



This Thing called Love in Life and in the Consulting Room

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One reason for choosing the title for this paper is because there has often been an idea that what may be curative about therapy is not so much the benefits of interpretation but a patient's sense of being loved by the therapist. Let's think about this some more. Another reason for choosing this title is related to one of the chapters in my earlier book, *Learning from Life*, which is called "Hate and containment". Now I am proposing that we consider Love. But this is not necessarily the opposite to hate. It is often the other side of hate itself — just as hate can be the other side of love.

Some people speak of love as if it were something pure, much as we might see white light. Either it is "on" and the world is bright, or it is "off" and everything goes dark. I want to hold up a metaphorical prism to this light — to explore some of the many different colours that we can find in the spectrum of this thing called "love".

Love can be tender; it can be harsh. It can be giving to another; it can be demanding of another. It can be pure; it can be perverted. It can provide security; it can become a great threat to security. It can be resilient and able to survive much testing. It can be fragile and liable to collapse when tested. It can lift us to great heights; it can dash us down and leave us broken. It can free us; it can imprison us. It can lead us to where we most want to be; and yet it can likewise lead us into dreadful misery. It is also so much more than any of this. And often, when we are least wanting to realise it, the person we feel that we so much love may be largely an image we have created in our own minds. Inevitably we wish to believe that this image is a reality rather than, to some extent, a fantasy. So, let us try to explore some of this further. But, of course, I can only touch upon a very small part of the spectrum of this thing we call love.

I would like to begin with the birth of a baby.

When things go well, and a mother bonds naturally with her infant, she can feel that she is holding the most beautiful baby in the world within her arms. And it is a very common experience that we who have babies, or who have grandchildren, often regard our own off-spring as *the* most wonderful. By contrast, we may sometimes look at other children and wonder how it could be that any parent could love such a baby, or child, whom *we* might see as quite unattractive. We would probably then be shocked to realize that some of those parents may be thinking the same about our own adored baby, or grandchild. So how can this be?

Some of this could be nature's way of ensuring that babies are cared for by parents who are drawn into a bond of loving their own children. It is, after all, this bond that can help them to endure the costly struggles of being a parent — not only at the start but also for the years it will take for those children to become better able to manage their lives for themselves.

Another part of the bond that parents form with their children is often a result of seeing their offspring as an extension of themselves. But there can be hazards in this. A parent may be able to love this extension of themselves quite readily when things go well, as if they are seeing themselves in a mirror and seeing what they want to see. But children need a freedom to become *themselves* — not to be confined to the expectations of a parent or parents. And we can see this breaking out of the symbiotic bond from quite an early stage, especially when a child has discovered how to say “No.”

Children may sometimes say "No" in response to almost anything that a parent is asking or requiring of them. This is part of what Winnicott later speaks of, when parents have succeeded in allowing a child to develop a mind of its own. As he says, a child will in due course insist on exercising this separate mind. And this will often be difficult for the parents. But this standing up to a parent is usually a great deal healthier than when a child gives up having its own mind in order to continue fitting in with a parent's demands or expectations.

When a child grows up being unnaturally good this may be a lot easier for parents (and teachers) but this is often a bad sign, for it may indicate what we have learned to call false-self development. This means that a child has learned to give up some of its own personality in order to fit in with what is being required of the child by parents, or by those who have power over the child. And it can take a long time for such a child then to break out of the learned habits of compliance, and that anxious fitting in with the expectations of others.

We sometimes encounter this pathology in compliant patients who often present as trying to be good, admiring the therapist and wanting to please him/her, wanting to know how to do this thing called therapy and wanting to do it well. But, however encouraging it might seem to be that a patient is wanting to work “well” in therapy, this idealizing attitude towards the therapist can get seriously in the way of such patients *discovering themselves* and their own personality in their therapy. And when they do begin to find themselves in the course of therapy this may lead to far more difficult times for the therapist than when the patient had been trying to be good.

