# The Analyst's Love: An Exploration

*By Ellen Y. Siegelman, Ph.D.*


## Abstract

In the course of their work, analysts come to feel a deep and uninvested love for most of their patients. Yet analytic love has not often been addressed in the literature except as a countertransference problem—an idealization or the grounds for an erotic enactment. After addressing the reasons for this gap in the literature, the paper considers the important contributions of Jung, Lambert, Gordon, Searles, and Coltart, among others. A review of the literature is followed by reference to the author's own clinical experience, and an examination of the distinction between and intertwining of eros and agape in the countertransference. The difference between analytic love and love in extra-analytic life is considered, as well as the way in which the mother/infant parallel is and is not a good fit. Finally, the author presents a way to think of analytic love as the container, or temenos, for the analyst's countertransference feelings of hatred and envy.


Keywords: love, analyst, countertransference, eros, agape

This paper, on a topic close to my heart, is about changes in the field that allow us to talk about a wider range of our experience as analysts, and about changes in my own understanding of the place and nature of the analyst's love.[1]

A British analytical psychologist, Robert Hobson, has written that while factual terms like "jam jar" retain a relatively constant meaning, *feeling* words—such as "love"—change their meaning for us as we develop. The child's definition of love and loving is very different from the mature adult's. And the love we may feel for patients is experienced differently in the course of our professional lives. There was a time early in my postdoctoral training in psychoanalytic psychotherapy at Mt. Zion Hospital in San Francisco when I would have cringed at the idea of "loving" one's patients, dismissed it as an irrelevance or a departure from so-called neutrality.

I am much less afraid of that term now, and I see it not as a sufficient but often a necessary condition in helping a patient constitute or reconstitute a self. If it is, indeed, a "growing" word, then I need to see my definition of it vis-à-vis patients as a "work in progress" or "a word in progress," and this paper as an attempt to circumambulate the meaning it has for me right now.

I'd like to start with a quotation from a wonderful book called A *General Theory of Love* by three University of California-San Francisco psychiatrists who write:

*A patient asks to surrender the life he knows and to enter an emotional world he has never seen; he offers himself up to be changed in ways he can't possibly envision. As his assurance of successful transmutation he has only the gossamer of faith. At the journey's end, he will no longer be who*

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*he was and his guide is someone he has every reason to mistrust. What Richard Selzer, M.D. once wrote of surgery is as true of therapy: only human love keeps this from being the act of two madmen. (Lewis et al., 2000, p. 190)*

I have subtitled my paper "An Exploration." Although I have read fairly widely in this area and have pondered it for years, I do not claim to have the last word on this complex, rather neglected, and at times disturbing topic. I hope that in reading this exploratory piece you will relate my observations to your clinical experience of love, attraction, and sometimes hatred that you have felt toward your patients.

In what follows, I will first examine the long silence of analysts on this subject and speculate about reasons for it. Next I will present some of my own experience with analytic love. Following that, I will reflect on the agape/eros distinction. Then I will sketch how analogies to the parent/child relationship are both useful and misleading in talking about the analytic dyad. Finally, I will say something about what I think defines this very special relationship and how analytic love can contribute to containment.

## The silence of the analysts

Much has been written in the literature of psychoanalysis and psychotherapy about the patient's loving—and especially erotic—feelings toward his or her therapist. However, the loving feeling of the analyst for the patient, according to psychoanalyst Irwin Hirsch (1988), is not usually discussed in the literature or in professional conferences, "but is probably inevitable in, and possibly essential for, fruitful long-term analytic experience" (p. 210) .

Why the silence on this complex and thorny subject, if it is, indeed, a significant component of analytic work? I can think of several possible reasons. One is that this kind of mature love is so unproblematic that there is nothing to say. Even if that were the case, it might still be useful to speculate about what constitutes such love on the part of the analyst and what differentiates it from the mature love we feel in other circumstances of our lives.

But the historical avoidance of the use of the term in the literature, especially the literature of psychoanalysis, may have other roots: Most of the early theoreticians of psychoanalysis were men who were notoriously uncomfortable with the word "love." Because psychoanalysis originally focused on drives and oedipal dynamics, the sexual dimension of love was highlighted. And the classical analysts clearly knew, some from painful personal experience—I found I had just written "sexperience"!—what the prophetess Diotima declared to Socrates in Plato's *Symposium*: "Eros, my dear Socrates, is a mighty daimon." Perhaps they felt there was no way to conceptualize a love that was not primarily erotic and that did not carry fearful potentiality for acting out. So when Freud wrote Jung in December, 1906, that "essentially, one might say, the cure is effected by love" (McGuire, 1974, pp.12-13), it was the *patient's* love he meant—a transference repetition that needed to be contained by the watchful analyst.

