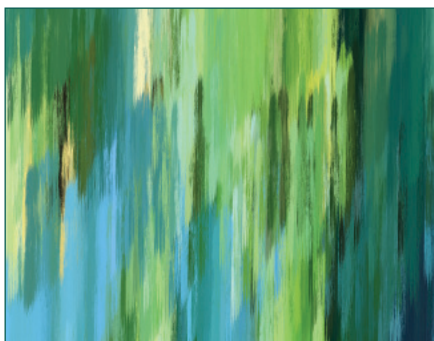

How Should Therapists Treat Patients who are so Altruistic They Regularly Harm Themselves for the Sake of Others?

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EDITOR'S NOTE

The patient cases presented in Psychotherapy Rounds are composite cases written to illustrate certain diagnostic characteristics and to instruct on treatment techniques. The composite cases are not real patients in treatment. Any resemblance to a real patient is purely coincidental.

ABSTRACT

Mental health providers sometimes encounter patients who are exceptionally altruistic toward others and, at the same time, are willing to ignore their own needs and even significantly harm themselves to best achieve these ends for others. Traditionally, therapists have seen it to be their role to discern patients' negative symptoms, then seek to reduce them. This article reviews gains based on positive psychology that highlight the importance of therapists giving priority to supporting patients' strengths, particularly the sources of meaning they have in their lives. As is consistent with this view, it is suggested that therapists working with this group of self-harming, altruistic patients not only support their altruism, but particularly consider and remain cautious as to whether or not they should explore unconscious factors with the patient that might fuel their altruism. It is suggested that the discovery of such factors might be harmful because it could risk decreasing the degree to which these patients continue to show and personally value their altruism, thus potentially decreasing the meaning they derive from their altruism.

KEYWORDS: Altruism, self-harm, therapy, positive psychology, meaning

Altruistic-motivated behavior exists on a spectrum. At one end of this spectrum, for example, some people look for and save worms drowning in puddles on the street after it rains. Some people at this end of this spectrum might regularly help others, even when it significantly harms themselves. For example, a retired man living on Social Security income alone often gave what little money he had to others who were worse off; as a result, in some instances, he did not have enough money to adequately eat. This combination of altruism and self-harm exists in numerous guises. Consider a second example: a physician was so moved by a patient's plight, she, at no gain to herself, crossed usual professional boundaries to help this patient. She was professionally disciplined as a result. Like this physician, many therapists have, I imagine, wanted to help patients, such as by giving them money when they are suffering from extreme debt, especially, perhaps, when the patient's issue is not due to fault of their own. Such therapists might even wonder if the reason they do not offer these patients some relief at these times is because they lack courage.[1]

People who choose to help others despite harming themselves might not be uncommon, but when a patient reports this to their treating psychotherapist, it poses unique clinical and ethical problems. That is, altruism, even when it causes self-harm, can be exceptionally praiseworthy. Altruism is a virtue and to some, at this extreme, it approaches the virtue of saints. However, in other contexts, this self-harm calls for treatment. Therapists might therefore feel that if these patients harm themselves substantially, they should intervene. Therapists might then seek to discover unresolved feelings, such as guilt, with and within these patients that could be driving their altruism in an effort to assuage these unresolved feelings. In addition, for some patients, acting altruistically might add great meaning to their lives, and this sense of meaning might sustain them through difficulties more than anything else could. Allowing them to fully retain this source of resilience might then be the optimal way to help them do well. Should, then, therapists seek to treat these patients at the risk of undermining their altruism, or should they, to some extent, great or small, let these patients be?

Altruism is a greatly respected virtue.[2] Exceptional altruism can be harmful, though. For example, an article in *The Washington Post* reports on tourists who engage with wild animals in National Parks.[3] The author asserts that tourists might perceive themselves as helpful when they seek to help, for instance, a baby elk or bison they think has been abandoned. They might see themselves as "do-gooders" and might even "suffer from a

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savior complex."[3] However, as a result of this interference, they might end up being attacked and, in some cases, killed. These people's exceptional desire to do good might be driven by unconscious needs other than guilt. For example, they might seek to bolster self-esteem that they otherwise lack.

