

Contents

Introduction	vii
1 Taking the Measure of Love	1
2 The Strong and Weak Adaptive Approaches	26
3 Patient-love: The Literature	41
4 Two Approaches to Patient-love	52
5 Therapist-love: The Literature	67
6 Love is the Puppet, Death the Puppeteer	83
7 Patients' Loving and Wishing to be Loved	106
8 Love and the Psychotherapist	135
9 The Search for True Love	165
<i>Bibliography</i>	182
<i>Glossary of Terms</i>	188
<i>Index</i>	196

1

Taking the Measure of Love

‘What is this thing called love?’

This age-old question, asked so plaintively by the songwriter Cole Porter, has intrigued and baffled humans since the dawn of awareness and the story of Adam and Eve. Through the centuries, efforts to define the experience of love and to identify its manifestations have confounded the best of our philosophers, psychologists, and writers. And this uncertainty has carried over into the arenas of psychotherapy and counseling (terms I use interchangeably), where little has been written and even less has been clarified on the subject of love between patients and their therapists.¹ Like so many other abstract terms that allude to the actual transactions between the therapeutic couple – terms like transference, resistance, countertransference, and the like – the subject of love is more a source of bewilderment and consternation than illumination. This book has been written to bring light into this darkness.

The dictionary, which addresses conscious feelings, tells us that expressions of love for others range from God’s beneficence on His children to the experience of strong sexual desires for another person – with countless forms in between. Love implies an intense need for another person, a strong wish for involvement or attachment, a sense of longing and caring, and a preparedness to make sacrifices on behalf of the loved one. Love may also entail commitment, passion, affection, romance, concern, exclusivity, intensely concentrated attention,

¹ The subject of this book is love, conscious and unconscious, between psychotherapy patients and their therapists. Although the findings generalize to everyday life, I will not explicitly explore love between patients or therapists and other people in their lives. Unless otherwise stated, then, when I allude to love per se or to love in psychotherapy, I am referring to experienced feelings and actions taken by patients and therapists towards each other.

2 *Love and Death in Psychotherapy*

worship, idealization and over-idealization, devotion, adoration, fondness, involvement, sexual desires, and hopes for return satisfactions and love from the person (or entity) who is the object of these feelings. Along different lines, love may be unilateral or shared, and it may be felt consciously as such or masked by conscious feelings like anger or indifference. Many of the attributes of *conscious love* also characterize the expressions of deep *unconscious love* – the form of love that is experienced outside of awareness and encoded in narrative images.

Both conscious and deep unconscious love are adaptive or maladaptive responses to triggering incidents – so-called environmental impingements – that are experienced and processed with or without awareness. In general, conscious love is evoked by consciously registered triggers and their implications, while deep unconscious love is evoked by meanings of triggers that register and are processed outside of awareness. These triggering events may come from within the therapeutic interaction – i.e., from the other member of the therapeutic dyad – or from the outside life of the patient or therapist. It is noteworthy that by and large, while in psychotherapy, patients are far more sensitive unconsciously to love-related triggering events within their treatment situation than they are to incidents outside of the therapy. In contrast, therapists, who also are sensitive to both kinds of love-evoking incidents, tend to be especially affected by triggering events in their daily lives – more so than their patients.

Anger is Easy, Love is Hard

During my many years as a psychotherapist and supervisor of other therapists, I have been struck by how easily most therapists approach the problem of patients' hostility towards them while assiduously avoiding the slightest indication of positive feelings aimed in their direction. Should a patient express outright loving feelings, they tend to be embarrassed and unable to think clearly. And if the patient's feelings have a sexual component or if they realize that they have said or done something striking that has moved the patient to act in a seemingly loving manner, they become rattled and guilt ridden and tend to avert their eyes from their clients. This is not meant to imply that the guilt is necessarily inappropriate or that therapists are without responsibility when patients express feelings of this kind. To the contrary, as we shall see, therapists have considerable accountability in this regard.

Noteworthy too is the impression that because therapists often fail to consciously notice what they have done to arouse a patient's ardor, an unconscious sense of culpability and guilt often plays a significant role in their discomfort.

For example, a male psychologist, a supervisee whom I will call Dr Stuart, came to a supervisory session eager to talk about anything but his last session with a young woman patient whom I will call Ms Trent. When I pointed out his evident avoidance of the patient's session, Dr Stuart turned beet red and said that he was very anxious about telling me what had happened in the patient's hour. It seems that midway through her session, Ms Trent described a fantasy of having oral sex with Dr Stuart and wondered if she was falling in love with him.

Dr Stuart had tried to trace the fantasy to his patient's childhood wishes towards her father, but the effort fell flat. He also brought up some sexual fantasies Ms Trent had been having about her married boss, whom she sees as very attractive, and suggested that she was displacing these fantasies onto him – again to no avail.

Could this be a positive sign that she is relating well to me in the therapy, he wondered aloud in the supervisory session. Is it an indication that she's investing her transference feelings in me? Almost as an aside, he mentioned that he couldn't see anything he had done to evoke his patient's fantasy and feelings, which had made both of them quite uncomfortable.

I asked Dr Stuart to present the session in sequence as he recalled it. (I ask supervisees to present sessions from memory, without making or using notes.) It turned out that about ten minutes into her hour, the patient had brought up her dire financial situation and said that she could no longer afford to continue in treatment. After some discussion, Dr Stuart asked if a twenty-five dollar fee reduction would enable her to remain in therapy. Ms Trent responded by saying that Dr Stuart was a love, adding that the fee reduction certainly would make it possible for her to continue. The sexual fantasy emerged soon after, as did memories of her father's extramarital affairs and his trying to buy the patient's love by giving her large sums of money with which to shop for clothing.

It seems clear that Dr Stuart's fee reduction had evoked his patient's erotic fantasy and loving feelings towards him. Much as the patient's father had tried to buy her love, the therapist was doing something similar in the therapy. What the patients saw consciously as a loving gesture was seen unconsciously as a seductive bribe. Subsequent material in this

4 *Love and Death in Psychotherapy*

session involved recollections of her father's quasi-sexual seductiveness with the patient when she entered adolescence. This lent support to the thesis that by reducing the patient's fee, the therapist had behaved in a manner that had repeated earlier seductions by the patient's father.

Without delving further into other ramifications of this vignette, my intent in presenting it here is to emphasize that many of the most troublesome problems that therapists experience in dealing with loving feelings and fantasies within the therapeutic interaction lie with their own contributions to their patients' expressions of outright love towards them. In many instances, therapists are quite unaware consciously of what they have said or done, much of it inadvertent or seemingly innocuous, to provoke these loving desires. We can see then that the interactional aspects of love in psychotherapy loom large for both parties in the therapeutic dyad. We will be well advised to think about love in psychotherapy with this in mind.

In general, it is assumed in the psychotherapy literature that patients will love their therapists as a way of expressing some kind of transference fantasy or wish derived from past relationships (Freud, 1912b, 1913; Gabbard, 1996). As for themselves, therapists uniformly believe that they approach their patients with basic love towards them and that their interventions express that love in ways that are therapeutic (Friedman, 2005). Love seems to become a problem for therapists mainly when they inadvertently behave in manifestly unloving ways towards their patients (Gabbard, 1996; Rabin, 2003). More broadly, however, there is a growing literature on the subject of therapist-love, or as it's called in recent writings, 'countertransference-love,' a term that is currently used to allude to all types of positive feelings, inappropriate, but mostly appropriate, in therapists towards their patients (Searles, 1965; Gorkin, 1987; Davies, 1994, 1998; Gabbard, 1994, 1998; Gabbard and Lester, 1995; Rabin, 1995, 2003; Hoffman, 1998; Slavin *et al.*, 1998; Mann, 1999; Renik, 1999; Slavin, 2002; Natterson, 2003; Friedman, 2005).

