
Impediments to the Experience of Being Loved in Psychotherapy

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Introduction

There appears to be increasing acceptance amongst therapists that psychotherapy involves 'a cure through love', as first expressed ninety years ago by Sigmund Freud. Ferenczi, Suttie, Halmos, Laing, Yalom, Greben, Hobson, Lomas and Vaillant are among those who have expressed this view.¹ Closer to home, Dr Eng-Kong Tan, analytic psychotherapist of Sydney, alluded to it with sensitivity and wisdom in his keynote address to the 1991 Annual Conference of NZAP.² I think it is likely that Dr Maurice Bevan-Brown, whom we particularly honour in connection with the fiftieth anniversary of NZAP, would have concurred. It is certainly, in my reading, consistent with *The Sources of Love and Fear*, the little book he produced for a lay audience and first published in 1950. In a brief section on psychotherapy, good psychotherapy is based on providing the patient with 'a new and more adequate parent', and

1 Freud, S. *The Freud/Jung Letters*. The Hogarth Press and Routledge and Kegan Paul, London, 1974, p 12 - 13.

Ferenczi, S. The principles of relaxation and neo-catharsis. *International Journal of Psychoanalysis* v 11, 1930, p 428 - 443.

Suttie, I. *The Origins of Love and Hate*. Kegan Paul, Trench, Trubner & Co Ltd, London, 1935, p 212 - 213.

Halmos, P. *The Faith of the Counsellors*. Constable, London, 1965, Chapter Three.

Laing, R. *The Divided Self* Penguin Books, 1965, p 165.

Yalom, I. *Existential Psychotherapy*. Basic Books, 1980, p 407 - 408.

Greben, S. *Love's Labour: The Experience and Practice of Psychotherapy*. Plume Books, New American Library, New York, 1984.

Hobson, R. *Forms of Feeling: The Heart of Psychotherapy*. Tavistock Publications, London, 1985, p 211 - 212.

Lomas, P. *The Limits of Interpretation: What's Wrong with Psychoanalysis*. Penguin Books, 1987, p 147 - 148.

Vaillant, G. *The Wisdom of the Ego*. Harvard University Press, 1993, p 4.

2 Tan, E. *Love and Intimacy: Reflections of an Analytic Psychotherapist*. Keynote Address, Christchurch, NZ at the Annual Conference of the NZ Association of Psychotherapists, 15th February 1991. (Published, Newsletter of the Association, March, 1991)

for Bevan-Brown a loving attitude is the essence of good parenting.³ Philosopher and psychoanalyst Jonathan Lear in similar vein, though more precisely, asserts in a recent book that love is the force in nature that promotes individuation.⁴

Nevertheless there has been no systematic attempt to delineate why it is often so difficult for clients in therapy to experience that they are loved, when circumstances often show that they are. I refer to those clients, more difficult to treat or help who are ordinarily described as severely psychoneurotic or character disordered, where effective change seems to take two to five or more years of committed involvement by therapist and client.

In this time of rationed resources and preoccupation with briefer methods, it behoves us as dynamic psychotherapists to discover what impediments or obstacles there may be to clients experiencing what appears to make the difference and supports whatever other interventions promote remediation, growth, change and symptomatic recovery.

What is meant here by 'a cure through love'? These were Freud's words and in my observation he meant something different from the later authors. He was referring to transference love in the conditions in which it developed in psychoanalysis after he replaced hypnosis with free association, that is with the evolution in the treatment of an established transference neurosis. The assertion appears to have been most clearly expressed by him according to Bergmann in the *Gradiva*:

The process of cure is accomplished in a relapse into love, if we combine all the many components of the sexual instinct under the term 'love'; and such a relapse is indispensable, for the symptoms on account of which the treatment has been undertaken are nothing other than precipitates of the earlier struggles connected with repression or the return of the repressed, and can only be resolved and washed away by a fresh tide of the same passion.⁵

Ferenczi by contrast clearly identified that it was love in the other direction, from therapist to client, that was curative. 'It is the physician's love which cures

3 Bevan-Brown, M. *The Sources of Love and Fear*. The Raven Press, Christchurch, 1960, p 4.

4 Lear, J. *Love and its Place in Nature: A Philosophical Interpretation of Freudian Psychoanalysis*. Faber and Faber, 1990.

