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Altruistic Love in Psychoanalysis: Opportunities and Resistance

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Many patients manifest a desire to help the analyst. This is usually understood as being derivative of defensive aims or in the service of other primary motivations. This paper argues for the developmental and clinical importance of primary *altruistic aims, which are often warded off by the patient because of his or her fears of exploitation or rejection. Several pathogenic beliefs and varieties of psychopathology result from the failure of the patient's caretakers to allow the child to contribute to their welfare, to "take" the child's "help." Similarly, some patients require tangible evidence that they are having a positive impact on their analyst. Ordinary "good-enough" technique often reinforces the patient's view that he or she has nothing to offer. A full appreciation by the analyst of the importance to patients of having their altruistic gestures and concerns recognized* and accepted *can open up possibilities for analytic progress and therapeutic growth. Various sources of resistance to and misunderstanding of these dynamics are explored, ranging from ethical concerns to certain traits that cluster in the personalities of analysts.*

All patients manifest an altruistic need and wish to help the analyst in some way. Whereas for some patients, this desire operates silently and in the background of the analysis, for others, it is prominent. By altruistic I mean that quality of a person's desire that has, as its primary and irreducible aim, the concern for and improvement of the welfare of the other. Thus, although altruistic concerns and behavior might sometimes appear clinically as compromise

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formations, or, at least, as defensive, there are many other occasions in which these desires operate as *primary* motivations and are themselves subjected to defense, disguise, disavowal, and distortion. I have found that it is often important in these cases for the analyst to be aware of the vicissitudes of the primary and progressive meanings of these altruistic wishes, to be prepared to interpret them to the patient, and even to allow himself or herself the freedom to authentically gratify the patient's wish as part of a necessary and mutative experience. By "authentically gratify" I mean that there are moments when the analyst—guided, in part, by an overall understanding of the patient—should allow himself or herself to feel *and* express a genuine acceptance of and pleasure in being helped, bolstered, and enhanced by the patient.

In my experience, analysts tend to overlook the mutative potential of a full appreciation of the patient's altruistic wishes and efforts, a subtle blind spot that results from a bias against normalizing this dimension of the analytic relationship. In other words, I believe that our tendency to subtly frustrate our patients' attempts to help us stems not just from our attitude toward engaging in gratifying enactments in analysis in general but from our implicit pathologizing of altruism. Certain theoretical and countertransference pressures lead us to tend to misinterpret healthy strivings as necessarily or exclusively defensive, restitutive, pathologically reparative, seductive, or self-defeating. To the extent that the patient's efforts to contribute positively to the analyst's well-being are thus pathologized by the analyst, an opportunity for both analytic work and therapeutic progress can be missed. The analyst's resistance to being helped can contribute to the patient's resistance to helping, and thus the conflicts surrounding these wishes may never be explored and the potential therapeutic benefits of their gratification never realized.

Helping or taking care of the analyst can be seen as one aspect of loving the analyst. Common sense dictates that we want to help the person that we love. We want to give something to this person that will enhance or gratify him or her or, as Searles (**1975**) says, "help the other to fulfill his or her human, psychological potentialities." We want to see that what we give has positively influenced the other in an authentic way and has been valued. Clinically, these desires can take an almost infinite variety of forms. The patient gives us a gift, advice, a

compliment. The patient implicitly or explicitly critiques our dress, appearance, health, approach, style, character, or theory. The patient tries to cheer us up, or help us feel smart, or otherwise make our experience a healthier or happier one.

We're all familiar with the complex conflictual meanings of such behavior and sentiment. The psychoanalytic literature is replete with clinical vignettes and observations pertaining to the multiple motivations, the fantasies, and the symbolic significance that lie behind expressions of generosity or a patient's altruistic concern for the analyst. Whether it be the literature on gift-giving in analysis (A. Freud, 59; **Stein, 1965**; **Orgel and Shengold, 1968**; **Silber, 1969**), reparative impulses in development and analytic work (**Isaacs, 1933**; **Klein, 1961**), or pathological idealization (**Kernberg, 1975**), the dynamic underpinnings of the patient's manifest altruism have been frequently analyzed. Sometimes, the unconscious meanings can be found in the patient's aggression, disguised (via restitutive or reaction-formation mechanisms) as altruism or generosity. The patient might be warding off dependency needs by various forms of turning passive into active. And, certainly, the altruistic part of loving the analyst often repeats the peculiarities of the patient's early romantic passions and conflicts in the family. Gift giving by a patient, for instance, may represent a bid for oedipal love or a coercive attempt to bind the analyst to the patient in a preoedipal symbiosis (**Orgel and Shengold, 1968**). One can even see the echoes of altruistic desires in the complex ways that patients "teach" the analyst to be more responsive or empathic, or "coach" the analyst about how to alter his or her theory in the patient's interest. Because we seem to increasingly appreciate how the patient "supervises" our analytic work (for different permutations on this theme, see I. **Hoffman, 1983**; **Langs, 1976**; and **Renik, 1955a**), we should acknowledge the probable gratifications that these patient-supervisors might derive from doing their job well!