Interestingly, there is a fairly abundant literature on countertransference *hate*—a more acceptable four-letter word that is used unblinkingly by Winnicott and others—as though these negative feelings are helpful countertransference responses that do not pose

an enormous danger of enactment. In receiving our patients' transferences to us, we may have a predisposition to see their hate as more "real" than their love. Why should that be? Are we so afraid of idealization or so-called transference cures? I think as depth psychologists we generally assume that we are on safer ground with the negative emotions, because this means we are not whitewashing the shadow. And in addition, some analysts may be made more uncomfortable by their patients' love than by their other feelings.

Perhaps the early psychoanalysts were also reacting against the supposed excesses of Ferenczi, who believed it was the analyst's love that ultimately heals the patient. Ferenczi's insight and his genuine foreshadowing of many current clinical notions about intersubjectivity, mutuality, and the two-person field may have been obscured by some of his practices—including the physical touching and the reversal of roles with one female patient, who for a time acted as a therapist to Ferenczi. (The last idea, of course, while not carried out literally, was reflected in Harold Searles's path-breaking paper "The Patient as Therapist to His Analyst" (1975), which took the view that the patient often has a particularly astute take on his analyst and is seeking to preserve or heal the analyst.)

Freud himself was conflicted about the analyst's love and affection. In a letter to Binswanger in 1913 he wrote, "To give someone too little because one loves him too much is being unjust to the patient and a technical error" (quoted in Weinstein, 1988, p. 193). On the other hand, Marie Bonaparte reported that Freud had said to her: "One must never love one's patients. Whenever I thought I did, the analysis suffered terribly from it. One ought to remain completely cool" (ibid.). But we can see that the classical psychoanalytic position is itself a countertransference phenomenon. As one writer put it, "It is the therapist's fear of using himself; it indirectly discourages the patient's confidence and daring in respect of his own contribution" (Tauber, 1979, p. 65).

Even more recently, when Roy Schafer wrote in *The Analytic Attitude* (1983) of the analyst's positive feelings for the patient, he eschewed the word "love" and instead talked of analytic appreciation of the analysand "as analysand, that is, of the unitary though conflicted person living out all this adversity and achievement during the analytic process itself and reflecting on it with benefit" (p. 65). To me this sounds rather tepid and denatured.

Under the classical drive-conflict model, interpretation is what matters and is mutative. Of course, that means that a certain degree of respectful empathy is required in order to provide a safe container, but its function is secondary. With the development of two-person psychology stemming from the object-relations analysts and the interpersonalists, the emphasis shifts. Balint and even Kernberg can talk about "tenderness" as a component of mature love. The relational-model theorists attribute more power to the relationship than to interpretations per se. They take as a model parent-child love in an atmosphere of regression to dependence, focusing on the pre-oedipal aspects of their patients' dynamics.

The object-relations analysts and more recently the intersubjectivists are less authoritarian, more likely to consider the possibility that their patients' perceptions of them may be accurate,

rather than automatically labeling them as transference distortions. The analytic relationship becomes more of a dialogue, in which each participant is attuned to the unconscious of the other. This understanding was anticipated of course in Jung's classic work "The Psychology of the Transference" (1946), whose prescience has yet to be acknowledged by our psychoanalytic colleagues. What Jung added to the one-person Freudian view of the analyst as receiver of the patient's unconscious is the notion of *mutual* communication and influence, with both analyst and patient sending and receiving unconscious projections. To cite one of the most justly famous passages in "The Psychology of the Transference," Jung compares the "doctor" to the alchemist, "who no longer knew whether he was melting the mysterious amalgam in the crucible or whether he was the salamander glowing in the fire. Psychological induction inevitably causes the two parties to get involved in the transformation of the third and to be themselves transformed in the process" (*CW 16*, p. 198). In this way, long before Thomas Ogden propounded the concept of "the analytic third," Jung was writing about it and clearly recognizing the emotional intensity generated in the analytic couple.

The classical psychoanalytic view that either the analyst's feelings toward the patient are the product of neurotic countertransference or have been put into her by the patient (via projective identification) seems from our vantage point too extreme and one-sided. Searles regarded feelings of love for his patients as also originating in himself. He was quite open and courageous in revealing his feelings in print and occasionally directly to his patients. In his paper "Oedipal Love in the Countertransference" (Searles 1959a), he wrote of the necessity of relinquishing the patient both as a cherished infant and as an adult responded to at the level of genital love. He felt there was a direct connection between the extent to which the analyst experiences loving and erotic feelings—along with the impossibility of enacting them—and the patient's psychological growth.

In a strange way, this "love that dared not speak its name" in most classical psychoanalytic circles is talked about by mavericks like Searles, and more recently by Bryce Boyer, a Berkeley, California, analyst who was known until his recent death for his impatience with orthodoxy, his willingness to work with severely disturbed patients, and his ready access to his own emotional life. Both Searles and Boyer were somewhat larger-than-life figures with a distinct sense of their own personhood that went beyond school or doctrine. Perhaps their work with primitive mental states freed them up, or perhaps their greater psychological amplitude allowed them to experience and write about such feelings. Boyer, who was persona non grata to many classical psychoanalysts, wrote in the preface to his last book:

> *I have come to believe that in a successful analysis, the analyst develops a form of deep love for his patient, one that has both maternal and paternal aspects. The love is never stated directly or acted out in terms of violations of the analytic frame. Nonetheless, the love is experienced by the analysand and introjected as a good, but not idealized, internal object. Sometimes I think that the patient's introjection of the loving object provides such patients with a self that can be analyzed." (1999, p. xxii)*

And Thomas Ogden (personal communication, 2000), both mentor and student of Boyer has said, "I do agree with Bryce [Boyer] that countertransference love is an important part of what goes on, and if it doesn't *ever* occur in an analytic treatment, there's something badly missing."