5 Bergmann, M. On the Fate of the Intrapsychic Image of the Psychoanalyst after Termination of the Analysis. *Psychoanalytic Study of the Child* v 43, 1988, p 138.

the patient'.⁶ Suttie further clarified the matter when quoting Ferenczi ... "the nature of the love being understood as a *feeling interest responsiveness – not a goal-inhibited sexuality*."⁷ It is in this latter sense that I use the word love in this paper, but in doing so I am conscious of the need to explain a statement I made recently in a paper reviewing my thirty years as a psychotherapist. In asserting that love is the vital ingredient, I said, 'It is mainly agape, though it may include philias and be inspired by eros.'⁸ Eros here denotes transference love in a broader relational sense than Freud intended and assuredly does not mean that a therapist's sexual passion is likely to be helpful, even if not overtly expressed. As Sheldon Kardener pointed out in discussing the incest taboo as it applies in the physician-patient relationship, because the physician or therapist is experienced as a parent, the patient or client "becomes an orphan" if the relationship becomes sexualised by the 'parent'.⁹ And of course the incest victim who comes to therapy is grossly re-traumatised. Ferenczi eloquently warned of the damage in his famous paper, 'Confusion of Tongues Between Adults and the Child: The Language of Tenderness and Passion.'¹⁰ Whelan recently wrote a devastating account of the child's predicament.¹¹ Confusing also is that there is a higher form of eros referred to by philosophers. Rhodes states that 'agape does have an objective, namely that everyone shall realise his/their full potential'. And it does not differ from eros, 'for even the most cursory reading of Plato makes it clear that this is what eros wants for its human object'.¹² The directional difference, Freud's "relapse into love" from patient to analyst, versus the opposite, 'the physician's love' which 'cures', can I think be understood as reflecting the different patient populations being worked with. The first is with predominantly oedipal problems, the latter, pre-oedipal.

I have been interested in impediments to the experience of being loved for some years. The most telling or crystallising event for me occurred quite recently when a client said to me, 'How can I know that you care for me when you are

6 Ferenczi, S. op. cit.

7 Suttie, I. op. cit. p 212.

8 McDougall, I. *Psychotherapy and Me: A Personal Account*. Unpublished paper presented to Wellington Branch NZAP, April 1995.

9 Kardener, S. Sex and the Physician-Patient Relationship. *American Journal of Psychiatry* v 131 no 10, 1974, p 1134 - 1136.

10 Ferenczi, S. Confusion of Tongues Between Adults and the Child: The Language of Tenderness and of Passion. In Balint, M (ed) *Final Contributions to the Problems and Methods of Psychoanalysis*. 1933. London, Karnac Books, 1980, p 156 - 157.

11 Whelan, M. The Loss of Sense of Reality in Incest and Child Sexual Abuse: A Psychoanalytic Perspective. *Australian and New Zealand Journal of Psychiatry* v 29 no 3, 1995, p 416 - 417.

12 Rhodes, C. *The Necessity for Love: The History of Interpersonal Relations*. Constable, London, 1972, p 88.

part of me.' This happened during a phase of therapy when she was more often experiencing me as separate from her and feeling panicky about it. I certainly had not been asking her about the matter directly and it seemed to me that she needed to have noticed the distinction before she could comment. She could not cognitively recognise the quality of her relationship with me when she was still largely imbedded in needed self-object experiences of me.

For the purposes of raising the inquiry I shall consider the Client, the Therapist and the Context.

The Client

In my earlier thinking, informed by Transactional Analysis theory, I had mainly seen impediments in the client as based on a refusal or reluctance to recognise what was incongruent with hard won survival decisions, often elaborated cognitively somewhere between three and eight years of age.¹³ Work at that developmental level leading to redecisions and changed beliefs about self, other, the world and the future, was undertaken in phantasy or chair work with projected internal self and object representations, or in the transference. It often enabled quite rapid progress to be made. In TA terms, second degree impasses could be resolved, but third degree preverbal ones, related to a sense of always having felt a particular way, for example evil, were much harder to resolve and often required a much longer time in therapy.¹⁴

I now consider that the much longer time in therapy is related to a need to reattach to the therapist, to be involved in healthy dependency, rather than dysfunctional symbiotic systems dictated by the other, and have related self-object experiences leading to self cohesion and object distinction.¹⁵ Developmental and/or remedial experiences appear to be necessary before redecisions can be made.¹⁶ Whether in childhood or adult life, renewed development and change has to be initiated in the face of closedness and

13 Goulding, R. New Directions in Transactional Analysis: Creating an Environment for Redecision and Change. In Sager, Clifford and Helen Singer Kaplan (eds). *Progress in Group and Family Therapy*. Brunner/Mazel, New York, 1972, p 105 - 134.

