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When Does Psychotherapy Encourage Selfishness?

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Abstract: This paper explores how psychotherapy, with its inherent focus on the self, may inadvertently contribute to problematic selfishness. By comparison with religious traditions which have encouraged humility and dedication to serving others, psychotherapeutic schools have historically emphasized ways to meet one's own needs. We review here the evolution of ego-centric approaches toward more relational and growth- and virtue-oriented ones, before considering four clinical contexts which risk fostering undue absorption with oneself and one's therapy. A greater awareness of these risks can help clinicians and patients appreciate the role of moral values, world views, and religious commitments in shaping the direction of their work.

Keywords: religion; psychotherapy; selfishness

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1. Introduction

Medication, surgery, and psychotherapy are interventions which can be lifesaving, abused, and/or a source of harm. In the prototypical scenario, a distressed and/or impaired individual benefits from psychotherapy in ways that enable them to be less focused on their own needs and more able to consider the needs of others. But are there features of psychotherapy, like potentially habit-forming medications, that can lead to inappropriate dependence? Are there, analogous to "chemical copers" focused on medication, certain individuals who are more vulnerable to depending on therapy as a substitute for life? Can psychotherapy's focus on one's own wants and feelings promote an inappropriate preoccupation with the self?

A focus on the self can be admirable if it refers to self-awareness, realistic self-regard, or self-esteem, but concerning if it connotes self-absorption, self-centeredness, or self-aggrandizement. Furthermore, many patients' views of the self are shaped by religious commitments to humility, the service of others, relinquishing attachments or desire, and/or preferential devotion to God. The Buddhist practice of mindfulness encourages individuals to transcend the ego and detach from personal desires, fostering a state of selflessness. Similarly, Christians are called to self-forgetfulness in order to meet the needs of others and align their will with divine purposes.

Here, we review the evolution of secular psychotherapy, beginning with Freud, who openly rejected religious calls to selflessness, and proceed to more contemporary, relational, and virtue-oriented forms of therapy. It is crucial to emphasize that not all forms of therapy informed by a given school are the same, as they vary in individual orientations, techniques, and clinical contexts. Therefore, we follow this review of theory with an exploration of four clinical contexts which highlight the risks that psychotherapy can lead to an unhelpful focus on the self and the therapy itself.

Finally, we consider how paying attention to these risks can help clinicians to minimize them by taking into account the moral, religious, and world-view dimensions of their work.

2. Historical Overview

Sigmund Freud's pioneering concepts of the unconscious mind, transference, and the significance of early childhood experiences laid the foundation for psychoanalytic therapy.

By uncovering a patient's unconscious thoughts and feelings, psychoanalytic therapy was seen to release the id from the control of the superego, further strengthening the ego to assimilate the id's desires. However, Freud's focus on the unfulfilled desires and needs of an individual as the root of neurosis drew criticism for its encouragement of egoism. If the inhibition of one's impulses is unhealthy, a well-adjusted person should seek the satisfaction of internal needs first and foremost rather than being hampered with duty. As Freud wrote, "All who wish to be more noble-minded than their constitution allows fall victims to neurosis; they would have been more healthy if it would have been possible for them to be less good" (Freud 1959). Freud often described societal prohibitions to be a source of unhappiness. For Freud, focusing on an individual's relationship with oneself by bringing their unconscious motivations to consciousness would not only transform their self-relationship, but ultimately impact their connection with the larger community.

