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Conditions for love: The psychoanalytic situation and the analyst's emotions

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Abstract

Freud has stated that the psychoanalytic cure is effected through the love of the patient for the analyst. This paper claims that the analyst's love towards the patient is often essential as well. Countertransference love might indeed be associated with therapeutic risks, yet it is often a crucial part of the analytic process, since in order to be able to change, many people need to feel loved. The analyst's curative love is defined by being both sublimated and passionate, modulated as well as libidinal. In addition, it is conscious, aware, and reflective, and hence any act based on it is directed solely to the patient's psychic growth. Developing and maintaining such love is not easy. What comes to the aid of the analyst is the special construction of the analytic setting, which brings up a profound, loving interest in patients' psyche as well as a "second self" that is consistently benevolent and loving and acts at a level of empathy rarely encountered in ordinary life.

Keywords: countertransference love, transference love, analytic setting.

Psychoanalysis is a procedure for investigating the processes of the mind, a treatment devoted to ameliorating the ailments of the mind and a general theory of the mind (Freud, 1923). However, the genius of psychoanalysis lies perhaps beyond these three workings – in the foundation that allows them. That is, in the psychoanalytic situation itself.

The analytic setting may be "Freud's most significant contribution to psychoanalytic technique," wrote Modell (1988, p. 583). Earlier, Khan (1972) claimed that:

The greatest invention of Freud will always be the invention of this unique human situation where a person can explore the meaning and experiential realities of his life, through a relationship with another, and yet not be intruded upon or manipulated in any way that is not true to his own self and values. (p. 127)

From this perspective, the creation of the analytic setting is not just a means towards some other goal. As Küstlicher (1996) argued, the aim of psychoanalysis is not primarily to achieve any therapeutic effectivity,

but "*to provide the very space for thoughts, not previously thought, words, not yet articulated, and feelings, previously unexperienced*" (p. 164, emphasis added).

In this paper, I focus specifically on loving feelings experienced in this special context. The analytic frame, I argue, has formed and evolved, mostly unconsciously, to allow and even invite the emergence of such feelings, in the patient and, even more importantly, in the analyst. This argument is original and has not been put forward in the existing analytic literature, as far as I could find.

Love, we have to keep in mind, is not a "thing" but can appear in various forms, in everyday life, as well as in the clinic. Novick and Novick (2000) wrote that "there is a potential either for growth-promoting, mutually enhancing forms of love in the treatment or for perverse, sadomasochistic 'loving' arising between patient and therapist" (p. 194). Love's presence could be problematic – but so can be its lack.

In the first section of the paper, I briefly describe the analytic setting and what characterizes it. I then proceed to explore how the setting enables and

encourages love in the patient towards the analyst, before discussing the more central love to arise in analysis in my opinion – that of the analyst towards the patient. I discuss the unique properties of the analyst's love, as well as problems that might be associated with it, and show how this special type of love is largely made possible by the intricate design of the analytic setting itself.

“A spirit of timelessness”: on the analytic situation

The analytic “situation,” “frame,” or simply “setting” is usually associated with the establishment and maintenance of the physical setting of the clinic and with the psychoanalytic contract. The latter is an agreement between analyst and patient that mainly concerns “two formal elements of mutual exchange: time and money” (Bleger, 1967, p. 511). In addition to negotiating the frequency and length of sessions, regular breaks, and means of payment, the contract also deals with use of the couch, limitation of communication to a verbal level, free association, and role of the analyst.

Some analysts also include the analytic attitude as part of the setting, perhaps even the most important part (Carpelan, 1981). This attitude is defined by a series of values that are not commonplace in everyday life, such as compassion, care, rationality, fairness, and truthfulness (Tubert-Oklander, 2008), as well as “endless curiosity; endorsement of the patient's thrust; an evocative sort of affection; a faithful intimacy” (Friedman, 1997, p. 31).

Another vital element of the psychoanalytic situation is its extraordinary interpersonal arrangement. This arrangement takes a specific shape at any moment of the treatment as a “co-construction” of the analyst and analysand (Hernández-Tubert, 2008, p. 248).

Collectively, the structural elements of the analytic situation create a room where two people have the opportunity to listen to and partake in their own and in each other's thoughts and feelings and the movements of the unconscious. This gives rise to “a spirit of timelessness,” which corresponds to the timelessness of the unconscious and our reveries (Künstlicher, 1996, p. 151).

The frame is, however, not all limitless. The boundaries set by the setting serve to guarantee the safety of both participants by channeling and absorbing the powerful psychological forces released by the analytic process. This important function of the setting is described by analytic terms such as Winnicott's “holding” or Bion's “container” (Green, 1975).

Rather than saying that the establishment of the setting reproduces an object relation, Green (1975)

found it “more appropriate to say that it is this which allows the birth and development of an object relation” (p. 11). When analysis succeeds, this new object relation, born in a context of holding, containing, and understanding in a timeless, faithful spirit of compassion, curiosity, and care, is a relationship that is loving in essence, even if at times it might be seen otherwise.

