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Altruism in relationship to the therapeutic process : an exploratory study of the perspectives and experiences of clinical social workers

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Leslie Hammer
Altruism in Relationship
to the Therapeutic Process:
An Exploratory Study of the
Perspectives and Experiences
of Clinical Social Workers

ABSTRACT

While engaging in altruism has been found to be therapeutic in many settings including mutual aid groups, there is a lack of empirical data regarding altruism in the context of clinical social work with individuals. Using qualitative methods, this study gathered perspectives on the current state of altruism in clinical social work, and inquired specifically about the use of altruism as a clinical tool. Semi-structured interviews were completed with 13 licensed clinical social workers. Participants varied in their perspectives about engaging in conversations about altruism with clients and the therapeutic use of participating in altruistic acts. Clinicians expressed being guided in these matters by their own principles, theoretical backgrounds, and use of “clinical judgment”. Participants also spoke about the impact of altruistic acts on their clients and the factors that prevented clients from engaging in altruistic acts. The findings call for increased consciousness regarding altruism in the field of clinical social work and for future research, including the incorporation of the client’s voice. The study also prompts the clinical social workers to consider the construction of egoistic clinical practices and their participation in the splitting of the needs of individuals and the needs of the greater community.

**ALTRUISM IN RELATIONSHIP TO THE THERAPEUTIC PROCESS:
AN EXPLORATORY STUDY OF THE PERSPECTIVES AND EXPERIENCES
OF CLINICAL SOCIAL WORKERS**

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

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2015

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CHAPTER I

Introduction

Although psychotherapy was firmly founded on assumptions of universal egoism (Wallach & Wallach, 1983), there is room for new exploration of altruism in therapeutic work. Many clinical social workers themselves are altruistic, yet they work with individuals in an egoistic framework, focusing on the individual and joining with them to work toward their therapeutic goals. Perhaps perceiving clinical social work in an altruistic lens goes against clinicians' understanding of their role—promoting altruism is akin to promoting an unwelcome agenda, or giving advice. Or perhaps, egoism is also an agenda and the field of clinical social work perceives it as the norm. This study seeks to explore these questions and hopes to shed light on the ways the phenomenon of altruism connects with social work's primary mission, "to enhance human well-being and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty" (NASW 2008).

This study explores clinical social workers' understanding of altruism in their practice, including altruism's relevance to their work, the emergence of conversations about activities that benefit the welfare of others within clinical encounters, and the degree to which clinicians have promoted altruism with their clients. Participants in the study also commented on their perspectives regarding clients' motivation to engage in altruistic acts, the ways participating in altruistic acts have impacted their clients, and the limitations their clients have faced in accessing altruistic outlets.

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Research Questions

This study addresses two primary research questions:

1. What are the experiences of clinical social workers regarding altruistic interventions with their individual clients?
2. What are clinical social workers' perspectives on clients' involvement in altruistic acts in relationship to the therapeutic process?

For the purposes of this study, *altruistic interventions* are not actions that clinical social workers take on behalf of the welfare of their clients, but rather actions that clients take outside of the clinical relationship. I use the word *intervention* to describe an initiative that comes from the clinical encounter.

Motivation

Much of the recent literature in this area has focused on the significant therapeutic implications of mutual aid groups (Zemore, 2007). Other research has pertained to understanding the motivations and impacts surrounding altruism in general and within varying cultural contexts (Draguns, 2013). Within studies measuring the impacts of altruism on individuals, there seems to be a consensus that participating in altruistic acts can be beneficial to people in their mental health and in their healing processes (Massey, Kranenburg, Zuidema, Hak, Erdman, Hilhorst, & Weimar, 2010; Morrow-Howell, Hinterlong, Rozario, & Tang, 2003; Post, 2005; Rietschlin, 1998; Van Wiliigen, 1998; Vollhardt & Staub, 2011). However, limited research connects the helping profession, social work, with the potential benefits of this phenomenon, altruism, in the context of clinical work with individuals.