However, these possibilities, even if true, are only one way of explaining such behavior.[4] Inferring that such deficits are the main cause of these peoples' altruistic behaviors is wrongly reductionistic.[5] Seeing these people as only or even mostly having a savior complex can risk erroneously undervaluing the caring choices these people make. This altruistic behavior might reflect exceptional empathy.[6] Should therapists, if these patients want to continue to act altruistically, look for possible sources of this altruism, such as conscious or unconscious shame or guilt?[7] Or should therapists primarily or exclusively explicitly acknowledge these patients' altruism and praise them for their exceptional strength, even if giving this praise might encourage these patients to continue to engage in self-harming behaviors?[8,9]

The main goal of this article is to discuss how therapists can best try to not undermine these patients' altruism, while at the same time helping these patients gain greater control over the compulsive aspects of their altruistic behavior, if their behavior has compulsive components and they indicate that they would want this. More specifically, I discuss how therapists, in light of these possibly competing and mutually exclusive concerns, might best intervene.[10,11] Initially, I will discuss core overarching principles therapists should keep in mind. I will then address practical approaches for implementing these principles. Finally, I will consider a hypothetical case, using the French writer Simone Weil as an example. We shall test the above formulations by asking what we would and, more importantly, should want to do if she were our patient. There might be no better paradigmatic example we could choose. Weil showed, as we shall see, extraordinary altruism in both what she did in her life and said with her writing.

PRINCIPLES IN TREATING PATIENTS WHO SELF-HARM

Is altruism at its extreme pathological? A principle underlying emotional strengths and liabilities is the oft-cited notion that every psychological asset carries with it a flaw if taken too far. Thus, bravery can become folly and altruism can become somewhat foolhardy if taken too far.[11] Yet, people choosing to sacrifice even their lives for others might be both admirable and ethically justifiable. I think here of parents who say that they would sacrifice their own lives for their children, if necessary, and sometimes do. For example, pregnant persons might want to undergo fetal surgery for the sake of their not-yet-born children, regardless of the risk to themselves.[12] This can pose problems for their surgeons, who might feel that they have to turn these patients down. I think also of social contexts in which people are suddenly faced with whether to risk their lives to save others. This situation was exemplified, of course, in the notorious case of Kitty Genovese, who died after her slayer returned to assault her in plain sight. No one, despite seeing the attack, came to her aid.[13]

Is feeling meaning better than not having symptoms? Patients might incidentally report conflicts involving altruism even when they go to therapy for wholly other reasons.[14,15] A general question applicable to virtually all psychotherapy cases is the extent to which therapists should focus on helping patients acquire positive capacities in their lives, such as finding meaning in what they do and enjoying humor, as opposed to focusing on reducing or eliminating negative symptoms, such as shame and guilt.

Psychiatrist Viktor Frankl famously put forth what he saw as the singular and preeminent importance of people feeling they have meaning in their life.[16–18] After he was in a concentration camp and lost many people he loved, he came to believe that those people in the camp who had tended to do better were those who had been able to continue to find meaning in their lives. Directly in response to this view, he established logotherapy, a kind of psychotherapy that focuses on helping patients find meaning, especially to cope with suffering. This focus on feeling and finding meaning is now often emphasized throughout medicine. For example, providers now focus on how to help patients find meaning in their lives even as they are dying, as from cancer.[19] Their capacity to find meaning from living longer and "beating their cancer" might at this time be lost, but patients might still be able to find meaning in other ways, such as by providing their loved ones with memories of their last moments together that they will cherish.

Frankl also emphasizes the importance of humor.[20] Humor might, he says, allow patients a means by which they can distract themselves from their suffering, even if only briefly. It might also, and more importantly, provide an uplifting, different perspective, evoking mirth at an otherwise sad or tragic time.

Frankl's emphasis and the priority he gives meaning and humor are consistent with the major tenets of positive psychology, a field that has emerged relatively recently. This field holds that mental health providers should enhance their patients' strengths more than they had previously, since in the past they had strived more or even exclusively to reduce and eliminate their patients' psychological deficits. Some therapists believe they should instead focus more on helping their patients acquire positive gains, such as the capacities to experience meaning, humor, and happiness, because this does more for them than removing negative symptoms.[21] In addition, studies have also shown that patients who acquire these positive assets might also be more resilient than those who solely become freer from negative symptoms.[22–26] Martin Seligman, a leading proponent of positive psychology, illustrates this view by referring to the experience of one of his own patients before he offered these positive interventions. "Did I get a happy patient?" Seligman asks. He answers, "No, I got an empty patient because the skills of positive emotion, engagement, meaning, and good relationships are entirely different from the skills of fighting anger, anxiety, and depression."[27]

A somewhat analogous question for therapists regarding altruistic patients is then posed: should they risk undermining the positive aspects of altruism by seeking, with their patients, to identify possible underlying causes? If a patient comes to see their altruism as being caused by psychological deficits, they might cease being altruistic. The net effect might be harmful.[28]

How, then, might these patients' providers respond in light of these advances in positive psychology? As a first task, therapists should check within themselves to try to discern whether they might have an underlying bias that could thwart their capacity to maximally support patients who retain their exceptional altruism.[29] An example they might use as a test

case is one we described before—pregnant persons wanting to undergo fetal surgery for the sake of their fetuses, even when this is potentially, seriously harmful to themselves.[30,31] Providers without undue bias might share with these patients that they have the exceptional gift of being unusually altruistic and that the degree to which these patients' care for others goes beyond what is expected of most people. Ethically, therapists might point out that what these patients do goes beyond what most people see as morally obligatory.[32,33]

