is it okay to love your patient as a daughter? And in that case what would be the influence of being a daughter, or having a daughter?

6) What are your thoughts about “countertransference” disclosure?

- Under what circumstances would you disclose your countertransference feelings to a patient?
- How would you assess that?
- When has it been difficult to disclose countertransference feelings?
- What has been the impact of disclosure?
- Under what circumstances would you disclose loving feelings?
- Under what circumstances would you disclose erotic feelings?

7) Think of a patient you have loved.

- In retrospect, how do you think your love for the patient impacted the treatment?
- If positively, was there any downside to loving the patient?
- If negatively, was there anything helpful or useful about it?
- In light of this discussion, would you think differently about it?

8) Did you feel loved by your own therapist/analyst?

- What made you feel that way?
- Was it discussed?
- If so, what was that like for you?
- If not, reflecting on it now, do you wish it had been?

9) Arguably, discussions of love for patients seem to generate anxiety among psychotherapists.

- Do you agree or disagree, and why?
- As a supervisor, how have you handled supervisee's anxiety about loving patients?
 - What do you think people are afraid of?

References

- Aron, L. (1991). The patient's experience of the analyst's subjectivity. *Psychoanalytic Dialogues*, 1, 29–51.
- Aron, L. (1996). *A meeting of minds: Mutuality in psychoanalysis*. Hillsdale, NJ: Analytic Press.
- Barsness, R. E., & Strawn, B. (2018). Core competency seven: Courageous speech/disciplined spontaneity. In R. E. Barsness (Ed.), *Core competencies of relational psychoanalysis: A guide to practice, study, and research* (pp.179–200). New York: Routledge.
- Benjamin, J. (1994). Commentaries on papers by Tansy, Davies, and Hirsch. *Psychoanalytic Dialogues*, 4, 193–201.
- Bergmann, M. S. (1982). Platonic love, transference love, and love in real life. *Journal of the American Psychoanalytic Association*, 30, 87–111.
- Bergmann, M. S. (1987). *The anatomy of loving: The story of one man's quest to know what love is*. New York: Columbia University Press.
- Bollas, C. (1987). *The shadow of the object: Psychoanalysis of the unthought known*. New York: Columbia University Press.
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3, 77–101. <https://doi.org/10.1191/1478088706qp063oa>
- Buechler, S. (2019). *Psychoanalytic approaches to problems in living: Addressing life's challenges in clinical practice*. New York: Routledge.
- Burton, N. (2016). These are the 7 types of love. Retrieved from <https://www.psychologytoday.com/us/blog/hide-and-seek/201606/these-are-the-7-types-love>
- Casement, P. (1985). *Learning from the patient*. New York: Guilford Press.
- Celenza, A. (2007). *Sexual boundary violations: Therapeutic, supervisory, and academic contexts*. New York: Jason Aronson.
- Celenza, A. (2017). Lessons on or about the couch: What sexual boundary transgressions can teach us about everyday practice. *Psychoanalytic Psychology*, 34, 157–162.
- Charmaz, K. (2006). *Constructing grounded theory*. London: Sage.