Therapists do from time to time feel consciously guilty over being openly provocative with a patient who feels or acts in a loving or hateful manner towards them. Even so, unconscious guilt caused by interventions whose incitement qualities have not been consciously recognized appears to be a far more common occurrence, and in the absence of explicit awareness, far more difficult for therapists to deal with. Helping therapists to identify such incidents in treatment and facilitating therapeutic work under these circumstances is one of the many goals of this book.

Some Basic Dimensions of Love in Psychotherapy

There are many ways of classifying love within the therapeutic interaction. Patient- or therapist-love may be fantasized or enacted; accepted as wishful and illusory or believed to be real and genuine; sexual or non-sexual; homosexual or heterosexual; demanding of satisfaction or quiet, without wishes for gratification. In more abstract terms, there are expressions of love that are genuine and caring, in contrast to love that is manipulative or defensive, or part of evident attempts to harm the other party to a given psychotherapy. There also is a patient's so-called *transference love* that is said to be derived from past relationships and misappropriated to the therapist, and so-called *non-transference love* which is said to be an appropriate response to a therapist's healing ministrations. Similarly, as noted, therapists are said to experience forms of countertransference love which may be healthy and truly loving or pathological and a way of falsely loving their patients.

Many difficulties in exploring and understanding love in the therapy situation seem to arise because love is so multidimensional. Problems also stem from the fact that the manifestations of love can take such a wide variety of forms and serve so many different conscious and unconscious functions and needs – love in psychotherapy is by no means a unitary matter. There are, for example, various types of *patient-love*, the term I use for patients' loving feelings and love-based enactments towards their therapists, and similarly, many forms of *therapist-love* that therapists experience or enact towards their patients.

Given the complexities of the situation, I have selected for initial discussion what appear to be three of the most fundamental ways to describe, define, and understand love in psychotherapy: True versus false; conscious versus unconscious; and subjectively experienced versus enacted – forms of love.

True versus False Love

Patient-love and therapist-love come in two basic forms, as either true or false expressions of love.

True love may be thought of as a reflection of genuine caring and affection that is conveyed in a manner that is in keeping with the respective role requirements of being a patient or a therapist. It also is a love that is expressed with full respect for the other party and for the conditions and boundaries of therapy that best serve the healing process. It is conveyed without efforts to modify the ideal or archetypal

6 *Love and Death in Psychotherapy*

ground rules and limits of the psychotherapy situation. Most importantly, true love is a feeling, communication, or behavior that is validated unconsciously by the patient's material and by the therapist's private efforts at self-processing. Thus, it is a love that is supported by the patient's and therapist's encoded narrative themes which emanate from the deep unconscious wisdom subsystem of the emotion-processing mind. All in all, true love is, then, comprised of appropriate, unconsciously validated, sincere feelings that advance or are responsive to healing interventions within the therapeutic process – it is love in the service of the insightful cure of the patient.

False love, on the other hand, may be thought of as a feeling or enactment of seeming care and affection that is harmful to the other party to therapy and quite often, harmful to the perpetrator as well. This kind of love is motivated unconsciously by wishes to seduce or do damage to either or both parties to the therapeutic process. Such love also may be recruited to show appreciation for the other party's offer of inappropriate defenses and thereby to support the use of denial and other costly defense mechanisms that are invoked primarily to deal maladaptively with unmanageable forms of anxiety and conflict. Thus false love is secretly harmful to self and other and is mobilized in the service of pathological satisfactions and defensiveness.

The inappropriate qualities of an expression of love in psychotherapy often goes unappreciated consciously by one or both parties to the treatment experience. However, the deep unconscious wisdom subsystem of the emotion-processing mind encodes narrative themes that clearly indicate the falsity and maladaptive qualities of this kind of love. This means that in the case of a false expression of love, a manifest, conscious expression of patient- or therapist-love is refuted and invalidated by the encoded narratives that emanate from this subsystem. All in all, then, false love in psychotherapy is inappropriately satisfying, maladaptive, invalidated unconsciously, an obstacle to a soundly healing therapeutic process, and operates as a resistance or counter-resistance to therapeutic progress.

The split between the conscious and unconscious views of love is reflected in the brief excerpt from Ms Trent's psychotherapy offered earlier in the chapter. While the patient consciously reacted to Dr Stuart's fee reduction by seeing him as a loving therapist, the encoded story that followed was about her father's attempt to buy the patient's love with monetary gifts. This is not a true expression of love and it speaks for the falsity of the therapist's well-meaning, but inappropriately seductive fee reduction.

Conscious versus Unconscious Love

Another basic classification of love lies with the distinction between consciously and unconsciously expressed love. Conscious love entails manifest loving feelings and behaviors, while unconscious love entails non-manifest expressions of love that are reflected in encoded narrative material like dreams and stories. This differentiation has many important implications.

Because they emerge in displaced and disguised narrative imagery, unconsciously expressed loving feelings tend to be overlooked by many psychotherapists. To correct this oversight, therapists are well advised to monitor their patients' narrative themes for what they say about the course of love in psychotherapy. It has been found clinically that while conscious, manifest or direct expressions of love may be true or false, quite often they are false. In contrast, unconscious expressions of love are almost always true and deserved. The rare exception to this rule may occur when a therapist has been extremely hurtful to a patient, usually through a very damaging remark or harmful frame violation. Paradoxically, the encoded themes that initially follow this kind of intervention may be exceedingly loving in nature. Such images are unconsciously activated in the service of *deep unconscious denial*. As a rule, however, under these circumstances, devastatingly negative encoded themes soon follow and serve to set matters straight.

Subjectively Experienced versus Enacted Love

As expressed in psychotherapy, love may be confined to feelings, fantasies, and wishes or alternatively, conveyed through actions and efforts at enactment. Loving feelings, fantasies and wishes may be consciously or unconsciously experienced and they may be constrained or overly intense. The relatively controlled expressions of conscious love generally are sublimated and true, while the overly intense and exceedingly arduous expressions of love tend to be unsublimated and false. Similarly, loving actions or enactments tend to be true if they are limited in nature and carried out within the confines of the therapeutic contract – e.g., a passing offer by a patient to give his or her therapist financial advice. But these efforts at enactment are likely to be false if they are insistent, involve a breach in the ideal boundaries between patient and therapist, or are otherwise violations of the optimal ground rules of the therapy. In general, then, love that is fleeting and confined to feelings tends to be truthful, while love that is enacted and extended most often is false.

Recognizing and Evaluating Love in Psychotherapy

Given the complexities of love in psychotherapy, therapists also are faced with a variety of problems in tracking its vicissitudes and assessing its attributes in the course of a treatment experience. In light of the defensive alignment of the conscious mind and, as we shall see, its tendency to be affected and biased by unconscious guilt and unconscious needs for punishment, conscious evaluations of the actual nature of a loving expression tend to be quite unreliable. It follows then that basic decisions about the nature and classification of a loving expression in psychotherapy, whether emanating from the patient or therapist, should be based on unconscious perceptions and deep unconscious assessments of these loving gestures. Patients respond unconsciously to every loving expression made by themselves and their therapists. These unconscious evaluations are encoded in their dreams and stories and can be decoded in light of their love-related triggers – i.e., as valid perceptions of the true nature of the loving gesture to which the patient is responding. These encoded, unconscious appraisals are based on universal, archetypal values common to all humans, patients and therapists alike, and therefore tend to be highly reliable.

