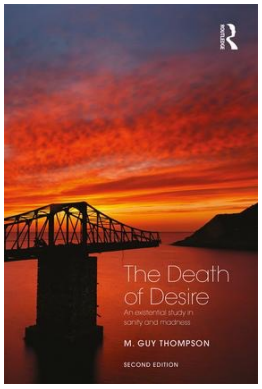
On Sympathy:
The Role of Love in the Therapeutic Encounter[1]

M. Guy Thompson, PhD



Of all the words that we use as a matter of course in our daily lives, love is probably the most difficult to define or grasp. I have yet to meet anyone, no matter how wise or worldly, who claims to know precisely what love is. Yet even if no one understands it, there is little doubt that love in fact exists. For virtually everyone, no matter how rich or poor, crazy or sane, handsome or ugly, has experienced it, both in the passive and active sense of the word. Everyone has loved and been loved, or they wouldn't be human. Yet we have no paucity of opinion as to its effects and, like happiness, we employ all manner of cunning and device to procure it, despite our failure to ever fully possess it. Like a visitor we wish would stay but has other places to go, we reconcile ourselves to its presence on terms we can neither dictate or control.

It is a matter of common wisdom that we are never more vulnerable, or foolish, than when we are in love with another human being. Our only protection from its artifice is to try our best to defend ourselves against it, by telling ourselves we don't need or want it, or to set our standards so high that no one can possibly meet them. Such strategies are employed regularly by the neurotic, though not without a substantial cost. For what value does life have without it? No matter how much we may deny it, all of us share a common bond that makes us the human creatures we are: *we cannot live without love in one form or other*. No matter how loath we are to admit it, our singular goal in life is to procure as much love as we can get, no matter how successful or futile our efforts may be. Even when we feel without love, our longing persists in the deepest depressions of our being.

The topic of this paper is to explore the specifically therapeutic aspects of love. This may seem like a futile exercise, and to others perhaps foolish. After all, many therapists today doubt that love plays any role in therapy and, indeed, if and when it manifests its appearance, it may well signal the end of the therapy

---

[1] Earlier versions of this paper were given at Esalen Institute, Big Sur, California, under the auspices of the **R. D. Laing in the Twenty-First Century Symposium**, August 8, 2016; and at the **Windhorse Foundation**, Boulder, Colorado, September 29, 2016.

relationship. This perspective may explain why the word love is seldom invoked when describing the basic elements of the therapeutic process. Sigmund Freud, the inventor of psychotherapy, was also reluctant to sing love's praises in the context of the therapy relationship. Acting on such feelings was strictly forbidden. *Yet, it was Freud who was the first to suggest that all neuroses are the consequence of a broken heart*. To suggest that love, or its absence, is capable of driving us crazy doesn't necessarily imply that it may also heal. Yet, in rare moments, Freud acknowledged that love is the key to a successful therapeutic outcome. This, however, was a rare occurrence in the corpus of Freud's writings.[2] Freud's reluctance to employ the word love in both his theoretical and technical papers has been championed by subsequent analysts, virtually all of whom opt to focus instead on the so-called "transference" aspect of the relationship. Even to this day, few analysts realize that this convoluted, and much-misunderstood technical term was originally employed by Freud as a synonym for love.

The word, love, just doesn't sound scientific, does it? More than ever before psychotherapists today seem eager to demonstrate just how scientifically valid their version of psychotherapy is. To suggest that therapy is really about love doesn't further this argument. If anything, it makes the therapeutic dyad sound sentimental, superficial, soft-hearted and simplistic. And it makes the therapist who dares to invoke this word look foolish, unprofessional, not well trained. So we come up with all kinds of alternative, scientific sounding terms in its place, including the just-mentioned transference, as well as the words countertransference, cathexis, sublimation, attachment, and perhaps the most ubiquitous of all, empathy. In fact, most therapists insist that a capacity for empathy is the single-most important trait that we can develop as clinicians. My thesis is that empathy, whatever its value, isn't enough. In fact, I want to argue that if therapists focus all their efforts on furthering empathic intuition alone, but neglect to embody heartfelt *sympathy*, the results may well border on the grotesque.