14 Mellor, K. Impasses: A Developmental and Structural Understanding. *Transactional Analysis Journal* v 10 no 3, 1980, p 213 - 220.

15 Holmes, J. Attachment Theory: A Biological Basis for Psychotherapy? *British Journal of Psychiatry* v 163, 1993, p 430 - 438.

Phillips, R. *Structural Symbiotic Systems: Correlations with Ego-States, Behaviour and Physiology*. 1975. Monograph obtainable from the author, 100 Eastdowne Drive, Chapel Hill, North Carolina, 27514.
Wolf, E. *Treating the Self. Elements of Clinical Self Psychology*. The Guilford Press, 1988, p 54 - 55.

16 Joines, V. Using Redecision Therapy with Different Personality Adaptations. *Transactional Analysis Journal* v 16 no 3, 1986, p 152 - 160.

circularity.¹⁷ What is being protected is segregated, developmentally early states of mind such as those referred to by Winnicott as 'primitive agonies' in his last paper, 'Fear of Breakdown', with compensating beliefs in magical transformation or rescue.¹⁸

I have schematically listed difficulties arising in the client as follows and will clarify some clinical aspects of the operation of the impediments listed. It is not possible to give in depth development within the compass of this paper but my hope is that the items will be sufficiently recognisable to evoke your own clinical experience.

(1) The **inability**: – to perceive love when therapist/other is part of self.

There are clients who note that they are loved by friends, family members and perhaps their therapist but do not feel that they are. They don't have the experience and when the fact is clarified with them they are likely in the first instance to say, 'yes of course' they know that they are. But related affect is absent and they reply briefly and defensively. They don't go on to talk warmly about the gift of being loved. It is in my experience threatening to have the matter noted and any of the need related causes detailed in this account may be operating. If therapist and/or client do not discover the discrepancy they may labour long and fruitlessly. On the other hand, as earlier mentioned, there are clients who do not recognise the fact in a cognitive sense at all, as their experience of being cared for is too embedded in primitive self object experience of the therapist. They cannot challenge their negative cognitive beliefs about love until they move to at least the beginnings of whole object relating with the therapist, and become effectively aware of the therapist's separate existence. That is a crucial and often very frightening step. I discovered from the client mentioned previously, that she had to test my acceptance and support for her individuality before she was able to do so. More than that, she had to cognitively recognise me as providing a 'bridge' for her.

Love of the necessary kind, can be defined in systems terms as inputs of an informational character, verbal and non-verbal cues, words, facial expressions, touch, which elicit the meanings within systems associated with normal dependency, that one's existence is important to the other, needs will be freely

17 Erskine, R and J Moursand. *Integrative Psychotherapy in Action*. Sage Publications, London, 1988, p 29 - 40 & p 51.

Ryle, A. Object relations theory and activity theory: A proposed link by way of the procedural sequence model. *British Journal of Medical Psychology* v 64 1991, p 307 - 316.

18 Winnicott, D. Fear of Breakdown. *International Review of Psychoanalysis* no 1, 1974, p 104.

met and dangers avoided.¹⁹ The earliest of such experiences within the first few hours, days, weeks and months of life include merger, graphically alluded to by Michael Balint as resulting in a 'harmonious interpenetrating mix-up'.²⁰

Recent psychobiological research in affect, attachment and memory is worth noting in connection with the inability to perceive. Implicit, non declarative memory is involved in extracting prototypical information from the character and quality of early attachment experiences, and is not accessible to consciousness. The authors, Amini et al, of the synthesising report from the Langley Porter Psychiatric Institute, state:

In such a view, when patients come to psychotherapy and engage the therapist in their transferenceal life, they are exhibiting the outward manifestation of the implicit memory inside them of the early attachment relationship. This is not a discrete record of an event, and it can never be accessed directly by consciousness (my emphasis). What these patients do in their lives and in the office, while it seems at times baffling to the outside observer, follows naturally from this implicit knowledge. At the same time, when patients participate in psychotherapy, they not only activate this implicit memory, but also engage the mechanism whereby such stored material can be modified. To the extent that the therapist becomes an important figure of attachment, the patients begin to extract the rules that govern the nature of the relationship between patient and therapist, and the modification of stored prototypes has begun. In a gradual, iterative process, the attachment-related generalisations of the patients are revised closer to those which approximate healthy interactive functioning in the larger social environment.²¹

- (2) The need: – to avoid catastrophe, death/suicide, madness, abandonment, loss of self (fragmentation);
to be found unlovable (confirmation of beliefs), I am, 'dirty', 'evil', 'bad', 'defective';
to avoid the pain of not being appreciated, cared for, protected, shame, rage, sadness, despair/hopelessness, longing, emptiness;
to avoid knowing what actually happened, deprivation, physical abuse, sexual abuse.