Similar principles apply to therapists' self-explorations *or self-processing activities*, as they are called (Langs, 1993, 2004c), when issues of love arise in their work with patients. Conducted privately, outside of the sessions with their patients, these self-processing efforts are designed to shed light on therapists' own unconscious evaluations of expressions of love by either themselves or their patients. Here too, conscious thinking is to be mistrusted, while trigger decoding unconscious perceptions is likely to be an eminently helpful guide to understanding and technically handling the love-related interludes at hand. When it comes to love in psychotherapy, as therapists, we are well advised to access and make use of as much deep unconscious wisdom as possible.

Dealing with Love in the Treatment Situation

It seems evident that the vicissitudes of love in psychotherapy deserve to be one of the many features of a treatment experience that we, as therapists, monitor with some consistency. We also need to more clearly define the various manifestations of this love so we may better understand their unconscious meanings and functions. Their more precise clinical definition will enhance our efforts to analyze, interpret

and resolve pathological expressions of love, be they from our patients or ourselves. This kind of work can contribute greatly to insightful cure in that patients' displays of false love always reflect on their basic emotional problems. On the other hand, therapists' realizations that the love that they are feeling and/or expressing towards a patient is false rather than true can facilitate the insightful resolution of what is sure to be a significant obstacle to the patient's sound emotional healing.

In this connection, it is to be emphasized that, as material permits, expressions of patient-love should be explored and dealt with in the course of their psychotherapy sessions. On the other hand, manifestations of therapist-love need to be quickly examined subjectively during a session with a patient, but should be more elaborately explored and dealt with privately by therapists on their own without burdening their patients. That said, every episode of love, be it from a patient or therapist, presents a psychotherapist with challenges that call for deep understanding and the application of sound principles of technique. Errors and failures in dealing with love can cause much harm to patients and considerable unconscious guilt in errant therapists. On the other hand, discovering the triggers or stimuli that have evoked a patient's loving feelings and behaviors, whether true or false, and determining the deep unconscious meanings and functions of this love, is remarkably healing for both parties to therapy.

By and large, dealing with false expressions of patient-love poses many problems for psychotherapists. There is the natural wish of therapists to be loved, so identifying a loving expression as false threatens a therapist's self-image and feelings of worth. Also problematic are the many pressures from patients to satisfy their needs to be loved falsely in some extra-therapeutic or pathologically satisfying manner. These demands tend to be triggered by their therapists' ground rule violations and other erroneous interventions and they therefore evoke considerable unconscious guilt and may cause cognitive dysfunctions in the errant therapist.

Therapists' difficulties in dealing with patient-love tend to be compounded when therapists themselves feel love towards a loving or non-loving patient. Quite naturally, therapists want to believe that the love that they feel is genuine and if it is constrained and limited to feelings of affection and caring, this may well be the case. Nevertheless, therapists often express their love through some kind of seemingly caring, loving action, but this is a sign that their love is likely to be quite false. Therapist-love also may extend into sexual fantasies and this too should serve as a warning that it probably is false and treacherous. Any inclination in a therapist to mention these wishes to a patient, or to enact or satisfy them in

a session, should be taken as a strong indication that false love is at work. In general, therapists abhor the experience of conscious guilt and degradations in their conscious self-image and as a result, they have considerable difficulty recognizing the falsity of their own false love. For this reason, as therapists, we are well advised to keep our loving feelings and wishes to ourselves. We also should avoid any enactment of that love and instead, actively and privately engage in self-processing activities geared towards the resolution of such feelings and the renunciation of these impulses when they arise.

In this context, we may be reminded that feelings of love, true and false, can arise in any relationship and interaction between a patient and therapist, be it under the rubric of counseling; cognitive, behavioral, or existential psychotherapy; psychodynamic or psychoanalytic treatment paradigms; or any of the over three hundred other forms taken by efforts to heal emotional maladaptations. Indications are that the greater a therapist's distance from a psychodynamic position, the more likely the therapy will be carried out in framework that is some distance from the archetypal ideal and thus, the greater the chances that patients' and therapists' loving feelings and enactments will convey false rather than true love. This proves to be the case even when a particular expression of love is sanctioned by the therapist's colleagues and is part of the standard therapeutic approach used by the therapist. To safeguard against the use of these errant love-related interventions, therapists are well advised to take into account the evocative triggers for all loving expressions, especially as they pertain to their own interventions, and to decode their patients' narrative themes in light of those triggers. This approach can help to insure that true love prevails for both parties to therapy, and that false love, if it arises, is insightfully resolved.

Four Traditional Components of Love

In a somewhat scattered manner, traditional psychotherapists have considered four dimensions of love in psychotherapy: The genetic, intrapsychic, interactional, and contextural components.

Love in psychotherapy has *genetic* aspects in that early life experiences with love and its polar opposite, hatred, influence its vicissitudes in the treatment setting.

Love has *intrapsychic* aspects because the character structure; inner mental state, needs, defenses, and conflicts; and the personal history of both patients and their therapists affect its vicissitudes and form.

Love has *interactional* components because an expression of love primarily is in part a product of the bipersonal therapeutic field (Langs, 1976) and a reflection of patients' and therapists' conscious and deep unconscious attempts to adapt to the words and deeds of the other party to therapy – and secondarily to outside life events.

And love is *contextural* in three inter-related ways:

First, expressions of love are affected by the nature and goals of the therapeutic relationship and the satisfactions that patients and therapists can expect from their work together.

Second, love is influenced by the role requirements for being a patient or therapist and the tasks assigned to each of them.

And third, expressions of love are affected by the physical, interpersonal, and psychological conditions within and under which a therapy unfolds – the setting, boundaries, and explicit and implicit ground rules that are established for a given therapeutic interaction.

These three components have extensive effects on the form that love takes; its fidelity or falseness; the causes of, and intentions behind, a loving expression; the needs that the love is intended to satisfy; the kinds of loving feelings and actions that are – and are not – permissible for a patient or therapist; and the range of consequences that a loving expression has for the course and outcome of a psychotherapy.

The Genetic Component

For both patients and therapists, there appear to be two kinds of early childhood experiences that affect the vicissitudes of love in a given psychotherapy. The first unfolds along a continuum of being loved or unloved by parental and other family figures and secondarily by other important childhood and later figures like teachers and religious leaders. The overall quality of these cumulative experiences for both patients and their therapists have lasting effects including many that are love-related in a treatment experience.

The second important type of love-affecting genetic experience involves another continuum, with loving rescue operations and acute care of the patient or therapist as a child when they were in dire need or in danger on one end, and on the other, the opposite experience of a harmful, acute traumatic event that entails experiences of being unloved and hurt by critical caretakers. Examples of positively-toned, loving incidents include care and concern at times of personal loss or threat and natural disasters, while examples of unloving incidents are the death or serious illness of, or abandonment by, a parental figure; the

lack of care when the child was ill, injured or otherwise in acute distress; direct harm to the child by a parental figure; natural disasters that cause the child to feel unprotected and similar kinds of adverse incidents. In general, these early-life traumas are experienced unconsciously as death-related and they evoke significant forms of death anxiety that in turn, cause strong feelings of being unloved. In turn, these incidents greatly affect the course of love in psychotherapy, biasing these expressions towards false rather than true love. Thus, patients who have suffered significant unloving traumas, cumulative as well as acute, tend to love their therapists falsely and to seek forms of false love in return.

To cite a brief example, Mr Blake, whose therapy I supervised, was born in Asia and was two years old when his parents left him to live with his grandmother so they could arrange to relocate in America. In his therapy with Ms Thomas, a social worker, he repeatedly tried to express his love for his therapist by giving her inappropriate gifts and offering her financial advice regarding which he had considerable expertise. He also made incessant demands that the therapist show her concern and affection for him by changing the time of, and extending, his sessions, providing him with reading materials, allowing him to borrow or take magazines from her waiting room, and the like.