Before turning my attention to what I mean by the term sympathy and how it manifests in therapy, I want to say a few words about the other kinds of love that sympathy is sometimes associated with. For the most part, the Greeks spoke about three distinctive kinds of love: *eros*, *philia*, and *agapé*, the last of which is often Latinized as *caritas*, from which we get the English word *charity*, which isn't exactly what *caritas* means.[3] *Eros* is the edition of love with which we are most familiar. This is because Freud made it ubiquitous in our lives, arguing that it is operative in virtually all relationships, however intimate or impersonal they may be. Even if Freud is correct in this, the Greeks believed there are higher forms of love than the kind that is explicitly erotic, or sexual. What these higher forms of love share in common is that they assume a capacity for self-sacrifice, for putting the other person's needs over our own. Everyone, except for perhaps the craziest person, is conversant with erotic love. But what about *philia*? This is an explicitly non-erotic form of love that the Greeks believed epitomizes friendship, which I have explored in some depth elsewhere.[4] Montaigne, for example, suggested that friendship occasions a unique type of love that is necessarily free of sexual interest. R. D. Laing confided to me once that he thought friendship comes closest to embodying the therapeutic relationship. He even proposed

---

[2] See my "Manifestations of Transference: Love, Friendship, Rapport," for more on Freud's positive statements to this issue.

[3] Charity: benevolence, giving. *Caritas*: the ultimate perfection of the human soul, derived from *agapé* – divine love; the absolute requirement for happiness, man's highest effort. *Caritas* entails love of god, love of one's neighbor, and love of oneself. Genuine self-love is rooted in sympathy.

[4] See Chapter Five in my *The Ethic of Honesty*, 2004; Chapter Six in my *The Death of Desire*, 2016; and my recent, unpublished lecture on friendship, Thompson, 2015.

that the so-called therapy "patient" or client is essentially a person you sell an hour of your friendship to, like a prostitute might, but without the sex. This is perhaps the reason that sex is antithetical to therapy, because it compromises the subtle forms of selfless compassion that sexual interest abandons.

However, it is the third form of love, *agapé*, that is most relevant to the development of genuine sympathy. This is because *agapé* is by far the most selfless form of love. Meister Eckhart, the fourteenth-century German theologian and mystic, conceived *agapé* as the kind of love we feel for God, which epitomizes Christian love. This is also the specific form of love typically referenced in the Bible. But in place of the Greek term *agapé*, the King James version of the Bible substitutes the Latinized *caritas* instead. Thomas Aquinas, the thirteenth-century Aristotelian theologian, effectively integrated *philia* with *agapé* when he defined charity, or *caritas*, as "a friendship between man and God." He also extended the definition of *caritas* to include the love for one's neighbor, which is just about everyone with whom you come into contact, as well as love for oneself. It was Aquinas's integration of *philia* and *caritas* that helped me entertain the therapeutic relationship as one that is rooted in a special form of love, one that is intrinsically giving, self-effacing, and compassionate, in the Buddhist sense of the word.[5]

So how is all this related to sympathy, and how should we distinguish sympathy from its kissing cousin, empathy? The word sympathy has been so plagiarized by greeting card companies that applying this term to the highest, most selfless love possible may seem trite. But when you take a closer look at the word and its various shades of meaning, I think you will agree that there is no better word in the English language to depict it. Etymologically, both sympathy and empathy derive from the Greek word *pathé* (the same root that gives us "pathology"), which literally means to *feel*, *suffer*, or *experience* something, especially emotions, at the deepest level. All three verbs, to feel, suffer, and experience are closely intertwined. But whereas empathy denotes the capacity to identify with and essentially intuit what another person is feeling, and even thinking, sympathy entails the ability to *agree with* and, so, be in harmony with another person's *pathé*. This is why empathy and sympathy are not the same thing, though they ideally complement each other.

I don't think what I'm proposing is something radical or new. The Webster dictionary, for example, defines empathy as "the ability to share another person's feelings and experiences." Their definition of sympathy is "the feeling that you care about and are sorry about someone else's trouble, grief, or misfortune, a feeling of support for the other person."