The possibilities are as varied as our patients. However, one unifying theme in this literature is that the altruistic gesture is seen as the outcome of the story and not its starting place. In other words, the altruistic or caretaking behavior and desires of the patient are usually seen as derivative of or a means to some other aim or concern (e.g., safety, security, gratification, connection or some form of narcissistic self-enhancement). In general, psychoanalysts seek to deconstruct the

manifest wish to help into its underlying component motivations and not view it as itself an underlying and central motivational system.

Further, even if one understands a patient's gesture as originally and primarily altruistic, its clinical expression is rarely unambiguous, often containing elements of disguise or defense. In other words, the clinical waters are further muddied by the fact that altruistic desires suffer the same fate as other important developmental aims, namely, they are warded off, inhibited, and distorted. For instance, just as a greedy or self-aggrandizing impulse can be kept from awareness through an attitude of exaggerated generosity, so an altruistic impulse can be repressed through a display of exaggerated selfishness. In addition, some patients are embarrassed or anxious about their altruistic wishes and gestures, whereas others seem to parade them proudly. Thus, the particular need or defense configuration underlying a patient's manifest altruism can often be exceedingly complex.

Perhaps more than any other analyst, Searles has attempted to understand the vicissitudes of the patient's conflicted experience of primary altruistic aims. In his seminal paper, “The Patient as Therapist to His Analyst,” Searles (**1975**) equates the altruistic desire to help and enhance the other with an essentially “therapeutic” aim. He translates the altruistic into the therapeutic because his interest is to establish a symmetry between the activities of the patient and those of the analyst. He asserts, first, that “innate among man's most powerful strivings toward his fellow men, beginning in the earliest years and even earliest months in life, is an essentially psychotherapeutic striving,” and goes on to conclude that “the patient wants to give therapy to, as well as receive therapy from, his doctor.” For Searles, the fate of this wish in childhood often determines the development of later psychopathology. If the child perceives the parents as so impaired and symbiotic that they cannot provide a modicum of security or developmental nourishment, then the child will sacrifice his or her individuation, become a therapist to the parents, and develop a serious psychological disturbance as a result. Searles's emphasis is on the disturbed patient in whose symbiotic family therapeutic aims were so exploited, frustrated, and repressed that individuation itself became unconsciously equated with a “murderous dismembering or lethal abandonment” of the parents. In his or her analysis, the patient continues to function as a therapist,

unconsciously introjecting the analyst's pathology and working in complicated ways to repair the latter's *real* deficiencies.

Searles's emphasis on the psychotherapeutic forms that altruism can take is extremely important. It suggests that a deeply affirmative desire underlies even the most disturbed and destructive behavior. In addition, his emphasis on the "real" nature of the patient's help—the patient's accurate assessment of the analyst's (mal)functioning and the potentially genuine mutative effect of the patient's therapeutic efforts—moves us away from viewing altruism as a transference-based distortion or as intrinsically derivative.

Searles's equation of altruistic with psychotherapeutic strivings, although profoundly important in some cases, is not necessarily the most useful lens through which to view all such behavior. His particular emphasis on the therapeutic dimension does not mean that altruism may not have additional important meanings. Sometimes, for instance, a patient desires to positively influence or help the analyst simply out of love. A patient might work to make the analyst happy not so much because the analyst's psychological conflicts are disabling or are in the patient's way and need to be cured, but because the patient feels a need to be useful and contribute his or her strengths to an important relationship. The need to be constructive or helpful need not emerge in therapy only in relation to the analyst's psychopathology, but can be seen as a constitutive part of the patient's optimal functioning and of a healthy mutuality with a healthy analyst. Searles, while appreciative of the universal role of altruistic desire, chooses to highlight its vicissitudes in the most disturbed lines of development and its expression in the later symptoms and transferences of the most disturbed type of patients—patients for whom helping the analyst is often a means of creating the conditions necessary to ensure their psychological survival. My interest, however, is to consider a wider range of meanings within a wider ranger of patients and clinical situations.

In addition, I am also suggesting that altruistic intentions may be transparent and phenomenologically uncomplicated. Although altruistic desires are sometimes derivative, interwoven with other motives, and disguised, there are clinical moments in which the vicissitudes of the wish to help are a necessary and sufficient explanation of the patient's experience and behavior. At those moments I have not found

it useful or necessary to presume—much less interpret—that the patient's altruistic mental state is a compromise formation or "overdetermined" by other motives. In my view, an a priori assumption that all mental life is a compromise formation, a dialectic of opposites, or overdetermined, although appealing in the abstract, can fail to grasp what the patient is struggling with in these moments, namely, the expression and experience of a thwarted need to positively contribute to the other's welfare. Instead, I believe that a more useful model is one in which the patient's wish to enhance the analyst's welfare is viewed as the leading edge of a developmentally progressive and deeply authentic subjective desire. At the phenomenological core of the patient's experience of these moments lies a primary altruistic desire—often disguised and conflicted—which is, effectively, the *only important psychological constituent of this experience* for the patient even if, at the highest level of abstraction, our model sees this desire as standing in some kind of complex relationship to other, egoistic needs.