This notion of the importance of the analyst's love for the patient may be an idea whose time has come round at last. I note that within the last dozen years a number of books and papers have appeared in both the analytical psychology literature and the psychoanalytic literature with titles like: *The Love Cure* (J. Haule, 1996); "Love in the Therapeutic Alliance" (Novick & Novick, 2000); "Should Analysts Love Their Patients?" (Weinstein, 1988); *Love and Hate in the Analytic Setting* (Gabbard, 1997). Not to mention an article by psychoanalyst Zvi Lothane (1999), who wrote a paper on the "tender love" between Jung and Sabina Spielrein, taking a position that their relation was not sexually consummated and emphasizing the function of non-erotic love in the therapeutic relationship.

Still, analysts are wary in writing about this subject. In his review of the history of mature love in the countertransference, Hirsch (1988) cites Erich Fromm and Rollo May, whose "existential strain...seems to echo Buber's I-Thou relatedness." He dismisses this as "cloying and ministerial" (p. 205). Yes, it can be. And yet the analysts with whom I feel the greatest kinship in this enterprise—Nina Coltart from the psychoanalytic object-relations tradition and Kenneth Lambert and Rosemary Gordon from the London Jungians—converge despite their differences on a Buber-like notion of the analytic relationship. What is missing from the psychoanalytic literature in general is any sense of the sacred in the analytic relationship—and if the word "love" is almost unpronounceable for many psychoanalysts, then "sacred" is like a huge bone that sticks in the craw.

## My own experience with analytic love

In moving away from the theoretical realm to draw on my own clinical experience, I am prompted to ask myself: Is this kind of love something I feel for all patients, or only for some? And if only some, what makes it possible? Is analytic love separable from the erotic? Is it demanding? Is it hopeful? Is it prayerful? What does it mean to say one "loves" one's patient? How does this differ from extra-analytic love? What about patients who are and remain almost intrinsically unlovable?

Leon Festinger, the social psychologist who propounded the theory of cognitive dissonance, once said in a class, "You love what you have suffered for." Is it the patients who cause us the most grief whom we love the most? Not in my experience. Jung wrote that analysis begins when the patient becomes a problem for the analyst, and in some sense that's true. But before that, to contain the problem that the patient becomes, one needs to have established some kind of mutual trust and respect.

I find myself thinking of the patient from whom *I* suffered most and with whom I was never able to establish that ground during the course of her six-year therapy. This was a woman I saw some thirty years ago when I was a fledgling therapist, after she had been dismissed by her previous therapist. Even with the zeal that beginning therapists bring to the enterprise I could

never feel love for her in the face of her verbal attack, disparagement, and occasional physical threats. The closest I could come to a positive feeling was some genuine admiration for her persistence and her care for the one being in the universe she loved—her cat. But when at one point I expressed appreciation for that capacity in her, she returned my acknowledgment with a hostile, "What's *that* supposed to mean?" Perhaps the only time we connected was when I said to her at one point, "It's terrible that when you most need love, you behave most hatefully." Years later, she quoted it back to me, realizing it was all too true. After years of work, with some slight gains, the therapy had become really stalled and I felt exhausted. I had pondered "dismissing" this patient for months, and although our work was incomplete, I felt I couldn't justify seeing someone about whom I was increasingly having negative fantasies, the mildest of which was extending my vacation so I wouldn't have to meet with her. My consultant validated my decision. When I finally told my patient that I had done all I could and it was no service to her for me to go on seeing her, she actually seemed relieved. It was as though she herself had been wanting to end our work and, not knowing how to do it, she was sending out cues that I had unconsciously been picking up in what I would later in my career come to understand as a projective identification. I generally wait for the patient—or the patient's unconscious—to initiate ending. But perhaps in this case her unconscious had been cuing me without my recognizing it.

I started to write about analytic love and have found myself writing about analytic disaffection and even hate. I don't think this seeming departure is an accident: For it is essential to acknowledge the possibility that at times an analyst may actually hate a patient, even one she loves. Indeed, lacking that possibility, one cannot allow its opposite. If we cannot allow ourselves the freedom occasionally to hate—even the patients we care about deeply—analytic love becomes reduced to mere sentimentality and piety.[2] Furthermore, these occasional flashes of hatred may tell me something I need to know about myself (for example, that my narcissism has been attacked and I feel defensive, which can interfere with considering the function the patient's superciliousness or contempt may have for him). Or a more "objective hate" may tell me something I need to know about the patient: This disaffection is what she evokes in others around her, and she is testing me to see if I can take her provocation without retaliating.