With utmost consistency, the encoded themes in Mr Blake's dreams and stories indicated that he was offering to, and demanding from his therapist, false forms of love and that their satisfaction would be harmful to both her and himself. A typical example is reflected in a dream that he had soon after he offered Ms Thomas a stock tip. In the dream, a jailed criminal is bribing the guards so he can escape prison. Associations were to Mafia payoffs.

These encoded themes speak clearly for the dishonesty and falsity behind the patient's seeming loving gesture. The patient evidently felt trapped in the secure framework of the therapy offered by Ms Thomas and other material from the patient indicated that the genetic connection evidently went back to the sense of imprisonment that the patient had felt when he was left behind in his native country while his parents were in America. At the time, he felt that he was being punished for his bad behavior and he wanted badly to be with them.

In general, true patient-love is grounded in a foundation built from early experiences of being truly loved and loving truly in response. In the therapy situation, this kind of patient-love is primarily an immediate response to unconsciously validated interventions made by psychotherapists – i.e., interventions that are followed by patients' positively-toned

displaced, encoded narrative themes. On the other hand, false patient-love is grounded in a foundation built from early experiences of false love, received and given, and is, as noted, a common response to death-related traumas. In psychotherapy, this kind of patient-love tends to be an immediate response to erroneous, deep unconsciously invalidated interventions made by the therapist. In principle, the non-validation of an intervention indicates that the therapist's efforts have been experienced deep unconsciously by the patient as unloving and harmful.

In like manner, for therapists, offers of true love are founded on formative loving experiences. In their work as therapists, this kind of love is expressed through a basic caring attitude, securing the ground rules of treatment, and making deep unconsciously validated interventions. By way of contrast, false therapist-love is grounded in early falsely loving and death-related experiences and in therapy, it is expressed through a wide variety of interventions that do not obtain deep unconscious confirmation.

The Intrapsychic Component

There are many inner mental, characterological, and historical factors in both patients and therapists that affect the manifestations of love in psychotherapy and how they are responded to by both participants to treatment. In regard to patients, when a loving feeling or impulse is expressed towards a therapist, the therapist must define its nature and consider its sources. There is, as noted, a group of background factors that lead to intrapsychic attitudes and inclinations within patients that stem from their life histories and resultant inner psychic conflicts. These factors include such matters as the nature of their early and later-day loving experiences, the quality of parental care, the nature of early-life interactions, and their death-related and sexual traumas. Consideration also should be given to patients' preferred current modes of coping with emotionally-charged triggering events, including the extent to which they make use of defensive forms of denial and have, in the past, used loving feelings and sexual acts in the service of this denial and of gaining pathological satisfactions.

Related to these considerations, therapists are well advised to ascertain a patients' history of relationships with loving individuals like parents; their current capacity for true love in their daily lives; and the noteworthy love-related experiences, favorable and unfavorable, that they have experienced in the past and more recently. These perspectives should be applied to all expressions of patient-love, but are especially relevant to loving feelings and acts that have false qualities to them.

Negatively tinged intrapsychic structures and preferences are factors that render both patients and therapists vulnerable to turning to expressions of false love at times of trauma and stress. On the other hand, healthier and more adaptive inner mental structures favor expressions of true love by both patients and therapists.

The Interactional Component

Patients' experiences of love towards their therapists, which may be true or false and expressed consciously or unconsciously, should be accounted for interactionally by identifying the triggering event – and the meanings of that event – that has activated the patient's loving feelings and impulses. In this regard, patients' unconscious perceptions of their therapists' interventions are of prime importance, while acts of nature and the behaviors of figures outside of therapy are, as a rule, of secondary relevance. As noted, true patient-love is usually a response to an unconsciously validated, healing intervention by therapists, while false patient-love is a reaction to erroneous, invalidated, traumatic interventions, most often in the form of a therapist's uncalled-for violation of one or more of the deep unconsciously sought ideal ground rules of therapy.

The intrapsychic and interactional components of love tend to work together in the sense that patient-love, which is motivated and partially directed by inner needs, is activated and given direction by emotionally-evocative external, environmental events – a term that alludes to acts of nature and the words, deeds, and feelings of other humans. For patients in psychotherapy, these events almost always involve their therapists' interventions.

As for therapists, their loving feelings towards their patients are affected by the physical attributes and demeanor of their patients and their patient's life histories, as well as the manifest and encoded meanings of their patients' ongoing communications and behaviors. Importantly, when faced with personal death-related traumas, therapists are unconsciously driven to experience and interactionally enact falsely loving feelings towards selected patients – usually those who are unconscious sources of death-related anxieties for the therapist. On the other hand, when the personal life of a therapist is going well and he or she is in good health, there's an inclination to experience muted feelings of admiration and true love for selected patients as evoked by empathic responses to their emotional suffering and their struggle to find relief from their emotionally-founded symptoms.

Therapists who are not well loved in their everyday lives are vulnerable to feelings of false love towards their patients in a search for compensatory love and in their hunger for someone to care for them and for them to care about as well. Although they are more reactive to their therapists' interventions, patients also may show this kind of effect. The occasional interactional experience outside of therapy that arouses false love in the treatment situation almost always involves a severe death-related trauma, such as the death of a loved one or a personal illness which enormously increases the patient's or therapist's death anxieties. In these instances, feelings of false love are unconsciously activated as maladaptive attempts to deny feelings of helplessness, inadequacy, vulnerability, and hurt, and as an unconscious way of trying to use the celebration of love, however false and ill-conceived, to deny death and the terror that it evokes, much of it deep unconsciously.

To cite a brief example, Dr Thomas, a male psychiatrist-psychotherapist, suffered the death of his wife, who died unexpectedly of a pulmonary embolus after chemotherapy for lung cancer. In response, he abruptly canceled his sessions and was out of his office for two weeks. On his return, he unexpectedly found himself attracted to, and having sexual fantasies about, two of his unmarried women patients. His dreams were mainly about his incestuous, adolescent sex play with his sister who was two years older than him. In addition to these dreams, Dr Thomas experienced a large number of lapses in managing the ground rules of his sessions with these two patients. For example, he inadvertently left his office early and missed a session with one of them and he mistakenly extended the session of the other woman by fifteen minutes.

On the conscious level, Dr Thomas recognized that his attraction to these women patients was motivated by his wish to undo the loss of, and replace, his wife. He also tried to rationalize that these women were unattached and attractive, and that his loving feelings would enhance his therapeutic work with them – i.e., that there was a measure of true love in his feelings towards, and sexual fantasies about, these women. But his unconscious mind saw this love in a very different light. The encoded themes in his dreams spoke to the inappropriateness of his feelings and fantasies, stressing their incestuous qualities and characterizing them as falsely loving.

As for his frame lapses, his conscious sense was that in forgetting his patient's session, he was reenacting the loss of his wife and turning his role as the passive victim into one in which he is the active, abandoning figure. His extension of the other patient's session

was viewed as an expression of his wish to undo the loss of his wife by keeping his patient as his prisoner. But here too, his unconscious mind, as reflected in several dreams he had after these incidents, saw these acts in a different light and as both unloving and hurtful. By and large, the dreams were about ruthlessly harming women and in one dream, he murdered an old girlfriend. His private associations to these dreams revealed that unconsciously, he held himself accountable for the death of his wife and that his frame violations were motivated by unconscious wishes to be punished by his victimized patients – e.g., by their leaving therapy – because of the murder he unconsciously believed he had committed.

