Transference Love: An Artificial Rose?

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The following material selectively focuses on the presentation and consequences of love at certain nodal points in the psychoanalytic treatment of an individual. These nodal points correspond to predictable phases of the psychoanalytic process (initial, middle, and termination) and on the process of internalization that precedes and allows the constructive termination of analytic therapy. Because dreams often capture treatment themes and personal conflicts in a particularly rich and condensed manner, the case material is organized around a series of dreams at critical points of the analysis and the analytic understanding achieved from these dreams.

Case Description

Dr. A was a 38-year-old psychologist in an academic setting who consulted me when she was depressed, overwhelmed at work, conflicted in her relationship with her parents, and inhibited in the sexual relationship with her husband, whom she deeply loved. She met diagnostic criteria for dysthymic disorder with a supervening major depression of low intensity. She had required pharmacotherapy and had made several attempts at psychotherapy during two previous periods of mood disturbances. Her dysphoria had increased significantly over the 3 months preceding our first contact. The increase in symptoms followed Dr. A's appointment to a position of administrative responsibility in her institution. Her new position brought her under the critical scrutiny of faculty and students from whom she felt quite unprotected by the head of her department. She felt totally inadequate to meet her responsibilities. She scoffed at her recent promotion and stated that she would be better off "as a psychometrician" than the chief of the educational program. However, she also noted that she was "not a terribly good follower" because she often resented people in authority who seemed "controlling."

Dr. A was the second of three children. Her father was an extremely successful businessman. He had provided her with an ample trust fund accompanied by the admonition, "The principal of the trust is never to be touched." She was trapped in a cycle of angry resentment about her father's stipulation followed by guilty brooding about her own "ingratitude." She described herself as the "least favorite" of the three siblings. She was the product of an "unwanted pregnancy." She was conceived shortly after her father returned from military service. The pregnancy "forced" her mother to relinquish a job of responsibility and autonomy, which she had assumed while Dr. A's father was abroad in military service. Her internal picture of her mother was as a relentless, exacting critic who incessantly found fault with all she did without ever providing a soothing or affirming interpersonal or intrapsychic source of support. A major developmental interference in Dr. A's history was the accidental drowning death of her older brother when she was 13 years old. This older brother had "clearly" been her mother's favorite child. Her other brother, who was 6 years younger, was a pleasant but emotionally minor influence in her life.

Dr. A was the mother of a 2½-year-old son. She had had two pregnancies before her marriage. She had ended both with therapeutic abortions. I eventually learned that both pregnancies occurred at times of major life transitions. Her sexual difficulties began before her marriage, after she experienced what she referred to as a "spontaneous orgasm" of great intensity during a romantic exchange with "another man" before she and her husband had actually become engaged. During sexual activities with her husband, Dr. A initially reported that she "felt nothing." However, she noted that her body "responded with vaginal lubrication and perineal sensations." She impressed me as a rather serious but pleasant woman who initially seemed quite timid and shy. However, she promptly engaged in the early analytic process in an active, lively, and curious manner as soon as she began to lie on the couch. In contrast to her rather unremarkable physical appearance, her psychological brightness and her imaginative and curious mind made her a most attractive and interesting woman.

"Love is what you've been through with someone."

Dr. Gabbard

When the death of a sibling occurs, the surviving child often has a particular form of survivor guilt. The patient probably had hostile wishes toward her older brother, whom she felt was always her mother's favorite child. A basic psychoanalytic assumption is that each child wishes that he or she were the only child. The death of the older brother may have been experienced at some level by the patient as her own doing since she resented the success of her rival to such a degree. Dr. A, like many other siblings who have survived the death of a brother or a sister, felt deeply conflicted about her own success. Because of her brother's death, we can hypothesize that she unconsciously could not let herself be successful because she did not feel that she deserved to thrive while her brother's life was cut short at an early age. Another dimension of this feeling is that she should suffer and be punished for her hostile wishes toward him. In addition, it is likely that the patient unconsciously connected her decision to have two therapeutic abortions with the loss of her brother. The decision to have abortions is often experienced unconsciously as the killing of sibling rivals. Hence, the patient's

guilt was compounded by the two abortions. She may also have needed to deprive herself of sexual pleasure because of her overall sense that she must suffer and be punished for her murderous wishes. She recognized the association between sexuality and pregnancy, which had led to two abortions.