Why do some patients inspire love more than others? This is a complex question. Often, the feeling comes from a deep affinity based on likeness of type or taste or way of apprehending psychic reality. But not always. I have sometimes felt a tenderness that surprises me for people totally unlike me—perhaps it's a fascination with their very otherness—their political skill, their ability to experience without judgment, their extraversion.

But of course it is not surprising that I feel this affinity more with people who are intuitive, who "get the hang" of things without elaborate explanations—that is, people who are more self-reflective and psychologically minded—than with those who have trouble seeing the symbolic nature of the enterprise.

Sometimes I experience for women analysands a kind of love as for the

daughter I never had. I think of one woman in particular, a potter, who wore soft, drapey Art Nouveau clothes in subtle blues and mauves. As she lay on my couch with her hands crossed over her chest, she looked to me like a medieval princess lying atop a sarcophagus in a Gothic cathedral. She had a grace, an almost mythic quality, and her love of music was as great as mine. Our deep affinities meant she could intuit things about me that many people would not: her fantasies about what my house would look like, what I would seek in a book or a friend were stunningly accurate. I was a little in love with her. And I think it was that bit of being "in love" that made the difference. She could sense without my saying it how proud I was of her newfound dedication to her craft. But in the period when she descended into an agitated depression, I was able to withstand her attacks on me and on our work without caving into discouragement and despair and without any impulse to retaliate because I could hold in mind the weave of our enduring connection.

My caring about her was not contingent on her performance in the room or in her outside life. And perhaps that is the essence of analytic love—it is felt for the whole person. It hooks into some connectedness, even at moments some merger, between my patient and me. Perhaps it is because I feel I have glimpsed what Winnicott calls "the true self" or what Jung calls the Self of this person. And that self, as we know, is not all pretty. Completeness means embracing the dark side of oneself and the other. When anyone presents to me from his or her depths, beyond the persona, whatever they are giving me—or sometimes hurling at me—inspires a kind of awe.

It can be the mute or anguished pain of feeling blocked, yet struggling again and again to find a foothold in the difficult work of analysis and, indeed, of living. It recalls the starkest paradox in Samuel Beckett's grim and funny existentialism. At the end of Beckett's short novel *The Unnameable*, the protagonist's last lines are: "I can't go on. I'll go on." It takes grit to hold those two opposite feelings in tension *and* continue to go on. Analytic love means respecting this persistence in the face of almost overwhelming impulses to give up.

I think of a woman analysand who taught mostly black children in an inner-city school. Having grown up in rural Louisiana, daughter of a stern Baptist sharecropper, she had managed to educate herself with loans and get an advanced degree. And now she was doing the difficult work of analysis with sparse and intermittent rewards. I loved her humor, her zest despite being without a partner, her determination to work at analysis no matter how terrified she was of expressing her deep and contradictory feelings about me, how anguished the recollections of her bleak childhood, how much she wanted to flee.

But to say "I loved her humor" is to belie the nature of analytic love. It can be broken down into attributes, but really what one loves is the unique gestalt of this particular human being. In that sense it feels a bit like the love of a mother for her infant: I love him because he's himself, not because he has silky brown hair, or a dimple in his left cheek. A mother might say, "There are times, when he's colicky, too clinging, stubbornly flailing in my arms, when I actually hate him." (And Winnicott has given us 18 good reasons why a mother sometimes hates her child.) Yet that does not destroy the ground of love. The

opposite of love, after all, is not hate but indifference. Indeed, in any deeply related couple, moments of hate are inevitable, whether it's a husband and wife, a parent and child, an analyst and analysand. I don't want, however, to push the analogy (analyst is to patient as mother is to baby) too far. There is a danger of grandiosity in a therapist who presumes to be "a better mother." Furthermore, in most ways, the analogy doesn't hold. To lose sight of the adult in the patient is to capitulate to a metaphor that is only partly accurate. Analysts need to relate to their patients as adult to adult as well as adult to child. And on a few occasions in my work, I have felt myself like a child being nurtured or instructed by an analysand. I think of one patient who in her maturing has taught me a lot about decentering from the position of hurt ego to an awareness of the other as truly *other*, an independent source of being whose motives are not always directed at hurting, pleasing, attacking, or adoring oneself. And I have been helped to play by patients who have the capacity to take something from me—an association or a metaphor—and embellish it, as in the squiggles Winnicott made with his young patients.

Analytic love at its best is not sentimental because it is differentiated and because it is not blind. Constant idealized admiration does no service to an analysand. This is *knowing* love: love that knows how difficult, envious, despairing, crotchety, colicky the patient can be, how he can "heap and task" us, as Captain Ahab is heaped and tasked by Moby Dick, the white whale. I think of a woman patient, a therapist herself, sensitive and properly brought up, as I had been. For her it became a triumph that she could tell me off, criticize my office and my gray satin blouse, disparage an interpretation I had given her as off the mark, and rail against me when I raised my fee. I have found it interesting that the criticism I fear elsewhere in my life, I can generally hold in suspension in the analytic process. I can go beyond the purely personal to look at the possible truth in a patient's criticism as well as to see the meaning of his or her wanting to criticize or disparage me. In this context, I can take and even welcome criticism. Perhaps my function as analyst gives me a more solid container in which to reflect on the meaning of these attacks.