In the configurations I'm describing, then, the patient's core conflict is over the expression of a primary altruistic love. Sometimes the patient is struggling against his or her impulse to help the analyst because of a fear that the analyst will, in fact, treat it as "really" something else. The patient, in essence, defensively regards her or his own altruism as defensive. By "analyzing" this loving motive as "really" something else, or as simultaneously self-serving, the patient seeks to ward off various psychological dangers. My view is that only by normalizing and validating the patient's wish to benefit the analyst—in word and, sometimes, in deed—can certain important conflicts be reached. Minimally, then, I am simply underlining the importance of our empathic acceptance of the patient's conflicted wishes to help us and suggesting caution in interpreting them as concealing other motives. Believing that altruism is healthy enables the analyst to more confidently disconfirm the patient's pathogenic idea that it is not. In other words, this process is facilitated by the analyst's recognition that the healthy aims of object-love in fact include a primary concern for the well-being of the other, a concern that is hardwired into our biological and psychological selves but which, itself, often becomes disguised, distorted, or repressed in response to perceived psychological dangers. Thus, although the altruistic dimension of love is ontologically woven through the selfobject, libidinal, and object-relational aspects of

love that psychoanalysts take for granted, it is clinically crucial to posit that, at a given moment, a patient can be primarily altruistic.

This emphasis on the importance of the analyst's accepting and appreciating the patient's altruistic concerns and gestures is not radical within contemporary psychoanalysis, which increasingly assumes mutuality and reciprocity in the analytic relationship, taking as its starting place a view of analysis as a system of mutual influence. Modern theorists have increasingly emphasized the importance of the analyst's openness, via empathy, projective identification, and other intersubjective processes, to the patient's influence. My focus here on both the patient's need to positively influence the analyst and the analyst's receptivity to being influenced is consistent with this broader trend. The suggestion that we, as analysts, should be receptive to this positive influence and that we should accept and even, at times, gratify the patient's need to give to and help us is also not radically controversial in the current intellectual atmosphere in psychoanalysis. Self psychology has helped analysts to understand the value of accepting the patient's need to recruit us to fulfill certain developmental needs without our necessarily having to interpret these needs. I am proposing that altruistic desires may constitute such a need. Sandler (**1976**) and others have described the importance of the analyst's role responsiveness and object relations theorists (**Ogden, 1982**; **Bollas, 1987**) have sensitized us to the ways that the patient uses the psyche of the analyst as a container for projective identifications. My emphasis here is on a particular way that a patient needs to influence the analyst, this is, to enhance the analyst's welfare and to experience a particular authentic openness and pleasure from the analyst in response to this influence. Finally, there is no longer as much alarm (although certainly a great deal of debate) in contemporary theory at the suggestion that the analyst sometimes provides a corrective emotional experience to the patient, whether it be spontaneous or deliberate, rigorously interpreted or not (**Renik, 1993**). The mutative ways that new relational experiences in analysis help modify pathogenic ideas (**Weiss, 1993**), gratify thwarted developmental needs (**Kohut, 1984**), or provide a healthier interpersonal context for new learning (**Wachtel, 1987**) have been increasingly discussed and freely debated (for relevant reviews of this literature, see **Mitchell, 1993**, and **Stern, 1994**). My purpose is simply to focus on how the analyst's willingness to be helped is, for some

patients, a crucial aspect of this new and potentially corrective experience within the analysis. Thus, it is my intention not to reinvent the wheel and argue for the mutative centrality of the corrective emotional or developmental experience in analysis, but to use this as a starting place for a study of a particular neglected dimension of this experience.

Given the emerging sensibilities in modern psychoanalysis about mutual influence and corrective experiences, it is noteworthy that when it comes to the technical issues involved in accepting a patient's help, allowing the patient to enhance our welfare in various ways, or gratifying a patient's altruistic wish to contribute positively to our lives, we still tend to impose subtle constraints and prohibitions on the experience of both parties to these transactions, which can dilute and mitigate opportunities for analytic and therapeutic gain. I hope to explore these prohibitions against the backdrop of an exploration of the clinical vicissitudes of altruistic desires in development and analytic work.

Illustrative Clinical Vignettes

I will present three clinical vignettes that suggest the clinical importance of recognizing, appreciating, or gratifying a patient's altruistic desire. My plan is to present instances in which the patient's wish to enhance the analyst's welfare is clear, discrete, and concrete. I do not mean to limit the scope of my argument through this focus on episodes of *literal* help because, as I have argued, patients altruistically work to help their analysts in a wide variety of ways. My aim in choosing these three rather dramatic enactments of helping is to throw this need into the boldest and simplest possible relief in order to explore its vicissitudes as deeply as possible.