In general, therapists have tended to underestimate the extent to which the vicissitudes of their personal lives, and especially traumatic events, affect their work with, and loving or unloving attitudes towards, their patients, including their management of the ground rules of therapy. This is another aspect of love in psychotherapy that needs further scrutiny.

The Contextural Component

The contextural aspects of psychotherapy frame the therapeutic experience both psychologically and physically, and they define the background conditions for the treatment experience and for the emergence of love, true or false. These components tend to have a settled core that is, as well, open to variations from one session to the next. They exert a continuous influence on the therapeutic couple, most of it unconsciously mediated.

Goals and Satisfactions

The primary goal of psychotherapy is to alleviate patients' emotional suffering, their maladaptations, and dysfunctions. In addition, there are a number of secondary, complementary goals that pertain to the therapists' satisfactions, such as helping patients to heal their emotional wounds; developing fresh understanding of human emotional life as it pertains to their patients and themselves; and having an adequate income through the fees paid to them by their patients. In principle, loving feelings in, and behaviors of, patients or therapists that are consonant with these goals are true and appropriate. Those that are not, fall into the false love category.

Uncertainties arise in trying to precisely define the kinds of feelings, verbal communications, and behaviors that are, in fact, in keeping with the appropriate goals and satisfactions of the treatment experience. For example, do they include opportunities for a therapist to write a professional paper about the new insights that he or she has garnered in working with a particular patient? Is it appropriate for the patient to be told about the paper so he or she can approve the material and possibly share in that satisfaction? These and many other similar questions cannot be answered through conscious system observations and thinking which are quite varied from one therapist to the next. Patients' deep unconscious experiences and adaptive processing of these satisfaction-related issues do, however, offer a consistent set of answers because they reflect universals far more than individual propensities. Therapists therefore should make ample use of trigger decoding when a satisfaction problem arises in a given psychotherapy situation and they are well advised to learn to accept the encoded pronouncements of the deep unconscious wisdom and moral subsystems in these matters. Satisfactions that stay within the boundaries of the role requirements and ground rules of psychotherapy tend to be acceptable and viewed as truly loving deep unconsciously, while those that extend beyond these boundaries are viewed as unloving and exploitative.

In regard to the question of writing a well-disguised paper or book about a particular treatment experience, for example, deep unconscious guidelines indicate that there is an unresolvable conflict between the needs of the field of psychotherapy for informed presentations of clinically-grounded new ideas in the one hand, and on the other, the therapeutic needs of patients and the appropriate satisfactions of psychotherapists. Writing about a patient, however well disguised, is seen deep unconsciously by both patient and therapist as unloving and exploitative no matter how valuable the particular contribution. This clinical finding should be given full consideration in these situations. One solution is for the therapist-writer to make up representative vignettes based on his or her collective clinical experiences so that the main points are clinically illustrated while the ground rules regarding privacy and confidentiality are sustained.

You can deceive the conscious mind, but not its deep unconscious counterpart. This is especially pertinent when it comes to love in psychotherapy because true love is seen deep unconsciously as adaptively wise and moral, while false love is viewed as maladaptive and immoral. Unconsciously mediated consequences unfold accordingly.

Role Requirements

Another set of contextual consideration regarding love in psychotherapy pertains to the prescribed role requirements for both patients and therapists. The form that love takes, the ways in which it may be appropriately expressed, and the limits set on these expressions are contingent on the identity of each party to therapy and what is required of them. This specificity is seen, for example, in the differences in the optimal and permissible expressions of love that occur between a mother and child as compared to that between the mother and her husband. In some cases, as with a mother and child, the nature of acceptable expressions of love change with time as their responsibilities and expectations of each other – i.e., the role requirements of the relationship – are altered. On the other hand, there are relationships for which the form and boundaries of expressed love are fairly stable and persist throughout the entire span of the contacts between the parties – and in many cases, after direct contact has ended as well. The therapeutic relationship is of this latter type – one of several ways in which it differs from the mother-child dyad to which it so often is mistakenly compared.

There are significant differences in the role requirements that prevail for the two parties to the therapeutic relationship and these differences are pertinent to the form taken by true and false love expressed by each of them. Although the patient's therapeutic needs are primary, the therapist nonetheless has the dominant role in the treatment situation. He or she has the greater responsibility for framing the psychotherapy experience and for defining the nature of the satisfactions that are consciously deemed appropriate for both parties to treatment. This role requirement creates what is often alluded to as the 'tilted therapeutic relationship' in which the therapist wields a measure of qualified power over the patient. With this prerogative, however, comes the greater responsibility for what happens in the course of the therapy.

The main role requirements for the psychotherapist include having the necessary expertise as a therapist; setting up the consultation session; providing the patient with a secured office for his or her sessions; establishing the patient's need for therapy; creating and maintaining the ground rules and boundaries of the therapy; informing the patient directly or indirectly as to his or her responsibilities and role in the treatment experience; intervening in a manner that is empathic and healing for the patient; and placing the patient's therapeutic needs above all else.

As for the matter of love, the therapist has the basic responsibility to define the parameters within which it can or should be expressed. This task generally is carried out without explicit instructions, but is reflected in the therapist's demeanor and ways of handling the ground rules and boundaries of the treatment. It also is expressed in the therapist's selection of material for interpretation and in the meanings that the therapist proposes in connection with the patient's loving expressions. Quite critical is the manner in which the therapist responds to a patient's loving feelings and gestures when they arise. Essentially, this entails the absence of a reciprocal response, the maintenance of the therapeutic boundaries and ground rules, and sustaining the effort to understand the sources and nature of the loving feeling or action, along with making the necessary, relevant trigger-decoded interpretations.

For their part, patients are required to have a need for and to seek help with their emotion-related problems; to work with their therapists in the manner prescribed; to cooperate with and respond to the reasonable interventions of their therapists; to attend sessions regularly and pay the therapist's fee in timely fashion; to be honest and forthright and not conceal information and feelings from their therapists; to respect the valid ground rules and boundaries of their therapy as established by the therapist, and to explore any impulse to do otherwise; and to be prepared to end treatment when their emotional problems have been resolved. Expressions of patient-love should fall within the sphere of these role requirements and not entail a departure from these requisites.

Ground Rules and Boundaries

All of the distinctive contexts in which a given psychotherapy unfolds have features that involve the ground rules and boundaries of the treatment experience, as they are explicitly implicitly defined by the psychotherapist. There are, of course, rare exceptions to this rule in which a patient sets one or more of the conditions of treatment. Nevertheless, the therapist, who has the prerogative of accepting or not accepting the patient's proposal, still has the greater responsibility in this regard.

The setting and rules of psychotherapy are called the *frame or framework of treatment* (Langs, 1998b, 2004c). The deep unconscious mind harbors an ideal, archetypal set of conditions for a psychotherapy experience and a therapy that is conducted under these conditions is called a *secured frame psychotherapy*. A therapy for which one or more of these universally sought ground rules is altered or omitted is known as a *deviant- or modified-frame psychotherapy*.

Operating with considerable influence, there are two basic ways in which the ground rules and framework of a psychotherapy affects the emergence and nature of loving feelings and impulses, true and false, in the parties to a given psychotherapy situation. The first entails the effects of the type of setting and ground rules set up by the therapist. In principle, establishing a secured-frame psychotherapy situation is an expression of true therapist-love and implicitly enhances patients' expressions of true love in return. On the other hand, creating a deviant-frame psychotherapy is an expression of false therapist-love and inherently, it promotes patients' expressions of love that are false as well. Similarly, patients who accept and work within a secured frame for their therapy tend to be truly loving, while patients who refuse to do so or press for a modified frame tend to love falsely, if at all.