An outstanding feature of analytic love is that it is "aim-inhibited"; that is, it does not press for gratification of the analyst—whether for sexual desires or narcissistic needs to be admired. Of course, being human, we do want and get some narcissistic rewards from working well and being valued. But I am thinking of more grandiose needs to save, rescue, or redeem. Any time we think, even subliminally, "I will heal this broken, traumatized person with my love," we are on the dangerous ground of hubris.

Healing occurs in the presence of love, but not because it is used instrumentally. In fact, one might question whether love "used instrumentally" is love at all. Clearly, the kind of love I am talking of arises from some place in the analyst that is beyond the ego, and it cannot be used to further the aims of the ego.

Furthermore, analytic love does not attach itself too tightly to a particular outcome. Yes, it is better when our patients are more successful in work and love and play, when they are beginning to unfreeze what Beverley Zabriskie (1997) has aptly called the "frozen accidents" in their psyches. But

I hope my caring for a patient doesn't ultimately depend on how good he or she makes me feel by succeeding—whatever that means—and thus indirectly giving me a good report card. "If you look good, we look good" goes the slogan of a noted hairdresser. But analysis is not about looking good, it's about being real. And anyone being authentically himself or herself is intrinsically worthy of love and respect. But is that *really* true? What if being intrinsically oneself means being a monster? Are there irredeemable people, irredeemable patients? These are hard questions that we analysts struggle with, either theoretically or through painful experience. Speaking for myself, there are certain kinds of people (e.g., child molesters) I would have great difficulty working with. I think it is essential to know the limits of one's own capacity for caring because it is no service to take on a patient for whom one doesn't feel the *possibility* of love.

On the other side of the Scylla of not being able to love enough is the Charybdis of loving too much, becoming too attached. In analysis, as in life, loving may mean letting go. It means letting go of the need to move in first with the stunning interpretation and often waiting till the patient comes to it himself. This, as Winnicott (1971) movingly pointed out, has not to do with the analyst's internal framing of interpretations; it has to do with delivering them to the patient. He wrote:

> *If only we can wait, the patient arrives at understanding creatively and with much joy, and I now enjoy this joy more than I used to enjoy the sense of being clever. I think I interpret mainly to let the patient know the limits of my understanding. The principle is that it is the patient and only the patient who has the answers. (Winnicott, 1971, pp.86-87)*

Loving the patient also means letting go of the connection when an analysand is ready to stop. Someone once defined psychoanalysis as "the longest goodbye." The actual endings of analyses are unique among human endings. How often does one *choose* to end a deep, intimate, fruitful relationship? The closest analogy is to adolescent children leaving the parental home. But it's not a very good analogy, because we can continue to have sustained and sustaining relationships with our children into their adulthood.

Having presented some of my own reflections and questions I should like to move to a larger arena, looking all too briefly at the amalgam of eros and agape in analytic love.

## Eros and agape

While eros generally connotes love that is sexually colored, agape is a less pressing kind of love. Erotic feelings do arise between analysts, male and female, for their patients. Schaverien (1996) has explored erotic feelings in the countertransference of female analysts and their male patients. These feelings must be honored for the coloration and intensity they bring to the work; they must not, of course, be acted out. I have found that sometimes when I feel erotic attraction to a patient, it is because the patient needs me to feel that for him or her. Betty Meador's important paper (1984) illuminates the female analyst's archetypal erotic as well as agapaic countertransference to the wounded child in a woman patient. David Sedgwick in *The Wounded Healer* (1994) movingly

describes his struggle to understand and contain his erotic countertransference to a woman analysand. We are also indebted to Peter Rutter (1989) for his courageous exploration of his erotic attraction to a female patient, which became one of his motivations to write about sex in situations of unequal power. This love is unspoken and not made concrete but rather is an ingredient in the analytic bath we swim in. I think of a male analysand who was constantly testing me by his denigration, often alternating with idealization. It takes a lot of inner work to receive these affects and attempt to understand them rather than viscerally responding. But my continuing to experience him as physically attractive was, I believe, a way to preserve something of value in him even when that was difficult. I think of another male patient who became much more erotically attractive to me over time as he became more developed and brought more of himself into the room. Indeed, some writers, among them John Haule, a Boston Jungian and author of *The Love Cure* (1996), feel the analytic experience is *quintessentially* erotic.