Case 1

A 38-year-old graphic artist and interior designer had been in analysis for two years. She began to hint, in an indirect and vague way, that she had certain opinions about the way that I dressed. At first, I could not even tell that her opinions might be critical. Instead, I commented on her vagueness and, eventually, on her inhibition about having the right

to perceive something personal about me at all. Eventually, she told me that my ties didn't go with my shirts and that my choice of colors was perhaps a bit drab! She then quickly apologized for treading into territory where she didn't belong. I told her that it was noteworthy that she *assumed* she didn't belong and that I didn't want her there. Why was that? Why did she assume that it was forbidden for her to help me and to give herself *and me* the potential benefits and pleasure of hearing her expertise and aesthetic advice? She became dimly aware of certain experiences in her family that seemed to involve a feeling of being devalued and excluded by her father. She then proceeded to give me her critique and suggestions more forthrightly. I knew that my drab manner of dress reflected a combination of certain factors in my personal history and a subtle identification with the rather drab analysts who had trained me, perhaps influenced by a need to be "neutral" to the patient. I genuinely liked her suggestions and saw them as an improvement, so I began to adopt some of them. I felt pleased with the results and made no attempt to hide it. When she noticed that I had taken her advice, she was quite moved. She didn't expect it. It led her to recover further memories and feelings about how she didn't expect her opinions and expertise to be respected and appreciated by her parents or others or for her talent and ability to bring pleasure to others. This bore directly on her presenting problems and we were able to do some good work as a result.

Case 2

A 40-year-old woman with a background in English literature had been in therapy with me for three years. She had come from a family environment in which she was profoundly traumatized. Her mother liked to have her around as an audience, but rarely showed much interest in the patient's mind or ability. The patient's father communicated to her that he felt she was unattractive and she felt little connection to him. We learned a great deal about her problems with depression and her work inhibitions, and she had made significant therapeutic progress. However, she still tended to experience herself as a outsider and operated too much on the basis of a background assumption that she wouldn't really be welcomed by any group or community if she was really "herself." In the transference, she had a pathogenic belief that I

wouldn't want her involved in my life, that I would rebuff her love, and that I would experience her curiosity about me and her wish to become involved in my life as a noxious intrusion. This curiosity had more than enough opportunity for arousal, as her main area of academic interest was psychoanalytic criticism and our paths overlapped increasingly frequently. While she and I talked about this, our "analytic" mode of conversation intrinsically seemed to reinforce her feeling that I viewed these longings of hers as grist for the analytic mill, which to her meant that they were somehow illegitimate. It's not that I was a cardboard analyst, pathologizing her feelings from "on high." I felt that I responded to her from my principled position of always seeking to understand *her* point of view. I repeatedly pointed out that she expected to be rejected, that she had various fantasies about what this meant, and attempted to explore the dangers associated with her curiosity, professional self-assertion, and intimacy with me. This is what "grist for the mill" meant to me. To the patient, however, this "mill" was a confirmation of her belief that I didn't really want to get involved with her because she was unworthy. She interpreted my attempts to empathically understand and articulate her feelings of exclusion as paradoxically—but continually—communicating my detachment because my "real" self remained hidden behind my therapeutic self. And even when I sought to explore this distortion, she didn't really buy it. She felt that the very mode of analytic discourse itself confirmed her pathogenic expectations. When she did appear to analyze it, I felt that she was only complying with what she sensed was my need to strike a neutral analytic position and simply "talk" about and analyze her wishes and fears.

I decided to allow myself to gratify her curiosity and wish to get involved more collegially with me. By "decided" I mean that I deliberately gave myself the psychological and professional freedom to respond to her in a warmer, more self-disclosing, and open way (for a discussion of the paradoxical but ubiquitous phenomenon of "deliberate" authenticity, see **Bader, 1994**, **1995**). At the time, I was writing a scientific paper about a subject that she and I had discussed (she was working on related ideas and had periodically talked about them). I decided to tell her that I was working on this particular paper and, when she evinced curiosity about it, offered to let her read it and to give me feedback. She returned it with extensive and substantial

editorial changes, most of which I felt greatly enhanced the paper and which I incorporated. I acknowledged to her the specific ways in which she had helped me. My willingness to let the patient read and contribute to my paper was tremendously gratifying to her and altered the ambience of the therapy. In response to this ambience, she began to put herself out more in her professional circles, as she was less afraid of being rejected or criticized. She felt she had "more to offer." The resulting successes she experienced in this arena enhanced her self-esteem and led to greater social involvements. In addition, she was able to talk about her sense that I had presented evidence (that she could now not discount) that I welcomed and respected her and this made her feel more "like a person." My openness to her helping me thus disconfirmed her pathogenic belief. As a by-product of this process, the patient was able to think more clearly about how excluded and rejected she had always felt in her family and how terrible my prior stance had secretly made her feel, even though she had tried to be a good sport and properly analyze everything.

Case 3

A 41-year-old successful physician entered psychotherapy for help in feeling more intimate and less defensive with his wife and less aggressively impatient with his large office staff and medical partners. He was intensely uncomfortable with taking help from me or feeling dependent in any way. His style was to lecture me in a somewhat angry tone. He was always on the offensive with me and with others. The patient often interpreted and responded to situations in a somewhat paranoid way and frequently reacted by becoming contentious, aggressive, and controlling. He was, however, also capable of genuine insight at times and seemed to be able to use therapy to soften his manner somewhat.

It soon became clear that the patient had identified with a father whom he experienced as dictatorial, controlling, judgmental, and highly competitive. The patient had not been able to stand up to his father—also a doctor—and, instead, felt repeatedly humiliated and beaten down by him. Through the mechanism of identification with the aggressor, the patient had survived, but at a great cost. He became harsh with himself and others. His fear of being put down and

humiliated, along with his defensive efforts to control others, interfered with his ability to love and to be emotionally generous. The patient's mother failed to protect him from his father and was often disabled by hypochondriacal concerns for which she resisted getting or taking help of any kind.