Insecurity in loving

There are very different kinds of caring. There is an insecure kind of caring, which some people show when they are trying to prove their love for someone by keeping everything nice and as far as possible without conflict. There is a quite different kind of caring that is shown when someone cares enough to engage with conflict, as when they are able to say “No” to unreasonable demands, even if that “No” is met with anger and hate, and accusations of not caring.

Example 1

When I was a social worker I came across many examples of insecure parenting. For instance, an insecure mother (whom I shall call Mary) had been trying to fend off her children's demands by giving them almost whatever they asked for.¹ Even though she could not afford it, she would buy them expensive gifts — trying to show that she loved them. However, she had regularly spent money on presents when she really needed that money for paying her rent and other essential expenses. As a result she had got into serious debt and was about to be evicted because she was owing so much rent.

I had been called in to help Mary to see if I could prevent this family becoming homeless. I therefore had to sort out her debts. To that end, I had been able to obtain a grant from a Charity, to clear some of what she owed in order to bring the rest of her debts to a point where she could deal with them herself through weekly payments. The situation thus came to be stabilised and, for quite some time, this mother was paying her own way and her debts were being reduced. However, having been helped with her debts, in a way that seemed so easy to her, Mary was tempted to get into *further* spending. She told me of an additional expense she was planning, claiming that this was so important to her that I would have to get more money from the Charity so that she would not again get into debts that she could not manage. However, I made it very clear that, if she added to her debts in the way she planned, she would have to deal with that herself. I would not again be providing her with any easy way out of this. I knew that Mary *wanted* to spend money in this extravagant way but it was not on anything she actually *needed*. And I believe that there is an important distinction to be made here between wants and needs. “Wants” sometimes need to be frustrated whereas “needs” are usually to be attended to. But Mary's planned expenditure was not on anything that she actually needed.

When I next visited her, Mary was ready to challenge me. Despite what I had said, she had spent the money as she had planned, having borrowed money for this additional expense. She said that I would therefore *have* to get that money for her, otherwise she would be owing more money than she could possibly manage to re-pay. She and her children might again be in danger of becoming homeless and it would be my

¹ I also present this case in *Learning from Life* (2006: 80-85).

fault if they were evicted. I reminded her that I had made my position entirely clear to her. She would now have to deal with this new debt herself. But I assured her that I would still visit her, as her social worker.

Mary then became violently angry with me — throwing things at me. Nothing actually hit me, but the shoes, and whatever else she found to throw, were all flying past my head. It was a clear crisis in my relationship with this very deprived mother. I therefore kept calm and simply repeated that I was still not going to change my mind, however angry she was with me. But, as I had said, I would continue to visit her as I knew that the time ahead was going to be difficult for her, especially now that she had this new debt to deal with.

Many months later, I noticed that Mary's old habit of trying to win "peace at any price" with her children had changed. She was no longer buying them sweets and ice creams as a way of shutting them up whenever they were annoying her. Christmas had also come and gone, without the excessive buying that had been her usual practice in past years. This time she had only given the children what she could afford rather than the extravagant presents they had usually had before. She had also managed to clear all of the recent debt from her needless spending earlier in the year.

Mary was feeling a great pride in her achievement and she told me how she had managed her money during this year. She said: "You said 'No' to me when I demanded that you get more money, to help with that unnecessary debt. I then got very angry with you when you stuck to what you had said to me, that you would not pay for that. I even threw things at you, but that did not stop you coming to see me. In fact, all of that helped me to realize that you really cared. It also helped me to realize that I could say 'No' to my children even when they shouted at me and said they hated me, just as I did to you."

A bit later Mary said: "I have a new sense now of what loving means. It means being able bear difficult times with the children rather than always giving in to them in order not to have those bad times." She ended by saying: "I have now realised it was that kind of love they needed rather than more ice cream or sweets."

Mary was an unusually insightful person. She had discovered for herself that things bought with money were substitutes. They had often been given because she had doubted her own capacity to love her children when things were difficult. But no substitutes can ever make up for what they are meant to substitute for. That is why the use of substitutes, of whatever kind, will often become addictive, whether these substitutes are food, cigarettes, drugs, sex, excitement, or whatever.