More generally, though, I believe that agape is the hallmark of the analyst's love. If eros is felt in the loins, agape may be experienced physically as a warmth or tenderness around the heart. Agape can be thought of as compassion or "charity" as the King James version of the Bible defines it. I have found the writing of Kenneth Lambert, a British Jungian, to be particularly helpful and moving on this subject. He cites the passage in 1 Corinthians (13:4-8) in which Paul is addressing pastors in the church—whom Lambert (1981) regards as the early prototypes of psychotherapists:

> *Charity suffereth long and is kind, charity envieth not; charity vaunteth not itself, is not puffed up. Doth not behave itself unseemly, seeketh not her own, is not easily provoked, thinketh no evil; beareth all things, believeth all things, hopeth all things, endureth all things. Charity never faileth.*

Lambert sees parallels in this definition of charity to the analyst's constancy, freedom from requiring narcissistic gratification from patients, capacity for kindness and for deferring anger, and a kind of selflessness. One of the cardinal qualities of charity in this passage from Corinthians is that charity "*hopeth* all things." One of the analyst's most difficult and essential tasks is to continue to hope when the patient cannot. It is not an easy thing to be uninfected by another's despair. But to carry the self when the patient cannot means to carry the hope for his or her potential. This may be a kind of maternal function, whether the analyst is literally male or female.

Barbara Stevens Sullivan (1989) has written thoughtfully about psychotherapy conducted under the aegis of the feminine principle. I too believe the analyst must embody the "feminine"—the side that wishes to contain, to hold psychologically, to spare the patient from pain, as a mother wishes to spare her children from pain. But as Sullivan herself acknowledges, the so-called feminine may be the ground but is not the entirety of the analytic landscape. In fact, as Murray Stein (1984) has warned us, we must question any countertransference stance that becomes monolithic and repeated. One such stance is what he calls the *maieutic* (or midwife) countertransference. The midwife, he explains, has to produce a birth; but as we all know, in analysis the birth is often

prolonged or even aborted. If we require that our patients give birth prematurely, they may shut down and stop their labor.

So apart from a "feminine" or more receptive capacity, the analyst must also embody a kind of "masculine" principle of tough-mindedness, boundary-keeping (Winnicott suggests that the analyst's hate is exemplified in calling the time at the end of the hour), and the knowledge that the patient *cannot* be spared pain, because psychological growth often comes through pain. We can only hope that our analysands can be spared repetitive, self-defeating, self-induced pain.

The charity or agape Lambert writes of must also be able at times to transcend not only hatred but envy of the patient. The crucial point is that the therapist needs to be able to understand and titrate these feelings so that they are no longer destructive but can be used in service of the work. Unlike St. Paul, Lambert does not decry the so-called base feelings in the analyst. His only concern is that they do not get inflicted or enacted upon the patient but instead become "a stimulus to constructive work." This "constructive work" may require the analyst to work on herself—to understand more about her own history of envy (going back to the rivalry among brothers and sisters, the competition for parental love) and how envy can be the other side of the coin of admiration. I have sometimes envied patients I cared deeply about: I have envied their psychological intimacy with friends or family, envied their ready access to the unconscious in painting or writing, envied at times their capacity to have and recall significant dreams, envied—as well as rejoiced in—the ways they have sometimes outdistanced me. If the envy had been more than fleeting, if it had persisted or made it hard for me to listen with an analytic attitude, I would have sought consultation or further analysis.

At bottom the distinguishing quality of agape, as opposed to sexual love or even *philia* (the love of friends) is esteem, coupled with reflection. Here again, it is not idealizing or simple-minded: "What is required is an attitude that is benign enough because the malignant elements have been made conscious and partly overcome," says Lambert (1981, p. 40), linking it to love of one's fellow humans as creatures of God. In the braid of analytic love, surely one strand is respect. This respect prevents compassion from devolving into pity, where "pity" could imply looking down on, rather than "feeling with." In Jungian terms, it is respect for the patient's emergent self.

Having said all this, I now want to introduce the sympathetic but somewhat countervailing view of Rosemary Gordon, another analytic psychologist whose work I very much admire. Gordon (1993) agrees with Lambert that agape, as the defining characteristic of the therapist's love, helps to guard against Dionysian excess. But she feels it can lead to a kind of leached-out, Apollonian nobility that requires almost superhuman purity. Agape may feel, as it sometimes does to me, a little too churchy. Although the word itself is Greek, it was more prominently used in Christian doctrine. Indeed, agape, Gordon tells us, was the name given to the meal shared by the Christian brethren that later became condensed and symbolized in the Eucharist.

And the word "eros" may helpfully be glossed as well. The Greeks used eros more often than agape, and with more enthusiasm, since it had to do with magic, power, and ecstasy, which

in its extreme form could extend to Dionysian frenzy. But as Bruno Bettelheim (cited by Gordon) pointed out, Eros is not to be confused with Cupid, "who is only a mischievous irresponsible little boy." Eros is "fully grown, at the height of his beauty and strength of young manhood, and he is wedded to Psyche, the soul, in everlasting love and devotion" (Gordon, 1993, p. 250). Agape, if not annealed with eros, can be too dull and arid. The passionate part of analysis, the vitality and deep mutual involvement, comes from the presence of eros, from being "a little bit in love" with the patient. Gordon says that one of her criteria in accepting a patient is that it be someone she could imagine literally touching or being touched by, even if that were never to become enacted. I agree with her conclusion that "both forms of love are necessary and both play their part in the powerful yet fragile interaction and interdependence of patient and analyst-therapist" (Gordon, 1993, p. 256).