- Coen, S. J. (1994). Barriers to love between patient and analyst. *Journal of the American Psychoanalytic Association*, 42, 1107–1135.
- Coen, S. J. (1996). Love between therapist and patient: A review. *American Journal of Psychotherapy*, 50, 14–27.
- Cole, G. W. (2007). Love and work: Analysis and ordinary ongoingness. *Psychoanalytic Inquiry*, 27, 348–365.
- Cooper, S. H. (1998). Flirting, post-oedipus, and mutual protectiveness in the analytic dyad: Commentary on paper by Jody Messler Davies. *Psychoanalytic Dialogues*, 4, 767–779.
- Corbin, J., & Strauss, A. L. (2014). *Basics of qualitative research: Techniques and procedures for developing grounded theory* (4th ed.). Thousand Oaks, CA: Sage Publications.
- Creswell, J. W. (2007). *Qualitative inquiry & research design: Choosing among five approaches* (2nd ed.). Thousand Oaks, CA: Sage Publications.
- Davies, J. M. (1994). Love in the afternoon: A relational consideration of desire and dread in the countertransference. *Psychoanalytic Dialogues*, 4, 153–170.
- Davies, J. M. (1998). Between the disclosure and the foreclosure of erotic transference-countertransference: Can psychoanalysis find a place for adult sexuality? *Psychoanalytic Dialogues*, 8, 747–766.
- Davies, J. M. (2003). Falling in love with love: Oedipal and postoeidipal manifestations of idealization, mourning, and erotic masochism. *Psychoanalytic Dialogues*, 13, 1–27.
- Ehrenberg, D. B. (1992). *The intimate edge: Extending the reach of psychoanalytic interaction*. New York: W. W. Norton & Company.
- Ferenczi, S. (1932). *The clinical diary of Sandor Ferenczi* (J. Dupont, Ed.; M. Balint & N. Z. Jackson, Trans.). Cambridge, MA: Harvard University Press, 1988.
- Ferenczi, S. (1949). Confusion of tongues between the adult and the child (The language of tenderness and passion). *International Journal of Psycho-Analysis*, 30, 225–230.
- Fine, R. (1971). *The healing of the mind: The technique of psychoanalytic psychotherapy*. New York: David McKay.
- Fitzpatrick, K. (1999). Terms of endearment in clinical analysis. *Psychoanalytic Quarterly*, 43, 119–125.

- Fonagy, P., & Target, M. (2004). Playing with the reality of analytic love: Commentary on paper by Jody Messler Davies, *Psychoanalytic Dialogues*, 14, 503–515.
- Fosshage, J. (2007). Searching for love and expecting rejection: Implicit and explicit dimensions in cocreating analytic change. *Psychoanalytic Inquiry*, 27, 326–347.
- Fox, R. P. (1996). The “unobjectionable” positive countertransference. *Journal of the American Psychoanalytic Association*, 46, 1067–1087.
- Freud, S. (1915). Observations on transference love. In J. Strachey and A. Tyson (Eds.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 12, pp.157–171). London: Hogarth Press.
- Friedman (2005). Is there a special psychoanalytic love? *Journal of the American Psychoanalytic Association*, 53, 349–375.
- Fromm, E. (1956). *The art of loving*. New York: Harper & Row.
- Gabbard, G. O. (1994). Sexual excitement and countertransference love in the analyst. *Journal of the American Psychoanalytic Association*, 42, 1083–1106.
- Gabbard, G. O. (1996). *Love and hate in the analytic setting*. Northvale, NJ: Jason Aronson.
- Gabbard, G. O. (1998). Commentary on paper by Jody Messler Davies. *Psychoanalytic Dialogues*, 8, 781–789.
- Gabbard, G. O. (2017). Sexual boundary violations in psychoanalysis: A 30-year retrospective. *Psychoanalytic Psychology*, 34, 151–162.
- Geist, R. (2009). Empathy, connectedness, and the evolution of boundaries in self psychological treatment. *International Journal of Psychoanalytic Self-Psychology*, 4, 165–180.
- Gelso, C. J. (2011). *The real relationship in psychotherapy: The hidden foundation of change*. Washington DC: American Psychological Association Press.
- Gelso, C. J., Perez Rojas, A. E., & Marmarosh, C. (2014). Love and sexuality in the therapeutic relationship. *Journal of Clinical Psychology: In Session*, 70, 123–134.
- Gerrard, J. (1999). Love in the time of psychotherapy. In D. Mann (Ed.), *Erotic transference and countertransference: Clinical practice in psychotherapy* (pp.21–41). New York: Routledge.
- Gitelson, M. (1962). The curative factors in psycho-analysis. *International Journal of Psycho-Analysis*, 43, 194–205.