For example, consider the case of a patient, a father, who blamed himself for the failure of his daughter's marriage. Her husband had been penniless prior to their getting married. This father had then told his daughter to marry for love, not for money. He blamed himself for giving her this advice. I told him that I believed, in opposition to his view, that he had given her what I saw as the most important lesson in life—to live and act based on love, not money. His demeanor changed abruptly. His facial features softened, and he showed a bit of an immodest grin. He said that he then saw himself in a way he had never before considered. He valued himself then more than he ever had. Such life-changing responses to another person's acknowledging a previously unseen personal strength might occur more often than is commonly recognized. In another case, a person saw himself as a failure because his adult child had adopted wholly opposite views to his own. I said, "But success as a parent is exactly what you achieved. . . your son being able to determine his own views as opposed to his only being able to mirror yours." He said, excitedly, "I feel so much better!" This feeling persisted.

When therapists share an exceptional strength with patients, the patients might also feel less alone. As Rassoulian and Löffler-Stastka[19] wrote, "A reliable, empathic and stable doctor-patient-relationship with an adequate holding, affect-marking, reflecting and containing function can help to work through difficult moments and re-establish meaning." Elvin Semrad is a psychiatrist particularly well-known for his success in connecting with hard-to-reach patients. He held that all most of us need is to be genuinely connected with someone.[34,35] He said, "If patients have one relationship in which they feel comfortable, they don't go crazy."[36] Therapists taking such exceptional efforts as acknowledging the positive quality of altruism might even represent a "fourth wave of psychotherapies," promoting patient wellbeing, rather than focusing solely on correcting deficits.[37]

ASSESSING WHETHER TO LOOK FOR OTHER CAUSES

What, more specifically, might therapists do to affect optimal ends for these excessively altruistic patients? I will answer this using a case example. A college student was at home during a break, hosting a friend who lived far away. The friend asked if he could drive the student's car. This friend took a turn badly, and the car crashed. No one was hurt, but the police then arrived and asked who was driving. The student said himself to protect his friend from repercussions. He did this, he told me later, because he saw this as altruistic and therefore right. Anything less, he said, would be neglectful by omission. Explicit recognition of such rare altruism by therapists might validate and increase its meaningfulness to patients. Alternatively, therapists who seek the psychological origins of such altruism might risk erasing it.

In such cases, therapists might choose not to follow their common practice; they might choose not to address the potential underlying psychopathology. In the above case, for instance, the student's exceptional altruism might have come about from his religious beliefs or the teachings of his parents. The therapist could say, "One can never know whether other factors can contribute to such a caring, altruistic act. Thus, our exploring together past factors that might have contributed to your altruism may increase your ability to choose when you would and would not wantto be this altruistic." The therapist could then ask, "Would you like to explore this together or just take rightful pride in how exceedingly caring you were at this time and how exceedingly caring you can and most likely will continue to be?"

The therapist asking this last question gives patients a choice. Asking this question, rather than making an assertion, might also help make the therapist more the patient's ally, as opposed to possibly evoking an oppositional reaction from the patient due to the question's implicit challenge of the patient's heartfelt belief.[38] Their working together to resolve negative past experiences contributing to their altruism, such as those involving trauma, shame, or guilt, might be beneficial, but not necessarily at the steep price of causing patients who take pride in their exceptional altruism to lose this source of pride and the deep sense of meaningfulness their altruism gives them. Ethically, some therapists might see the approach of not looking for these sources as akin to lying by omission, which thus violates their professional ethical obligation to seek these truths with patients.[39] A rebuttal to this perspective and possible justification for therapists who do not seek underlying causes of altruism is that this search, even if mutual, might risk stripping these patients of what is most meaningful to them and at the core of their identity. The relative gains of leaving patients' identities intact may be difficult to quantify.[40] The offsetting gain of recognizing the potential contributing past factors might not come close to compensating patients for what they could lose.

Therefore, adopting this approach might involve that therapists, in some cases, not ask themselves nor seek to infer or judge whether they think these patients' altruistic acts are or are not psychopathologically fueled, even though not doing so might go against what therapists see as their typical chief priority, seeking to identify and rectify whatever is or may be emotionally suboptimal. Even asking these patients whether they want to pursue this deeper inquiry could result in some patients inferring, just from this question, that there might be pathological underlying factors that contribute to their altruism; this might weaken their altruism. Alternatively, merely raising this possibility might be beneficial for some patients by alerting them to the possibility that they can choose to explore this later, wholly on their own.