19 McDougall, I. Psychic Energy, Physical Energy and the Body Psychotherapies. *Australasian Journal of Transactional Analysis* v 3 no 1, 1982, p 27.

20 Balint, M. *Thrills and Regressions*. The Hogarth Press, London, 1959, p 62 - 69.

21 Amini, F, T Lewis, R Lannon, A Louie, G Baumbacher, T McGuinness and Z Schiff. Affect, Attachment, Memory: Contributions Toward Psychobiologic Integration. *Psychiatry* v 59, 1996, p 213 - 239.

Where the impediment to feeling loved in later life is the avoidance of catastrophe, that is death/suicide, psychosis, life threatening psychosomatic disorders, abandonment terrors and fragmentation fears, there has been competition for survival between parent and child,²² and such a traumatic level of impingement that one might speak of a 'discordant interpenetrating mixup'. Alternatively there have been gross deficits in life supporting contact, or both. Such experiences include Winnicott's 'primitive agonies', for example, 'falling forever' and 'failure of indwelling', for which he says anxiety is not a strong enough word.²³

For the client to be open to experiencing the feeling of being loved in archaic states of self, connected in somatic and primitive affective memory with contemporary states related to attaching anew, is from the position of the 'infant inside' to risk catastrophe, He or she cannot 'know' without regressing to that level again, that primitive introjected elements of the historical parent will not overwhelm or attempt to destroy elements of his/her emergent self as happened many years previously.

The outcome for some who survive such horrors in their growing up experience is to protectively identify in the depressive position with the traumatising and rejecting other's view of them; or conjure similar beliefs from their own creativeness, that they are 'bad', 'dirty', 'evil' or 'defective', With such beliefs, and the specifics are many, they cling through life to the hope of perfectability and retain the illusion that they may yet be found loveable, that the caretakers can be induced to have a change of mind. Those more developmentally fixated in the schizoid-paranoid position, the time of 'toxic mixup' can be left with virtually no hope, with the feeling or conviction, which if it could be articulated would say something like 'I have always been this way and am utterly beyond redemption.' Hence in therapy when such people regress to the archaic states potentially connected with attaching anew, they are likely to feel, crazy, profoundly defeated and lacking in viability.

It is however regularly discoverable that life-related affects persist, though they are strongly warded off, dissociated from or disavowed. In the absence of loving containment they are too disturbing to be experienced and sustained by the fragile, barely hatched self. The somatic aspect should not be forgotten in this connection, with extreme tensions, gross physiological dysregulation and terror, which may signal not just psychic fragmentation, but threat to physical

22 Phillips, R. op. cit.

23 Winnicott, D. op. cit.

existence and bodily integrity. Shame, rage, sadness, longing, emptiness and despair/hopelessness occur. Even the last, associated with what Engel described as a biological state of depression-withdrawal, a kind of mini-hibernation, waits I believe for the environment to become beneficent again.²⁴

Richard Erskine, in an excellent, comprehensive and clinically seasoned paper on the psychotherapy of dissociation, defines what he means by 'contact', and identifies the dilemma for many clients posed by juxtaposition:

The juxtaposition of the therapist's attunement with the memory of the lack of attunement in previous significant relationships produces intense emotional memories of needs not being met. Rather than experience those feelings, the client may react defensively to the contact offered by the therapist with fear, anger, or even further dissociation. The contrast between the contact available with the therapist and the lack of contact in the original trauma(s) is often more than clients can bear; so they defend against the current contact to avoid the emotional memories.²⁵

Buie and Adler in their paper on the definitive treatment of the borderline personality identify the rageful and primitive guilty ('I am evil') obstacles which are effects of aloneness, to developing needed holding introjects, for patients suffering from severe psychopathology. They state that:

This process would simply require a period of time for its occurrence were it not for the psychodynamic obstacles that block it in therapy just as they block it in life. They are consequences or corollaries, of aloneness. The inevitability of rage is one such corollary that interferes with the process of forming holding introjects.

They go on to say that there are three sources of this rage which are summarised here as, 1) holding is never enough, 2) experience of the object is distorted by means of projection of hostile introjects and 3) the object is so endowed with holding sustenance as to be deeply envied.²⁶

Michael Lewis points out that the development of shame requires maturation and that socialisation is the eliciting force. He also notes a distinction between the sexes:

24 Engel, G. *Psychological Development in Health and Disease*. W B Saunders Company, 1962, p 55 & p 127.

25 Erskine, R. Inquiry, Attunement, and Involvement in the Psychotherapy of Dissociation. *Transactional Analysis Journal* v 23 no 4, 1993, p 185 -186 & p 187.