Dr. Lomax

Dr. A began the first session after I had recommended analysis by asking me if she got to "lie down today." Without waiting for me to reply, she said that she might as well lie down, did so, and immediately began to tell me about a recent dream:

> I just remember a single scene. I was seeing you, but the scene was strange in that I was small. I wasn't a child, but I was small. The dress I was wearing was one I made when I first left for graduate school. It has a lot of happy connotations. I have a picture of me in it with my father at the airport. Dad and I were smiling. I feel like I am choking up as I am saying this. The picture was taken at Thanksgiving break after I had been at school a couple of months and was about to go back. Mom must have taken it at the airport. It was a pleasant and happy time. It was also a dress I often wore with […], one of my first love affairs. He was an older guy by 17 years, but he was "young at heart." He was a teacher at [her graduate school] and had a reputation for dating students. I worked as his assistant on a research project for about a year after the picture with Dad. [He] made amazing changes within me. I remember shopping with him for a shirt when he was going to be on television. He just walked in and bought the first shirt he saw! I had *never* done *anything* like that. He told me that his time was worthwhile. While dating him, I started brushing my teeth regularly and wearing a seatbelt in the car and started enjoying my sexuality for the first time [a useful internalization]. The problem was, he was always role-playing. He could read what someone wanted him to be *like* and just *be* that way. It was wonderful for me, but eventually the relationship disintegrated. He really wanted to have children. I wasn't ready for that, but the real thing was his role-playing. Eventually he got involved with another first-year graduate student, but it was the most in love I have ever been.

I commented that her dream connected the boyfriend, her father, airports, and beginnings of journeys. Dr. A told me about the important associations she had to airports and how they had marked various transitions in her life. She recalled flying home from graduate school after her father had had his first stroke. Her mother seemed irritated that she had come home and after a few days complained that "Everyone was concerned about Dad, but what about me? I'm the survivor!"

In this first session, Dr. A demonstrated an usual capacity to participate in the analytic process. She was focused inward in an effort to understand her chronic unhappiness. She began analysis with a dream that recalled an experience with her father, the man from whom she learned to love, and her first adult love. Neither Dr. A nor I dwelt on my presence in this first dream or the symbolic connection of the beginning of analysis and embarking on a trip. An explicit transference interpretation about her implicit hopes for our relationship seemed premature. However, she connected the beginning of analysis to the important men she had loved who had facilitated her development. I did comment aloud but without elaboration that thoughts of her mother intruded into pleasant, romantic associations in a negative, complaining manner (Dr. A's pleasure, excitement, and joy were dampened by an internal critic).

About 2 months later, Dr. A had already experienced a substantial subjective improvement in her dysphoria. She felt more excited about her work and somewhat better about herself. She began a session by commenting on the numerous dreams she had had the previous night and noticed herself wondering what I would ask her about the dreams. From a particular dream, she could only remember a couple of scenes:

> I can't remember much of that dream either, but I do remember the part that *you'll* be interested in. [You could almost hear her growl!] I know I am going to have trouble talking about this. I dreamt I had a diaper on and I had a BM in it. It was a fluffy, mucusy stool, and I had a difficult time cleaning it up. I *thought* you would be interested in this, and I *knew* it would be difficult to talk about.