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In response to this gap in the literature, I developed this research study. The intention of this study was to gather perspectives on the current state of altruism in the context of clinical social work, inquiring specifically about the use of altruism as a clinical tool with individuals. This study employed qualitative research methods to explore the perspectives of a sample (n=13) of clinical social workers. Interviewing a relatively small group of clinicians in depth about their perspectives and experiences allowed space for salient themes to emerge in this broad area of new research.

This study investigates how a social work value, altruism, is employed by clinicians and within the clinical setting. Discussing the phenomenon of altruism in the clinical encounter brings to light interesting examples of the ways clinicians' personal style and theoretical background shape their work with individuals. The study will reference several different theoretical perspectives that clinicians mentioned in the interviews in clarifying their role with clients. Object relations theory will serve as a tool for making meaning of altruism in the clinical sphere.

Exploring clinician's perspectives on altruism in their practice has the potential to be relevant to the field of social work in various ways, including implications for clinical practice, new topics of conversation in educational settings, and further research. The study aims to highlight the principle of altruism in connection to social work values, to prompt reflection from social workers about their own values including those associated with altruism, and to suggest the importance of having awareness of the ways in which those values are present in one's work with clients. The study will raise questions about the therapeutic implications of separating and/or integrating the self and the greater community.

CHAPTER II

Literature Review

Introduction

For the purposes of this study, altruism is presented in contrast to egoism, the motivational state with the ultimate goal of increasing one's own welfare (Batson & Shaw, 1991). Whether or not altruism is entirely separate from egoism is up for discussion. Philosophers, sociologists, and psychologists have had varying perspectives on whether or not humans have the capacity to act entirely on behalf of others without having awareness of how that act might impact one's self (Batson & Shaw, 1991). Although this is an interesting avenue of inquiry, this study does not implicitly seek to understand whether or not *true* altruism is possible. Instead, this study seeks to use the word *altruism* and its associations to explore how this principle, despite its complexity and limitations, might be relevant in furthering the understanding of clinical practice and the realization of social work values. For the purposes of this study, altruism is defined simply as *the principle of unselfish concern for others*, based on a definition in the *Oxford Handbook of Positive Psychology* (Batson, Ahmad, & Lishner, 2009).

Altruism is related to prosocial behavior, behavior that is intended to improve the situation of the help-recipient (Bierhoff, 2002). However, pro-social behaviors may or may not have an egoistic motivation behind them. The other difference is that altruism is not a behavior, but a principle that informs behaviors. It is an intention of increasing another's welfare that manifests into an action (Draguns, 2013). "Altruism encompasses

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both heroic, self-sacrificing acts and relatively inconspicuous and mundane instances of intentional helping” (Draguns, 2013, p. 2).

To specify the difference between altruism as a principle and altruism as an action, I will refer to *altruistic acts*, defined as *actions that benefit the welfare of others* (Tankersley, Stowe, & Huettel, 2007). Altruistic acts could be synonymous with other terms such as compassionate acts, acts of service, giving of one’s self, helping others; but these words evoke slightly different meanings. Altruism and altruistic acts will be the terms used throughout the study as a way to maintain consistency and connection to the general meaning of altruism. I will refer to the specific context or type of altruistic act when applicable, i.e. volunteering, advocacy work, community engagement, giving to a charitable cause, helping a family member or neighbor, etc.

In this literature review, I will begin by explaining how altruism is relevant to the field of social work. I will then draw from different fields of study to highlight the ways that altruism has been found to impact people’s well-being; focus on how areas within the field of clinical social work address altruism including its use as a clinical tool; explore the competing perspectives on the role of altruism in this context; and highlight areas from which altruism is absent in the literature. Objects relations theory will provide a framework for understanding the relevance of altruism in a therapeutic context.

Relevance to Social Work

According to the *National Association of Social Workers (NASW) Code of Ethics*, social workers’ primary goal is to help people in need and to address social problems. Social workers value service and the importance of human relationships; they are invested in social welfare. “Social workers engage people as *partners* in the helping

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process” (NASW, 2008). They ascribe to the ethical principle of “elevating service to others above self-interest” (NASW, 2008). The *Code of Ethics* encourages social workers to be altruistic, and to volunteer some portion of their professional skills with no expectation of significant financial return.