26 Buie, D and G Adler. Definitive Treatment of the Borderline Personality. *International Journal of Psychoanalytic Psychotherapy* v 9, 1982-83, p 65 - 67.

Parents who practice love withdrawal or who express contempt or disgust affect their children's sense of pride and shame. The available data indicates that girls and women are more likely than boys and men to make global self-attributions 'I am bad,' not 'My performance was bad' - when they fail. Thus, girls and women may experience more shame than boys and men.²⁷

To be open to the experience of being loved in the present is to be open, at least for part of the time, to the full range of human feelings and their undefended connection in memory to the past. It is I believe not possible to feel loved in the states of self connected with attaching anew, of being open to merger and the 'harmonious interpenetrating mix-up', without also encountering the 'discordant' equivalent. It is not possible to simply be open to isolated 'safe' fragments of experience without risking further fragmentation. What is encountered, what the therapist and the client expect to be encountered is often almost unimaginably terrible. And this is so even when the client has always 'known' at some level 'the way it was', or has been able to recall some related sensations, affects, images, even words, and talk about them. It is another thing again to experience what happened within the boundary of the self with full intensity, and the immediacy of a reliving, feeling vulnerable and dependent as very young child. A child moreover whose only psychological need or 'Wish', at the times of maximal deprivation and or trauma may have been to be 'held, touched and taken care of'.²⁸

To 'know' that one's existence, one's once and forever particularity was of so little account to the people who should have been there to provide tenderness, constancy and encouragement, at the start of the growing up and becoming a valued part of the world enterprise, but were not, is cruel beyond measure. I'm talking here of the meaning caught by the child who experiences him or herself as neglected, not the observation of a sophisticated observer, or an older part of the client who for example can understand, that it wasn't for example mother's fault that she was so clinically depressed in the first few weeks and months, that she could not respond. And associated with that meaning, however dimly understood in the physical cum primitive affective experience of the earliest emergent self, is the terror of threatened non-existence as previously noted. Add to neglect the threat of grossly inconstant or chaotic care, impulsive or concerted violence, and the child may have had to ward off the conclusion, correct or not, that their death was actively sought. Change

27 Lewis, M. *Shame: The Exposed Self*. New York, The Free Press, 1992, p 10.

28 Levin, P. *Cycles of Power: A Users Guide to the Seven Seasons of Life*. Deerfield Beach, Florida, Health Communications Inc, 1988.

from that position can consequently be experienced as risking annihilation and being murdered.

- (3) The demand: – to be loved by people from the past;
to be rescued/saved by particular (phantasy) figures;
to receive justice;
to be revenged.

Those clients who as children were resilient enough and creative enough, who were fortunate in having some support from others, an older sibling, a caring grandparent or teacher, may, out of hurt or spite, continue to hold to an early formulated preconscious demand.²⁹ That is, they will not allow themselves to be fully touched by love and 'insist' that only their parents will do, and that when they are, everything will be as it should 'by rights' have been. Also the setting will be that earlier time and they will still be little as they were then.³⁰ Any risk of being open to people in the present is avoided because it doesn't fit the demand and would spoil what 'should have been'. The client may alternatively require that their therapist behave precisely as a phantasised rescuer would, and not permit themselves to fully accept the meaning of being loved in the here and now. Another client for some time could only accept what she felt conditionally, that is for as long as she could believe that it would go on 'forever'. She also insisted that unless I was thinking about her continuously, during every moment of the day then I couldn't really care for her, as she had always thought that was the way it would be.

Others hold out for justice and believe that their lives cannot properly go ahead unless justice is substantively achieved. A client worked extremely well in a group where he was very much liked. He appeared to be moving to where he could embrace a very different and non masochistic future. But when he recognised that his deceased abusive father could not be brought to trial he left the group and didn't come back.

Related is the wish for revenge. The daughter of a holocaust survivor was grossly controlled by her traumatised and extremely domineering mother. She had a phantasy of confronting her and saw her visibly wilt like a dying flower, but then became blocked by guilt and concluded that if she could not have her revenge she wanted no part of life.

29 McNeel, J. The Parent Interview. *Transactional Analysis Journal* v 6 no 1, 1976, p 65.

30 Berne, E. *What Do You Say After You Say Hello: The Psychology of Human Destiny*. Grove Press Inc., New York, 1972, p 50 - 51.