Abraham Maslow and Carl Rogers similarly believed that society and interpersonal relationships could deter one's self-determination. Instead, they promoted the ideal that each person should construct their own lives independently from society or others. Maslow described a healthy "self-actualizer" as "not dependent for their main satisfactions on the real world, or other people or culture or means to ends or, in general, on extrinsic satisfactions. . . The determinants of satisfaction and of the good life are for them no inner-individual" (Maslow 1970). Rogers described a healthy individual similarly: "Less and less does he look to others for approval or disapproval; for standards to live by; for decisions and choices. He recognizes that it rests within himself to choose; that the only question which matters is, 'Am I living in a way which is deeply satisfying to me, and which truly expresses me?" (Rogers 1961) To some, this concept of self-actualization is equivalent to selfishness due to preoccupation with the self and detachment from others. However, Maslow argued that concern for oneself was required prior to concern for others, much like lower-level needs requiring satisfaction before others in the hierarchy can be met. Expressing a similar sentiment, Rogers wrote "Each person is an island unto himself, in a very real sense; and he can only build bridges to other islands if he is first of all willing to be himself and permitted to be himself" (Rogers 1961).

Virginia Satir's and Murray Bowen's approach to marital therapy aligns with the view of self-actualization as a path to stronger interpersonal relationships. Satir believed that dysfunctional relationships and communication styles were byproducts of low self-esteem and poor self-concept (Gurman and Fraenkel 2002). For Satir, the goal was "not to maintain the relationship nor to separate the pair but to help each other to take charge of himself" (Satir 1965). Bowen similarly believed that differentiation of the self and differentiation from others was a necessary precondition to psychological health and the marital health. Bowen therefore encouraged his patients to take "I-positions" to clearly express their emotions and needs without judging their partners, an approach still widely used in marital counseling.

While Maslow and Rogers argued that self-gratification ultimately leads to concern for others, they did not examine situations in which furthering one's own actualization came at the expense of others. In his criticism of Freud's psychoanalytic perspective, Philip Rieff argued that Freud's focus on individual fulfillment over social good created a culture in which an individual is isolated, adrift, and has no reliable source to turn to for moral guidance. In his work "The Triumph of the Therapeutic," Rieff further wrote that the ego-centric therapeutic model promoted a "manipulable sense of well-being" in which "a man can be made healthier without being made better," and released people to their own narcissistic agendas (Rieff 1987).

By comparison, positive psychologists such as Martin Seligman later suggested that other-regarding virtues were essential elements to full mental health. In addition to the subjective experiences of the individual, such as well-being, contentment, satisfaction, hope and optimism, and flow and happiness, Seligman emphasized the vitality of group or civic virtues: responsibility, nurturance, altruism, civility, moderation, tolerance and work ethic (Seligman and Csikszentmihalyi 2000). In "*The Culture of Narcissism*", Christopher Lasch argues that therapists, when emphasizing the importance of "meaning" and "love," tend

to define these concepts narrowly as the satisfaction of the patient's emotional needs rather than to promote the idea of the individual placing their needs and interests behind those of others, a cause, or a tradition external to themselves (Lasch 1991).

Victor Frankl believed that ego-centric forms of therapy are often counterproductive, inviting the neurotic patient to fixate more on their own feelings. Frankl reasoned that states of self-reference, such as happiness and fulfillment, are never effectively attained when pursued directly, but must naturally arise as by-products of our actions and pursuits (Frankl 1985). Through his own experiences and those of his fellow inmates at Auschwitz and Dachau during the Nazi occupation, Frankl observed that a sense of purpose beyond oneself was a primary driving force that allowed one to endure difficulties and persevere. Irvin Yalom also emphasized the benefits of turning outwards rather than looking inward for self-actualization. He firmly believed in the therapeutic significance of stepping outside of oneself and caring for another person without any expectation of reciprocation (Yalom 1980). As a therapist, he sought to free a patient from the barriers to fully engaging in commitment to people and to tasks. Frankl's perspective is echoed by Wallach and Wallach's concern that a psychological emphasis on fulfillment and freedom which prioritizes individual wants and feelings might run counter to what helps to give people a sense of meaning in their lives (Wallach and Wallach 1983).