The code instructs: “Social workers should promote the general welfare of society, from local to global levels, and the development of people, their communities, and their environments” (NASW, 2008). The principle of altruism is ingrained in the foundational ethics of the field of social work; it is a requirement of social workers to be altruistic in their work. However, the literature connecting altruism and the field of social work, particularly within the clinical framework, is quite sparse.

The Therapeutic Nature of Altruism

General application. The “helper” therapy principle suggests that helping others is therapeutic to the helper (Reisman, 1965). Altruistic acts have been found to help the helper by benefitting one’s mental and emotional well-being, physical health and social life.

Tankersley, Stowe, & Huettel (2007) explain the neurological response to altruistic acts. In their research, they found that participants engaging in actions that intentionally benefitted another person and incurred no direct personal benefit activated circuits in the brain involved in attachment and close interpersonal relationships. These circuits are involved in both empathy and understanding of the motivations and intentions of others (Tankersley, Stowe, & Huettel, 2007). Moll, Krueger, Zahn, Pardini, de Oliveira-Souza & Grafman (2006) explain that acting for the benefit of others releases “feel good” neurotransmitters such as oxytocin and vasopressin.

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Goetz, Keltner, & Simon-Thomas (2010) suggest that being compassionate has implications for people's physical health. They found that situations that evoke distress tend to heighten arousal and increase heart acceleration, whereas situations that evoke compassion tend to decelerate heart rate. Post (2005) describes how positive emotions (kindness, other-regarding love, and compassion) enhance general health by virtue of pushing aside negative emotions that can have a negative impact on health. In collecting existing research data on altruism and its relation to mental and physical health, he found a strong correlation between well-being, happiness, health, and longevity and being emotionally and behaviorally compassionate.

Participation in altruistic acts inherently provides opportunities for social connection. Rietschlin (1998) explored this phenomenon within the context of voluntary association membership, specifically looking at the effects of belonging to groups whose stated purpose extends beyond the individual well-being of its members. He found that this type of voluntary association membership decreased the study participants' psychological distress, such as depression, and improved their capacity to tolerate stress. These benefits were not only linked to participants' social engagement, but also to their role of helping others (Rietschlin, 1998).

Another study followed the well-being of older adults in relationship to volunteering with organizations in their community (Morrow-Howell, Hinterlong, Rozario, & Tang, 2003). They used three well-being indicators: self-rated health, functional dependency, and depression. Their findings suggest that volunteering positively affects well-being in late-life. The level to which volunteers perceived that their actions benefitted others did not affect their well-being outcomes, raising the

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question of whether or not the volunteers benefitted from their experience of engaging in altruistic acts, or if there were other factors that improved their well-being outcomes such as the level of social interaction or sense of belonging they enjoyed as part of the volunteer experience. The study briefly mentioned that volunteerism for older adults not only benefitted the individuals, but the greater society as well (Morrow-Howell, Hinterlong, Rozario, & Tang, 2003).

In addition to participating in volunteer opportunities and organizations, acts of generosity can serve to connect people to each other. A study done by Massey, Kranenburg, Zuidema, Hak, Erdman, Hilhorst and Weimar (2010) measured the psychological outcomes for people who donated one of their kidneys anonymously to a stranger. About half of the participants reported having some history of mental health concerns prior to donation such as depression, bulimia, and alcoholism. The researchers found that donors' level of psychological distress was unaffected by the donation process. However, participants reported a very positive impact on their physical and mental well-being and an increase in interpersonal sensitivity for some (Massey, et.al, 2010). This somewhat extreme example of an act of altruism demonstrates the therapeutic implications of generosity.