“The essence of the whole change”: on the patient's love

Love as the epitome of a worthy, healthy life has always been a central tenet in analytic theory and practice. As Fromm (1950) wrote: “Analytic therapy is essentially an attempt to help the patient gain or regain his capacity for love” (p. 87). Concluding his classic, *Theory of psychoanalytic technique*, Menninger (1958) wrote that the outcome of a successful analysis is a patient who has learned to live, that is – to love and to be loved. Within the philosophy of psychoanalysis, Menninger continued, it is implicit that “love is the greatest thing in the world” (pp. 178–179). Half a century later, to take an incidental example, Fosshage (2007) wrote similarly that “Fundamental experiences of love – that is, to love and to be loved – are central in development and maintenance of vitalized self-experience” (p. 330).

Of these two vital human growth experiences, to love and to be loved, analysts have usually focused on the first as the aim of treatment. This line of practice originated in Freud's famous remark, in his 1906 letter to Jung, that psychoanalysis is a healing effected through love (“eigentlich eine Heilung durch Liebe”; Freud, 1974). The idea was repeated in a letter to Eitingon, where Freud (1909) wrote, “the secret of therapy is to cure through love” (quoted in Falzeder, 1994, p. 310).

What he had in mind, Freud made clear, was the patient's love towards the analyst, aroused in the transference. “[W]hat turns out to be the essence of the whole change [is] the awakening of feelings,” Freud (1907) elaborated on how the patient's love facilitates the desirable transformation. “The process of cure is accomplished in a relapse into love ... Every psycho-analytic treatment is an attempt at liberating repressed love which has found a meagre outlet in the compromise of a symptom” (pp. 89–90).

This “liberation” is actively evoked by the analyst and by the “medical situation” (Freud 1915, p. 162). Celenza (2007) stressed “the seductiveness” of this situation: the patient's falling in love, she wrote, is “structured into the setting. This fact is definitional and must be accepted as a given” (p. 298). The setting models the analyst as a constant, caring, empathic, understanding, powerful presence,

which naturally “seduces” the patient to develop loving feelings towards them.

“One must never love one’s patients”: the taboo on analysts’ love

Transference love is considered a universal element of therapy, as it allows the patient to form new modes of relating. The love of analysts for their patients, however, was considered by Freud as a problem and hindrance. In his observations on transference love Freud (1915) reminded us of “the universally accepted standards of morality” and insisted “that the analyst must never under any circumstances accept or return the tender feelings that are offered him” (p. 163). In the aforementioned letter to Eitingon, Freud advised his friend “to develop the thick skin we need ... to dominate ‘countertransference,’ which is after all a permanent problem for us” (quoted in Falzeder, 1994, p. 310). To Marie Bonaparte he wrote in the clearest words: “One must never love one’s patients. Whenever I thought I did, the analysis suffered terribly from it. One ought to remain completely cool” (quoted in Weinstein, 1986, p. 104).

In the many decades that passed, this warning did not disappear from analysts’ minds. There remains a “surprising dearth of theoretical writings relating to this subject of analyst’s love for patients,” noticed Cohen (2006, p. 140).

There is a “consensus,” wrote Coen (1994), that analysts have difficulty tolerating intense passion between the analytic couple. Although we have acknowledged the need to deal with our anxiety, hate, rage, etc., dealing with love, affection, and tenderness in our work remains a profoundly uneasy task for many analysts (Charles, 1999).

Long after the “relational turn” in psychoanalysis, Shaw (2003) noted that case presentations referring to the role of analytic love are rare to find. Erotic or aggressive countertransferences are indeed widely conferred the status of therapeutic agents, he continued, and natural warmth, openness, and expressiveness are no longer considered anti-analytic, “Yet case presentations where feelings of tenderness, affection, and love for an analysand are openly expressed are often greeted with suspicion” (p. 253). The main objection is that if the analyst has loving feelings for a patient, these will make it very difficult to preserve the analytic posture of neutrality and might lead to an “acting out” of the analyst’s narcissistic need to cure (Coen, 1994).

Analytic love is not exiled in the twenty-first century, but it is still “fair to say that it is not readily and universally embraced, either,” concluded Shaw (2003, p. 255).

“The core mechanism of therapeutic action”: the importance of the analyst’s love

Yet the seemingly non-analytic position of love towards the patient is exactly where the setting leads the analyst. And the claim that loving the patient is crucial for therapeutic success is becoming more common.

The first to claim that the analyst’s love is central in the process of cure was Ferenczi (1988). He wrote that “an all conquering love” for each and every patient is a necessary condition for a curative process to take place: “no analysis can succeed if we do not succeed in really loving the patient,” he claimed (pp. 129–130).