The psychologist Allen Bergin focused on the therapeutic value of selfless service to others, commitment to family, and the acceptance of guilt and suffering rather than one's own sense of gratification (Bergin 1980). He believed the conduct most conducive to wellness, espoused by many religions, included dedication to service, sacrifice for others' sake, and abiding by commitments even at the expense of one's comfort. In most major religions, ego-centricity or self-centeredness is a flawed human trait leading to suffering that only love can help overcome. Consider, for example, this well-known passage from the Bible: "Do nothing from selfish ambition or conceit, but in humility count others more significant than yourselves. Let each of you look not only to his own interests, but also to the interests of others" (Phil 2: 3–4). Religious psychologists such as Paul Vitz have expressed concerns that secular psychology has promoted the celebration of self and failed to consider that human nature is tainted with evil (Vitz 1994). Lasch contended that "contemporary climate is therapeutic, not religious," asserting that contemporary individuals yearn not for personal salvation but for the fleeting perception of personal well-being, health, and psychic security (Lasch 1991). Vitz felt that humanity's flawed nature could not be trusted to provide a basis of hope and healing. Rather than encouraging self-actualization through the gratification of one's desires, Vitz believed the answer to true self-fulfillment lies in realizing Christian virtues of humility, the curbing of pride, and service to others (Vitz 1994).

Contemporary models of psychoanalytic therapy have shifted away from a strictly ego-centric approach to one that takes into account the individual's relationship with the broader community in which they reside. L. Nique Dworkin contended that post-Freudian, relational models of therapy based on self-psychology and attachment theory include an implicit morality based on empathy leading to respect for others—criticizing Freudian psychic determinism for rationalizing away culpability and removing personal agency and accountability (Dworkin 2015). In self-psychology, the objective of therapy shifts from establishing "a position of power, independence, and proud autonomy" for the patient to fostering a lifelong, healthy dependence on ideas, institutions, and nurturing relationships with others (Goldberg and Kohut 1980). This type of therapy, rather than pathologizing these dependencies, works to strengthen a client's fragile self-identity by fostering connections with admirable figures and ideas in hopes of strengthening the individual's ties to communities and, in turn, benefiting those communities as well. Like self-psychology, attachment theory departs from the notion of the mind as isolated and moves toward a view of individuals as situated within and influenced by their surrounding environment (Dworkin 2015). Attachment-focused therapy aims to help individuals both become more aware of their choices and bolster their sense of responsibility to others.

Other Fourth Wave psychotherapeutic approaches (Peteet 2018) focus on forgiveness and gratitude as a path to emotional well-being through the healing and development of healthy interpersonal relationships. While various definitions exist within the literature, Bono and McCullough assert that "forgiveness is a positive psychological response to interpersonal harm, and gratitude is a positive psychological response to interpersonal benefits" (Bono and McCullough 2006). By cultivating positive responses to harm from others and in appreciating benevolent interpersonal encounters, patients develop skills fostering psychological well-being that would otherwise remain untapped.

Forgiveness is believed to hold structural and functional parallels with altruistic behavior, which occurs as a function of empathy (Batson 1991). The aims of forgiveness therapy often include developing empathy for the transgressor, the recognition of one's shortcomings, generous appraisal for the transgressor's behaviors, and renunciation (Bono and McCullough 2006). Forgiveness interventions work to help individuals overcome the anger and resentment that hold negative beliefs in place and serve as barriers to actualizing virtues (love, compassion, etc.). The therapeutic benefits of forgiveness can occur through the promotion of the repair and maintenance of close, supportive relationships (Karremans et al. 2003).

Research demonstrates that gratitude interventions, which promote one's appreciation of positive qualities, situations, and individuals in their life, can enhance psychological well-being (Seligman et al. 2005). McCullough et al. observe that gratitude emerges from and encourages actions driven by genuine care for the well-being of others (McCullough et al. 2001). They propose that gratitude functions as a moral barometer, signaling shifts in relationships based on one's perceptions of individuals who contributed to their well-being. Secondly, it acts as a moral motivator, encouraging people to reciprocate kindness and suppress harmful impulses towards their benefactors. Finally, gratitude acts as a moral enhancer, as expressing it enhances the likelihood of future benevolence from the benefactor, while ingratitude can trigger anger and resentment, potentially curtailing future acts of kindness. The therapeutic value of gratitude-enhancing practices and therapy thus results from strengthening an individual's ties to his or her environment.