Cautions in general applications. Studies finding no benefit to altruistic activities were absent from the literature perhaps due in part to publication biases, given that null findings are not likely to get published. Due to this lack of research, theories of social psychology can shed some light on potential cautions regarding the impacts of altruism. Batson (1998) explains that altruism may lead to strengthening a sense of collectivism and feelings of loyalty and group pride, as well as patriotism, and even

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ethnocentrism. Altruistic involvement could also intensify a person's previous feelings of moral offense or outrage, guilt, and shame (Batson, 1998).

Application within vulnerable populations. Although altruistic acts seem to benefit people regardless of their circumstances, they may have a particular purpose for people who are experiencing psychological distress. Post (2005) proposes that altruistic acts prompt people to think of others and can cast out the fear and anxiety that come from a preoccupation with one's self. For those struggling with self-esteem or depression, altruistic acts can reinforce and maintain their positive self-images or personal ideals, as well as help to fulfill their own personal needs (Omoto & Snyder, 1995).

Post-traumatic growth. Researchers who have explored the phenomenon of posttraumatic growth provide insight into the ways helping others creates positive consequences for clients with a trauma history. For example, helping others can increase coping, provide meaning, and thereby foster healing (Vollhardt & Staub, 2011). Mollica (2006) describes altruism alongside work and spirituality as major components of any trauma recovery program that can also be relevant within individual therapeutic work. He describes altruism's place in the self-healing process: "Altruism as a behavior enhances the healing of traumatized persons, because everyone has someone who needs them and can profit from their help, no matter how difficult their own situation" (Mollica, 2006, p. 165). He explains that participating in acts of altruism can help victims of genocide, torture, and abuse to build new lives even if they have very little to give.

Herman (1992) explains that some survivors of trauma discover that they can transform the meaning of their personal tragedy by making it the basis for social action in their community. She says, "while there is no way to compensate for an atrocity, there is

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a way to transcend it, by making it a gift to others” (Herman, 1992, p. 207). She describes participating in altruism as a way for people to have a shared purpose with others who have also survived trauma, and to participate in their own healing: “In taking care of others, survivors feel recognized, loved, and cared for themselves” (Herman, 1992, p. 209). This sentiment is shared by Mollica (2006) who writes, “Altruistic behavior is a form of mirroring: I find you in my pain and joy and you find me in your pain and joy (p. 167).

Empowerment. Vollhardt and Staub (2011) explore “altruism born of suffering,” when individuals appear to be motivated by their own adverse experiences to help others and prevent further suffering. The authors present this phenomenon as an empowering view of the role of victims in society (Vollhardt & Staub, 2011). They also see “altruism born of suffering” as a way that disadvantaged members of society can contribute to social justice (Vollhardt & Staub, 2011). Although Vollhardt and Staub (2011) propose that facilitating “altruism born of suffering” could be an important therapeutic element for individuals who have suffered, they do not explore how clinical social workers could be a part of this process.

Vollhardt and Staub (2011) caution that some people who are in a vulnerable position or who have been traumatized may be so absorbed by their own suffering that they are unable to perceive or empathize with the suffering of others. They also point out that individuals who experience adversity such as poverty or violence may not have certain material resources necessary to help others.

Perspectives on Altruism in the Clinical Sphere

Integrating egoism and altruism. Although I have primarily focused on the

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ways altruistic acts impact individuals; an individual's family, friends, and surrounding community naturally receive the impact of the altruistic acts as well. Discussing implications of altruism in a person's life separate from discussing the implications for the greater community may be creating a false dichotomy. In the clinical sphere, some clinicians are starting to orient themselves away from the clear distinction between the individual and the individual's community in the focus of their work.

Some practitioners advocate for movement away from the traditional egoistic framework of clinical work, one in which the singular focus is to further the individual client's well-being (Tjeltveit, 1999). Canale (1990) suggests that having an other-directed perspective in psychotherapy is as therapeutic for clients as having a self-centered orientation:

This other-directed focus can help free us from the motives and drives (greed, envy, lust, hatred, and revenge) that compel us to act in maladjusted and pathological ways, and can reduce the unnecessary fears and anxieties we often create for ourselves by clinging to self-centered and vindictive mindsets (p. 301).