Therapists who raise the possibility of earlier contributing factors may suggest to these patients that their altruism might not be as willful, and thus perhaps as much of an admirable strength, as they previously envisioned. The net effect of this, too, might be negative. Thus, therapists not telling these patients the whole truth might be a price worth paying to enable patients to continue to retain maximal gains from their altruism, no matter its causes. When there are or might be such countervailing factors, the degree, if any, to which their altruism should prevail might be best left up to these patients.[41]

Patients might ask therapists what they would do in the situation. Here, therapists

might refuse to answer on the grounds that they are not the patient. This response might, however, leave the patient feeling emotionally abandoned. Rather, therapists might say that they will share their answer but would like to discuss the pros and cons of their doing so first, so that these patients might better decide whether they would still want their therapists to answer the question. The pro is obvious; patients will learn how the therapist would put together all that they know from different sources. The con is this: if patients hear what their therapist would do and decide then to go with or against this response and the end result turns out badly, they might blame themselves for going along with or against what their therapist would do. If influenced at all by their therapist's choice, they might blame themselves for not having made the decision wholly on their own.

The core question for therapists then is whether they should merely respect such patients' altruism as a strength or try to discern, with these patients' permission, whether their altruism is at all driven by psychopathology and, if it is, to then try to treat it. The problem with the latter route is that this can risk implying to these patients that their altruism is less a strength and more a result of their underlying psychopathology. The latter effect might deflate their altruism, this source of meaning to them, and thus their futures. These patients might thereafter newly doubt themselves, losing their joy of feeling and being committed to others.

SIMONE WEIL AS A PARADIGMATIC (FICTIONALIZED) PATIENT EXEMPLIFYING THIS CHALLENGE

In asking the above questions, I am reminded of Simone Weil, who epitomized a commitment to others and self-disregard that the most profound altruism can bring about. For one example of her character, at the age of six years, she refused to eat sugar because soldiers on the front lines had to go without it.[42] In another example, during World War II, she sought to go with others behind enemy lines in an attempt to stop the war, though this likely would have resulted in her death, as that of others with her. Charles de Gaulle saw seeking to go behind enemy lines by parachuting unarmed nurses onto these battlefields as "the ravings of a lunatic."[42]

Yet, Weil's wisdom emotionally and intellectually moved and inspired others and continues to do so today. For example, she spoke of how an owner of a factory might feel sincerely sorry for his workers but still not connect this feeling with what they most need. "We hate the people," she said, "who try to make us form the connexions [sic] we do not want to form."[43] "Love," she said, "on the part of someone who is happy is the wish to share the suffering of the beloved who is unhappy. Love on the part of someone who is unhappy is to be filled with joy by the mere knowledge that his beloved is happy without sharing in this happiness or even wishing to do so."[43] How much more loving could a person be than this? However, she also said, "May I disappear in order that those things that I see may become perfect in their beauty from the very fact that they are no longer things that I see."[43] How much more self-effacing than this could a person be?

Let us ask, as a hypothetical question, what we believe we should do if Weil were our patient, coming to us for a reason unrelated to her altruism. For example, she ate poorly at times in her life; we could be seeing her for this reason.

Should we challenge her views that to love, we should want to share the suffering of those whom we love, or that we might want to disappear so that things we view could then be perfect? It is hard to imagine that our challenging these beliefs would at all change her. But should we even try? We could, perhaps, safely ask her or other patients who practice extreme altruism if they want to imagine with us how they would want to respond to situations that could occur in which they are invited to be altruistic.[44] The rub is that even this exercise might do more harm than good. It might then be wrong to not leave her just as she is; this might apply to many others like her as well. This might clearly be the preferable course, for example, for those patients who rescue worms in the road after it rains.

CONCLUSION

Some people sacrifice their own interests to help others. This is praiseworthy but might also reflect unmet psychological needs. These unmet needs might limit the ability of these patients to choose whether and when to be altruistic. This piece reviews how therapists can best respond to these patients. I suggest that therapists might always state explicitly that they see these patients' altruism as the strength that it is. I note, too, the possible risk of directly or indirectly seeking to unearth unconscious factors that might contribute to such altruism. Namely, this inquiry may risk undermining and then reducing a patient's altruism, their identity, and the chief source of meaning they have in their lives.

However, as opposed to not inquiring at all about these patients' self-harming altruism, therapists might alternatively ask these patients if they would want to explore the possible etiologies with them in the hope that this might leave them more informed and freer to choose when and when not to be altruistic. I suggest that if these patients ask their therapists what they would do, therapists should consider asking the patients in return whether they might want to discuss together the pros and cons of this exercise before these patients decide. Having considered the risks that could come about either way, patients, hopefully, might be slightly more able to decide. They might, though, have greater angst.

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