This distinction implies that when we sympathize with someone we don't just know or comprehend what they're feeling; we also *feel* what they are feeling *with* them. We suffer *their* suffering, not a facsimile of our own. We resonate with their experience and feel moved by it. This means that we develop a profound affinity for that person. In other words, I am in agreement with, and of *the same mind* as this person, by commiserating with him or her at the deepest, existential level. This isn't a novel idea. After all, Freud was the first analyst to propose that the ideal attitude we should all adopt with our patients is one of "*sympathetic understanding*."

Why sympathetic *understanding* and not just sympathy, full stop? Freud recognized that because infants lack verbal language with which to express their needs, whether they are hungry, wet, or lonely, they

[5] The etymological roots of the words sympathy and compassion derive from the same roots, the Greek term *pathé*, meaning, passion, suffering, emotion. To feel sympathy or compassion is to *be with* one's *pathé*.

rely on their parents to anticipate their needs and intuit what they are. The baby doesn't spell out that she wants to be held, caressed, or nurtured, because she can't. The mother or father, as if by magic, figures it out and provides what is needed. The parent's love for the child plays a central role in this understanding, brought to bear by the extraordinary attention parents bring to the task of parenting. In turn, whenever the infant's needs are understood and met, the infant equates the parent's ability to understand his or her need with love. Children soon learn to equate being understood with *feeling* understood, and feeling loved. When we grow up, we seek friends and sexual partners who "understand" us, so to speak. In fact, we all know that nobody is really capable of understanding anyone else. We can't even understand ourselves! What we're really asking for when seeking understanding from a lover, friend, or therapist, is a special kind of benevolent, sympathetic *attention*. Freud realized that this is precisely what all of us want from our therapists. This is why it's no accident that the word "therapy," or *therapeia* in Greek, means attention, etymologically. It is a form of attention that is, in essence, a gift of love.

Yet, sympathy isn't an attitude that one can literally *adopt*, because it cannot be accessed by will. I don't choose to be sympathetic, I succumb to it, naturally, spontaneously, irresistibly. Like the divine interventions the Greeks were so fond of invoking, sympathy, properly speaking, is a *gift of grace*. It spontaneously comes over us and, once felt, holds us in its grip. We have no choice but to feel sympathy whenever it comes over us. When it beckons, we cannot push it aside – nor can we contrive to beckon it on command. Though we cannot control our sympathy, it is anything but blind emotion. Like all emotions, there is an intelligence at work, an intelligence that recognizes the gravity of the other person's situation. Sympathy visits us whenever we feel closest to someone, when we yield to that person's predicament.

In turn, I may express a word of sympathy when someone tells me, for example, that her mother just died. But merely saying the words doesn't guarantee that I genuinely *feel* sympathy. Yet many psychotherapists, especially psychoanalysts, seem loathe to use this word or even allude to it in their publications. Instead they opt to talk about *empathy*, as though it is equivalent, or even superior to sympathy. As I noted earlier, the word empathy doesn't connote a feeling of love or anything remotely approximating it. To empathize with a patient is essentially a mode of attention that can be developed and perfected, like the act of interpretation. The fact that it may be spontaneous doesn't necessarily imply that it is always heartfelt.

Empathy implies the ability to recognize what the other person is feeling and sometimes thinking, but it is an action of the intellect, not the heart. Its principal vehicle is identification, recognizing something of

myself in the other person. Let's take a moment to explore what the psychoanalytic conception of empathy entails, because this is where the concept was first applied to the therapeutic process. For many, it is the psychoanalyst's most cherished technical device.

When I empathize with a person's pain, I have a visceral sense of the pain that person is experiencing. But that's as far as it goes. Empathic attunement doesn't in itself imply compassion. So what are the possible reactions I may experience when I sense anguish in another person? How should I respond? If I don't also feel sympathy for that person's plight, I am left to ponder what to do with this information. What can I say that may nonetheless prove useful? My mind will race to connect my patient's experience to my *own* experience, and though this may elicit a sense of connection with this person, it also tempts me to do something with it. This is where the danger lies. I may decide that I have to do something more than simply recognize this person's pain, and in that moment my mind may seize on something critical to say. Instead of simply sharing the moment and resonating with it, I may instead urge my patient to take a closer look at that experience, *differently*. Instead of commiserating with his or her anguish, I may question it. Instead of accepting my patient's experience, I want to *change* it.