He claims that altruism and forgiveness are untapped therapeutic resources due to their religious associations.

Doherty (1995) criticizes psychotherapy's overemphasis on individual self-interest and calls for a sense of moral responsibility in therapy. He proposes that psychotherapy should connect the "private good and the public good." He explains, "We are like fish in the ocean: our personal well being is tied inexorably to our natural and social environment" (Doherty, 1995, p. 100). From his perspective, self-interest and the

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common good are not mutually exclusive, but rather, self-interest can be “embraced and transcended in an ethic of the common good” (Doherty, 1995, p. 100).

Similarly, Newdom and Sachs (1999) call for the integration of clinical work and social action. They demonstrate that all clinical practice is political and they examine new practice paradigms that encourage clinicians to engage with social change at the individual, agency, and social policy levels (Newdom & Sachs, 1999). These authors provide frameworks and theoretical orientations to guide clinicians in bridging the gap between egoism and altruism.

Mutual Aid. Notably, the healing modality that perhaps embraces altruism and the “helper” therapy principle the most is not led by clinicians, but by consumers and peers. Mutual aid groups such as support groups and Alcoholic’s Anonymous operate with the understanding that supporting others in the group is an essential part of participants’ therapeutic process (Zemore, 2007). Zemore (2007) suggests that people benefit the most by helping others who are in a similar situation; the process of persuading and encouraging others can effectively help people persuade and encourage themselves. Roberts, Salem, Rappapon, Toro, Luke, & Seidman (1999) demonstrate that mutual aid group members providing support or advice to others in the group predicted improvements in psychosocial adjustment. They suggest that, in addition to giving and receiving help, participants benefitted from being a part of a caring, social community (Roberts *et al.*, 1999).

Clinical social workers have an important role in referring clients to mutual aid groups and promoting the “helper” therapy principle in therapy groups. However, within the realm of work with individual clients, there seems to be a lack of established practices

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regarding altruism. Several clinical practices are related to the phenomenon of altruism in clinical social work and provide a background for this study.

Clinical practices related to altruism. Gilbert (2011) explains that if clients are not able to experience feelings of reassurance, compassion, and kindness, their therapy will have a limited impact. Some individual psychotherapists have adopted Compassion Based Therapy as a way to encourage clients to feel compassion for themselves as they engage with their healing process and move towards personal growth (Gilbert, 2014). Although this technique supports clients tolerating distress and being less critical of themselves and others—elements that are aligned with altruism—it does not propose that clinical work foster acts of compassion beyond one’s self, the interest of this research project.

As mindfulness has become integrated into the field of social work (Boone, 2014), clinicians are proposing techniques that draw from Buddhist spiritual practices such as meditation. Fredrickson, Cohn, Coffey, Pek, & Finkel (2008) demonstrate that doing loving-kindness meditation can enhance a wide range of positive emotions in varied situations, especially when interacting with others. This intervention, although it may have indirect effects on the ways clients relate to others, also primarily enhances the client’s individual experience.

Insights from Objects Relations Theory

Object relations theory provides a helpful framework in understanding both the reason a person may or may not be inclined toward concern for other people’s welfare and the role of altruism in clinical social work.

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Self in relation to the object. Batson (1998) proposes that altruistic leaning stems from varying degrees of one's relationship to objects, or people in their life:

Concern for another's welfare may be a product of 1. a sense of we-ness based on cognitive unit formation or identification with the other, 2. the self expanding to incorporate the other, 3. the self-other distinction remaining and perhaps even intensifying, 4. the self being re-defined at the group level, where me and thee become interchangeable parts of a self that is we or 5. the self dissolving in devotion to something outside itself, whether another person, group, or a principle (p. 306).

This understanding warns that perhaps not all people would benefit by engaging in helping others, for example, those who tend to lose their sense of self in relationships with others. Ekstein (1972) agreed with this conceptualization and clarified the circumstances in which a person may be able to engage in altruism in a balanced manner:

It seems to me that true altruistic feelings based on genuine sympathy will reach a mature level only if the altruistic person is capable of avoiding over-identification which is identical with the loss of self, and is able to maintain helpfulness based on difference rather than fusion (p. 80).