As for the second major effect of the ground rules and boundaries, once established, they operate as a steady influence on the emergence of loving feelings and the form that they take, true or false. As noted, secured frames tend to create the conditions under which both patients and therapists are motivated to express true love, while modified frames motivate expressions of false love. Of note in this regard is the finding that patients' efforts to enact or gratify loving feelings directed towards their therapists, which almost always are false expressions of love, are rare in secured frames and quite common in frames that are deviant.

Finally, frame-related issues outside of treatment may play a role in expressions of patient-love, but as a rule, the effects are relatively minor. Such issues do, however, have a greater influence on expressions of therapist-love. Much of this appears to arise because deep unconsciously, patients are more invested in their therapies than their therapists, much of it because patients have but one therapist, while therapists tend to have many patients.

Is True Patient-love a Necessity?

Having framed and contextualized the experience of love in psychotherapy, we may now ask if true patient-love is an essential requirement for an effective psychotherapeutic experience. The answer to this question is rather complicated.

By and large, patients enter psychotherapy without love for their therapists, true or false. The emergence of patient-love is contingent on the interventions of the therapist – interpretive, non-interpretive, frame-related, and otherwise – which begin with the referral and the patient's

first therapeutic contact. Through it all, the hallmark of true patient-love is that it is a response to unconsciously validated interventions and is itself unconsciously validated. It may emerge consciously in one of several guises, such as a deserving respect and trust of the therapist or an appropriate admiration of his or her wisdom, empathy and therapeutic skills. Transient conscious feelings of closeness, affection, positive regard, and actual love may also express true patient-love. A patient's occasional passing sexual fantasy or other kind of wish directed towards the therapist that does not spill over into efforts at satisfaction may be a form of true patient-love as well.

However, in order to insure the truthfulness and healing qualities of a patient's loving expression, the intervention that has triggered the feeling of love must be investigated and shown to be one that the patient has, in fact, validated deep unconsciously. In addition, the patient's deep unconscious perceptions of the nature of his or her love must be determined because of the reliability of the deep unconscious system's evaluations of loving expressions themselves.

Should a therapist appear to be ill or impaired in some way, muted feelings of love or concern also may well be within bounds. This does not, however, hold when a therapist deliberately reveals that he or she, or a family member or any other personal acquaintance, is or has been suffering with an illness or injury. This kind of deliberate violation of the therapist's relative anonymity is a consciously wrought appeal for help and love, and as such is, according to deep unconscious assessments, a non-loving intervention. Any patient-love that such an intervention evokes very likely will be false and defensive.

In addition to its above-noted conscious forms, true patient-love often is experienced deep unconsciously and conveyed in patients' encoded narratives. This love is disguised in dreams and stories in which healthy and satisfying forms of love for and between others encode a patient's true love for a truly loving therapist. With a truly loving psychotherapist, unconsciously expressed true patient-love is far more common than comparable conscious feelings. This is the case because expressions of true therapist-love inevitably bring the patient face-to-face with their death-related issues and their unconscious ramifications. Some of this arises because true therapist-love often is expressed through frame-securing interventions which, while ideally holding and caring, evoke severe forms of existential death anxiety. Thus, the lovingly secured frame disturbs patients even as it offers them the exceptional opportunity to be truly loved and to experience, explore, and resolve their dreaded death-related anxieties. Similarly, valid, deeply insightful, trigger-decoded interpretations are lovingly healing, yet

they also touch on or lead to patients' death-related traumas and the activation of the death anxieties and deep unconscious guilt that they have aroused. Patients working with truly loving psychotherapists therefore can be expected to alternate between expressing their true love for their therapists and pulling back and becoming resistant and fearful of them.

True love never runs smoothly in an unconsciously validated psychotherapy experience.

Summing up, true conscious patient-love is not a requisite for a successful insightful psychotherapy, whereas true deep unconscious patient-love is vital to the healing process mainly because it is a sign that the therapist is being truly loving and deeply helpful to the patient. Deep unconscious loving expressions are displaced onto other individuals who appear in patients' dreams and stories, and their associations to these so-called *origination narratives* – i.e., images that serve as sources for further narrative associations. These truly loving storied themes are, as a rule, triggered by an unconsciously validated intervention and almost always are reflections of appropriate, well-deserved positive feelings towards the deeply effective, truly loving therapist.

True patient-love of this kind greatly facilitates the well-secured, insight-oriented therapeutic process.

Is True Therapist-love a Necessity?

The love-related requisites for therapists are different from those for their patients. Indications are that muted or neutralized feelings of affection, love, and loving concern for their patients is a *sine qua non* for effective psychotherapy – i.e., that patients do not need to earn their therapist's true love, that it should be given freely to all. A cold, unemotional, unloving approach to patients is likely to be unconsciously perceived by them as hostile and harmful and it can interfere with emotional healing. Transient personal feelings of more intense therapist-love towards a patient may be acceptable if they are short-lived. These feelings do, however, call for private self-processing by the therapist – the strong adaptive, narrative-based form of self-exploration (Langs, 1993) – or for an interlude of psychotherapy with an effective psychotherapist. Much the same applies to persistent conscious feelings of therapist-love and to all consciously loving sexual fantasies about and wishes towards a patient. Intractable, elaborate sexual desires and fantasies of love towards a patient is an indication of a serious emotional disturbance within the therapist and calls for insightful resolution.

There are, then, a limited number of avenues for expressing the kind of true therapist-love needed for a patient's successful psychotherapy experience. On the other hand, expressions of false therapist-love are legion and probably unavoidable to some degree. They take many forms and their detection and resolution is a major challenge for all psychotherapists.

Summing up, *true therapist-love of patients should be unconditional*, even though it may wax and wane in response to a given patient's behaviors and reactions to the therapist's interventions and the treatment process. In contrast, true patient-love is contingent on true therapist-love, which in turn is contingent on intervening in ways that earn patients' deep unconscious validating responses and appreciation.

Some Final Perspectives

There are a number of basic perspectives regarding love in psychotherapy that sum up these introductory ideas and that will put us on the path to clarifying and making constructive use of loving feelings in the treatment situation.

Appropriate feelings of love in psychotherapy – and they may be conscious or unconscious – are multi-determined and basically, are part of a patient's or therapist's efforts at adaptation to emotionally-charged triggering events, most of them caused by the other party to a particular psychotherapy. Such love is highly dependent on the conditions and framework of the therapy, the nature of the therapist's interventions (for the patient) and the patient's material (for the therapist), and a variety of other factors within the patient and therapist, their interaction, and personal lives.

For patients, true love, affection, and caring for their therapists is an adaptive response to true therapist-love – i.e., it must be earned by the therapist. It tends to arise as a momentary conscious feeling that can be described as neutralized, desexualized, and sublimated. It also features respect for the therapist's interpersonal boundaries and for the ground rules of treatment, especially in regard to privacy, confidentiality, and the relative anonymity of the therapist. The truly loving patient is comfortable with, and accepting of, the restraints and limits that apply to loving gestures and shows no need to seek actual satisfaction of sexual and other kinds of extra-therapeutic fantasies and wishes. This kind of patient-love also has elements of empathy, sympathy, and tolerance for the arduous aspects of the therapist's position and role. Patient-love also may be experienced deep unconsciously

and conveyed in encoded narratives. Most patient-love on this level of experience is true and has been rightfully earned by the therapist.

Therapeutic work is needed to determine a patient's deep unconscious assessment of his or her consciously expressed loving feelings and urges. True patient-love is based on positive unconscious perceptions of the therapist in light of his or her unconsciously validated therapeutic interventions, which is its defining feature. By way of contrast, false forms of conscious patient-love are marked by being triggered by therapists' interventions that are not unconsciously validated. In such instances, the displaced, encoded themes from patients speak of their therapists' interventions as inappropriate, unloving, seductive, or harmful.

