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Intersubjective Observations on Transference Love

Peter Buirski, PhD, and Michael Monroe, BA
University of Denver

In this article, the clinical phenomenon of transference love is used to make 3 contributions: (a) to illustrate how the intersubjective field can encompass more than just patient and therapist, (b) to provide an intersubjective framework for understanding transference love, and (c) to demonstrate how selfobject and antidote functions of the therapeutic relationship can alternate within the same patient–therapist dyad as figure and ground.

> I want to make love with you. There's a difference between sex and making love. Sex is a dime a dozen, right? Making love is like . . . is kind of like a symbolic, uh, culmination of everything. And it makes two people closer. Brings 'em closer together. That's what I would think because I never had that. I've had sex, but, you know, whoopee do.

What, we might wonder, would arouse these sentiments in Jennifer, a 53-year-old woman, for her 35-year-old male therapist? Might she be rationalizing feelings of love to disguise her lust? Might she be displacing onto her therapist feelings she had as a child for her father? Might she be attempting to seduce or overpower her therapist so as to defeat his attempts to treat her?

These hypotheses are examples of the kind of explanations Freud, in his 1915/1958 paper "Observations on Transference-Love," offered to

Peter Buirski, PhD, and Michael Monroe, BA, Graduate School of Professional Psychology, University of Denver.

Correspondence concerning this article should be addressed to Peter Buirski, PhD, Graduate School of Professional Psychology, University of Denver, 2450 South Vine Street, Denver, Colorado 80208. Electronic mail may be sent to pbuirski@du.edu.

account for the seemingly inappropriate, perhaps irrational, emotions that Jennifer was expressing. Freud believed that such "falling in love" was a manifestation of the patient's transference and had nothing to do with the person of the therapist. He cautioned that therapists not be unduly flattered by being the objects of such emotions (as Breuer was by Anna O's profession of love), for it is not the therapist's charms that evoke such emotions. Rather, for Freud, transference love was motivated by displacement or the repetition compulsion. It represented a false connection or a distortion of reality. Because it had little to do with the person of the therapist, Freud predicted that the patient would certainly fall equally in love with the next therapist and the next.

The notion that the patient's love of the analyst is a product of displacement "has," according to Stolorow and Lachmann (1984/1985), "perpetuated the view that the patient's experience of the analytic relationship is solely a product of the patient's past and psychopathology and has not been determined by the activity (or nonactivity) of the analyst" (p. 24). Intersubjectivity theory offers a very different conception of the nature of transference in the therapeutic relationship, and in this article, we hope to contribute further to this understanding.

From the perspective of intersubjectivity theory,

> transference in its essence refers neither to regression, displacement, projection, nor distortion, but rather to the assimilation of the analytic relationship into the thematic structures of the patient's personal subjective world. Thus conceived, transference is an expression of the universal psychological striving to organize experience and create meanings. (Stolorow, Brandchaft, & Atwood, 1987, pp. 45–46)

This should not be misunderstood as implying that transference is solely an intrapsychic process generated within the mind of the patient. On the contrary, both patient and therapist contribute to the construction of the patient's subjective experience of the therapist and the relationship with the therapist.

We hope to illustrate how, in Jennifer's case, her love for her therapist does not derive from her unconscious longings for a real or fantasied love object from childhood being displaced onto her therapist. Rather, it is a complex construction that developed in the intersubjective field created by the coming together of two subjectivities. The intersubjective field includes Jennifer's life experience and her organization of that subjective experience in relationship with her therapist and his organization of experience. (As will become evident, the intersubjective field also includes the therapist's supervisor and his impact on the subjective experience of both

Jennifer and her therapist.) Nor, we contend, is her love merely an irrational distortion of the present relationship in terms of the past. It is important to recognize that Jennifer has not fallen in love in a vacuum. She has spent many hours over the past year alone in a room with a man whom she reports experiencing as attractive, caring, and able to understand much of her experience. It is crucial to acknowledge Jennifer's subjective experience of being cared for by her therapist. Her therapist experienced genuine feelings of concern and care for Jennifer and it is unlikely that given her sensitivity to others, she missed the subtle (or not so subtle) expressions of these feelings. It seems likely that Jennifer used these very real feelings as building blocks on which to base her romantic attraction.