This position was highly criticized at the time, and Ferenczi was accused by Freud on these grounds of showing *furor sanandi* (lit. “rage to cure;” Shaw, 2003, p. 253). Classical, “one-person” psychoanalysis emphasized understanding the patients and not the relationship formed with them (Lev, 2016). Slowly, though, other voices appeared, such as that of Segal (1962), who wrote that “a good therapeutic setting must include unconscious love in the analyst for the patient” (p. 232). More recently, claims such as “Love is the glue that cements the analytic work” (Weinstein, 2007, p. 306) or “successful treatment is based on feelings of love by the therapist/analyst toward his or her patients” (Cohen, 2006, p. 139) have become more mainstream.

The point is that, in order to be able to change, many people need to feel loved. Fairbairn (1952) said that the greatest need of children is to obtain conclusive assurance of two things: that they are genuinely loved as a person by their parents, and that their parents genuinely accept the child’s love. Frustration of this twofold desire, Fairbairn went on, “is *the greatest trauma* that a child can experience” (p. 39, emphasis added). Ferenczi’s idea was that in order to undo this common, yet “greatest” of traumas, the analyst must be able to genuinely love the patient.

In a contemporary description of this line of thinking Gerrard (2005) wrote that most people who approach therapy feel themselves unlovable in a deep way, and hence until the analyst feels moments of love towards the patient, the patient will not be able to develop fully. “I think it is only when a patient can arouse our deepest loving feelings (not empathy) that we can really hope for a truly positive outcome from our work”, she wrote (p. 27).

Such loving feelings convey to patients a deep and full acceptance of who they are, which is by itself therapeutic. The American psychoanalyst Thomas Malone (1976) claimed the following to be “the

most significant discovery” he has come to in thirty years of practice:

Before you can help anyone be different, you have to accept them as they are. ... Unless this occurs, nothing eventuates in the therapy. This means loving – enjoying – being with them as they are, without any insistence they have to be different for you to love them. (quoted in Field, 2005, p. 95)

Such love is to be thought of in “real” terms, that is, not just in terms of transference and countertransference. Of course, there are in analysis forms of love that are “merely” transference, but the love under discussion here is not one which necessarily constitutes the reconstruction of some previous relationship (see Cohen, 2006). Indeed, “real,” spontaneous expressions of love performed by the analyst “can be extremely powerful and transformative” (Stern, 2011, p. 497).

The genuineness of such expressions, and their effect on *the analyst*, might explain their powerful therapeutic effect. Fosshage (2007) gave a personal example of such a moment. At the end of an emotionally touching session, his patient at the door said genuinely, “I love you.” Fosshage recounted:

Feeling strongly the same toward her, I responded simply, ‘I love you too.’ I closed the door and the traditional analytic models came crashing down in my head. I thought to myself, ‘What have I done now? Was I seductive? Was I sexualizing the relationship? Did I lose my analytic position?’ ... For the patient, it so happened that this moment became a nodal experience of loving and feeling loved. (p. 334)

The next clinical vignette from my work in a psychiatric hospital can perhaps serve as a more detailed example of the intensity of love felt by the therapist.

Moses, about twice my age, very unorganized, and quite repulsive in appearance, was an unlikely candidate for a love story. Nobody at the ward wanted to work with him. When trying to convince me to take the case, this is what his psychiatrist came up with: “Moses is like a patient from the beginning of the twentieth century – a full-blown paranoid schizophrenic, with all textbook symptoms.” Moses was off medication, as the side-effects he suffered from all drugs were too severe. “You can’t find cases like this any more,” the psychiatrist pleaded.

Moses was indeed unremittingly psychotic. During our many meetings he would weave bizarrely complicated tales of personal involvement in espionage and global political affairs. He was very intelligent and his stories most compelling. But his paranoia soon turned towards me. I faced murder threats on a weekly basis and practically feared for my life. Moses was allowed to leave the hospital

grounds and could easily buy a knife at the nearby shopping centre. I didn’t have to figure this out myself; he elaborated his plans in our meetings.

The anxiety stayed with me all week, and the nights before my hospital days were sleepless. Still, I would go to work not because I had to, but because I wanted to. I wanted Moses to know I cared about him. I really did. I loved him. It was not because I was afraid of him, although I do think he made me afraid because he felt I loved him, and this was too frightening for him; I loved him in spite of that. We met twice a week and gradually I got to know him, discovering a radiant gentleness that was buried under hardened defensive layers, the outcome of many years of illness and deprivation. He was one of the most honest and true persons I have ever met, a completely authentic human being. It was not the schizophrenia, it was his soul, which I could glimpse in our conversations through the psychosis.

I survived the period of murder threats (and one actual physical assault), and our relationship endured too. Moses’ condition improved drastically, almost unbelievably (to the staff). After a long hospitalization in the chronic ward, it was planned that he would be transferred to an outpatient unit. But that is not the central point here. The central point is my love for him – for this shabby, smelly, toothless, uneducated person. In his traits and opinions he was almost the complete opposite of what I usually appreciate in people. In no other imaginable circumstances other than therapy could I recognize and learn to know this brilliant soul. I felt so lucky.