This is often touted as the principal benefit of psychoanalysis, the ability to look closely at our experience and learn to question our most cherished assumptions. This is indeed a remarkable skill, the same one that is utilized in other disciplines as well, including Buddhism and phenomenology. But this skill can be deadly if not utilized with compassion, with a heartfelt capacity for *caritas*. Ironically, one of the chief proponents of the use of empathy in psychoanalysis, Heinz Kohut, arrived at similar conclusions about this concept as I did, but insisted on referring to sympathy as simply an edition of empathy. In his famous inaugural paper on empathy first published in 1959, Kohut states that he encountered similar reactions from his patients as the ones I outlined above whenever he attempted to "enlighten" a patient with well-formulated, yet critical observations in the form of incisive interpretations. In the case of his patient, Ms. F, whenever he offered an interpretation that was not a precise recapitulation of what she had just said, she became enraged and accused him of "wrecking" her analysis (Kohut, 2011). Once he stopped accusing Ms. F of resistance, Kohut came to realize that she was teaching him *how to see things exclusively from her point of view*. In other words, once he stopped trying to reformulate what she was saying from the vantage of a theoretical schema and began to sympathetically listen to her instead, Ms. F felt heard and understood. She was immediately appreciative of his efforts. Kohut termed this way of listening *experience-near*.

Yet, Kohut also insisted on referring to this ostensibly sympathetic manner of interacting with his patients as an edition of *empathy*. I doubt that Kohut was familiar with Max Scheler's (1954) work on sympathy and so concluded that working from a more experience-near sensibility was an aspect of empathic attunement. Moreover, nowhere in Kohut's characterization of this process does he acknowledge the manifestation of love in the relationship. Instead, he refers to invoking empathy as a strictly "observational" tool that enhances the analyst's capacity for introspection in the analytic process. I believe this explains why Kohut failed to fully understand what had been missing in his earlier formulation. *What was missing was the heartfelt feeling of sympathic love for his patient*, not more observational techniques. Kohut wanted credit for inventing a novel psychoanalytic technique, not for recognizing the ubiquitous role that love plays in therapy. The former is presumably easier to market than the latter. Kohut even argues it is vital that the analyst, in adopting this new

perspective, *not* completely abandon the more adversarial use of empathic interpretation. Instead, it should be applied alternately with (sympathetic) experience-near listening, in order for the latter to "repair" the damage wrought by the former, instead of employing them simultaneously.

Perhaps one of the lessons we can derive from this is that the practitioner who privileges empathic over sympathic engagement (or as in Kohut's case, treats them as the same) does so because he over-identifies with the patient. This is the moment when the practitioner's narcissism may leave his (or her) patient in the lurch, when he is more invested in educating his patient than sympathizing with him. Whenever I identify with another person, I perceive that person's experience from the vantage point of my own and, so, bring myself as well as my intelligence to bear. This is where all the knowledge I have accumulated comes in handy. I have so many ideas, so many possible explanations and theories to call on. This is when my critical faculty comes to the fore, when my mind searches for a way to fix, change, critique, or challenge the other's experience instead of simply *being* with it. Empathy by itself, devoid of a sympathic component, lends itself to working the mind in an intrinsically critical manner. Again, I'm not suggesting there isn't a role for this critical faculty. There most certainly is. There would be no therapy without it. But if this faculty is substituted for sympathy and not guided by it, the consequence can be ugly.

For example, what is it that analysts or therapists are trying to accomplish with their capacity for empathic attunement? How is the mutative element of therapy conceived? It seems to me that the aim of therapy is to engender a capacity for *confiding in one's therapist*, not merely obtaining information, whether conscious or unconscious, by hook or by crook, simply for the sake of divining this or that secret that one's patient isn't yet ready or able to disclose. Kohut is like many analysts who fancy themselves as proficient at getting inside the mind of their patients by divining secrets that may otherwise stay hidden. Harold Searles was also adept at this method.[6] It is as though all that matters to them is knowing stuff, no matter how such knowledge is obtained, smug in the conceit that nothing can ultimately be hidden from them. I don't believe that this kind of regard is therapeutic. It seems to me that what is therapeutic must on the contrary derive from developing a modicum of trust that in turn encourages one's patients to share things they have never revealed to anyone else, *when they are ready to do so*.