I asked her what had occurred to her. She told me that her 2½-year-old son was very curious about his stool. She wished she could get him toilet trained, but it did not seem to be a priority for him. Her mother had said that she, Dr. A, was potty trained early and easily. She recalled a memory of having to call someone to help wipe her after a BM. She didn't want to call her mother. I told her that I thought the dream came from a time in her childhood when she, too, was very curious about her body and in conflict with her mother over who was in control of her body. She responded, "You think so, huh?" She went on to describe her mother's efforts to control various aspects of her behavior without any direct comment about what I had said. As a little girl, Dr. A had sucked her thumb when she read. Her mother convinced her first-grade teacher to say something about her thumb sucking in front of her whole class. She remembered feeling embarrassed. She wanted to cry at the time and also as she was telling me the story. I commented that she was afraid that I, too, would embarrass her about things that gave her pleasure. She said that might be true. Without pause and without any reflection on my comment about the here-and-now transference, Dr. A said that she really didn't enjoy reading much and then noted she had a thought that she did not want to tell me about. She rarely read for pleasure but usually did so in bed and at times masturbated when she did so. I said, "You're afraid that I'll make you feel badly about that, too." She commented that she "already did" and remembered when she had begun to masturbate. At about age 13, she began stimulating herself while reading *For Whom the Bell Tolls*. She had never read anything so erotic before. Her mother had been concerned that

the book might be "too grown up." Her eyes began to itch with tears as she recounted these memories, and she told me that she was feeling "really resistant."

Dr. A entered her treatment with an unusual capacity for introspection and an ability to shift back and forth between current life events, the important relationships and events of her childhood, and our current relationship. She was alternately quite excited about her efforts to understand herself and then quite fearful that I, like her mother, would suddenly participate in a negating, deflating manner. She connected our relationship with her liberating first love. He, too, had helped her to feel better about herself. Buoyed by their relationship, she began to take better care of herself than she had during the 8 years after her brother's death. I was curious and surprised based on her initial history about the appearance of indicators of a positive relationship with her father. Much of what she had initially told me about their relationship was colored by their more recent struggles over her efforts to separate and differentiate herself as an adult woman. I eventually learned that Dr. A had had a positive "little girl" relationship with her father. In their early relationship, she had felt treasured and valued by him, and she unconsciously had hoped to reexperience those feelings in our project. The lively, affirming relationship with her father was reawakened in her transference relationship to me in a powerful way, but Dr. A experienced the romantic and loving elements of our relationship with great conflict. Such feelings seemed "inappropriate" to Dr. A. I inferred that her mother had felt threatened by her relationship with her father and responded with complaints of being neglected.

Much more of the positive relationship with her father was recalled from before his death about 8 months into the analysis. Dr. A eventually concluded that her father's increasingly compelling business and professional activities took him away from her during her preteen years. The paternal oedipal transference relationship she experienced in analysis was a fundamentally positive one. However, it was vulnerable to particularly intense disappointments around separations and to suspicions that I would "lead her" to love and depend on me in a way that I would ultimately frustrate and disappoint. Dr. A experienced critical, deflating, and devaluing maternal preoedipal transference reactions as well. The negative transference was connected to her reluctances and inhibitions in her current life and to her "resistance" in the analysis. It was as if she were saying, "I know what you will want from me, and I will not give it or give in."

Dr. Gabbard

In her first dream, the patient connected her analyst with her dad and with her much older first love. Dr. Lomax was wise not to make this connection explicit. Just as a good surgeon knows when not to operate, a good analyst knows when not to interpret the transference. To do so not only would have been premature, but it also would have created an impression that the analyst was interested only in the patient's perception of him, rather than in learning about the details of her life.

The early dreams conveyed by the patient also suggest an eagerness to please her analyst. She said that she remembered the part that "*you'll* be interested in." She assumed that her analyst was interested in the dirty, anal aspects of the dream, which is typical of professional people who enter analysis and know something about the historical origins of psychoanalytic treatment. In addition to impressing the analyst, she may also have been subtly competitive with him by trying to beat him to the punch through making her own interpretations of the meanings of the dreams. Although most patients believe that their analysts are thoroughly enamored of dreams, what they don't know is that dreams often serve as resistance against getting into other areas of analysis, such as the immediate experience of the present with the analyst. As Dr. Lomax points out, the patient may have been concerned about repeating experiences of humiliation by her mother with her analyst, so she tried to dazzle him with her dream interpretations.

Dr. Lomax

Material from the middle phase of the patient's analysis illustrates the further development of the transference relationships.