3. Clinical Contexts

These historical and theoretical considerations raise the possibility that psychotherapy could contribute to undue selfishness, but are there clinical contexts in which this is more likely to occur? We suggest four here:

First, individuals with narcissistic personality traits often appear both selfish and in need of validation. As Kohut pointed out, therapists may need to mirror a grandiose self to allow for the development of an idealizing transference, which can then be used to work through empathic failures by a good enough therapist (Kohut 2011)—a process that can risk the encouragement of a self-centered perspective until it can be effectively queried. Narcissistically injured or depressed individuals who seem to need support can be challenging to confront, requiring the clinician to think clearly about the meaning of support. Does the patient need support in the sense of comfort, bolstering, maintenance, or advocacy (J. R. Peteet 1982)? Clinicians also need to attend carefully to countertransference feelings (e.g., of wanting to feel special, liked, or included in the patient's orbit of influence) that can inhibit needed confrontation and/or clarification of the goals of treatment (Pincus et al. 2014).

Consider the example of a retired single woman in her 70s with a long history of insomnia, and of contending with physician treaters over multiple sleep medications to which she felt entitled. Listening with interest to her accounts of encounters with other physicians seemed to gain the therapist respect and something of a hearing, but it was much easier to do so than challenging the patient to focus elsewhere. After years of monthly sessions, she had shown little change in her perspective or behavior, and little progress in looking beyond her own self-absorbed concerns. This raised the question of whether her supportive psychotherapy had contributed to her selfishness.

Second, survivors of trauma similarly need to experience non-judgmental acceptance—in their case, in order to feel safe and begin healing. Trauma-informed therapists may hesitate to question their patient's perspective to avoid re-traumatizing or triggering them, but at the risk of validating their identity as a victim and their need to maintain boundaries between them and those they find challenging. This can encourage splitting, a kind of solipsistic entitlement, and "ghosting" in the name of protecting one's bandwidth (Davis 2023). How a therapist strikes this delicate balance is influenced by their own core beliefs about the value of protecting an autonomous self as compared with the importance of maturity and the full relatedness of forgiving, sacrificing, and loving even one's abuser.

Consider the example of a 30 year old woman who presents to her therapist hurt and angry after being verbally abused by a boyfriend, which revives earlier traumatic losses. Hearing that she has broken off contact with her family for being unsympathetic, her therapist responds by validating her experience and attending to her safety, hoping that feeling heard will help her to settle emotionally and achieve some perspective. At this point, some therapists would focus on (1) her ability to set and maintain boundaries with the boyfriend and her family to prevent future hurt, some on (2) understanding their interactions and possibilities for reconciliation, and some on (3) what the experience means for how she understands herself and her relationships—including how she wants them to be. Examples of possible identities include someone who suffers a harm she cannot control; someone who deserves sympathy and/or requires some type of action be taken against the victimizer; someone who is culpable for her experiences; and someone who is powerless and weak (Leisenring 2006). While the patient may not be able to engage questions (2) and (3), inviting her to consider them lowers the risk that the therapy will validate a self-centered identity as a victim (Zitek et al. 2010; Kaufman 2020).

Individuals with complex PTSD who experience ongoing sensitivity to feeling victimized often need to feel that they are being taken seriously in order to trust a therapist. Doing so in a way that also helps them look beyond their own fear, pain, and anger can be a challenging task that requires time and the recruitment of outside resources. Consider the example of a divorced woman in her 60s who presented for treatment after a hospitalization for an overdose. She described a verbally and physically abusive childhood, which she escaped by marrying a paranoid man who beat her regularly. She graduated from seminary as an older adult, but was never hired by a church. She was estranged from her three children, as well as from God, saying she could not understand why he "created me so damaged." Medication and cognitive behavioral therapy were not helpful with her chronic depression, but she seemed to benefit from being heard in weekly sessions, from caring for her dog, and from volunteering at a nature museum. Attempts by her therapist to broach the subject of her children or of another church experience were rejected, but over a period of years of his attention to her experience, she recontacted a daughter and visited a Buddhist sangha. After establishing a few sustaining relationships, including her therapist, she tried a small Pentecostal church where the pastor and his wife took a personal interest in her, in spite of her more liberal social and theological views. Feeling cared for and loved by them and once again by God led to a major change in her outlook, although she retained some interpersonal sensitivity. Topics which had been taboo at first became feasible as a result of this, along with the trust which she had developed in her therapist over the course of several years. She became able to put her traumatic past into perspective as only part of who she now felt called to be.