Well, I learned a lot from Mary. And she said some things that we can all usefully keep in mind in our clinical work. As I have tried to illustrate, experience shows that it takes a lot more real caring, for us to be there for the anger that can come at us from

patients, especially when we do not fall into the temptation to appear to be good and caring — as in trying to be the “better mother” or “better father” than they seem to have had. And it has often been said that the good analytic experience is not that which is better than a patient has had before. Instead it is that in which the analyst can bear to be used to represent the bad objects in the patient's mind, without the analyst either collapsing or retaliating because of this use of the analyst. And, what is meant by “object” here is the idea that a person has of another, in terms of which they have come to relate to that other person.

A continuing search for a lost good object

What I mean here by the “good object” is the *idea* of a good person that we put together in our minds on the basis of an idealized view of good experiences we have had, or wish we might have had, with a parent or some other key figure in our childhood.

But there are many problems with this idea of a good object. When we were very small we would naturally have wished to believe that our parents were the best in the world, accepting no replacements for our own mother or father, or the person we had come to know as mother or father. Other people, by contrast, were often treated as strangers or as people who would come and go. Parents, on the other hand, were expected to be always there. So we needed to find ways of preserving the notion of an all good parent: *especially when things were not going well for us.*

We now know that children protect their inner sense of security by developing what we call “primitive defences” in their thinking whereby they preserve in their minds a notion of a good mother, kept safely separate from any bad experiences of her. To that end they create a split between the good and the bad, attributing all good experiences to the “good” mother in their minds and all bad experiences to the “bad” mother in their minds. Thus, when things were going badly with the actual mother, they can imagine that they could recover the good mother by getting rid of the bad mother. Only later does a child come to realize that the good mother and the bad mother are the same person. That is when a child may begin to develop a capacity for concern — wishing sometimes to repair the hurt caused to the mother during those times when she has been treated as if she were all bad.

Another way that a child may attempt to preserve the notion of a good mother is to assume that, when the mother treats the child badly, it must be because of something bad in the child. Even a cruel mother, still being idealized as good, may be seen as treating the child in hurtful ways because the child is apparently so bad. Such a child may then feel: “If only I could be really good then I might be able to win back my good mother's love for me.”

Having had to accept the loss of an idealized mother/father in childhood, it often happens that the child will be in search of what is sometimes called “the lost good object.” This search is also in evidence, later on, when a person is looking for a life partner, I think of this as looking for the “dream partner,” someone who is meant to match, as nearly as possible, that person's idea of the perfect partner. It is believed that a dream partner will exist somewhere and might be found. And this dream partner is often built up around the notion of some lost good object of childhood. This search can be manifest in many ways.

Example 2

A most convincing example of this unconscious search for the lost good object was discovered by a patient I used to see. His mother, as he remembered her, had always had white hair. The girl he fell in love with had striking red hair. *What he did not know, until years after he had married her, was that his mother used to have red hair of exactly the same colour as that of the person he had married.* But, when the patient was just two years old, his mother's own mother had committed suicide. The shock of that suicide had turned his own mother's hair white, apparently over night. (I understand that this can sometimes happen.) So, the mother he had known (the one with red hair) had suddenly been replaced by one with quite different hair, and it seems he had been unconsciously searching for that lost mother ever since — until it seemed he had found her in the woman he married.

Falling in love and falling out of love

Let me start this section with a quotation I came across some years ago, from an English poet called Samuel Rogers:

It doesn't much signify whom one marries, for one is sure to find next morning
that it was someone else.

That was written early in the 19th Century, at a time when people more often used to wait until they were married before starting a sexual relationship. What a shock it must have been then to be faced with something of that real relationship only after a long courtship and engagement, during which a couple would each be developing a fantasy relationship to the future spouse. But something like that can happen in any relationship, even today.