During an extended initial phase of our work, the patient would frequently give me advice about matters ranging from office decor, malpractice insurance, and investments, to restaurants, hotels, and personal attire. He did so in a somewhat pompous and controlling manner, often with a lecturing tone, and always with a somewhat aggressive and bullying edge. I interpreted his discomfort about being in a position of taking help from or relying on me and pointed out how he turned the tables in order to feel safer and to ward off the various dangers he imagined might accompany being on the "receiving end" of our relationship. I also believed that he was testing me by turning passive into active, treating me as his father had treated him and monitoring my reaction to see if I would comply with or cave in to his bullying authority (as he had felt coerced to do as a child). I believed that he wanted me to be strong and not let myself—my habits, tastes, behavior—be unduly influenced by his opinions. So, in addition to interpreting the controlling nature of his generosity, I was also inclined to calmly assert and good-naturedly defend my own tastes, choices, and independent judgement in these interactions. He generally seemed relieved and often visibly relaxed when I did *not* accept his offers or advice. He began to talk more about the loneliness and humiliation he felt in his home and the helpless rage that his father's judgmental "know-it-all" attitude would inevitably provoke.

As the patient began to be able to tolerate feeling more dependent, he also felt less compelled to tell me what to do. However, during a session in which he had been particularly self-reflective, he noticed a European guidebook near my chair. He asked me where I was planning to go and I decided to tell him. He began to give me recommendations for restaurants and museums that he had discovered during his extensive travel throughout the region I was planning to visit. The tone of his "help" was completely different than it had been earlier. His advice had the stamp of a wish to help rather than to control me. He seemed a bit hesitant or even deferential about his offer of help. I sensed a quality of shyness or embarrassment that had not been there previously. At

first, I interpreted his offer as a way to counteract his anxiety and helplessness about our impending separation, but this line seemed sterile and flat to him. At some point, I suggested that he seemed more aware of his feelings of closeness and gratitude toward me, that my vacation highlighted these feelings, and that he was looking for a way to express these sentiments. He agreed and added that he was aware of feeling highly vulnerable at this moment. I told him that he was afraid his help—and the emotions behind it—would be rebuffed and that he would feel like a fool for having offered it. He told me that his father always acted as if he was superior to him and that while his father let himself be admired, he never seemed to take much pride in or pleasure from anyone, much less the patient.

When I returned from my vacation, I thanked him for his recommendations (which were genuinely excellent). He appeared quite pleased. In my experience, this pleasure seemed to be authentic and presaged a deeper exploration of the difficulties he had always had in connecting with his parents and, later, with other significant people in his life. He had always felt that he had to be right all of the time and that he couldn't take help. However, on a deeper level, he didn't expect that his love would be accepted and valued by others. The only way he knew how to relate was to be aggressively controlling like his father or "unhelp-able" like his mother.

In my view, our analysis of these issues, along with certain corrective experiences in the transference, enabled the patient to feel safe enough to begin to give up his pathogenic identifications with his father, accept help from me in a way he never could from his parents, and eventually experiment with an authentic generosity and altruism that he had long since warded off because of his expectation of rejection. My understanding and real acceptance of his help seemed to contribute to his attempts to disconfirm these crippling beliefs.

I hope that this case demonstrates how at one moment the patient's need to help the analyst can result from an anxiety-driven effort to exert influence over the analyst in the service of psychopathology, while at another moment the same manifest gesture might be in the service of an expansion of psychological (including analytic) space, a confirmation of a healthy, but warded off, wish and dimension of object love. Therefore, it is especially important for the analyst to be sensitive to the different meanings that can underlie the patient's altruism.

The Clinical Importance of Altruism

In various ways, these three patients were profoundly traumatized by the experience that their parents didn't accept and appreciate what they, as children, gave to them. I have frequently heard patients describe their frustration or despair that they couldn't influence or give anything to their parents. In one scenario, the patient felt that one or both parents needed to appear perfect and therefore could not accept help from their children. These parents were not able to give the child the sense that he or she brought genuine joy to their lives. In another scenario the patient's parents appeared to be either indifferent or preoccupied and thus the patient's attempts to connect through helping, giving, or other channels were rebuffed. In yet another version, the patient saw the parents as overly dependent and needy and therefore as exploiting the child's altruism. A wide range of character types, styles, and pathologies can be found in the families of such patients. Whether the parent appeared to be overwhelmed and a bottomless pit into which the child poured help and concern, defensively self-contained and invulnerable to the child's influence, or narcissistically exploitative of the child's altruistic concern and love, the result was that the child's wish to make the parent happy with her or his charms, talents, concern, and therapeutic effort was not welcomed and appreciated as something unique and valuable *in the child*. The fact that the child had something to offer that genuinely enhanced the parent's welfare was either taken for granted and narcissistically used or else ignored. The parents appeared as if they could not learn from the child. This was experienced by patients as subtly demoralizing and as a rejection.