A third context in which psychotherapy can promote selfishness is that in which patients with disordered attachment, such as those with borderline personality features, develop an intense focus on what a therapist can do for them. Driven by transference-based, unrealistic expectations, they may demand more time, pursue the therapist between sessions and after hours, and devalue outside relationships. A clinician who extends themself in an effort to meet the patient's needs, or conversely, tries to become less available may find the patient becoming even more preoccupied with what the therapist needs to do for them. A frank discussion of this process, the clarification of therapeutic boundaries,

and the recruitment of additional resources such as another therapist, a group, or a hospital are often indicated to provide additional support and diffuse the transference. After stabilization, the patient may function better, and be more able to engage with others in their everyday life, perhaps in less intensive treatment.

Consider the example of a 30 year old single mental health assistant with borderline and obsessional features in limited contact with family or friends, who, after several months of weekly therapy, began to call her therapist between sessions because of anxiety. She requested additional sessions, refused to leave the office, and eventually presented to the therapist's home. Only when told he would not see her unless she entered a hospital did she find another clinician.

A fourth context is the routine use of psychotherapy in settings where this is culturally reinforced as a way of investing in and caring well for oneself. As one critic has put it: "I no longer save for the Chanel bag I've lusted after for years. Instead, I save money for my barre classes (average class costs range from $30 to $37 in New York City) and weekly therapy sessions (depending on health insurance, it can cost hundreds for one visit). But it's not about pouring all my money into exercising and my mental health that makes it a status symbol—it's the bragging" (Noble 2017).

And another: "Notice how the term "everyone needs therapy" gets thrown around way too easily and often. It's scary to think that therapy isn't just only a status thing. . .it's also replacing meaningful relationships, it's teaching us that we shouldn't be able to trust our friendships and ourselves to take care of ourselves. We are being taught what to think, feel, and do from therapists" (Lifeisblue444 2023).

In such settings, despite the shortage of resources for individuals in significant need of treatment, clinicians often see more patients who are relatively healthy (and more able to pay what they charge) than they do those who are more distressed and impaired. While it can be tempting to be paid well to continue a mutually gratifying relationship with an interesting patient, good therapists will try to understand the underlying dynamics, to engage the patient in learning why this is happening, and to help them gain a sense of mastery (Clemens 2010). Success can lead to improvement in the patient's sense of self and relationships with others, with less need to focus on oneself in regular therapy. A therapist's interest in clarifying the need for continued sessions can also help to model a pragmatic concern for justice, and for meeting the needs of others.

These third and fourth contexts illustrate how psychotherapy can lead to inappropriate dependence on therapy as a substitute for living and finding fulfilment in other relationships.

A clinician in of these four contexts needs to be fully devoted to the patient while challenging them to look at what their best interests are—a task with important moral dimensions. As discussed elsewhere (Peteet, forthcoming), attending to moral life is fundamental to shaping the direction of treatment, achieving clinical aims, and approaching the moral challenges faced by clinicians. Since an important feature of moral functioning is acquiring needed virtues (Peteet 2004, 2023), it is worth considering what virtues are relevant to conceiving and achieving "healthy selfishness" and a life well lived. Narcissistic patients may need to develop humility, and compassion for others. Those limited by a victim mentality may need to learn self-compassion, forgiveness, and love. Patients engaged in transference binds may need to learn equanimity and phronesis, or practical wisdom. Those substituting therapy for other commitments and relationships may need to learn to hope that more is possible. And therapists treating these challenging patients need virtues of self-knowledge, integrity, and unselfing (Radden and Sadler 2010).