- Glaser, B., & Strauss, A. (1967). *The discovery of grounded theory*. Chicago: Aldine.
- Gorkin, M. (1987). *The uses of countertransference*. Northvale, NJ: Jason Aronson.
- Greenberg, J. (1998). A clinical moment. *Psychoanalytic Dialogues*, 8, 217–224.
- Greenberg, J. (2001). The analyst's participation: A new look. *Journal of the American Psychoanalytic Association*, 49, 359–381.
- Guest, G., Bunce, A., & Johnson, L. (2006). How many interviews are enough? An experiment with data saturation and variability. *Field Methods*, 18(1), 24. doi: 10.1177/1525822X05279903
- Guntrip, H. (1969). *Schizoid phenomena, object relations, and the self*. New York: International Universities Press.
- Hirsch, I. (1994). Countertransference love and theoretical model. *Psychoanalytic Dialogues*, 4, 171–192.
- Hoffman, I. Z. (1998a). Poetic transformations of erotic experience. *Psychoanalytic Dialogues*, 8, 791–804.
- Hoffman, I. Z. (1998b). *Ritual and spontaneity in the psychoanalytic process: A dialectical and constructivist view*. Hillsdale, NJ: Analytic Press.
- Hoffman, I. Z. (2009). Therapeutic passion in the countertransference. *Psychoanalytic Dialogues*, 19, 617–637.
- Kernberg, O. F. (1994). Love in the analytic setting. *Journal of the American Psychoanalytic Association*, 42, 1137–1157.
- Kristeva, J. (1987). *In the beginning was love: Psychoanalysis and faith*. New York: Columbia University Press.
- Lear, J. (1990). *Love and its place in nature: A philosophical interpretation of Freudian psychoanalysis*. New York: Farrar, Straus & Giroux.
- Little, M. (1951). Countertransference and the patient's response to it. *International Journal of Psycho-Analysis*, 32, 32–40.
- Little, M. I. (1977). *Psychotic anxieties and containment: A personal record of an analysis with Winnicott*. New York: Jason Aronson.
- Lin, L., Stamm, K., & Christidis, P. (2018, February). How diverse is the psychology workforce? *Monitor on Psychology*, 49(2).
<http://www.apa.org/monitor/2018/02/datapoint>

- Loewald, H. W. (1960). On the therapeutic action of psycho-analysis. *International Journal of Psycho-Analysis*, 41, 16–33.
- Lothane, Z. (1987). Love, seduction and trauma. *Psychoanalytic Review*, 74, 83–105.
- Lothane, Z. (1998). The feud between Freud and Ferenczi over love. *American Journal of Psychoanalysis*, 58, 21–39.
- Mann, D. (Ed.). (1999). *Erotic transference and countertransference: Clinical practice in psychotherapy*. New York: Routledge.
- Maroda, K. J. (1998). *Seduction, surrender, and transformation: Emotional engagement in the analytic process*. New York: Routledge.
- Maroda, K. J. (2002). No place to hide: Affectivity, the unconscious, and the development of relational technique. *Contemporary Psychoanalysis*, 38, 101–120.
- Maroda, K. J. (2010). *Psychodynamic techniques: Working with emotion in the therapeutic relationship*. New York: Guilford Press.
- Maroda, K. J. (2013). *The power of countertransference: Innovations in analytic technique* (2nd ed.). New York: Routledge.
- McCracken, G. (1988). *The long interview*. Newbury Park, CA: Sage Publications.
- McGuire, W. (Ed.) (1974). *The Freud/Jung letters: The correspondence between Sigmund Freud and C. G. Jung*. (R. Manheim & R. F. C. Hull, Trans.). Princeton, NJ: Princeton University Press.
- McWilliams, N. (2004). *Psychoanalytic psychotherapy: A practitioner's guide*. New York: Guilford Press.
- Mendelsohn, E. (2007). Analytic love: Possibilities and limitations. *Psychoanalytic Inquiry*, 27, 219–245.
- Merriam-Webster (n.d.). Love. In *Merriam-Webster.com dictionary*. Retrieved March 10, 2020, from <https://www.merriam-webster.com/dictionary/love>
- Mitchell, S. (1988). *Relational concepts in psychoanalysis*. Cambridge, MA: Harvard University Press.
- Mitchell, S. (1997). *Influence and autonomy in psychoanalysis*. Hillsdale, NJ: Analytic Press.