These patients felt that, as children, their love was rejected because it was bad or not compelling. Fairbairn (**1952**) describes these relationships in his discussion of the etiology of certain schizoid disorders, focusing on how the child's experience of her or his own love changes from good and beneficial to bad and destructive. Weiss (**1993**) analyzes how children comply with and assume responsibility for experiences of parental rejection and come to experience their own love and empathy as unworthy because it is seen through the lens of their parents' rejection. Wolfe (**1988**), in discussing a person's efficacy needs, highlights the dangers of the failure of the caretaker system to be flexibly responsive to the developing child's *influence*. These theorists are all

concerned with the psychopathology that can result from a perceived immunity of the environment to the child's wish and attempt to affect it.

It was my impression that, in the cases presented here, there was great clinical utility in allowing the patient to find an authentic way to help me. Some patients appear to require clearer evidence that their capacity and desire to give the analyst something of value, something "good," will be appreciated. In these cases, what we generally think of as ordinary everyday analytic discourse—a discourse that is structured around the role relationship of "patient" and "healer," of "helped" and "helper"—can be construed by the patient as confirmation of a pathogenic belief that he or she has nothing of value to offer the analyst. As in the cases presented here, attempts to analyze this fantasy may be limited by the ways in which an exclusive focus on the patient's feelings and welfare dove tails with that person's earlier experience of exclusion or helplessness, and thus reinforces the pathogenic belief that she or he couldn't really enrich the analyst's life. I believe that by opening myself up to the patient's positive influence, by allowing myself to be authentically gratified by the patient's help, I disconfirmed these expectations, implied that they were not a necessary part of the structure of reality, and enabled the patient to reflect on the ways in which this pathogenic reality had been constructed in the first place. By confirming the patient's capacity to express and experience an altruistically loving connection with me, I helped the patient feel healthier and, as one patient put it, more "human." I was more human and thus she could become more human. By human, she meant our not having to be perfect, our being willing to admit that there was room for improvement, and, most importantly, our not being immune to each other's influence. In other words, for some patients, the most dynamically relevant aspect of the analyst's comfort and openness with her or his "humanness" is not simply the analyst's fallibility but a corresponding willingness to enjoy being helped and positively affected by the patient.

The Ontological Basis of Altruistic Love

I believe that the altruistic love of a child for his or her parent can be usefully conceptualized as one dimension of a complex system of

mutual influence and regulation. Research into prosocial or altruistic behavior has shown how infants—almost from birth—seem to empathically register the distress of others and, by the time they are two years old, appear to be actively motivated to relieve this distress and provide the rudiments of caretaking (**Hoffman, 1982**; **Zahn-Wexler and Radke-Yarrow, 1982**). These researchers believe that there is a biologically based and independent altruistic motive system in humans that is mediated by empathy. This system is also related to the observations of some researchers (**Lichtenberg, 1989**) of the intense efficacy pleasures of the developing child, as she or he successfully attempts to influence and evoke contingent responses from the caretaking environment. In other words, when your parent is affected by and responds to your feelings and actions in the way you desire, the pleasure that results promotes growth. By extension, then, if the parent is in fact helped in the way that the child altruistically intends, the result is a pleasurable sense of efficacy. Like other forms of successful communicative "matching," an inner sense of competence grows. Patterns of either empathic or unempathic and misattuned systems of interaction get structured into self and object representations, which later act as motivators of behavior and relationships.

The pleasure in giving pleasure or help to the parent can be seen in the multiple ways in which the child gives the parent gifts, comfort, entertainment, and connection. We are accustomed to viewing such behavior and desire as ultimately selfish, that is, as subserving the child's more fundamental and egoistic needs for safety, attachment, gratification, mirroring, and recognition. However, a growing body of research in the field of social and evolutionary biology suggests that altruistic motives and desires are at least as important as egoistic ones in the human psyche. After an extensive review of the literature, Friedman (**1985**) argues that the fear of loss of parental love and other egoistic concerns are insufficient to account for altruism and that an independent altruistic motivational system more efficiently accounts for both biological and clinical findings. Slavin and Kriegman (**1992**) point out that there are powerful evolutionary reasons why altruistic or mutualistic dispositions and behavior might have become "hard-wired" into the human brain and psyche. Altruistic behavior increases the survivability of the group. For instance, it is highly adaptive for parents to be altruistic because it guarantees the viability of their offspring—offspring

who are dependent and vulnerable for a long time. Slavin and Kriegman suggest that the capacities and motivations that underlie altruistic love are better understood as innate potentialities that are activated and profoundly shaped by exposure to parental caretaking and love—in other words, to parental altruism. The child's innate capacities for attunement and altruism are nourished and develop in relation to the altruistically motivated responsiveness of her or his caretakers. The assumption that the child's empathy is harnessed, in part, to an essentially altruistic love and desire that later flowers fully in relation to her or his own offspring is far more consistent with modern evolutionary theory than are assumptions that the child's capacities for attunement and empathic concern begin and end in the service of self-interest and personal security alone.