We meet a rather different example of this sequence when we hear of someone “falling in love *at first sight*.” What is especially clear here is that the person who becomes the object of this sudden love and devotion is someone who is not known. And, being as yet unknown, there is then all the room in the world to imagine this person to be however we may wish them to be. They can be thought of as the complete embodiment of the dream partner we have unconsciously been in search of. Thus, all the gaps in our

knowledge of this unknown person can then be filled with whatever qualities we wish to imagine them to possess. This loved person may genuinely have some of the qualities we look for. But, in other respects, they will of course not be as we had imagined them to be. There will therefore have to be much adjusting to each other in this new relationship if it is not to break down.

To be healthy in any close relationship, each person will need to find a freedom to be themselves and to be accepted as themselves, but this often does not happen. *Either* one person feels a need to fit in too much with the expectations of the other, in order not to lose them, **or** there may be a “falling out of love” by either or both. It is often at this point that one or other person will return to their search for the dream partner that they have, after all, not found in the partner they are leaving.

The transference of strong feelings

In the analytic consulting room we are usually trying to help our patients to become more familiar with their own internal worlds and their unconscious motives in how they are and how they relate to others. So, how do we come across such issues to do with love and hate in the consulting room? Inexperienced therapists and analysts quite often have problems with a patient's strong feelings when these come to be brought into the analytic work. They often prefer to talk about these in relation to other people in a patient's life, as a way of protecting themselves from being the object of such feelings, rather than face seeing that these feelings are being felt for themselves. On the other hand, another defence against these difficult clinical experiences can be found in the language used by many analysts and therapists, when they speak of a patient's “positive transference” or “negative transference.”

Of course we do sometimes need to use this language of theory, in speaking of our clinical work, so that we can position ourselves alongside what others have said about such things as transference. However, if we are to get beyond the protection provided us by this jargon, we need to be able to face the fact that we are often referring to a patient's expressions of love for us, or their of hate for us, during our work with them. Such raw feelings, with the experience-near language of love or hate, can be much more difficult to engage with directly than when we are using the more distant language that we find in such notions as positive or negative transference.

One problem here is that when we interpret using the notion of transference, as an explanation of what is around in the consulting room, we can convey quite different meanings to a patient than we may intend. This is another aspect of our need to look *beyond interpretation*. We really do need to see that patients not only respond to the content of what we say but also to the implications of how we may be seeing them, and how we may be experiencing them, as conveyed by how we are interpreting to them. For instance, we may want to draw attention to something in a patient's past that seems to be finding expression in the clinical present of the analytic relationship. We therefore need to be able to get across to a patient that *not everything* that is experienced in relation to ourselves, as analyst or therapist, is necessarily about us as ourselves, whether a patient is either loving or hating us. But it is more complicated than that.

For a start, we need to remember that there is no such thing as “pure transference,” in the sense of it being purely transference and nothing else. There will always be some elements of reality upon which a patient hangs whatever else is attributed to us. Especially when a patient is angry with us, this is not just because we remind them of someone else. They may also be angry with *us ourselves*, and for something real that has been around between them and us. We therefore need to be able to accept what may apply to ourselves — to deal with whatever our own part may have been in this, in order that our patients can experience us as not running away from their anger.

Patients are always likely to be aware of those times we are being defensive, as when we too quickly try to deflect their anger away from us back to some other person in their lives (to father, mother or whoever else in the past) rather than staying with that anger in the present. Later, maybe, we can discover what else in the patient's life has contributed to the degree of anger or hate that is being felt in relation to us as analyst.

Part of the problem here is that we are likely to find a patient's anger, and even more a patient's hate, difficult to take. We should of course not take it all personally or we are even more likely to become defensive, thereby failing to be “there” for the anger that a patient may need to bring into the analytic relationship. On the other hand, when we are having to deal with a patient's expressions of love, during our clinical work, we will find this too can be extremely complicated. In fact we probably need to be even more careful in how we try to deal with this than when we are having to engage with a patient's anger and hate.

So, what I am trying to say here is that when we are trying to deal with hate in the transference we are in danger of being slow to recognize *how much* of this may actually have to be with how we are, or how we have been, in relation to the patient. By contrast, one of the problems in trying to deal with transference love is that we can be slow to recognize *how little* of this has to do with us.