At the beginning of a session, she reported what she described as "an interesting dream." She said that she couldn't remember much of it but felt she should try to tell me about it. She noticed she was "blocking" in the session but went on to say,

> I was in bed with you. It reminded me of previous experiences trying to get comfortable with someone new, how awkward I have felt in each situation that I've done that. It reflects the discomfort I am having now in settling into intimacy in here….I guess I have some other feelings that relate to the transference. They don't seem appropriate, and it seems like they involve some risk for me to tell you about. It is a new situation, and I feel uncomfortable.

I responded that one new thing was her more open acknowledgment of wishes that were evoked as we developed this deeper degree of intimacy. She said that I had made "a valid point." She next mentioned our schedule around the delivery of her baby, which was anticipated just before the first anniversary of her father's death. She wondered if I would visit her in the hospital if she had a cesarean section, but she condemned her thought as "ridiculous." She "knew" that I wouldn't come and that it was "not reasonable" for her to wish for me to. I commented that we had been involved with this baby before it was even conceived (referring to our exchanges about how her previous abortions affected her anticipated and realized pregnancy) and through some difficult times with it (a diagnostic procedure that might have led to a third abortion if the child had had a genetic illness). I wondered aloud, "What could be more natural than to want *me* there to share the joy of this baby?"

The following sessions at the beginning of Dr. A's last year of treatment indicated new inner standards for her and foreshadowed the termination process. She began a session by telling me that she had awakened from a dream and wasn't able to remember much of it. She felt annoyed and thought that she wouldn't tell me about it

at all. This was followed by a sad feeling as she began to report the dream:

> I was looking at a bolt of fabric. It was loose knit and red. The feeling [of the dream] was like I felt in our previous session. I had the distinct sense you were annoyed with me. I began to wonder why. It became a generalized feeling and thought it had something to do with a comment I made about your job and my being stubborn.

She thought that part of the reason she had a hard time in analysis was that she tended to stand back when other people took action. Standing back was "just her style." I said it was a style she had adopted but not her whole story. She commented that she was no longer afraid of "slugging me" or having the wish to, but she still enjoyed our sessions better when she felt like she was participating in a more "objective" fashion. She said that the fabric in the dream had not been suitable for quilting (an art she enjoyed) but that she had recently daydreamed of making a quilt—a nine-patch quilt in red and white. During the daydream, the thought intruded into her mind that she "could make it for Lomax." That thought was quickly replaced by her assertion that there was no way that she would ever do that, but she knew that daydream had been relevant to the fabric dream. Then she wondered whether I would like her better if she gave me a gift but quickly said that such ideas were "all so silly." She remembered her father's "humpty-dot tie" that she connected to a story that they had read together when she was little. He would wear a similar polka-dot tie when he knew that she was coming home from college. I commented that she was no longer afraid of the thought of slugging me but that she was still afraid of her wish for me to love her, to care about her, and to be silly with her in the way she felt loved and cared about by her father.

About 4 months later, Dr. A began the session with what she referred to as "an incredible dream after our last session." In her dream, we had a session at midnight. She had to sit up to stay awake and was facing away from me. In the dream, I said it was time to go. As she got up in the dream, I reached out and held her hand in a reassuring way. She had the thought that that was what our "goodbye session" would be like. Shortly afterward, she found herself with a puzzling plethora of angry feelings about me and our project. She began to wonder if she had made some sort of mistake. After those thoughts, she recalled the following dream, of which she remembered only pieces but immediately upon awakening thought, "This is something I don't want to talk about. It is playing into your hands." In the dream,

> There was a patient and a psychiatrist. Some gifts had been exchanged each day. They were kept in a drawer. One was a sort of T-shirt. It was kept in a drawer under a little wooden chair, a little potty chair like a kid would use.