By communicating a genuine receptivity to being "touched," comforted, and gratified by the child, the parent confirms and recognizes something important in the child's "being." Repeated instances of this successful feedback loop strengthen the child's sense that her or his love is good, efficacious, and deserving of reciprocity. Altruistic love, then, has an ontological basis, the recognition and nourishment of which is an important parental task in healthy development. By allowing the child to help, gratify, and influence her or his caretakers in age-appropriate and nonexploitative ways, a healthy family system enables the child to feel more fully human and better prepared to pass this along to the next generation. And by having such a model of altruistic mutuality available, the clinician is better prepared to notice, understand, and respond to the conflicts resulting from its breakdown.

The Analyst's Resistance to the Patient's Altruism

I believe that there are many factors that contribute to the potential for resistance in the analyst to a full appreciation of the adaptive and therapeutic importance of the patient's need and desire to give something significant and genuinely valuable to the analyst. First, manifestly altruistic gestures and desires are, *in fact*, often derivative and symptomatic expressions of painful underlying conflicts. Analysts see this so often that they tend to expect it. Many of our patients have been

profoundly traumatized by parents to whom the patient felt compelled to give *too much* emotional nourishment, and not whom the patient felt accepted too little. In other words, the more common clinical picture that we see involves the parent using or relying on the child pathologically. For instance, the child might have felt needed, but only if the child gave up his or her autonomy and took care of the parent in some way. The child sacrificed her or his own growth either out of compliance to the parent or as a way to restore or protect the parent. In these cases, although the parent is benefiting from the child, and the child is manifestly "helping" the parent, this "helping" is against the child's interests. The child feels fundamentally exploited, unconsciously victimized by parents who are overly dependent on the child for their emotional well-being or else are so absent that the child has to jump through hoops in order to influence them or bring them any pleasure whatsoever.

In these cases, the analyst is often tested in the transference to see if he or she will require the patient to be a certain kind of person—*for the analyst's sake*. Here we often see the complicated ways in which patients subtly maneuver and comply in order to make us, as analysts, feel good, from the covert attempts that patients make to provide the analyst with therapeutic help (**Searles, 1975**) to all of the commonplace forms of accommodation and false-self presentations intended to ensure our well-being, good humor, and loving approval. In response to these transference dynamics, analytic work tends to proceed best when the analyst positions himself or herself as a new object who does not need anything from the patient, and can thus both interpret the neurotic motives and pathogenic beliefs behind the covert altruism of the patient and provide a safe container for the patient to use in experimenting with genuine autonomy. Whether this mutative stance flows naturally from the analyst's stance of neutrality, is spontaneously enacted because of unconscious pulls from the patient, or is provided as a corrective emotional experience, there is thus often great analytic and therapeutic benefit that can come from frustrating these particular kinds of manifest attempts of the patient to help the analyst.

However, because of the frequency with which analysts observe these particular transference dynamics and tests involving patients who are pathologically burdened by their need to help others, we tend to be

less sensitive to configurations in which the patient's pathology is expressed by her or his *inability* to help others—the patient's thwarted altruism—and expectations that his or her help won't be welcomed. In these latter cases, the patient often tests the analyst to determine whether the analyst will repeat old traumas and reject the patient's help and advice. If the analyst, in word or in deed, is able to accept, *not* to reject, the patient's altruistic gestures, the patient is often relieved and able to proceed more safely with analyzing and revising his or her pathogenic conflicts. However, it is my impression that the frequency with which our patients appear to suffer from inhibitions of selfish and not altruistic aims lead us to be less attuned to these latter transference dynamics and to mistakenly emphasize the defensive meanings of the altruism that is observed.

There are other factors operating "behind the back" of the analyst that also account for what can seem, at times, to be an overly cautious attitude among analysts toward openly welcoming a patient's gifts or help. Analysts, like other helping professionals, have a deep professional commitment to focusing primarily on the patient's difficulties and subordinating all of their activity to the patient's welfare, as well as a fundamental prohibition against exploiting the patient's real and transference dependence. This professional stance is guided by an ethical and moral sensitivity that is based on respect for the autonomy and "otherness" of the patient (**Poland, 1993**; **Renik, 1993**, **1995b**). It is a value system that guides our theories of technique and arbitrates many of our clinical choices. We believe that it coincides with a model of treatment that provides the best outcome; however, the value system itself is not derived from empirical outcome considerations but exists instead as an overarching philosophical and professional framework. And although this is a framework that analysts share with other helping professionals, which is legally codified in the statements of ethical principles governing the various psychotherapy disciplines, it is particularly central to the psychoanalytic vision of treatment as expressed and experienced through the concepts of neutrality and abstinence. The principled view that the analytic relationship is "tilted" away from the analyst's welfare and toward a primary focus on the patient is axiomatic even within contemporary paradigms that acknowledge and welcome the analyst's passionate

engagement and involvement in a (now) two-way relationship. Regardless of the analyst's theoretical persuasion, analytic treatment is primarily for the patient's benefit and not the analyst's.