I still remember vividly the day after our last session. I was taking a shower, and cried bitterly. I was deeply sad at the thought of not seeing Moses ever again. I never did.

Moses was not alone. The analytic situation later allowed me, in another quite dramatic case, to love perhaps the most violent person I ever met – a militant Israeli settler, who appeared in our sessions with a gun and told me of his urge to murder “leftists” (like myself). Perhaps many successful therapies exhibit some variation on the theme of a bizarre love story.

“Betrayed by the promise of love”: dangers of analysts’ love

Love toward the patient, I argue, is a crucial element in the therapeutic process. Perhaps the most vivid, unapologetic expression of this idea was written by Harold Searles (1959):

I have found, time after time, that in the course of the work with every one of my patients who has progressed

to, or very far toward, a thoroughgoing analytic cure, I have experienced romantic and erotic desires to marry, and fantasies of being married to, the patient. Such fantasies and emotions have appeared in me usually relatively late in the course of treatment, have been present not briefly but usually for a number of months. (p. 180)

Still, feeling “romantic and erotic desires” in the way described by Searles can also be complicated and dangerous and, like all loving, carries the potential for “devastating disappointment” (Shaw, 2003, p. 275). In this section, some of the possible complications and dangers will be discussed.

First, even though transference love is important for analytic cure, many patients also need to experience and exhibit negative or ambivalent feelings toward the analyst during stages of their analytic process. In such cases, a loving, benevolent analytic position might unconsciously oppose and preclude these patients’ needs to experience the analyst, in the safety of the transference relationship, as a “bad” or even “terrible” object that does harm (Charles, 2017).

It is important to note that the analyst’s love, if genuine and professional, does not preclude the opposite feelings arising in him. As Winnicott (1949) wrote: “However much [the analyst] loves his patients he cannot avoid hating them and fearing them” (p. 69). Coltart (1991) described love as the quiet “living infrastructure of our life philosophy, and therefore of our philosophy of work” (p. 449). As such, she continued, “it is perfectly possible to dislike, or even hate, a patient for *necessary* periods of time during analysis and to be secure in the faith that this problem is temporary” (pp. 449, emphasis added).

Understanding the analyst’s countertransference love as “pure” and free from other, conflicting emotions is thus a simplistic view. Ehrlich (2010) wrote: “As analysts we recognize that even our most cherished values and ideals are infused with ambivalence” (p. 515). The natural ambivalence that characterizes all human relationships comes up also in analysis. This is very common for patients (e.g., Urmanche et al., 2019) but it is true also for analysts. Treating so-called “difficult patients” (e.g. Badaracco & Vermote, 2002) often raises unpleasant and seemingly “unloving” countertransference reactions. These can represent the patients’ conflicts regarding love, hate, or knowledge, projected into the analyst. Dealing with such reactions is an essential part of analytic work, as described for example by Waska (2011):

Once aware that projected aspects of someone else’s conflicts are being communicated, smuggled, or

forced into one’s mind via intrapsychic and interpersonal maneuvers, the analyst can attempt to step back, collect, and contain these pieces and patterns long enough to begin enduring, understanding, and processing them, with the eventual hope of interpreting them in some useful manner. (p. 167)

Allowing oneself to dislike or even hate a patient, or to let a patient experience oneself as terrible, are thus *in themselves*, in certain cases, expressions of analytic love. Only a loving attitude could allow analysts to fully take on themselves, and internalize and endure unpleasant mental pieces, roles or attitudes while facing the patient, if that is what is needed for the patient’s growth and health. Otherwise it is loving not the other, but oneself.

Another objection raised against the analyst loving the patient is that analysts may lose their freedom when not guarded by the principles of abstinence and neutrality. In this way one might develop “countertransference neuroses,” in which the patient becomes persistently and inappropriately of central importance to the analyst.

Of course, if unanalyzed by the analyst, such “neuroses” could hamper the analytic process. Yet the principles of abstinence and neutrality are means that allow the analyst to recognize the extent and form of love needed for the specific patient, and are not goals in themselves, as analysts sometimes conclude. If the analyst does not identify and process them, such “neuroses” may harm the analytic process. Neutrality allows the therapist to participate more freely in the regressive aspects of therapy and provides freer access to material close to their own and the patient’s consciousness.

Alongside this, a rigid adherence to the principles of abstinence and neutrality may also be problematic. The rules of anonymity and abstinence are important, but they must be distinguished from emotional detachment and sterility, which are not recommended and may not even be possible in the therapeutic session. It must also be remembered that neutrality means, among other things, non-judgmental empathy, the absence of intrusiveness, concern that does not create a sense of ownership, and a respectful appreciation of all aspects of the patient’s mental life.