Dr. A said it annoyed her that this dream came up. She was sure we could associate it with a stool being a gift. The dream annoyed her because she felt like this was something I wanted to hear. She did not want to cooperate. I said that when she gave something important in the form of a self-revelation, it seemed like I would give nothing back and that I would also use her gifts against her. She said she wished that I would find some other way to say that. She was sure that all this had to do with her relationship with her mother—something else she did not like to think about at all. The dream made her feel angry. She thought that she must have been potty trained early and strictly in order to be less trouble for her mother. I asked her if she had any ideas about the T-shirt. She said that it came from her current life. It looked like a little pink shirt on top of a pile in her house; the shirt was a gift she had bought for a little girl of a friend. As I was about to leave on another trip, which would interrupt the analysis, I commented, "A mommy or daddy will often buy a T-shirt to take back to their little girl when they are on a trip." She continued in saying that the dream also had to do with baby shower gifts and that the dream might be related to her longing for a third child, a little girl, in addition to the two boys she now had. As she said that, she noticed a difficult feeling. She felt like she was agreeing with me. She didn't want to do that. She felt like she shouldn't be "doing this." She ought to just close up and not say anything more. To close up and to seal herself off was the decision that she eventually made in dealing with her mother and father. She "realized" that decision was "not appropriate to her analysis." Nonetheless, she felt strongly inclined to close up tight at that moment.

Two months later, Dr. A had a dream that for the first time indicated feelings about my other patients:

> I dreamt I came for an appointment. It was a different room with a table. Mr. Cowboy Boots [her name for one of my male patients], the woman I saw yesterday, and some other big guy were all here. It was like a group session. The guy I see on Monday wasn't there. I was interested in what was happening but very annoyed. I wondered whether you were going to charge me and how much. Then you came in and looked very young. You had no gray hair. I was amused at all this. It would actually be neat to meet your other patients and know about them, what kind of people they are. Yet I was angry that all of this is not relevant to what we were working on in here. In the dream, we were missing our time, and I know our time is becoming limited.

I commented that the dream brought together her curiosity about my other patients, her wish that we had met when we were younger, and her anger at how my other patients kept me from giving her my full attention. She guessed it was bad enough that they existed at all, but in the dream, I made her deal with them all at once. She guessed that she got angry with me at times when I didn't meet all her expectations, like going away for Easter weekend or having a group session without telling me in advance.

Dr. Gabbard

Although this presentation is on the topic of transference love, the material that Dr. Lomax presents represents a well-known phenomenon—namely, that transference love almost always carries with it an undercurrent of aggression and hate. Inherent in the analytic frame is the no-

tion that there is an asymmetrical expression of feelings. The patient attempts to say whatever is on his or her mind, including all of the feelings toward the analyst. In most cases, however, the analyst expresses his or her own feelings judiciously, but only when it seems therapeutically helpful to do so. This asymmetry often creates a chronic sense of rage in the patient about the inequality of the setup. Moreover, the patient must pay the analyst, who, as the patient noted, is just "doing a job." Winnicott (1) stressed that both love and hate are inherent in the analytic frame for these reasons. While love is typified by the empathic holding environment that the analyst creates and the effort to understand the patient's life in a nonjudgmental context, hate is reflected in the fact that time with the analyst is always limited by the professional hour and that a fee is paid for the service.

The term "transference love" is deceptive because it contains only one aspect of the complex and ambivalent feelings a patient experiences toward the analyst. Experiencing love toward one's analyst, or toward anyone else for that matter, puts one in a vulnerable position. Those who have the most potential to hurt us are those we deeply love. There is a vulnerability in transference love that often angers the patient. Although the analyst has many patients, the patient has only one analyst. This fact of the treatment setting is another feature of the asymmetry that affected this patient and other patients. She also was struggling with her awareness that the love she so much desired was constantly hampered by the analytic frame, which included an ultimate ending to the relationship when she had gotten what she came for. She resented both that their time together was limited and that there were other patients in the analyst's life. Because she was someone who was deeply conflicted about her aggressive wishes toward her sibling rivals, I would probably have pointed out the linkage between her resentment toward the analyst's other patients and her own siblings. I would also have wondered with her if she thought that the other patients were the analyst's favorites in the way that she was convinced that her older brother was her mother's favorite.