Going even further, it is important to recognize that there are specific attributes about the therapist that Jennifer has identified as the reasons that she has fallen in love with him. She has told him repeatedly how much she appreciated his acceptance and attunement. Also, she has talked about such personal characteristics as his sense of humor and his beard. As the clinical material unfolds, we try to show that within the intersubjective field of the patient–therapist relationship, Jennifer is not a woman in love with the past but is using her love in the present to find her way through her past.

There is some debate in the self psychology literature as to whether Jennifer's love for her therapist ought to be considered transference at all. Shane, Shane, and Gales (1997) might be inclined to view Jennifer's relationship to her therapist as an example of what they describe as "the old self with new other patient–analyst relational configuration" (p. 104). In this relational configuration, the patient's old relational patterns are engaged by a new object—the caring, attuned therapist. This relationship between the old self and the new other provides the patient with a positive new experience of intimacy that promotes growth and change. Shane et al. (1997) have identified this positive new experience as "the self with self-transforming other" (p. 4) dimension of intimacy, in which "the analyst is experienced by the patient as an other who provides significant functions for the self, including self-regulation, self-affirmation, self-delineation, and self-state stabilization" (p. 5). This relational configuration is consistent with Kohut's (1971, 1977) description of the functions that the therapist provides in the selfobject transferences. Jennifer, then, might be understood to have fallen in love with the therapist as a self-transforming other, someone who provides needed selfobject functions.

Regarding the longing for the provision of missing selfobject functions, Orange, Atwood, and Stolorow (1997) have contributed an important clarification:

> the term *selfobject transference* is being used to refer to two types of relational experiences that have distinctly different origins and meanings. In one, the patient longs for the bond with the analyst to supply missing developmental experiences—what Kohut originally meant by selfobject transferences. In the other, the patient seeks responses from the analyst that would counteract invariant organizing principles that are manifestations of what we (Stolorow, Brandchaft, and Atwood, 1987) call the repetitive dimension of the transference. In the former, the patient longs for something missing; in the latter, the patient seeks an antidote to something crushingly present. (p. 65)

In the remainder of this article, we would like to examine and expand on the implications of this formulation for working intersubjectively with patients in general and Jennifer in particular.

During the first 8 months of the treatment, Jennifer asked that the frequency of sessions be increased from once a week, to twice a week and then three times a week. As the frequency of sessions increased, so, too, did her experience of and capacity to verbalize her love for her therapist. She seemed to become increasingly preoccupied with her therapist. Alone at night in her apartment, she constructed elaborate fantasies of their loving relationship. Whereas she had drunk a lot of wine in the evenings, she, on occasion, renounced alcohol to immerse herself more purely in the loving feelings. She could spend entire evenings lost in rapturous fantasy of their union.

Jennifer's fantasies can be roughly sorted into two categories: those that express the love she feels for her therapist, which is unlike any feeling she has ever had for another person, and the other, in which she imagines that her therapist loves her in return. In an example of the first type of fantasy, Jennifer imagines that her therapist, like the character of Charlie on the television show *Party of Five,* has cancer. But unlike Charlie's love interest, who abandons him when he is ill, Jennifer affirms that she would devote herself to ministering to the every need of her therapist. In the second type of fantasy, her therapist is involved with another woman. The other woman dies (of unelaborated causes), and Jennifer's therapist is now free to follow his heart and be with her. Although we are well aware that these two fantasies are rich in personal meaning for Jennifer and can be profitably viewed from multiple perspectives, we focus on the extent to which they parallel the selfobject and repetitive dimensions of the transference that Stolorow et al. (1987) identified.