- Nacht, S. (1962). The curative factors in psycho-analysis. *International Journal of Psycho-Analysis*, 43, 206–211.
- Natterson, J. M. (2003). Love in psychotherapy. *Psychoanalytic Psychology*, 20, 509–521.
- Novick, J., & Novick, K. K. (2000). Love in the therapeutic alliance. *Journal of the American Psychoanalytic Association*, 48, 189–218.
- Pine, F. (1985). *Developmental theory and clinical process*. New Haven, CT: Yale University Press.
- Pizer, B. (2017). “Why can’t we be lovers?” When the price of love is loss of love: Boundary violations in a clinical context. *Psychoanalytic Psychology*, 34, 163–168.
- Pizer, S. A. (2004). Impasse recollected in tranquility: Love, dissociation, and discipline in the analytic process. *Psychoanalytic dialogues*, 14, 289–311.
- Rabin, H. M. (2003). Love in the countertransference: Controversies and questions. *Psychoanalytic Psychology*, 20, 677–690.
- Racker, H. (1957). The meanings and uses of countertransference. *Psychoanalytic Quarterly*, 26, 303–357.
- Racker (1968). *Transference and countertransference*. New York: International Universities Press.
- Renik, O. (1995). The ideal of the anonymous analyst and the problem of self-disclosure. *Psychoanalytic Quarterly*, 62, 553–571.
- Richards, L., & Morse, J. M. (2013). *Read me first for a user’s guide to qualitative methods* (3rd ed.). Los Angeles: Sage Publications.
- Schafer, R. (1983). *The analytic attitude*. New York: Basic Books.
- Searles, H. (1959). Oedipal love in the countertransference. *International Journal of Psycho-Analysis*, 40, 180–190.
- Searles, H. F. (1979). *Countertransference and related subjects: Selected papers*. New York: International Universities Press.
- Shaw, D. (2003). On the therapeutic action of analytic love. *Contemporary Psychoanalysis*, 39, 251–278.

- Shaw, D. (2018). Core competency: Love. In R. E. Barsness (Ed.), *Core competencies of relational psychoanalysis: A guide to practice, study, and research* (pp.201–217). New York: Routledge.
- Sherby, L. B. (2009). Considerations on countertransference love. *Contemporary Psychoanalysis*, 45, 65–81.
- Slavin, J. H. (2007). The imprisonment and liberation of love: The dangers and possibilities of love in the psychoanalytic relationship. *Psychoanalytic Inquiry*, 27, 197–218.
- Slavin, J. H., Rahmani, M., & Pollock, L. (1998). Reality and danger in psychoanalytic treatment. *Psychoanalytic Quarterly*, 67, 191–217.
- Sonne, J. L., & Jochai, D. (2014). The “vicissitudes of love” between therapist and patient: A review of the research on romantic and sexual feelings, thoughts, and behaviors in psychotherapy. *Journal of Clinical Psychology: In Session*, 70, 182–195.
- Steinberg, A., & Alpert, J. L. (2017). Sexual boundary violations: An agenda demanding more consideration. *Psychoanalytic Psychology*, 34, 221–225.
- Steingart, I. (1993). *A thing apart: Love and reality in the therapeutic relationship*. Northvale, NJ: Jason Aronson.
- Stolorow, R. D., Brandshcraft, B., & Atwood, G. E. (1987). *Psychoanalytic treatment: An intersubjective approach*. Hillsdale, NJ: Analytic Press.
- Strauss, A., & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques*. Newbury Park, CA: Sage.
- Tansey, M., & Burke, W. (1989). *Understanding countertransference: From projective identification to empathy*. Hillsdale, NJ: Analytic Press.
- Tauber, E. S. (1979). Countertransference re-examined. In L. Epstein and A. H. Feiner (Eds.), *Countertransference*. New York: Jason Aronson.
- Toronto, E. L. K. (2001). The human touch: An exploration of the role and meaning of physical touch in psychoanalysis. *Psychoanalytic Psychology*, 18, 37–54.
- Weinstein, R. S. (2007). What heals in psychoanalysis? *Psychoanalytic Inquiry*, 27, 302–309.
- Winnicott, D. W. (1947). Hate in the countertransference. In *Collected papers* (pp.194–203). New York: Basic Books, 1958.

Wolstein, B. (Ed.) (1988). *Essential papers on countertransference*. New York: New York University Press.