(4) The **numbing and disconnection**: – of Post Traumatic Stress Disorder, biological/neurological impairments, functional psychoses and dissociative defences.

The flashbacks, hyper arousal, irritability and especially perhaps the emotional numbing caused by the neurological dysfunctions underlying Post Traumatic Stress Disorder, may all seriously interfere with the accurate processing of affective inputs in traumatised people.³¹ Care may be perceived as threat, or not perceived at all. Further, the biological impairments often compound many of the psychological impediments already discussed as well of course as the often radical distancing of dissociative defences. Residual impairments from Schizophrenic Disorders, prolonged treatment resistant Bipolar Disorders, Autism, Attention Deficit Disorder and organic brain disorders of varying severity, may also cause much difficulty. One client developed normally until around eighteen months when she developed viral encephalitis. She was extremely irritable and could not be held or touched. Her subsequent development was greatly skewed with underlying schizoid dissociation, foreground borderline characteristics and unbridgeable difficulties in the relationship with her parents who were clearly caring and wanted the best for her.

(5) The **fear**: – of deathtaking familiar introjects.

Common to all the impediments I have discussed is the profound difficulty experienced by clients in deathtaking their familiar introjects, related symbiotic engagements with people in their lives and psychological defence mechanisms, especially the more primitive ones.³² To do so involves renouncing the specifics of what they have always hoped for, but even more, internally facing fears of abandonment and other expected catastrophes. In the parts of self in which the risk must be taken the client does not know, though 'older' parts may see differently, that what is dreaded will not occur. The dilemma is that if they were able to freely acknowledge the new and more secure love in the here and now, it would be easier to take the risk; but to acknowledge that in any global and continued way, linking archaic mind to current states of being, is to enter what family therapist Virginia Satir has called 'the chaos'.³³ And as therapists

31 Rauch, S, B van der Kolk, et al. A Symptom Provocation Study of Post Traumatic Stress Disorder Using Positron Emission Tomography and Script-Driven Imagery. *Archives of General Psychiatry* v 53, 1996, p 380 - 387.

32 McDougall, I. *How People Change in Psychotherapy: A Transactional Analytic, Psychodynamic, and Systems View*. Paper presented at the NZAP Annual Conference, February 1989.

33 Satir, V. The Tools of the Therapist. In Lankton, S and J Zweig (eds). *Developing Ericksonian Therapy: State of the Art*. Brunner/Mazel, New York, 1988, p 513 - 523.

know, for many clients there are both internal loyalties, and external relationship and systemic family pressures very much supporting the 'no change' position as well.³⁴

In my observation it is extremely difficult for some incest victims to decathect the ambivalently loved and needed abusive father, as he may have been all they had when mother was effectively unavailable. To risk being loved in the present is to lose him, breach loyalty and experience the horror of the abuse.

The Therapist's Contribution

The literature originating from therapists indicates that this is an awkward and embarrassing topic to write about. Lomas is clear about the importance of the therapist's love but is keenly aware that anyone talking about it is likely to be viewed askance and thought to be narcissistically indulgent, or to be covering up less commendable motives.³⁵ Yalom, who is also very much in support, nevertheless quite early in a brief account states that it is a matter that readily makes one 'squirm'.³⁶ He goes on to say that that is not surprising considering the strange skewed sort of relationship the therapeutic one is. Both authors mention the neglect of a small number of key books on the subject, those already referred to by Suttie and Halmos, and that by Carlos Sequin, *Love in Psychotherapy*.³⁷ In reflecting on my own experience, I clearly recall reading Ian Suttie's, *The Origins of Love and Hate*, and especially the well known chapter, "The 'Taboo' on Tenderness", almost forty years ago and being much impressed by it.³⁸ But subsequently I relegated my old copy to a kind of mental Siberia on the basis that its language was archaic and didn't sound scientific enough! When finally many years later I revived my interest again, I found him even more admirable and prescient.

Heinz Kohut, who it is suggested might be a theorist capable of getting the question re-examined by the 'back door', acknowledges that love might have been responsible for some of the 'cures' effected by charismatic therapists such as CG Jung, but scathingly attributes the results to transferences induced by

34 Boromenyi-Nagy, I and D Ulrich. Contextual Family Therapy. In Gurman, A and D Kniskern. *Handbook of Family Therapy*. Brunner/Mazel, 1981, p 162 - 163 & p 166.

Watzlawick, P, P Weakland and R Fisch. *Change: Principles of Problem Formation and Problem Resolution*. Norton, New York, 1974.