The first fantasy, in which Jennifer provides loving ministrations to her ill therapist, reflects the selfobject dimension of her relationship to her therapist. She is in love with his idealized qualities and wishes to devote herself to him. Her experience of his attention to her concerns, his concern

for her well-being, his attunement to her fluctuating affect states and his ability to contain them, his validation of her subjective experience, and his constancy has fostered more coherent organization, positive coloration, and temporal stability of her self-experience. He has been unlike anyone else in her life, and her feelings for him are unlike anything she has felt for another. In her experience of her therapist, we can see movement toward what Shane et al. (1997) refer to as the "new self with new other patient–analyst relational configuration" (p. 104). Jennifer was beginning to experience herself differently and to be having a new experience of herself in relationship to another.

Like the first type of fantasy, the second also reflects a selfobject dimension of the transference. In the second, Jennifer fantasizes the mirroring she receives from her loving therapist. However, we would like to draw attention to one important way in which the second fantasy differs from the first. Whereas the first fantasy centers around Jennifer's subjectively experienced affect states, the second fantasy, that her therapist reciprocates her love, is centered on what she wishes the affective experience of the other might be. This fantasy reflects an attribution of reciprocal feelings of love, which have their seeds in her experience of his care and concern for her but do not match her therapist's subjectively experienced affect state.

What other function might be expressed or served by this fantasy? We believe that by attributing reciprocal feelings of love to her therapist, Jennifer has constructed what Orange et al. (1997) have described as an antidote to her invariant organizing principles. More specifically, her fantasy of reciprocated love functions to offset or undo the crushing affects of shame and self-loathing associated with her archaically formed organizing principles that she is inherently defective and unlovable.

The term *antidote,* suggesting a cure that works by counteracting the effects of a poison, lacks precision. The underlying crushing affect states are not cured but covered over. Like painting over rust, the underlying affliction continues to eat away underneath the healthy-looking surface. A medical analogy, such as the continuous need for insulin to control diabetes, might fit better. The insulin does not cure the disease process. Rather, it offsets the adverse effects of the disease process, but only as long as it continues to be applied. The need for continuous application is what gives the antidote the quality of an addictive substance. With this clarification in mind, we continue to refer to the offsetting function as the *antidote.*

Atwood and Stolorow (1997) have suggested that the selfobject dimension of the transference characterizes the central experience of some

patients whereas the antidote dimension of the transference may be in the forefront of the experience of other patients. Although one or the other may characterize the central concerns of different patients, there is reason to suppose that both concerns may be operating, at different moments of the treatment, in the same patient. In the case of Jennifer, we illustrate how both these concerns are expressed in her transference love, first as foreground and then as background.

As the two types of fantasy described previously illustrate, contained in Jennifer's transference love for her therapist are the selfobject dimension, in which missing developmental experiences are provided, and the repetitive dimension of experience, in which the antidote function is contained. Her love for her therapist exists in the selfobject dimension, where Jennifer can have a new growth-enhancing experience. At the same time, her fantasy of her therapist's reciprocated love functions as an antidote to the crushing affects associated with her invariant organizing principles. This aspect of the transference love has a ritualized, obsessional quality, much like an addiction. The antidote function of the fantasy that her love is reciprocated serves to cover over her crushing affects of shame and self-loathing. However, unlike the selfobject functions provided by the new experience with the therapist, which serve to organize and integrate her self-experience, the antidote function operates to obscure and defend against crushing affect, without bringing about any new illumination or transformation. Therefore, for the antidote to be effective, it must be constantly applied. Antidote functions do not promote change to the invariant organization of experience. Instead, like painting over rust, the antidote hides or obscures the underlying corrosive affect states.