The problem arises when our analytic superegos become overly rigid about the manner in which our gratifications have to be subordinated to the patient's welfare. In other words, if the analyst feels too guilty about benefiting in particular ways from the patient, certain clinical opportunities can be missed under the guise of adhering to ethical principles. Under this apparent aegis of a prohibition against exploiting the patient, an analyst might subtly rebuff certain altruistic gestures that bring the analyst "impermissible" gratifications or pleasures. The limits of "permissible," however, may derive more from superego-based abstract guidelines or a "principled" stance than from the case-specific and idiosyncratic needs of the patient. What might be experienced as exploitative by one patient might feel supportive and growth-promoting to another. Paradoxically, then, the ethic of subordinating one's own interests to those of the patient can result in the patient's altruistic interests being rebuffed.

Of course, analysts regularly permit themselves various work-specific gratifications such as money, pride, career enhancement, and other, more altruistic pleasures attendant on helping the patient. In contemporary circles, we also increasingly acknowledge a wider unconscious register of pleasures and satisfactions that accompany the analytic relationship, which sometimes are analyzed in the countertransference and at other times, are not. However, a reflex adherence to these underlying ethical strictures that dictate our putting the patient's long-term psychological interests first can unnecessarily restrict the range, intensity, and type of help that a patient might, in the short run, need us to accept and recognize.

A related set of factors that contributes to the analyst's discomfort with fully accepting, experiencing, and working analytically with a patient's need to give and contribute to the analyst's life are certain personality traits that are common among analysts. The problem here lies in the psyche and not the ethics of the analyst. Analysts tend to be helpers and have particular conflicts about being "given to." Whether these conflicts have to do with narcissistic inhibitions, anxiety about greed, or guilt over being self-centered, the resulting constellation of traits involving being helpful, self-sacrificing, overly responsible,

omnipotent, or even masochistic, at times can contribute to a subtle inclination to ward off a patient's need or wish to contribute to the analyst's well-being. When a patient tries to help us, and this help is actually perceived by the analyst to be something that the analyst needs or would benefit from, the analyst often experiences a twinge of conscience, a preconscious or even conscious signal of anxiety.

The sources of these anxieties are complex and no doubt, highly idiosyncratic. For many of us, accepting too much help from a patient threatens to bring with it the loss of security or power that the role of doctor, helper, or healer provides. For some, the reassurance of this role involves an experience of being a nurturing parent; for others, the comfort derives from being a scientific authority. Truly accepting the help, teaching, constructive criticism, therapeutic advice, or tender concern that might go along with gratifying a patient's altruistic desires can put the analyst in a vulnerable position and evoke signals of anxiety and guilt. A colleague of mine reported to me that when a patient was trying to be too helpful to him, it reminded him of his own intrusive mother's domineering attempts to help him. Another analyst felt that her primary discomfort involved a sense of shame that she had always associated with taking too much from anyone. Certain maneuvers are then instituted to reduce or ward off the implicit psychic danger. This warding off of danger might take several forms. Sometimes, the patient's associations or behavior in this regard are too quickly interpreted. At other times, the analyst will selectively emphasize the defensive or pathological aspects of the patient's apparent altruistic love for the analyst; for example, that it is reparative, a reaction formation, secondary to anxieties about attachment, a masochistic compliance—the list could go on. The kinds of behavior and fantasies that I'm describing are extremely complex and often contain progressive and regressive dimensions. The analyst may seem to be *correct* but ultimately not helpful because, as a result of a countertransference-based discomfort, he or she is missing the fact that the leading edge of the patient's attempt to help the analyst is, in fact, an attempt to create a corrective emotional experience that is highly adaptive. Sometimes the maintenance of an attentive, curious, tolerant, and respectful analytic attitude can be read by the patient as communicating that the analyst doesn't need anything from the patient and that therefore the patient doesn't really have anything of real value to offer. It is my

impression that personality dispositions that emphasize a strict altruism on the part of the analyst can discourage a full and comfortable acceptance of the patient's altruism.

Conclusion

As we move toward a paradigm that emphasizes the various processes of mutual influence within the analytic relationship, I believe that the patient's desires to help, to be useful and contribute, and to facilitate and enhance the other's welfare, should claim our increased attention. In a remarkable paper that anticipates this one, Singer (**1971**) argued that "much of the neurotic distress experienced by my patients seemed associated with their profound sense of personal uselessness and their sense of having failed as human beings because they knew that the only contributions they had made were embodied in nonconstructive reactions and behavior responding to equally nonconstructive demands…" p. 65. Singer, like Searles, is drawing our attention to a neglected or misunderstood aspect of human functioning. I believe that as we increasingly jettison a view of the psyche that emphasizes the motivational primacy of destructive and egoistic wishes, we need to find a new place for the foundational role of the so-called "higher" motives. Altruism is one such motive. And as we attempt to describe the crucial role of altruistic aims in development and in the psyche, we must attempt to describe how these aims are expressed and experienced in the analytic relationship. The consequences of neglecting or misinterpreting the clinical meanings of the patient's altruism are potentially great. Searles's (**1975**) warning in this regard is still true:

> If we never become conscious of [the patient's wish to help us], we remain relatively comfortable in our condescending view of the … patient, and he retains his usual status of someone we perceive as a pathetic and needful cripple. I can confidently say that the great bulk of our psychoanalytic and psychiatric literature is such as to make our recognition of the patient's symbiotic-therapist striving orientation toward us more, rather than less, anxiety-arousing, embarrassing, humiliating, and otherwise difficult for us [p. 138].

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