Neutrality itself can be seen as a dynamic process. This is a flexible position, one that characterizes a therapist who is a “participant observer.” This position requires finding a “middle ground” between being an objective and distant observer and a more involved participation – a balance that is created jointly by the therapist and the patient. As Charles (2017) wrote, “we are always up against the line between too much thinking and too much feeling”

(p. 187). Both extremes can be problematic, not just the “too much feeling” one, as common analytic training usually conveys.

This common approach is probably the outcome of the devastating effect of what is sometimes considered “too much feeling.” In the most extreme cases of countertransference neuroses the analyst may act as a perpetrator due to confusion with respect to the concept of love (Ferenczi 1949). Chesick (1997) distinguished malignant “eroticized” countertransference, which often leads to sexual enactment, from “erotic” countertransference, which is therapeutic once properly analyzed and understood. Yet eroticized countertransference has nothing to do with actual love *for the patient*.

According to Gabbard (1996), in eroticized countertransference, the “as if” character of countertransference is lost and the analyst is functioning predominantly in the paranoid-schizoid mode – the patient becomes the idealized object that will rescue the analyst from despair. The transitional space created together in the clinic is thus destroyed and no analytic work can be done (Charles, 2017).

Without discipline and reflection, analysts’ love could indeed be detrimental – even when no sexual enactment is involved. Charles (2017) presented her work with a patient who had been “betrayed by the promise of love” in a previous therapy relationship (p. 187). The previous therapist had the idea that love could provide the cure, and had become angry and rejecting when the patient needed more, a rejection that had further entrenched the sense of utter unlovability the patient felt.

When working with patients who are starving for love, Charles (2017) wrote, the analysts’ inability to preserve their own reflective distance can make the offering of love “utterly toxic” (p. 188). Such reflective distance, she added, “is precisely what distinguishes the psychoanalytic clinician from any other caring person” (p. 190).

In the next section, I will go into detail describing more aspects distinguishing this kind of love.

“A thing unto itself”: on the analyst’s love

Defining love is an impossible task, and defining analytic love is even harder. This love resembles at times parental love, at other times fraternal love, charitable love, friendly love, erotic love, and so forth, yet it is “not simply or actually any of those ... It is a thing unto itself” (Shaw 2003, p. 268). Nacht (1962) wrote that the analyst’s inner attitude “should be impregnated with love for his patient” (p. 233), and added that this kind of openness can be understood only by those who have experienced it themselves with their patients. This is a love unlike any other,

Nacht continued; “it is a kind of love in which [one] is not personally concerned, although it *is* a deep feeling” (p. 233, emphasis in the original).

This combination of deep feeling with a degree of detachment mandated by the analyst’s role could seem to be contradictory, yet is in fact perhaps the strongest defining characteristic of this love: that it should be sublimated and at the same time passionate, modulated as well as libidinal. Ferenczi (1988) said that this love is passionate and active, and at the same time self-controlled.

Another defining element of the therapeutic love is that, in essence, it is not equal or mutual in the ordinary sense, although the analyst and patient may both strongly love each other. It is the analyst alone who is completely committed to the patient’s safety, and to the attentive attempt of trying to understand patients and to help them understand themselves (Shaw, 2003).

Analytic love is thus characterized by an effort to make sure that whatever the analyst is feeling, and consciously does to act on these feelings, is in the interests of patients and their psychic growth (Stern, 2011). This means the analyst’s love must be maximally conscious, aware, reflective. It is the analyst’s job, wrote Charles (2017) “to be present with deep and intense feelings and longings,” but also to recognize and think about these feelings in relation to those of the patient and “to make use of her feelings and thoughts in relation to the psychic reality of the patient” (p. 187).

The non-equality also means, as Fink (2015) stressed, that “the analyst must love without wanting to be loved in return” (p. 78). The loving analyst refuses to adopt the position of the beloved in the analytic setting, remaining always in the position of the loving one. It is indeed the analyst’s love that becomes the motor force of the analytic work, but from the analysts’ side this love is to be directed to a knowledge of self, and/or to someone found outside of the confines of the analytic setting, and not to himself.

The question comes up again: is this love real? This question often arises, implicitly or explicitly, at some level in any patient’s mind. According to the philosopher Martha Nussbaum (2005), this means that the patient is wondering whether the analyst really needs the patient: “Would the analyst’s life have a gap in it if the patient was no longer there, or came to grief? Does the relationship with the patient really make the analyst vulnerable?” (p. 378). Her answer is that as the ordinary human sort of vulnerability in love is denied in the analytic context, “[the analyst’s] ‘love’ is not really love” (p. 383).

Analysts do not always agree. Hoffer (1993), for example, insisted that the positive feelings between

analyst and analysand “are real, not imitations” (p. 355). Similarly, Gerrard (2005) described “moments, not of compassion, pity or empathy, but of an unspoken rush of feeling of ‘I really love you’ for a patient” (p. 27).