35 Lomas, P, op. cit. p. 146.

36 Yalom, I. op. cit. p. 407.

37 Sequin, C. *Love in Psychotherapy*. Libra, New York, 1965.

38 Suttie, I. op. cit. Chapter 6.

their narcissistic characters. He appeared to seek a much cooler 'scientific' and dispassionate solution.³⁹

Therapists are more comfortable talking about care, unconditional positive regard, sustained empathic immersion, and metaphoric 'holding', but one wonders at what cost?

Ann France, in her excellent book, *Consuming Psychotherapy*, carefully argues for the need for love in psychotherapy, and in doing so questions the pronouncements of a number of analytic authorities. She concludes that "The "love" required in the therapeutic context is a warm, sustained concern which inspires security and is not afraid, at times, to express itself by human gestures, if appropriate to the relationship."⁴⁰ What France is saying is akin to the supposition arrived at by Canadian psychiatrist and psychotherapist Stanley Greben, which is that psychotherapy is and essentially needs to be, 'A simple human process'.⁴¹ Neither contend that technique and the use of the therapeutic frame is not important.⁴² Fanita English stated the need for both most cogently:

To be a loving human being is a prerequisite for a therapist. However, without solid technique and a certain artistic flair, a therapist can be engulfed by the problems of her patients, and she can end up crucified or devoured by their cannibalistic needs when they seek ways to fill a certain emptiness within themselves.⁴³

There is, as arrived at long ago by Carl Rogers, a need for emotional congruence and clarity in this matter, as it is difficult enough for the client to encounter the inevitable confusion of transference projections, and therapist countertransference.⁴⁴

The matter has also I think been bedevilled by a too pessimistic, even cynical view of love that has come down from Freud's account of 'Transference Love'.⁴⁵ Diane Ackerman, in her wonderful "A Natural History of Love", reports a brief conversation with a friend thinking of going into therapy. She reflects

39 Lomas, P. op. cit. p 147.

Kohut, H. *The Analysis of the Self*. International Universities Press, New York, 1971, p 222, footnote.

40 France, A. *Consuming Psychotherapy*. Free Association Books, London, 1988, Chapter 11.

41 Greben, S. op. cit. Chapter 12.

42 Fletcher, L. The Psychotherapeutic Frame and its Relation to Patient Abuse. *Australian Journal of Psychotherapy* v 8 no 1 & 2, 1989.

43 English, F. What is a Good Therapist? *Transactional Analysis Journal* v 7 no 2, 1977, p 49.

44 Rogers, C and J Wood. Client-Centred Theory: Carl R. Rogers. In Burton A (ed). *Operational Theories of Personality*. Brunner/Mazel, New York, 1974, p 226 - 227.

45 Freud, S. *Observations on Transference Love*. Standard Edition 12, 1915, p 160. Or in Gay, Peter (ed). *The Freud Reader*. Vintage Books, 1995, p 378 - 387.

something of the old position but lightens it up.⁴⁶ A review of the recent book edited by Ethel Spector Persons and others, *On Freud's "Observations on Transference Love"*, by Paul C. Horton is more directly critical. He states that:

The authors do little to challenge Freud's philosophically and politically tinged equation of normal love with the narrowly sexual. Surely, on the basis of their vast clinical experience, they must know that there are mature, reality based forms of love, expressions that transcend the self and serve as powerful mediators of emotional and intellectual growth, and that these forms sometimes arise, even passionately in the treatment setting. Yet, the reader is left to wonder if orthodox psychoanalysts think there is anything realistic or healthy about any form of love.⁴⁷

The Context

In 1957, Eric Fromm wrote about, 'Love and its Disintegration in Contemporary Western Society', and firmly placed the blame with the nature of capitalism. He stated that:

Both useful things and useful human energy and skill are transformed into commodities which are exchanged without the use of force and without fraud under the conditions of the market. Shoes, useful and needed as they may be, have no economic value if there is no demand for them on the market. Human energy and skill are without exchange value if there is no demand for them under existing market conditions.

He further said that 'Capital commands labour; amassed things, that which is dead, are of superior value to labour, to human powers, to that which is alive.'⁴⁸ A full analysis of the relationship is not possible here, but I doubt if there are many among you who have not experienced the related effects of the current new right ideology in health and mental health care, where people are confused with commodities in the interest of efficiency and money saving. The valuation of professionals as deliverers of care to the living needy is grossly discounted and the down stream or parallel process effect on patients or clients can be truly anti-libidinal and deadening. A very experienced, creative and innovative mental health worker, an advocate for 'A Better Life' for her patients long

46 Ackerman, D. *A Natural History of Love*. Vintage Books, New York, 1994, p 322 - 326.

47 Person, E, A Hagelin and P Fonagy (eds). *On Freud's "Observations of Transference Love"*. Yale University Press, 1993.