Most of us are naturally liable to feel flattered by expressions of appreciation, let alone expressions of love for us, from our patients. We therefore need to be extremely careful that we do not mistake this for any realistic evaluation of us or of our qualities. Much of what a patient may say, in terms of their admiration or love of the analyst, is likely to be an expression of the patient's unconscious search for someone they can feel about in this kind of way. In particular, when a patient's transference comes to be erotised, I think it is always important to be wondering about the more primitive relationships in the patient's life, which the patient may be re-experiencing in relation to the analyst, rather than to see this as a present-day relationship that they wish to believe they are discovering with the analyst himself/herself.

I think that some clinical situations can be much better managed if we can recognize the infantile relationship that is being relived in the transference rather than seeing an erotised transference as the present-day relationship to ourselves that a patient may wish to believe it to be.

Example 3

Let me give an example of a therapist who got into some difficulties around this kind of clinical problem. I think we might all be able to learn some useful things from this. An inexperienced therapist found herself seeing a married patient who was constantly looking for excitement in different relationships, behind his wife's back. This patient had spent some time in the early stages of the therapy boasting of his conquests, seeing himself as a modern day Don Juan, as if his potency lay in the frequency of his conquests. I believe that he was trying to avoid facing what could be called his "relationship impotence," in that he seemed to be barely able to sustain a relationship beyond the excitement of the chase and then the conquest.

It was not long before the problem this patient had been talking about began to show up in the analytic relationship too. The patient, I will call him Mr. A, began to tell his therapist how attractive he found her. And she was not immune to this flattery, blushing in supervision when she told me about it. Mr A began to make it even more difficult for this therapist by telling her that she must realize he had much to offer her, she being a young and attractive woman and he a successful man and a highly experienced lover. Could they not stop this therapy stuff and have an affair? She would surely not regret this, he assured her.

The therapist tried to clarify the analytic boundaries by reminding Mr A of how his therapy with her had begun. He had met her at a lecture and, finding that she is a therapist, had told her that he thought he ought to see a therapist. Could he see her? She had agreed, in spite of this being an unusual way of first meeting a patient. But, in

referring back to that first meeting, the therapist had pointed out to Mr. A that *he had originally had a choice*. He didn't have to choose to ask her to be his therapist. But, having chosen therapy with her, the therapeutic relationship was the only kind now available to him. She stressed that there could no longer be a social relationship as that would make therapy impossible.

In supervision, I had suggested to this therapist that she seemed to have slipped into sounding as if she might have had some regrets about the choice made by Mr. A. Because of the way she had put it to her patient, she could be heard as if she were saying that the relationship between Mr A and herself might have been different if he had invited her out rather asking her for therapy. But, as that therapy had begun, she was trying to say that the earlier moment of choice had passed and this relationship now had to be just therapy.

Mr. A seemed to be excited by what she had said. He then increased the pressure upon her for them to abandon this therapy for a sexual relationship. She stood firm and he also remained unchanged on this. Eventually, after a few more weeks, Mr. A announced that he was only interested in a sexual relationship with her. The therapy no longer meant enough for him to stand by his original choice to see her for therapy. He was either going to see her socially or not at all. The therapy then ended with this issue remaining unresolved.

Now, if we try to learn from this example, I think that this therapist needed to grasp the therapeutic opportunity being brought by this patient. His familiar problem with women had become alive between her and him. He had been bringing his unconscious search for a dream partner into his relationship with her as an important communication, showing that this is how he always tended to relate to women. And here he was trying to relate to her in the same kind of way. But this problem he had with women still needed to be better understood.

I believe that Mr. A's way of relating to women showed that he was still in the grip of his own unconscious search. And, as he got to know each sexual partner he quickly became disillusioned. Each one was not the one he was unconsciously looking for. He still wished to think that someone else might be. But he had never understood what this search was about. Instead, he had tried to rationalize his promiscuity in terms of the excitement of the chase and his sense of triumph when, each time, he was able to make another conquest. In this therapy there might have been an opportunity to explore the patient's unconscious search more deeply. But that would only have begun to be possible if his childhood search had been recognized, beneath the surface of these repeatedly sexualized relationships with women, and the recurring sequence of unsatisfying relationships he subsequently had with each of them. What was it that Mr. A

was most deeply searching for? Alas, this could not be explored further once the therapist had pointed out there had been a choice available to him at the start, as if he could have continued to act out his problem with her rather than asking to be her patient.