Jennifer's need to maintain the antidote function of her transference love can be clearly seen when it is most threatened or fails to operate. Jennifer is an experienced patient. In addition to having been hospitalized in her 20s for depression, she has had numerous therapies, although none of her prior outpatient treatments lasted long or were experienced as especially helpful. Nevertheless, she knows about the ethical boundaries that guard the patient–therapist relationship. Part of the threat to the maintenance of the antidote function is Jennifer's awareness that her sessions are being videotaped and shown to her therapist's supervisor. She will periodically turn to the one-way vision screen and address the supervisor, reassuring him that her therapist is behaving appropriately. Jennifer initially feared that expressions of her love for the therapist would be viewed by the supervisor as grounds for terminating her treatment. So she whispered her feelings or turned away from the camera. After reassur-

ance by her therapist and the passage of time without interference from the supervisor, Jennifer became more comfortable expressing her love. But she believes that reciprocal expressions of love by her therapist would be viewed as inappropriate and might jeopardize their connection. Thus, while she reassures the supervisor and her therapist that she understands her therapist will not act out his reciprocal love for her, she simultaneously maintains the fantasy that her therapist loves her in return—he dare not show it, but he nevertheless feels it. Here the supervisor serves as a kind of chaperon, whose presence prevents the therapist from reciprocating her love. In this way, the antidote function of her transference love is retained in the face of the absence of any direct confirmation of love by her therapist.

On one occasion, Jennifer presented her therapist with a gift of a key chain that she hoped would remind him of her whenever he used it. Her therapist, who had shown great courage in accepting her verbal professions of love in the past, became very uncomfortable with the meanings attributed to the gift. His discomfort was apparent to Jennifer as he struggled to find a way to explore the meanings of the gift without making Jennifer feel rejected. Jennifer grasped the nature of his discomfort and became enraged. She had never before displayed such rage, either to her therapist or, as she later reported, to anyone else. In fact, throughout her life, she has responded to narcissistic injury with depression and resignation.

To characterize Jennifer's rage reaction as the outgrowth of narcissistic injury does not capture the complexity of the experience. Narcissistic injury might result from the absence of needed mirroring or disillusionment with idealized others. What appears to have instigated Jennifer's rage reaction is that by rejecting her gift, Jennifer's therapist had threatened the antidote function of her fantasy of reciprocated love. Her therapist had, in effect, stripped the paint off the protective coating, exposing the underlying corrosive affects of shame and self-loathing that had been disguised by her fantasy of reciprocated love. In this formulation then, narcissistic rage results not from the failure to provide needed selfobject functions, but from exposing the overwhelming affects covered over by the work of the antidote function.

The antidote function is comparable to the familiar notion of defense. However, from the perspective of ego psychology, defense is understood to protect the individual from a knowledge of, or acting out of, unacceptable instinctual impulse. The antidote function, as it is conceptualized here, also serves a self-protective function. But instead of protection from unacceptable instinctual impulse, the antidote functions to protect the individual

from painful, disorganizing affects. In the case of Jennifer, the fantasy of reciprocated love functions to protect her from experiencing the searing shame and self-loathing that underlie her crushing organizing principles of fundamental unlovableness and worthlessness.

It is curious that Jennifer's therapist, who had courageously accepted her many expressions of love, became uncomfortable with the gift of the key chain. Apparently, the meaning of the key chain to Jennifer, that the therapist would think about Jennifer when he used it, threatened the therapist's sense of himself as an appropriate and ethical practitioner. He felt that if he accepted the key chain he would be validating her fantasy that he reciprocated her love and encouraging her to misconstrue the nature of the relationship. Jennifer's therapist was also concerned that his supervisor would be critical of him, which played into other of his archaic organizing principles. From this perspective, the patient's experience of her therapist as serving antidote functions felt comforting to her, but the therapist's experience of himself as effective, appropriate, and ethical felt threatened.