For therapists, true conscious love for their patients should be a quiet aspect of their approach to all of their patients. It also should be privately experienced as a background feeling that does not demand enacted satisfaction. Essentially, it is non-sexual and sublimated, and empathic of, and sympathetic with, the patient's emotional pain and the difficulties in being a psychotherapy patient. When subjected to therapists' own self-processing, these loving feelings are supported deep unconsciously by positive, healing encoded themes. This kind of therapist-love also is expressed by establishing a sound set of ground rules and boundaries for a patient's psychotherapy and in making effective, unconsciously validated frame-securing and interpretive interventions. Failures along these lines are experienced deep unconsciously by both patients and therapists as either falsely loving or distinctly non-loving. All in all, a loveless therapeutic relationship is fundamentally cold and cruel, and unlikely to provide the backdrop for effective emotional healing.

Among the many ways of categorizing love in the therapeutic relationship, the most critical distinctions are between its true and false forms, and between loving feelings, wishes, fantasies, and thoughts on the one hand and on the other, trying to satisfy or enact such feelings in some actual manner, sexually or non-sexually. Constrained expressions of love tend to be true, while enacted expressions of love almost always are false. Whatever form it takes, these four classes of love differ in respect to their unconscious sources and their consequences for both patients and therapists.

Expressions of true and false love in psychotherapy are motivated and affected by a large number of inter-related factors. They include the emotionally relevant histories of both the patient and his or her therapist, with an emphasis on sexual and death-related traumas; the healthy mental capacities of the participants to therapy, as well as their impairments; the vicissitudes of the unfolding therapeutic process;

incidents in the outside lives of the patient and therapist, especially the therapist; and the handling of the ground rules and boundaries that are defined and managed by the therapist and accepted or rejected by the patient as the framework for their therapeutic work together.

Feelings of love in psychotherapy have both manifest/conscious sources and non-manifest/unconscious sources. Similarly, the consequences of loving feelings and enactments are mediated directly and consciously, as well as indirectly and unconsciously. The conscious and deep unconscious sources and effects of loving expressions are very different: Those that are deeply unconscious tend to be the more powerful of the two and to be of greater consequence for the therapeutic experience and the lives and mental health of both the patient and the therapist.

While all conscious expressions of patient-love call for an exploration of the therapist's contributions to this love, this search is especially vital when patients' loving feelings persist or a patient attempts to satisfy that love directly with his or her therapist. While the patient's contributions to these situations is considerable, the therapist plays a significant role as well. Recognizing their role in patient-love, especially when it is false in nature, poses special difficulties for therapists because so much of their contribution is non-manifest and mediated unconsciously. These difficulties are compounded because conscious system evaluations of loving expressions are quite variable and uncertain, and often treacherously misleading even when they are carried out by therapists. This points again to the need for therapists to develop the ability to ascertain their patients' far more reliable deep unconscious assessments of contentious loving expressions and to use these evaluations as guides to both understanding and intervening.

In general, true expressions of love by either party to therapy need not be acknowledged or interpreted. On the other hand, when an expression of therapist-love is identified as false by the therapist, he or she needs to unilaterally, or at the behest of the patient's encoded directives, rectify the situation and interpret the patient's deep unconscious perceptions of the falsity of the love. As for false love from patients, properly interpreted and rectified, these expressions, which tend to be evoked by therapists' errant interventions, can be the basis for affording patients deep unconscious insights into their love-related problems. Much depends on therapists' being able to distinguish manifestations of true versus false love from their patients and themselves.

With these perspectives in mind, let's look now at the strong adaptive approach that I shall be using to expand these ideas and probe more deeply the many issues raised by experiences of love in psychotherapy.

Index

- Applebaum, A. 78, 186
- approach, clinical-theoretical
 strong adaptive viii, 26, 28–9, 111–13
 weak adaptive 26, 27–8, 110–11
 weak and strong adaptive, compared 26–40
- archetypes (universals), deep unconscious 8, 17, 19, 32, 33, 94, 109, 137, 145, 151, 158, 161, 168
- Arlow, J. 48, 182
- Aron, L. 27, 43, 182, 184
- Atwood, G. 27, 43, 182, 187
- Bacal, H. 27, 43, 182
- Blum, H. 48, 50, 69, 71, 72, 182
- Bolognini, S. 50, 182
- Brandchaft, B. 187
- Breckenridge, K. 78, 182
- Brenner, C. 48, 182
- Breuer, J. 43, 46, 182
- Carotenuto, A. 71, 72, 182
- Casement, P. 78, 182
- Celenza, A. 67, 74, 176, 182
- Chertok, L. 43, 44, 182
- Cohen, B. 110, 182
- Cooper, S. 77, 182, 183
- countertransference 41, 52–3, 67–8, 75, 78–82
- Davies, J. 4, 71, 75, 76, 183, 184
- Dawkins, R. 169, 183
- death 15, 62–3, 86, 88–9, 91, 124, 150, 162, 164, 178, 180
- death anxiety ix, 33–5, 62–3, 64, 127–8, 137–40, 147–8, 150, 166, 175
- existential ix, 34, 91–2, 99, 101, 109, 127, 137–8, 152, 166, 171, 176–7
- and love, in psychotherapy 12, 16, 99, 101, 109, 137–40, 167, 172
- predator ix, 34, 93–5, 99, 101, 127, 139–40, 147–8, 149, 152, 156, 158, 164, 166, 168, 169–70, 172, 176, 180
- predatory ix, 33, 92–3, 99, 138–9, 166, 172, 176, 179
- decoding, trigger ix, 28–9, 38–9, 63–4, 111, 116, 129–32, 143, 151, 158, 161, 162–3
- DeDuve, C. 95, 183
- denial
 conscious system, use of 30, 100, 103, 106, 112, 116, 118, 125, 138, 146, 153, 155, 157, 158–9, 168, 171–2, 181
- therapists' use of 44, 47, 58, 71, 109, 110, 112, 135
- Donn, L. 72, 183
- Dorpat, T. 27, 43, 186
- Ferenczi, S. 69, 72, 183
- Fosshage, J. 78, 183
- Fox, R. 76, 183
- frames, of psychotherapy ix, 19–20, 69, 86, 99, 103, 104, 170–1
- anxieties, caused by (entrapment) 92, 99, 101, 109, *see also* death anxiety, existential
- deviant (modified) ix, 19, 39–40, 56–66, 69–76, 93, 101, 113–15, 117, 119, 120–3, 125–32, 138, 141–3, 144–60, 162, 170–1, 174–5, 177–80
- rectification of 3–4, 132, 171, 175, 178
- secured xi, 19, 70, 92, 99, 101, 109, 132–4, 137, 156, 162–4, 170
- see also* ground rules
- Freud, S. 4, 26, 41, 42, 43, 44, 46, 48, 49, 69, 70, 72, 84, 86, 182, 183
- Friedman, L. 4, 44, 52, 67, 70, 76, 183
- Gabbard, G. 4, 27, 42, 43, 44, 50, 52, 59, 63, 67, 69, 70, 71, 72, 74, 75, 76, 78, 89, 176, 182, 183, 184
- Galatzer-Levy, R. 119, 138, 145, 177, 184
- Gay, P. 69, 71, 72, 184
- Goodman, M. 78, 184
- Gordon, R. 27, 43, 184