In the therapy he was being invited to face the pain of early loss, which almost certainly lay beneath this compulsive search for replacements. But the therapist's way of trying to address this problem seemed to have played into his idea that he could have had the other option available to him. She had also seemed to have indicated that, at the initial meeting, she might not have been averse to having an affair even though she was clearly married. So, this therapist's attempt at clarifying that the moment of choice was past seemed to have led the patient away from any further exploring of his problem, he getting stuck with his usual habit of trying to seduce — this now being directed at his therapist in a way that she had been failing to contain.

One final example

Example 5

I will now try to convey to you part of an analysis with a female patient I used to see. I shall call her Miss B. At one stage in her analysis Miss B began to tell me something which, for a long time, had been deeply troubling her but which she had not felt able to bring to her analysis before. The first part of what Miss B called her “confession” was that she had a perversion she regarded as a deep and shameful secret. At the time she had no sexual partner so she relied upon masturbation for her sexual release, but she had found that she could not reach climax without a particular kind of fantasy. The required fantasy had always to be sadomasochistic, in which she was being treated as disgusting and bad. The second part of her “confession,” which took many weeks for her to get round to telling me, was that I now figured in these fantasies. In her fantasy I was represented as a sadist. Miss B did not understand this at all as she had never experienced me as being sadistic towards her. I said to her:

I think that you may be using me in your fantasy to represent somebody who sees you as bad — then using me to punish you for what you have come to see as something bad in yourself.

As we tried to make sense of this, Miss B recalled that she had come to see herself as bad very early in relation to her psychotic mother, who had often told her how much she hated Miss B for being an unplanned and unwanted child. So the sense of badness went very deep. Then, when Miss B was aged 7 or 8, her mother had seen her sitting on her father's lap and had started screaming at her father, saying that he was disgusting. She had then yelled at the child saying that she was disgusting too and she sent her to her room. After that the patient had never sat on her father's lap again.

In the analysis of that moment Miss B, who is a talented therapist herself, wondered if her mother might herself have been abused as a child. Maybe,

seeing her sitting on her father's lap might have reminded her mother of something like that in her own life. Perhaps her mother had been abused by *her* father, or grandfather.

This way of trying to understand the mother at that moment certainly made more sense than any idea that Miss B may herself have been abused. That did not fit in with her experience of herself or of her father with her. However much Miss B had tried to explore that explosive moment with her mother, she had never sensed anything explicitly sexual between herself and her father. She had only thought of it as a precious time of physical contact and warmth with her father, such as she could never remember with her mother.

The patient continued to return to this fantasy relationship with me, sometimes also telling me some of the details in these fantasies. I, for my part, continued to explore these for what they might be telling us about her unconscious search. For instance, the kind of thing I said to her was:

“I believe that you are using me to represent two different kinds of man. One version of this man is somebody who seems to treat you as your mother had, apparently seeing you as bad — and therefore to be punished. The other view of me is as somebody who tries to understand what you are now telling me, rather than seeing you as if you are needing to be punished.”

After some months of Miss B telling me about this most private part of her life she began to find her sexual fantasies changing. (I should perhaps make clear that she volunteered to tell me this. I never asked her about it.) She then began to find that she no longer needed to experience her sexuality as bad, or as needing to be punished, and her fantasies stopped being sadomasochistic. Also, I no longer figured in these fantasies.

Miss B later told me she had felt understood by me through this. She had also felt that I was in no way shocked by what she was telling me. Instead I had seen this as her bringing into her relationship to me what had once been surfacing in her relationship to her father. It really had much more to do with her childhood sexuality than with any adult sexuality.

Some closing thoughts

I have managed only to touch upon a few aspects of our topic under discussion: “this thing called love.” I hope that we can each enlarge upon this in our own ways, to grasp more of this important topic than I have been able to put together in this paper.

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