Both a therapist's and a patient's values are informed by their world views, including their religious and spiritual commitments. Differing world views emphasize different preferred virtues—for Jews, these might be communal responsibility and critical thought; for Christians, love and grace; for Muslims, reverence and obedience; for Buddhists, equanimity and compassion; for Hindus, the appreciation of Dharma and Karma; and for secularists, respect for scientific evidence and intelligibility (J. R. Peteet 2014). While none of these traditions admire selfishness, autonomy is a relative value for those loyal to a

higher authority, and religious individuals are sometimes troubled that entering therapy with a secular clinician could make them less religious (Cragun and Friedlander 2012), and less concerned for others (Hunter 2000).

Therapists may be reluctant, in the name of therapeutic neutrality, to express, act upon, or encourage values that patients have not themselves espoused. However, Curlin and Hall (2005) have argued that a more appropriate ethic than one aimed at neutrality, autonomy, and competence for dealing clinically with spiritual and religious issues is an ethic based on candor, respect, and wisdom. Within such an approach (analogous to one in which a therapist might encourage, for example, exercise as a good), they might inquire about their patient's relationships, hopes for themselves and for others, sense of purpose, etc. They may also refer to the growing evidence base for the mental health benefits of positive psychology interventions (Peteet 2023). They may then give (e.g., paying attention to hopes for a more mature and balanced future) with one hand, while gently confronting, or taking (e.g., their ready availability to substitute for potential other relationships in the patient's life) with the other.

Finally, clinicians need to remain aware of the influence of their own world-view-based moral values or preferred virtues, as well as that of their countertransference feelings, on the balance they are attempting to help patients find between their own needs and those of others in life—or put another way, between healthy self-interest and undue selfishness.

4. Conclusions

There are a few reasons to reflect on the question of whether psychotherapy can encourage undue focus on oneself and one's therapy. One is obviously to help clinicians minimize this risk by anticipating it, and being aware of its potential to do harm by uncritically offering support that validates narcissistic or victimized self-perceptions, stimulates borderline patients' attachment needs, or perpetuates therapy as a substitute for other relationships.

Another reason is to heighten appreciation for the importance of the cultural context in which psychotherapy takes place. We have seen how shifts in thinking regarding the goals of therapy have shaped the approaches taken by therapeutic schools, and how some religious individuals continue to mistrust secular psychotherapy (Tjeltveit 2021). For example, it could be important to directly address the concerns of a religious couple that a secular therapist they have consulted might encourage divorce by focusing on the self-actualization of the individuals involved. Clinicians seeing patients from more religious or collectivist cultural backgrounds may need to consider clarifying their therapeutic goals to obtain informed consent for individual therapy as well.

A third reason is to help the therapist recognize and, if need be, articulate more clearly the role they play in the patient's moral life (Peteet, forthcoming). If a therapist wants to help a narcissistic patient become less self-centered, for example, by encouraging the virtue of humility, how do they conceptualize this as part of their role, and explain it to the patient as being in the interest of their flourishing?

A fourth and related reason is to clarify the therapist's relationship with resources outside of therapy, given that the therapist is not the most appropriate moral or spiritual authority for the patient. What options to inspire or guide the patient should be considered, and how can the therapist help the patient navigate among these (cf. the discussion above of the treatment of patients with complex PTSD)?

In conclusion, while schools of psychotherapy have become more relational over time, and therapy ideally should help individuals become less selfish by becoming less symptomatic and more capable of responding to the needs of others, there are at least four treatment contexts which present a significant risk of fostering undue self-absorption. Awareness of the risks presented by these contexts can help clinicians to mitigate them, including by clarifying the role they play in their patients' moral lives, such as through fostering a balance of self- and other-directed virtues.

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