Dr. Lomax

Two weeks later, Dr. A received a short letter from a psychiatrist she had seen during a previous treatment in another state. This physician had seen the birth announcement of her second child in an alumni magazine and had written her a short congratulatory note. She recalled that she had seen this psychiatrist on a weekly basis for 9 months or so and felt like she was a friend and that she, the psychiatrist, felt the same way. She noted, however, that she could never tell this psychiatrist about the abortions because she felt like she had "something at stake" in their relationship. I asked if it was the feeling of friendship that felt at stake. Dr. A said that their friendship wouldn't have been as strong had the psychiatrist known certain details about her. She and the psychiatrist had talked about getting together with their two husbands at the end of therapy, but the psychiatrist's supervisor decided it wouldn't be such a good idea. Dr. A noticed that as she told me these things she felt sad. She and I could not be friends in some more mutual way. She understood that those constraints needed to be there but felt sad about them.

During (and in the first session after) my next absence, Dr. A imagined what it would be like to be a little girl and sit on my lap. It would not be particularly comfortable. It occurred to her that my penis would be too big. She wondered if there had been sexual thoughts in the early time in her life, when she used to sit on her father's lap. She recalled that as a little girl she had been surprised by how large her father's penis was. She did not have any memory of wanting to marry her father, but her father's brother was someone she had thought about marrying as a little girl.

Two sessions later, she told me about an article she had read about psychoanalysis. In this article, a psychoanalyst described two cases of "very erotic transference." In one of those cases, the patient wound up at the end of her analysis not even being able to remember much about the analyst. The other patient said she thought about her analysis and the way it affected her life "nearly every day." The article said it was clear that one of those patients was successfully analyzed and the other was not. I responded that that was clear to me, too, but I was not so sure whether the writer and I agreed on which case was which. Dr. A noted that our relationship was different from her previous therapeutic experiences because there was less feedback from me in "standard" ways. She could see that she would gain from our relationship but saw it as "a sort of exercise" that she went through by herself while being observed by me. She felt self-conscious and uncomfortable being observed and observing herself.

In this middle period of the analysis, Dr. A demonstrated a steadily broadened awareness of her motivations and evidence that she was less critical of her wishes. She was preparing to terminate the analytic relationship. She assessed it as a means to an end with appreciation and gratitude for what it offered and sadness and disappointment for what it lacked. In the dream of the fabric and quilt, she had expressed her wish to respond to her feeling of gratitude with a gift for me.

Over the course of her analysis, Dr. A had achieved the goals that she had sought when she began treatment. Her romantic and sexual life with her husband had improved. She had a second son, whom she enjoyed a great deal. During that pregnancy and delivery, her participation in the pregnancies that had ended in abortions had been understood in a way that helped her live with the abortions with less guilt in her present life. The experience of her father's deterioration and death had been at the center of our understanding of Dr. A and her relationships in a helpful way. She became less constrained in her decision making about the trust fund that he had left for her. She used the trust in ways that allowed her more personal freedom. She decided that she did not wish to pursue executive administrative functions in her profession but did enjoy the daily clinical activities her education had prepared her to exercise. She decided that in a few months she would end her analysis. She was going to also make a move to a different part of the country and use some of her inheritance to make a purchase that would be the start of a new business for her husband.

Dr. Gabbard

The patient's goals for her analysis were starting to be met. She was less conflicted about having good things for herself and less guilty about her past fantasies of hurting others. Her questions about how and why she had changed appeared in the form of talking about a psychoanalytic article. In the article, one analysand who was in love with her analyst could not remember much about the analyst, while the other thought about her analyst and the way he affected her life every day. Dr. Lomax comments that he isn't sure which case was successfully analyzed and which wasn't. In a similar vein, we can't be sure what factors have been most helpful to the patient.

The mechanism of the therapeutic action of psychoanalysis is controversial. There are many assumptions about it based on various analytic theories of pathogenesis and therapeutic action, but we don't have the kind of data we need to draw definitive conclusions. Although we emphasize the value of interpretation of unconscious conflict, especially in the transference, most analysts have the experience of hearing from former patients that they don't remember much of what the analyst said. Often the patient will say that the most memorable experience was a joke that the analyst told or a tear in the analyst's eye. Throughout the course of analysis, internal representations of self and others are changed through the experience of being in a unique relationship with someone who tries to understand you rather than judge you. Because of this internalization process, one could have a good outcome in analysis without remembering much detail about what the analyst said. On the other hand, a different patient may highly value a cognitively based understanding of what caused the original problems and what interpretations were crucial to the shift in perspective that made the patient feel better. There are, of course, multiple types of therapeutic action, and they undoubtedly vary from patient to patient.