As with the paradox of the analyst’s love being both passionate *and* self-controlled, a similar “both,” instead of “either/or” solution could be given to the question of the realness of the analyst’s love. Stern (2011) suggested that the analyst’s feelings toward the patient are:

always both real and (counter)transferential, and that it is crucial to the patient that they be *both* – that the paradox be maintained and even held as sacred. The patient needs the analyst to *really* care about or love him or her. Nothing less can transform the patient’s real feelings of self-loathing and unloveability. However, he or she also needs the analyst always to ‘remember’ that these real feelings are occurring within the unique context of an analytic relationship – a relationship with certain purposes, a certain role structure, and a unique frame within which conscious and unconscious experience are ‘invited’ into a co-creative dialogue. (p. 496, emphasis in the original)

“Great love springs from great knowledge”: the setting’s effect on the analyst’s love

Such a love is not easy to deliver. How do analysts stand up to this high standard? We have the aid of our clinical experience and knowledge, but beyond these, and most essentially, we have the significant support of the analytic setting itself.

The analytic situation is founded upon a search for truth, that is, the truth of the analysand’s psychic reality (Freud, 1937). According to Steingart (1995), being devoted to uncovering this truth develops in the analyst an “extraordinary” love towards the patient’s psychic reality (p. 111). This devotion makes everything that the analysand produces with their mind of supreme importance to us. It does not matter whether the production is expressive, resistant, creative, perverse, adaptive, maladjusted, loving, or hateful, it is cherished, pondered – well, analyzed – with the effort, interest, and enthusiasm that characterize only loving relationships.

This deep interest in the patient’s mind is in a way similar to Winnicott’s “primary maternal preoccupation.” Parents can usually develop this attitude thanks to biological and social conditioning. In therapy, the setting is what allows this stance to arise. Freud thus created, suggested Steingart (1995), “a new type of love relationship that occurs uniquely in a psychoanalysis” (p. 112).

One might argue that a position of seeking truth and understanding about someone is not equivalent

to “loving” that person. Loewald’s (1970) words could serve as an answer:

Scientific detachment in its genuine form, far from excluding love, is based on it. In our work it can truly be said that in our best moments of dispassionate and objective analysis, we love our object, the patient, more than at any other time and are compassionate with his whole being. ... It is impossible to love the truth of psychic reality, to be moved by this truth as Freud was in his life work, and not to love and care for the object whose truth we want to discover. (p. 297)

The setting thus leads to a profound, loving interest in our patients’ psyche. This further allows a unique, intense knowledge and understanding of our patients’ personality and psychic life – a knowledge that deepens our affection and love. As Freud (1910) commented: “in truth great love springs from great knowledge of the beloved object” (p. 74). Such “great knowledge” is exactly what the analytic setting allows us. Friedman (2005) even claimed that the heightened knowledge achieved in analysis “might even be *the most intense knowledge possible of a singular existence*” (p. 362, emphasis added).

As discussed above, the deep involvement on the side of the analyst in the patient’s experience is uniquely combined with a position of detachment and neutrality. Ferenczi (1928) wrote that the analyst’s cathexes “oscillate between identification (analytic object love) on the one hand and self-control or intellectual activity on the other” (quoted in Friedman, 2005, p. 350–351).

The first, “identifying” feature of the analyst’s position creates closeness; the second, “controlled” feature allows clarity. This combination is very rare in daily life and is enabled by the setting: analysts feel themselves personally addressed by every action their patients perform, and yet they are also aware of not being fully the person intended. The analyst thus has a position that encompasses both that of an ordinary social partner, who feels genuinely and fully intended when addressed, and responds in the light of possible outcomes for themselves, filtered through their own hopes, fears, and capacities, and of an uninvolved witness, who can appreciate the appeal more “disinterestedly,” yet cannot experience its full thrust and true meaning. Unlike these two common positions, the psychoanalyst appreciates the patient’s appeal in its full intensity, without tainting this appreciation with the analyst’s own aims and capacities (Friedman, 2005). This allows the analyst to experience the patient’s appeal in perhaps the purest possible way.

The analytic attitude, as mentioned, is in itself an essential feature of the setting. This attitude is one

in which the analyst maintains a constant and reliable presence, directed to the patient's wellbeing while keeping their own needs from intruding. Such a position, wrote Modell (1988), is "analogous, but not at all identical, to a mother-child relationship, so that analysands may experience being held by the analytic setting" (p. 582). The analyst's dedication to the growth and to the safety of the analysand, wrote Shaw (2003), "is in essence an act of love" (p. 269).

Being dedicated to such a degree, hour after hour, day after day, week after week, could be seen to demand superhuman capacities. Most people are not able to perform in such a way in daily life, not even in close relationships. How can so many analysts manage to pull it together?