When I sense that someone I am with, whether a lover, a friend, or a patient is feeling sad, heartbroken, or lost, I find myself *commiserating* with them. I feel their pain so profoundly and am so affected by it that it may even move me to tears. This isn't empathy. This is *love*. And I suspect that this is why analysts are loathe to employ this term, and even discourage its role in the therapy process. Analyst's don't typically believe that loving one's patients is necessary, appropriate, or desirable. It probably violates one of the many boundaries that analysts seem so eager to erect between themselves and their patients, always at the ready to be proper, correct, professional. I suspect some of them even fear that sympathy may be perilous.

Instead, they see their mission as that of understanding their patients with appropriate detachment, but without the sympathetic component that even Freud, the so-called "classical" analyst, advocated. Yes, this cautious and circumspect manner may occasion some measure of concern for the other person, but that isn't the same as loving them.

---

[6] See the video presentation, *Approaches* (1976), featuring Harold Searles and R. D. Laing, each interviewing in turn a woman who had been hospitalized for depression, for Searles' uncanny ability to intuit information that the woman interviewed was not verbalizing.

One of the things I appreciated about my work with R. D. Laing, was his emphasis on the specifically spiritual component of love. Despite Laing's notorious preoccupation with the dark side of love, embodied in incidents of deception and subterfuge that sometimes occasion family dynamics, Laing believed there is an inherent goodness most people aspire to in their intimate relationships. Notwithstanding Laing's affinity for Eastern disciplines, it was Christianity with which he was most identified. For this reason Kierkegaard (1956, 1995), who was both an existential philosopher and Christian adept, was especially helpful. Laing once told me (1985) that it was from Kierkegaard that he realized the sincerest expression of love is to not "trespass" against others, which is to say, to never encroach into someone's personal space. When aspiring to be intimate with another person he felt it is incumbent on us to do so cautiously, carefully, and most importantly, tenderly. Though no relationship is free of encroachments, Laing believed that some people are capable of achieving states of communion with others that are relatively free of transgression. *The therapy relationship is explicitly designed to minimize incidents of trespass on another human being. It may very well be the most benign form of relationship that we have ever conceived, explicitly designed to help those most vulnerable.*

Sometimes in his seminars, Laing would read from the Lord's Prayer, inspired, he said, by a book of Aldous Huxley (2009). Laing was especially taken with the part of the prayer that speaks of *trespassing* against one's neighbors and the need to forgive those who trespass against oneself, but especially to forgive one's own trespasses against *them*. Laing seemed particularly sensitive to crossing that line, when therapists, for example, may inadvertently trespass into a space of vulnerability that is not therapeutic, but hurtful. He concluded that some of us are more callous in our conduct with others than we realize. Inspired by Foucault,[7] Laing reckoned that those to whom we entrust ourselves when most vulnerable are oftentimes insensitive to the power they bring to bear when offering help. In his research into families conducted at the Tavistock Institute (in the early 1960s) Laing learned that parents are often oblivious when exercising such power, always "for the child's own good." Laing's most controversial message was probably his accusation that the very people who hold themselves out to be helpful – mental health professionals and the like – oftentimes make matters worse by the carelessness they employ with their patients. What they often lack, he suspected, is the requisite sympathy, or *caritas*, with which to treat them. Instead of *caritas* their patients get "treatment," often of a brutal nature, masquerading as care.

[7] Foucault was a dear friend of Laing's and resonated with Laing's sensitivity to power dynamics in families as well as society. Virtually all of Foucault's works were in some way or another concerned with the currency of power in human relationships, but an especially telling and useful work was a collection of interviews and essays published in 1980.