Dr. Lomax

In the termination phase, Dr. A became more specifically aware of wishes to be more sexually and physically attractive "in here [referring to the analysis] and in our relationship." In this context, she reported the following dream with which we worked throughout the last 4 months of the termination phase:

> In my dream, somebody had a bunch of red roses. He came out into a waiting area where I was sitting with several other people. He gave a rose to each of the people sitting there. I was given one. When I looked at it, it was an artificial rose. I felt terribly disappointed.

When Dr. A thought about her dream, she "understood" that it was I who was passing out roses. Her rose was artificial, and she felt very disappointed. She said that real and artificial roses serve different functions. Red roses represent a symbol of love and specialness. However, when her husband had actually given her roses, she had also felt disappointed because they didn't last long. She would have preferred a rosebush but said, "They don't do well in Houston." She thought about a particular variety of roses, a little pink rosebush that grows satisfactorily with relatively little attention to it. In the dream, what she had gotten was an artificial rose, "a decorative item to improve only the esthetics of a room." She thought that sometimes I had implied that what I offered was "real love," but what she got was different. It would do what it needs to do and that she shouldn't be disappointed. It does last longer and serves a different function.

Dr. A went on to say that she guessed she should accept the limits and the artificiality of the therapeutic relationship. It had been valuable. Her father had prize-winning roses that he had enjoyed caring for and pruning. She noted that the only living plant that had ever been in my office had "died of neglect." She concluded that I was quite different from her father in regard to roses. She thought a rosebush was "like a relationship with someone." It grows and changes all the time. It is pretty, even when it is not blooming, but an artificial rose is fixed and has limits to it. I asked her, "What are the implications of 'artificial'?" She commented that she might have said it was a silk rose. "Artificial" implied some attempt to copy the real thing. Something artificial was supposed to serve some function but was man-made, artificial, and unnatural. She said that analysis was not exactly a deception, but it did involve disappointment. She had wished for more of a real rose. She felt deceived by implications of concern on my part and the way I used "love" to refer to her feelings toward or wishes from me. She "guessed" that love had many meanings and that the love she experienced was her own creation, just like her dreams. She thought of a friend who had gone through analysis and with whom she had spoken from time to time during her analysis. The friend's biggest disappointment was that her analyst had not come to her friend's wedding after being invited. She decided that her friend had "set herself up for that." Coming to a patient's wedding was not something an analyst would do. She wouldn't expect me to come for anything, "except maybe my funeral." After she said that, she wondered where that thought had come from. She noted that even a silk artificial rose was not soft or fragrant.

Thoughts about this dream emerged often during our termination phase. Dr. A eventually decided that an artificial rose could be silk and something with its own value, but she remained disappointed because it was not like the rosebush she desired. She was angry with herself for her wish. She was grateful and disappointed about our relationship and our analytic project. She noted that one had to consciously work through that conflict and that she had to recognize that she could have more than one feeling at a time. She became confident that our work was now something she could do on her own.

When Dr. A left analysis, she told me that she felt like she was leaving a part of herself behind. She quickly added that she hoped that "part" she left behind was her mother. (Indeed, she was trying to leave a hateful introjection of her mother.) She wondered if analysis "had to be this difficult" but felt it was a good experience. She was "glad it was over and sorry it was finished." She felt "mostly sad," but it did seem as if it was time to stop and that we had "done a lot in spite of [her] being so stubborn."