This highlights an interesting area for exploration: the countertransference experience of providing selfobject functions in contrast to antidote functions. It is our impression, at least in this example, that the experience of serving antidote functions may be much more disruptive to the therapist's self-organization than the experience of providing selfobject functions. In the key chain example, the therapist's rejection of the gift served to reduce his personal discomfort at the expense of injuring the patient. In other contexts, therapists feel inclined to provide reality testing, structure, or limits for the patient. These interventions are often justified as being in the patient's best interests, providing the patient with something needed but missing, when instead they often are functioning to reduce the therapist's personal sense of disorganization and fragmentation and restore and repair the therapist's threatened sense of self-cohesion. As the key chain example illustrates, selfobject and antidote dimensions of experience occur within an intersubjective field that engages the invariant organizing principles of both patient and therapist.

How might the therapist have addressed the antidote dimension of experience differently? Orange et al. (1997) suggest that mirroring of antidote functions, like defensive grandiosity, only leads to addictions to the analyst's responsiveness. They recommend that the approach to antidotes to affect states underlying painful organizing principles is "neither to mirror nor to puncture it, but to wait for openings in it—that is, for opportunities to make contact with the painful affect walled off on the other

side of the vertical split. Such efforts invariably evoke intense shame in the transference" (Orange et al., 1997, pp. 82–83).

During the weeks after the key chain incident, the treatment seemed to move back and forth between the selfobject and antidote dimensions of experience. Jennifer would expand on how wonderful it felt to love her therapist, with occasional inferences about being loved by him in return. At one point, Jennifer articulated a fantasy that her therapist was influencing her radio to play certain stations. This was alarming to both therapist and supervisor, who feared a pathological regression was in process. They were tempted to confront Jennifer with a dose of their reality but knew that although this would serve to reduce their anxiety, it would most likely feel very injurious to her.

In the end, therapist and supervisor adopted two approaches. First, they managed their anxiety by reviewing the healthy behavioral changes that Jennifer was making in her life. These included changing her midnight to 8:00 a.m. work shift to 4:00 p.m. to midnight, so that she would have more opportunity to interact with people, which she had been avoiding; distancing herself from a friend who has been verbally and emotionally abusive to her; making a new friendship with a more supportive, affirming woman; and moving from her old apartment where she had many painful experiences to a nicer location not associated with past hurts. Second, when openings presented themselves, the therapist offered a series of interpretations, the aim of which was to promote self-delineation and self-cohesion by putting words to her organization of experience (Buirski & Haglund, 1999). The interpretive sequence began with her therapist expressing his concern that Jennifer believed that he was the only person in the world who could love her and that only his love could save her. He explained that her conviction that no other person would find her worthy made her feel addicted to her therapist and the fantasy of his reciprocated love. Furthermore, sequestered behind this belief were her core organizing principles of worthlessness and unlovableness and the accompanying painful affects of shame and self-loathing. Within a few weeks, Jennifer reported several new experiences indicating greater self-cohesion. She renewed contact with a former friend who liked her but from whom she had withdrawn. Also, she began to reexamine her reasons for giving up her training as a dental assistant. (Apparently, several years earlier, Jennifer had completed a course of study to become a dental assistant. However, she believed that the woman who served as her mentor did not like her. She was suspicious and confused when this woman offered her a job, and she withdrew from this new possibility.)

This series of interpretations was directed at the antidote function of the fantasy of reciprocated love. However, care had to be taken not to undercut the selfobject dimension of the transference, which continued to be so growth enhancing for Jennifer. By moving back and forth between providing needed selfobject functions and interpreting antidote functions, the treatment promoted new self-transforming experience, greater self-cohesion, and the formation of new principles to organize her new experience.

In conclusion, we have examined both the selfobject functions and the antidote functions that the experience of transference love may serve for the patient. Both functions may operate in the same patient, with first one then the other being in the forefront of the transference experience. We have stressed the therapeutic importance of distinguishing between selfobject functions and antidote functions in furthering the illumination and transformation of self-experience. Finally, we have tried to demonstrate that both selfobject and antidote dimensions of experience occur within an intersubjective field that engages the invariant organizing principles of both patient and therapist.

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