This too could be seen to be a consequence of the meeting's structure. Some analysts claim that the analytic situation brings out a "second self," which is consistently benevolent and loving. Schafer (1983) stated:

In our best work as analysts we are not quite the same as we are in our ordinary social lives or personal relations. In fact, we are often much better people in our work in the sense that we show a greater range of empathizing in an accepting, affirmative, and goal directed fashion. This observation suggests that there is a kind of second self which we develop ... On this basis, a special kind of empathic intimacy, strength, appreciation, and love can develop in relation to the analysand which would be a mistake to identify with disruptive countertransference. (p. 291)

Outside the clinic, our relationships are "simply human" (Kernberg, 1994, p. 1147). We become defensive when criticized, we sometimes avoid intimacy, and we can get irritated, even quite easily. Yet in the analytic situation, we can regularly function, without too much difficulty, at a level of empathy rarely met in ordinary life. It is "precisely here," Bienvenu (2003) wrote, "that the genius of the analytic situation plays one of its central functions" (p. 408).

This rare empathy is supported by the strict and agreed-upon boundaries of the situation, which guarantee the safety of both participants. Privacy and confidentiality reign in the clinic, and so it can contain all kinds of intense or threatening affects that may appear. The clinical setting could thus be described as a "sanctuary" for emotions, which allows patient and analyst to come to know each other deeply, and to transform each other.

Part of the safety produced by the setting comes from the temporal boundaries it prescribes. Each session has a limited duration, and the analysis as a

whole has an ending too. These two essential features of the frame support the analyst's love.

The fact the session is time limited makes it possible to function with a high degree of intimacy and empathy, and exhibit the so-called "analytic second self." We can stay in this demanding and frustrating state of drive suspension, in which we are focused on the wellbeing of another, because we know that it is transitory. The end of the session is always quite near (Bienvenu, 2003).

The end of analysis has a vital effect too. From the moment treatment commences, we are aware of its termination. Every relationship will end, but analysis is *meant* to be ended. The growing awareness of the approaching end could bring forth resistance and anger – and indeed it does; but it also emphasizes the intimacy, the important place the relationship has in our life. Especially in the last stage of analysis, joint moments become extremely precious, to us. As the looming fact of termination gets more prominent, the love towards the patient deepens. Searles (1959) wrote: "the nearer a patient comes to the termination of his analysis, the more he becomes, *per se*, a likeable, admirable, and basically speaking lovable, human being from whom we shall soon become separated" (p. 187). "It is a mistake to minimize the emotionality for the analyst involved in the need to terminate this loving attitude," added Steingart (1995), "giving it up amounts to losing a loved other" (pp. 129–130).

Before ending this discussion, I would like to point to one more defining feature of the second self. Apparently, it involves a unique point of view, from which every weakness, every "flaw" the patient shows, is seen not as an expression of evilness, stupidity, or indifference – as would perhaps be seen if observed from the point of view of the "first," everyday self – but as an expression of the pain of non-love. Each scar, from this perspective, renders the face with beauty.

The setting creates in us the ability to see goodness and beauty in patients from the whole range of ages, appearances, characters, and pathologies, as I tried to convey in the clinical vignette above. Similarly, Searles (1959) wrote that one of his first experiences of profound analytic love, the sort under discussion here, was with a much older hebephrenic woman. The intense romantic attraction to her lasted for a long time, and existed both during and between the sessions, he reported.

This point of view enables us to see in our patients something which is true of every person, yet rarely observed. Flynn Campbell (2005) called this the "divine essence" of the patient (p. 71). She went on unhesitatingly:

There comes a moment with some patients when I feel like I am seeing them as through the eyes of a loving God. In these moments I am full of a kind of love that comes from something outside of myself, as if I am briefly possessed by a Godly presence that perceives the human condition in all its heart-wrenching beauty and pain. (p. 71)

In his *Symposium*, Plato (1999) wrote about humankind's greatest aspiration: to find our "other half" and be united with that person. This merger is the supreme good all humans seek "since ancient times," as the making of one out of two, "heal[s] the state of man." Such union, Plato warned, "rarely happens in this world." Making it more prevalent is perhaps the greatest achievement ever attributed to the analytic setting. Indeed, according to Eshel (2019), such union is what transpires in analysis: "the deep patient-analyst interconnectedness... is not one- or two-person psychology, but an emergent two-in-oneness that is fundamentally inseparable into its two participants – an analytic oneness that transcends the duality of patient and analyst, transference and countertransference" (p. 4).

Conclusion

When looking at all the methods developed by humanity to "gain happiness and keep suffering away," Freud (1930) concluded that the best was "the way of life which makes love the centre of everything, which looks for all satisfaction in loving and being loved" (pp. 80–81). Yet for many people this is not very practical advice. Perhaps the biggest obstacle in fulfilling this ultimate way of life, as Slavin (2007) wrote simply, is that "to be able to love, one must feel at some point that someone has loved you" (p. 208).