During termination, Dr. A expressed an urge to maintain connected in a fairly common form (the wish to

have a joint ongoing connection—the quilt and the third baby) and through a form reflecting her life and experiences (the rose, artificial rose, and rosebush metaphors). She experienced these wishes most intensely early in the morning, and they were accompanied by nausea. The experience evoked memories of her previous pregnancies. Earlier in her life, Dr. A had "acted out" urges to remain connected in the form of the two unfortunate pregnancies that had ended in abortions. At the termination of our analytic relationship, she fantasized about having "our" pregnancy, with a daughter representing her wish to redo her complicated relationship with her mother in a better way through our analytic relationship. For Dr. A, being involved in a loving relationship within analysis carried with it the risk of being lured into a conflictual, critical, and frustrating relationship. While sorting through these urges and the reluctances and prohibitions associated with them, she dreamt of my giving roses to each of my patients. Naturally, she wished for a real rose and a real relationship—one without the imbalance and artificiality of psychoanalysis. The artificial rose she received instead was, of course, disappointing. However, she also recognized that the artificiality of the therapeutic relationship allows it to last longer and to serve the function it was designed to accomplish. In her metaphor, in Houston (our relationship), the living roses (the natural expression of love) would not do well. I did provide her with some of the relational qualities offered by her father. But our relationship was a means to an end, with limits determined by clinical goals. She wondered if I had actively deceived her. Or did she wish for a relationship that might, in a different context, be possible and enjoyable but was just not compatible with the project we had agreed to pursue? At times, Dr. A had expectations that she did not want to articulate in order to avoid feeling disappointed. She did not want to expect me to participate in her life, although she could let herself imagine that I might come to her funeral. Our relationship did not directly gratify her senses; in her words, "Even a silk rose is not soft or fragrant." Dr. A alternately felt grateful and disappointed: pleasure that a difficult process was over and sorrow that it was finished.

At our "goodbye session," as she had named it in advance, Dr. A brought me a native Texas rosebush as a parting gift. She asserted that such bushes need little care. She thought that I might be able to keep a native bush alive. It would also help me remember her. Giving it helped her feel close to me in parting. A few months later, I received a quilt she had made, along with a note telling me about her subsequent use of our analytic project.

Dr. A was right. Love in psychoanalysis is an artificial rose. The psychoanalytic relationship does copy or include elements of more natural relationships. In that sense, it was a real relationship. Yet, if it was to serve as a means to an end, it must also have remained "artificially" within a therapeutic structure, providing the limits required to achieve therapeutic results.

Dr. Gabbard

In this termination experience of an analysis that was conducted in a highly skillful manner, we saw the patient's ambivalence about leaving. She was both gratified and disappointed. It really shouldn't be otherwise. An analysis that ends with excessive idealization of the analyst is suspect. An analysis that ends with excessive denigration of the analyst is also suspect.

However, at the risk of splitting hairs, I don't think I agree with either the patient or Dr. Lomax that love in psychoanalysis is an artificial rose. I think the love experienced in one's analysis is basically similar to the love experienced outside of analysis. The feelings are just as real, but the actions are different. The analyst, as Freud noted, pursues a course for which there is no model in real life. The patient, on the other hand, is confined to verbalizing all of the feelings that would ordinarily be enacted.

A common mistake made by beginning analysts and therapists is failing to recognize the "real" nature of the love the patient feels for the analyst. The beginning therapist or analyst may, in fact, try to convince the patient that the loving feelings are really for someone else, like a parent, instead of for the analyst. Many patients experience this as a failure to validate their internal reality. I am certain that Dr. Lomax recognizes this distinction, but I call attention to it as a way of clarifying that from the patient's perspective, the feelings are definitely real. In fact, the only difference between love inside and outside the transference is that the former is analyzed. All of our significant relationships are a mixture of real elements in the present situation and the recreation of past relationships.

The analyst's love for the patient is equally real. However, we must also recognize that the analyst's love may mask feelings of contempt, envy, rage, and hatred. Love is just as complicated in analysis as it is in real life. It does not appear in pure culture in analysis any more than it does in marriage. This dark side of love is often neglected by analysts who wish to think of themselves as feeling positively toward their patients. We must recognize that love is always a complex mixture of a variety of feelings in the analytic setting, and a good analyst spends a good deal of time self-analyzing to understand the multiple layers of feeling that lie behind a state of love for the patient. Although no poet and no psychoanalyst has ever succeeded in defining love, we certainly have vast experience with the phenomenon and a firsthand sense of what it is. The love experienced in psychoanalysis was aptly summed up by a quip once made by James Thurber: "Love is what you've been through with someone."

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