Some analysts may have to struggle more with keeping the erotic under control; others analysts may have to struggle with the maternal/protective countertransference that, as Gordon puts it, keeps the patient "so close to their metaphorical breast" that the patient may never want to leave home. This observation brings me to examine the accuracy of the metaphor of analyst/mother and patient/child.

## Parental love and analytic love

Hans Loewald has written of a vision of the patient that he or she can perceive in the analyst's eye—a kind of gleam. We know how crucial it is for infants and children to perceive this gleam or beam. Loewald (1960) likens the analyst's gleam to the vision parents have of their child:

> *This vision, informed by the parent's own experience and knowledge of growth and future, is, ideally, a more articulated and integrated version of the core of being that the child presents to the parents. This "more" that the parent sees and knows, he mediates to the child so that the child in identification with it can grow. (p. 20)*

In the work I do as an analyst, I can see the lineaments of the patient still waiting to emerge. Yes, analytic love is an act of faith as well as hope, directed at who the person may become. But I believe it must also be directed at who the patient is right now. Otherwise the respect may have too promissory or contingent a flavor.

I go back to my own experience as a first-time mother many years ago: When my first-born son was ten days old, a staff photographer from the magazine I had edited for a number of years came out to take our picture. It's a very revealing photograph: In the foreground, close up, is the baby, his face looking a bit wizened and smushed together, as the faces of newborns often do; and in the background, hazier, am I with a look on my face that I can only describe as rapture. But I don't think that that look was based on any sense that this baby would become the attractive and wonderful boy and man he grew into: I saw him as beautiful and miraculous even then.

Again, we shouldn't push the analogy between parents and analysts too far, but I believe the gleam in the analyst's eye is a necessary if not sufficient condition for analytic success. And this involves, according to Balint (1952), a tender feeling toward the patient that

does not press for reciprocation, and respect for who the patient presently is as well as who he or she can become.

An aside here: I have observed how hard it is to talk about the analytic relationship without analogizing it to other relationships. I do not say this in a disparaging way: this is how the mind works. We describe the unfamiliar in terms of what we already know. But, having written extensively about metaphor (Siegelman, 1990, 1991), I know that it is basic to the way we apprehend the world, useful, and also potentially misleading if taken too literally. Yes, the analytic relationship has aspects of mother/child, father/child, teacher/pupil, confessor/ congregant, friendship or "lovership." But we must recognize that none of these represents an exact analogy. The fact is that the analytic relationship, even when understood in a more mutual, more egalitarian way, is not like these others, because it is also a *symbolic* relationship in which the analyst both participates fully and at the same time continually monitors its conscious or unconscious meanings.

I want to highlight a couple of further statements by Nina Coltart, an analyst from the British independent school who wrote with extraordinary directness and lack of jargon about her clinical work, as well as her commitment to a Buddhist practice. In her essay on analytic love, Coltart (1992) cites two papers that undergirded her work—one was Winnicott's paper "Hate in the Countertransference" (1947). The other was Searles's paper "The Effort to Drive the Other Person Crazy" (1959b). Both these papers give the analyst permission to have the most painful negative feelings toward the patient, but also exhort the analyst to use them informatively and constructively. In the midst of Searles's paper, in which he describes the vengeful and hateful feelings of patients toward him which then stir up corresponding feelings in the analyst, Searles suddenly segues into this deeply felt, authentic (and neither cloying nor ministerial) paragraph:

*The fostering of the other person's intrapersonal and interpersonal integration and self-realization is a part of the loving relatedness defined by the philosopher-theologian Martin Buber. Buber refers to this as "making the other person present," and adds: "The help that human beings give each other in becoming a self leads the life between them to its height..." To put it in other words, it seems to me that the essence of loving relatedness entails a responding to the wholeness of the other person, including responding to a larger person in him than he is himself aware of being, to help restore that wholeness. I speak of psychotherapy here, but I mean, in some degree, to all people. (1959b, pp. 269-70)*

In applauding this passage, Coltart was not afraid to acknowledge the sacred dimension of therapy. Nor was she afraid, writing in a similar vein to use the word "love." She wrote:

*We [analysts]...all mostly have the repeated experience of coming to like, certainly to care for, and probably if we are deeply open to ourselves, and unafraid, to love each patient as the analysis unfolds....I hesitated to employ this emotive and frequently misunderstood word for many years until such time as it was borne in on me compellingly that it was the word I wanted. (Coltart, 1992, p. 90)*

She tells us that this love is comprised of patience, endurance, humor, kindness, and courage, as well as a special kind of detachment that is dedicated to helping the other lead a fuller,

more conscious life. She writes that this love is not always the *prevailing* affect in the analyst, but it is "the matrix...the only trustworthy container in which we may have to feel hatred, rage, or contempt for varying periods of time" (Coltart, 1992, p. 121).