The analyst's love is essential to the analytic cure. Vida (2002) remarked that we cannot even say that it "contributes" to analysis, since it is not an option or a conscious choice whether or not it is there. She likened the question of whether love contributes to analysis to asking "Does it contribute to the therapeutic action that the analyst draws breath, has a blood pressure, and a pulse?" (p. 437).

This is not a simple type of love, but one that demands discipline. The analyst is required to know and understand the patient in a profound way, which is based on, and draws from, the love towards their psychic reality, that is – towards the patient. The patient, feeling loved for who they are, truly, without the masks or pretense of daily social life, can come to love themselves – and then love back. With this regained capacity, the patient returns to the world a different person.

This map of cure can, however, pose a problem. Freud (1925) noticed that the emotional relation between doctor and patient could indeed be "stronger than the whole cathartic process," yet that "it was precisely that factor which escaped every effort at control" (p. 27). If the therapeutic process requires an emotionally positive response from the analyst, it might make the treatment method "too chancy" (Friedman, 2005, p. 366) – what if the analyst has a problem of loving in general, or a problem loving particular patients?

Yet there is something which makes the endeavor not very "chancy:" it is the analytic setting itself that promotes the analyst's love, not some "chemistry" with the patient or a special trait or quality the analyst needs to possess. The therapeutic encounter is a superficial structure whose aim is love, and that has evolved around this point. This unusual situation – two people meeting, regularly and often, for an intensely intimate conversation, on set and safe terms, where one side shares almost every personal detail of life, the other side listens with the greatest concentration and comments thoughtfully and kindly – is a perfect situation to achieve this aim, first for the listening side, and then for the sharing side.

Looked at from this perspective, we can add that, beyond being a theory, a practice and a method for investigation, psychoanalysis is *a relationship* of a very special kind. Steingart (1995) wrote: "The crux of the matter is that Freud created not only a new theory of human nature but, interrelated with that theory, a new type of human relationship" (pp. 108–109). Indeed, Freud (1915) himself was aware that this relationship "is one for which there is no model in real life" (p. 166).

What we are coming to understand is that the essence of this "unmodelled" relationship is that it allows love to arise. This is what many features in the setting in which this relationship takes place actually promote: the protective boundaries create an atmosphere of safety and trust – without which it is difficult to genuinely love; the topic of the conversation – the human psyche – encourages emotional involvement; the rare combination of passion and neutrality allows intense authenticity and knowledge.

At the heart of the matter lies perhaps the uniquely shaped inequality of the situation. Other types of relationship also facilitate trust and safety and present opportunities for intimate conversation. The analytic situation is different because of the demand from one party to become immersed in the situation, but in an attitude of abstinence and relative unresponsiveness. This allows for transference and especially transference love to develop; but perhaps more importantly it allows something very special

to happen to the analyst, who learns to know another human being to a very deep level, unique in itself, in a situation where the analyst is maximally protected. The analyst need not expose fears, hopes, vulnerabilities. The analyst just listens, and gets to know a fellow human, who puts enormous trust in them, a trust that grows as the analysis proceeds.

Still, some reservations have to be put forward. The analytic situation might indeed promote love, but we should not deny its possible sadomasochistic aspects (Bienvenu, 2003). When used wrongly, or put in unskilled hands, the same frame can bring out cruelty, not love.

In addition, we need to remember that while love might be crucial to most, if not all patients, it is not *all* that is necessary. Theory, knowledge, experience are vital too. “Love is certainly not enough,” admitted Gerrard (2005), before adding: “but then again, in my view, neither is interpretation, containment, reverie or any other psychoanalytical activity without the backing of love” (p. 37).

Focusing on countertransference love, as done here, could be a consequence of the therapist’s or theorist’s own needs. It has to be stressed and remembered that for love to be actually therapeutic, the therapist’s needs, including the need to love, must always be subordinate to those of the patient.

Psychoanalysts have been ambivalent for decades about the role of their own loving feelings: are they necessary, genuine, therapeutic? Is love a problem or a vehicle for change? Perhaps we have finally come to a time in the development of our profession when we can calmly and wholeheartedly trust our love to our patients – which is where the analytic setting itself steadfastly, securely leads us. As Freud (1909) wrote: “a man who doubts his own love may, or rather *must*, doubt every lesser thing” (241, emphasis in the original).

Coda

When I just started thinking, as a young psychotherapist, well over a decade ago, about the way the therapeutic setting influences my emotions, I had a vivid dream: I received a greeting card from a patient, the warm words were written in exceptionally pretty, arabesque letters. I knew in the dream that I was supposed to respond with a question such as “What does it mean for you?” yet an inner voice protested: “OK, this is the customary response, but what is the true one?” The answer was on the other side of the card. I flipped it. “LOVE” was written there, in huge letters. In the dream, I knew it was so: that I am to accept the gift, and the patient, with love,

that this is the most important thing in this new profession of mine.

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