- Gorkin, M. 4, 67, 71, 76, 184
- Green, M. 73, 184
- Greenberg, J. 67, 76, 184
- Grosskurth, P. 71, 184
- ground rules and boundaries 19–20, 70, 74–6, 101, 102, 136–7, 170–1, 174
- anonymity, of therapist 21, 33, 52–3, 56, 72–3, 75–8, 121, 128–9, 141, 152, 174–5
- confidentiality 17, 114, 149–59
- fees 3, 38, 136–7, 141, 150, 151, 174–5
- gifts 12, 122, 141, 142, 148, 149–59
- locale (place), of sessions 45, 145, 158
- and love, in psychotherapy 15–16, 20, 56–9, 99, 103, 149–59
- physical contact 33, 58, 70–6, 78, 121, 122, 141, 142, 144–8, 177–80
- privacy (third parties to a therapy) 17, 55–6, 58, 59–61, 61–3, 89–91, 113–15, 121, 122, 141, 142, 149–59
- responsibility for attending sessions 15, 38, 94, 162–4
- time and day of sessions 15, 53, 59–61, 121, 122, 125–34, 141, 142, 148–9
- see also* frames, of psychotherapy
- guilt, deep unconscious 4, 30, 63, 156–7, 169–70, 171–2
- see also* death anxiety, predator
- Hannah, B. 72, 184
- Hilsenroth, M. 74, 182
- Hoffman, I. 4, 27, 75, 77, 78, 184
- Holder, A. 78, 184
- illness, of therapist 94–5, 118, 119, 138, 139, 141, 145, 172, 177
- Kerr, J. 71, 72, 184
- Kohut, H. 27, 43, 85, 184
- Kriegman, D. 169, 186
- Langs, R. 11, 19, 22, 26, 27, 29, 33, 35, 49, 56, 57, 95, 121, 123, 136, 141, 144, 153, 154, 165, 168, 169, 170, 174, 180, 184, 185
- Lester, E. 4, 48, 50, 69, 71, 72, 74, 176, 184, 185
- Lindon, J. 78, 185
- Little, M. 44, 185
- Loewis, R. 27, 78, 185
- love, in psychotherapy
- components (dimensions) of 10, 11, 13–16
- conscious 2, 3, 7, 21–2, 106–10, 113–15
- deep unconscious 2, 3, 7, 21–2
- enacted 7, 25, 48, 102, 103, 104, 108, 117–20, 120–3, 133
- evaluation of
- conscious 6, 8, 34–5, 92, 98, 106–8, 122, 159, 174–5
- deep unconscious 6, 8, 24, 35, 92, 98, 125, 150–9, 174–5
- history, of writings on 41–51, 68–74
- patients' love 3, 5, 9, 23–4, 25, 53–4, 101, 102–3, 106–9
- conscious 2, 3, 7, 21–2, 106–10, 113–15, 121–2
- deep unconscious 2, 3, 7, 21–2, 107
- false 6, 12, 9, 25, 102, 103, 109, 112–15, 149–59, 162, 173
- true 12, 13, 20–1, 25, 87
- patients' requests for therapist-love 48, 50, 103, 117–20, 120–3, 123–4, 126–7, 132, 167–8, 173–4
- patients' unconscious attempts to heal therapists 89, 131–2, 178–80
- role in psychotherapy 20–3, 57–8, 66, 69–74, 83–105
- strong adaptive viewpoint on 37–40, 55–9, 61–3, 111–13
- strong versus weak adaptive views on 34–5, 52–66, 79–82, 83–7, 110–13, 115–17
- subjective 7, 24, 75–6, 105, 108
- techniques applied to 8–10, 14, 15–16, 25, 35–6, 53–9, 59–61, 63–5, 66, 76–80, 88, 102–5, 114–17, 123, 124–5, 126, 127–34, 149–59, 159–60
- therapists' contributions, to patients' love 56–9, 71, 102, 103, 127–9, *see also* triggers, for love in psychotherapy
- therapists' love 4, 9–10, 14, 15–16, 24, 52–3, 61–3, 67–82, 101–2, 104–5, 135–64
- false 38–9, 66, 69, 71–6, 80, 89–90, 98, 102, 104–5, 107–8, 113, 118–19, 128, 139, 141–60, 171–7, 178

- love, in psychotherapy – *continued*
 and outside life of therapist 15–16, 104,
 119, 125–9, 139–40, 145, 171–2,
 176–7, *see also* illness, of therapist
 true 21, 22–3, 83–4, 87–8, 111–12,
 135–6, 160–4, 166–9, 177–80
 therapists' requests for patient-love
 128–9, 140–2
 transference-based (so-called) 4, 37,
 41–51, 53, 59–61, 70–2, 84–6, 114–15
 weak adaptive viewpoint on 36–7,
 41–51, 53–6, 59–61, 67–80, 84–6,
 110–11, 149–59
- Mann, D. 4, 67, 75, 77, 185
 McGuire, W. 70, 83, 185
 McLaughlin, J. 78, 185
 McLynn, F. 72, 185
 Miller, M. 27, 43, 186
 mind, emotion processing 26, 30–3
 design of viii, 29–30, 30–3, 49–50, 79,
 95–6, 165–9
 evolution of 112, 165–9
 and love in psychotherapy 73–4, 86, 95–9
see also system, conscious, system deep
 unconscious
 mind, models of 26, 48–9
 Mitchell, S. 27, 43, 184, 186
- Natterson, J. 4, 54, 55, 67, 77, 78, 85, 186
 Newman, K. 27, 43, 182
- Orange, D. 27, 43, 78, 186
- Pizer, B. 78, 186
 Pollack, I. 186
- Rabin, H. 4, 52, 54, 58, 67, 71, 75, 76, 77,
 78, 186
 Rahmani, M. 186
 Raney, J. 27, 186
 Renik, O. 4, 77, 186
 resistances, and love, in psychotherapy
 108–9, 123, 155, 170
 Rose, S. 169, 186
 Ruderman, E. 78, 186
- Schermer, V. 110, 182
 Schlesinger, H. 78, 186
- Searles, H. 4, 75, 76, 89, 141, 179, 186
 self-processing (self-analysis), by therapist
 8, 22, 60–1, 78–80, 104, 136–7, 139,
 140, 168
 Singer, E. 27, 186
 Slavin, J. 4, 75, 77, 78, 186
 Slavin, M. 169, 186
 Smith, D. 27, 187
 Stolorow, R. 27, 43, 182, 187
 Strachey, J. 123, 143, 187
 system, conscious viii, 8, 30–1, 34–5, 39,
 96–8, 112
 system, deep unconscious viii, 31–3, 39,
 135, 98–100
 danger sensitive, subsystem of 32, 100,
 138
 morality and ethics, subsystem of 32,
 100, 134
 wisdom, subsystem of 31–2, 79, 100,
 134, 161, 169–70, 173, 180
 Szasz, T. 44, 187
- Teicher, A. 78, 184
 themes
 encoded 12, 28–9, 36, 61, 62–3,
 115–16, 122, 125–34
 pool (network) of, encoded 36, 62–3,
 115–16, 124, 136–7
 trigger decoding of 102–3, 129–32,
 136, *see also* decoding, trigger
 Toronto, E. 78, 187
 trauma, death-related 15, 86, 93, 103, 111,
 118–20, 139, 167, 176–7
 triggers, for love, in psychotherapy ix, 2,
 3–4, 9, 14–16, 44, 47, 56–9, 94, 98,
 102, 107–8, 117–20, 123–4, 126–9
see also love, in psychotherapy,
 therapists' contributions, to patients'
 love
 Trop, J. 48, 50, 187
- validation, deep unconscious
 (of interventions) 6, 13, 35, 64, 98,
 107, 116, 133–4, 135, 148, 160–1, 164,
 178–9
 absence of (non-validation), deep
 unconscious 13, 35, 79, 121
- Woodmansey, A. 78, 187