Max Scheler's conception of sympathy (outlined in his major philosophical work, *The Nature of Sympathy* [1954]), exerted a considerable influence on Laing's understanding of the spiritual aspects of love. Like Kierkegaard, Scheler was religious and much of his philosophical writing was concerned with understanding our relationship with God. Unlike erotic love, which partially blinds us to the other person, sympathy reveals the other person as he or she is, in the most intimate way possible. Scheler was convinced that the only way to truly know another person is through this special manner of regard. This implies that love isn't merely a feeling, but a metaphysical act that brings every aspect of my being to bear when reaching out to another person. *This is why Laing was convinced that sympathy is not merely a way of connecting with a patient who is in pain. It is the most healing component of our work as therapists.* It is love in its essence.

Sympathy is closely related to mercy, both are derivatives of compassion. Anyone who is in a state of distress and seeks help in alleviating it is at the other person's mercy. It implies that the supplicant is defenseless, not in the psychodynamic sense of the term, but simply that one's guard is down, if only momentarily. We ordinarily think of mercy as a sentiment offered to someone who is undeserving of it, as when a criminal asks for clemency. This is different from grace, which is tendered to the deserving. Why *undeserving*, and how is this applicable in the psychotherapy relationship?

It isn't difficult to feel sympathy when moved to tears, but what if a patient becomes hostile and the therapist feels under attack? Ordinarily, a man defends himself against acts of hostility. This is only natural, and more often than not the more prudent reaction. The analyst, however, is expected to *not* respond in kind to expressions of hostility, however much his or her countertransference has been stirred. On the contrary, the analyst is expected to show kindness for his or her patient who, despite the patient's behavior, is nevertheless at the therapist's mercy. Without a genuine *feeling* of mercy, however, any response, no matter how ostensibly proper or circumscribed, will never disguise the underlying resentment or turmoil that the analyst is likely experiencing. Like sympathy, mercy cannot be feigned. If it is not *genuinely experienced* any ostensibly sympathetic gesture cannot help but fall flat.

Being at the service of one's patients, giving them the kind of attention that no one else can or is willing to, letting them be who they are without judgment, isn't a technique that can be learned. True, it manifests in a job, a job the therapist is paid to perform, so in that sense it's a service. But what we are being paid for isn't to fix something broken, or to get someone to see the light, that only we possess. What we're really being paid to do is to learn to tolerate the incredibly difficult relationships our patients subject us to, in the most benign way possible.

The only way therapists are able to put up with such tortuous, oftentimes exasperating relationships, with people who are neurotic or crazy, is to accept them for who they are each and every step of the way. In effect, therapists are expected to care about them, to be patient with them and to love them, not in the erotic sense, but from a place of *caritas*, which is to say, with genuine sympathy. Contrary to erotic love, the kind of love that seems most helpful in this context is the kind that wants nothing. This means being completely at that person's service, however frustrating, monotonous, or exasperating such service can be.

Despite its elusiveness, our capacity for sympathy is innate. It is one of those things we take for granted, like the water we drink or the air we breathe. Like water and air, we don't do so well without it. In our most intimate relationships, whether lovers, friends, or family, sympathy is the key ingredient that makes them

special. We crave sympathy and need it in those moments when our pain is undeniable. Yet, we know that we are also capable of losing our sympathy for the very people we love the most. One of the remarkable phenomena I have noticed among some of the couples I have worked with was the absence of sympathy in their marital relationship. One of the first signs that a marriage is on the rocks is the loss of sympathy that one or both of the partners feels for the other's suffering. Each is so preoccupied with his or her own pain that there is little sympathy for that of the partner. In any close relationship, each expects sympathy from the other, and is acutely aware when it is missing. Whenever we complain about our jobs, our health, even the weather, to another person, the first thing we look for is an expression of sympathetic commiseration for what we have to put up with. It is the salve that keeps us going despite all the hardships we experience daily. It always improves my mood when I succeed in eliciting it, because its expression confirms that the person who offers it cares about me, and regards me with a loving disposition. Yet, like erotic desire, sympathy cannot be aroused on command. You feel it or you don't.