Horton, P. Book Forum. *American Journal of Psychiatry* v 152 no 4, 1995 p 642 - 644.

48 Fromm, E. *The Art of Loving*. George Allen & Unwin, 1957. Or Thorosons, an imprint of Harper Collins Publishers, 1995, p 65 - 66.

before that became a catch cry, quietly and tearfully complained to me that 'sometimes we don't get enough for ourselves.'⁴⁹

The outlook for our vulnerable clients is likely to worsen further if the health reforms include a further push for privatisation in mental health care. The culture of competitiveness furnishing more and better care for those who can afford it will be to the detriment of those who cannot. It will resonate with and unconsciously confirm their early experience and physiological/affective frames of reference which signify that their existence is not important, needs will not be freely met and protection from dangers will not be available.

In the linking of societal to individual influences, I have long been impressed by the synthesising views of anthropologist Ernest Becker. He argues, I think correctly, that self esteem is a principal buffer against anxiety. He refers to both fears about death and physical mutilation, and fragmentation of the self. He further argues that one crucial role of culture is to make **continued self esteem** possible. Its task is 'to provide the individual with the conviction that he is an **object of primary value in a world of meaningful action.**'⁵⁰ It should be clear that for the individual to have a convinced sense of primary value, he or she must be loved, and feel or experience that they are loved unconditionally. Achieving the other wing, of having value in a world of meaningful action, is another tragedy of our time with its scarcity of meaningful work and diminished ritual observances of cultural significance. Becker's synthesising statement is reminiscent of course of Winnicott's belief and statement that developmentally, security in the sense of being must precede doing. 'Now I want to say: "After being – doing and being done to. But first, being".'⁵¹ The structure of the competitive money driven society with its inevitable scarcities for many with little or no work, and pressure for those in work to anxiously cling to their jobs and work excessively long hours, places great burdens on families which increasingly break down. It is extremely difficult to achieve the kind of equanimity needed to establish and maintain real support and loving contact between partners, and consequently provide the love and adequate holding needed for the healthy and undistorted growth and development of children. Children are infantilised to meet dependent needs, or parentified in dysfunctional role reversals to take care of parents and sacrifice their own

49 Central Regional Health Authority. *A Better Life: Report of the Greater Wellington Mental Health Service Review*. 1994.

50 Becker, E. *The Birth and Death of Meaning. An Interdisciplinary Perspective on the Problem of Man*. 2nd Edition. Penguin Books, 1971, p 86.

51 Winnicott, D. *Playing and Reality*. Tavistock Publications, London, 1971, p 85.

possibilities. They are frequently unconsciously driven to seek value, or love and approval indirectly in the pathologies of giving and doing, and miss the kinds of personal contact which would assure them that they are loved and of primary value. This is how later in the transference they present to their therapists who affected by similar pressures themselves have difficulty being, in Satir's words, 'present in your presence'.⁵² I believe that the transformative work of therapy occurs when therapist and client are in contact. Transactional analyst Taibi Kahler, perhaps a bit tongue in cheek, pointed to the frequency of non contactful relating when he said that therapists were likely to be in their script drivers ninety percent of the time and while doing so were likely to induce their clients to cathect related (driver) Ego States.⁵³ Therapists are inevitably affected by the contextual factors I have mentioned and in reverse parallel process, may furnish their clients with powerful relational obstacles to the experience of being loved in therapy.

Conclusion

You will notice that I have not directly suggested solutions and yet I think this is a matter of very considerable importance for our profession, for as Diane Ackerman says:

Nearly everyone who visits a therapist has a love disorder of one sort or another, and each has a story to tell - of love lost or denied, love twisted or betrayed, love perverted or shackled to violence. Broken attachments litter the office floors like pick-up-sticks. People appear with frayed seams and spilling pockets. Some arrive pathologically disheartened by a childhood filled with hazard, molestation, and reproach. *Mutiles de guerre*, they are invisibly handicapped, veterans of a war they didn't even know they were fighting. What battlefield could be more fierce, what enemy more dear?⁵⁴

52 Satir, V. op. cit.

53 Kahler, T. The Annual Eric Berne Memorial Scientific Award Acceptance Speech. *Transactional Analysis Journal* v 8 no 1, 1978, p 3 - 4.

54 Ackerman, D. op. cit. p 136.

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