## The analyst's love as temenos

Much has been written by Jung, Bion, and Langs about the container and the contained in human relationships and in analysis. We know that the analytic frame—regularity of time and place and constancy of the analyst—provides a container or sacred space in which analytic change can occur. Some analysts believe that Freud's specification of the frame (couch, regularity, fees) was even more important for psychoanalytic practice than the fundamental rule of free association. And we know the value Jung placed, drawing on alchemical processes, of the *temenos* and the *vas bene clausum*—the well-sealed container.

How can we think about the frame of analysis? Marion Milner is helpful here. She wrote of frames that demarcate a unique space, whether it be the frame of a painting, of a play framed by the stage and an analytic hour:

> *Thus when there is a frame it surely serves to indicate that what's inside the frame has to be interpreted in a different way from what's outside it....Thus the frame marks off an area within which what is perceived has to be taken symbolically, while what is outside the frame is taken literally....[A]s analysts, we have learnt by experience that an apparently casual remark made within the frame of the session also makes sense if understood symbolically. (Milner, 1972, pp. 157-8)*

I like the "also" rather than "only" because it maintains the tension and the paradox. And it *is* a paradox. For while the feelings we experience in the room are felt, bodily feelings, the symbolic nature of the enterprise gives them a different cast or coloration. The paradox can be analogized by several of the paintings of René Magritte.[3] I am thinking of one in which the artist has painted a landscape seen through a studio window, in which the painting on the easel is continuous with the landscape outside, and it is only by noticing the edge of the canvas and the outline of the framing easel that we see it is a created work. Or the famous realistic painting of a pipe with the legend on the painting: "*Ceci n'est pas une pipe*." It *is*, of course, a pipe—but a picture of a pipe, not a real pipe. So the relationship between analyst and patients bears many of the hallmarks of "real" relationships—including deep and passionate feelings on both sides, but it is also a symbolic one, which is demarcated and set apart by the frame or container.

The first level of containment, then, is the analytic setting itself and its rituals and limits. But the additional kind of containment that Coltart described is supplied by the *person* of the analyst—not just the professionalism but the quality of his or her devotion—and that provides the real containment. If the love is not contained but obsessive or enacted, it is a signal that consultation or further analytic work of one's own is required. What keeps it from being enacted are the qualities I have mentioned—respect for the analysand, for the unconscious, and for the sacredness of the joint enterprise. I think, though, that a neglected aspect of what makes mature analytic love different from the love we feel for

our partners, our children, our dearest friends, even our pets is the deep and wonderful paradox of analysis: it is both real *and* symbolic, and as Winnicott says of the transitional object, that paradox must be maintained. If it feels only symbolic, it becomes too rarefied; if it feels only real, it becomes too concrete and presses too much for enactment.

And perhaps this very paradox accounts for the special quality of analytic love, why we don't take it home with us, brood about it, obsess about it. Our awareness of the paradox keeps it both real *and* "as if"—a duality that is absent from most of our "real life" relationships. This strange hybrid of the actual and the symbolic is the very characteristic of transitional or potential space. In the moment—in the session—the feelings of both participants are strong and very real; and we certainly think about pleasures and problems with our patients between hours, but unless something is amiss, we do not obsess about them, either in love or in hate.

I want to conclude not with a summary but with an image. Lying in bed one night some months ago, I was mulling over this paper, and especially thinking about containment and how the analyst contains. In that state of *abaissement du niveau mental*, I was given an image: What I saw was a lacquered, multicolored, gourd-shaped Russian doll which could be opened at the middle. (You may remember these nesting dolls from your childhood). In my hypnagogic state, I felt curious and waited to see what would unfold.

I imagined opening the doll and finding nested within it another doll. I opened that one and saw yet a third. And these thoughts came to me: The first is the analytic container itself, the symbolic space that contains whatever is in it against leakage from the inside out and the outside in. Then nested within that is the person of the analyst who is himself/herself a container—through dedication to the sacredness of the calling and respect for the patient. So the analyst serves as a container for the patient, the third doll. And then I asked, in a kind of dreamy active imagination, "What's inside the patient that is nested in these multiple containers?" I pictured myself opening the third doll. I saw, to my surprise and delight, that nested inside the innermost doll was a tiny black figure. And lo! It was the little manikin in the frock coat, top hat, and shiny black boots that Jung had carved from a ruler, painted black, and placed in *its* container in the attic for safekeeping. At that moment I thought to myself, "What this manikin symbolizes—the patient's self—*that* is the innermost treasure that we as analysts contain by our committed presence, by our skill, and yes—by our love."

## Notes

1) This is a revised version of the paper given at the National Conference of Jungian Analysts, Santa Monica, California, February, 2001.
2) I am enormously grateful to Ann Ulanov for her incisive, brave, and humane exposition of hate in the analyst, which appeared in the last issue of this journal (2001).
3) This analogy was first suggested to me by Sue Ezekiel, Ph.D.

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