If sympathy is so important to us, if we crave and expect it in virtually all of our relationships, then why does it break down? Why withhold it when it is asked of us, when it epitomizes the love we feel for that person? Why are we unable to *feel* sympathy, whenever we're called upon to offer it, even with our patients? There are many possible reasons, but perhaps the most common is that the person soliciting sympathy is no longer credible to me. In order to arouse sympathy one's pain has to be sincere and without guile, it cannot be faked. If I sense that your pain is genuine I am more likely to feel sympathy for you than if I sense it is not. If I suspect your expression of suffering is contrived, that you are orchestrating the pain you telegraph to me in order to elicit sympathy then you will lose your credibility with me, and with that credibility you will lose my sympathy. *I can love a person sympathetically only if and when that person is being genuine, or authentic with me, which is to say, so long as I believe them.*

This can be a two-edged sword. We may be so desperate for sympathy that we contrive to solicit it by feigning illness, even becoming ill, in the guise of this or that somatic symptom. Freud believed that all our psychological symptoms are the consequence of feeling love-sick. It's a short step from feeling unloved, to feeling sick about it, to asking a therapist for a sympathetic ear. We have known for millennia that for the most part it is the physician's *sympathetic attention* that does the healing, not the treatment itself. Sometimes we are obliged to contrive an illness in order to eventually admit to ourselves that, all we really wanted was a little love.

Freud once offered that psychoanalysis is a "cure through love." This observation is easy to misconstrue, but he was right. Psychotherapy is a cure through love in a double-sense. First, it is imperative that the patient comes to love the therapist, not erotically, but from the perspective of *philia*, like the crucial friend[8] with whom one shares everything. Second, the analyst must also come to love the patient, but not, strictly speaking, as a friend. The therapist may be a friend to her patient, but the patient will never be a friend to the therapist, nor can he. Their relationship is too inequitable, too asymmetrical for a conventional friendship, which needs to be rooted in reciprocity, to flourish. The kind of love therapists feel for their patients can only be rooted in *sympathy*, a selfless and giving over to the person who the patient happens to be, a

[8] See Thompson, 2004, pp. 79-94, for a critique of Masud Kahn's conception of crucial friendship in the transference relationship.

person that the therapist is able to cherish for as long as necessary. The love proffered is selfless because therapists don't need their patient's to love them in the same way their patients need to feel loved by their therapist. Patients need to be loved because that is what finally, if surreptitiously, heals them. Love is magical that way. Without it we feel lost.

Finally, therapists need sympathy too. But they aren't likely to get it from their patients! More likely they will get it from their partners, their colleagues, and their own therapists. They may even get it from themselves.

December 31, 2016

References

Foucault, M. (1980) *Power/knowledge: Selected interviews and other writings, 1972-1977*. New York: Vintage.

Huxley, A. (2009) *The perennial philosophy*. New York and London: Harper Perennial Modern Classics.

Kierkegaard, S. (1956) *Purity of heart is to will one thing: Spiritual preparation for the office of confession*. Translated by Douglas V. Steere. New York: Harper Torchbooks.

Kierkegaard, S. (1995) *Works of love*. Translated by Howard V. Hong and Edna H. Hong. Princeton: Princeton University Press.

Laing, R. D. (1970) *Knots*. London: Tavistock.

Laing, R. D. (1985) Personal communication.

Kohut, H. (1959) "Introspection, empathy, and psychoanalysis – an examination of the relationship between mode of observation and theory." *Journal of the American Psychoanalytic Association*, 7:459-483.

Kohut, H. (2011) *The search for the self, volume 3: Selected writings of Heinz Kohut 1978-1981*. London: Karnac Books.

Scheler, M. (1954) *The nature of sympathy*. (Peter Heath, trans.) London: Routledge and Kegan Paul.

Thompson, M. Guy (1998) Manifestations of transference: Love, friendship, rapport. *Contemporary Psychoanalysis*, Volume 34, No. 4: 457-481, 1998.

Thompson, M. Guy (2004) *The ethic of honesty: The fundamental rule of psychoanalysis*, pp. 79-94. Amsterdam and New York: Rodopi.

Thompson, M. Guy (2015) Sanity and friendship. Invited lecture presentation, R. D. LAING IN THE TWENTY-FIRST CENTURY SYMPOSIUM AND WORKSHOP: *What Is Sanity? What Is Madness?* Esalen Institute, Big Sur, California, July 21, 2015. Unpublished manuscript.

Thompson, M. Guy (2016) *The death of desire: An existential study in sanity and madness*, pp. 121-142. London and New York: Routledge.