This framework regarding a person's sense of self in relationship to objects in their life could be helpful in guiding the exploration of altruism as a clinical tool.

Development of altruism and clinical implications. Sharabany (1984) writes that objects in one's life assist in the development of altruism throughout the life span, beginning with very early psychic structures. By receiving adequate cycles of both frustration and satisfaction from objects, individuals gain awareness of their own needs as

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well as the needs of others. In this process, they cultivate empathic understanding, sympathy, and altruism (Ekstein, 1972).

Given that clinical social workers serve as objects in clients' lives, they could potentially have some role in the development of altruism. Especially if clinicians are seeking to emulate Winnicott's "good enough mother" (Weich, 1990), then perhaps they have a role in developing clients' capacity for altruism as a function of object relations development (Sharabany, 1984).

Summary

Taken together, this literature suggests that participating in altruistic acts has significant therapeutic potential for individuals and their communities. However, I have yet to find empirical studies that explore the ways that clinical social workers engage with their individual clients around altruism or the implications of altruism as a clinical tool. It seems that altruism is embedded into a variety of current practices but it has rarely been considered as an independent element in clinical intervention or formulation. Given the lack of research regarding this phenomenon, evidence identifying altruism's effectiveness as a therapeutic tool or parameters around its use as a tool are not present in the literature. Interviewing clinical social workers about this matter is a way to begin to understand the current perspectives and experiences regarding altruism in clinical social work. This study seeks to illuminate the reasons why there is such a gap in the literature and why this phenomenon has not yet been studied in the context of clinical social work.

CHAPTER III

Methodology

Formulation

This study is an exploratory investigation into the phenomenon of altruism in the context of clinical social work. For the purpose of this study, altruism is defined as the principle of unselfish concern for others (Batson, Ahmad, & Lishner, 2009). Altruistic acts are defined as actions that benefit the welfare of others (Tankersley, Stowe, & Huettel, 2007). The purpose of the study is to explore the perceptions of clinical social workers in promoting altruism as a part of their clinical practice, specifically with individual clients. The findings of the study intend to shed light on the role of altruism in clinical social work practice, inform clinicians and educators, and introduce topics for future research.

This study addresses two primary research questions:

1. What are the experiences of clinical social workers regarding altruistic interventions with their individual clients?
2. What are clinical social workers' perspectives on clients' involvement in altruistic acts in relationship to the therapeutic process?

These research questions pertain to a specific topic area that has had limited previous investigation. In order to begin exploring the phenomenon of altruism in the context of clinical social work, I chose qualitative methods to collect a wealth of descriptive responses from participants (Engel & Schutt, 2013). I interviewed 13 clinical social workers, using a semi-structured interview guide (*See Appendix C*). The open-

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ended nature of the questions sought to control for the researcher's bias and to give participants freedom in responding as they saw fit. I first piloted my interview questions with peers and my research advisor to ensure that the questions were relevant to my research questions, and that the ordering and word choice within the questions minimized cognitive burden and confusion.

Sample

Because the study aims to begin an exploration of altruism in a therapeutic context, I conducted interviews with a general sample of professionals who work within therapeutic contexts: licensed clinical social workers. In order to be included in the study, eligibility criteria required that participants be licensed clinical social workers who are currently practicing with individual clients. By limiting the participants to clinical social workers, the findings of the study inform the field of clinical social work specifically, but may not extend to informing other professions such as psychology or marriage and family therapy. The selection criteria required that participants were currently practicing to ensure that they were both actively engaged in the clinical social work context and that they drew from current experiences with individual clients. The requirement for licensure created a standard of experience and knowledge base within the participant pool. Because interventions associated with altruism are not established as practices in the field of clinical social work, the study did not require that participants had had any particular experiences regarding altruism in their work with clients.

I did not specify any particular demographic characteristic within the selection criteria, but in selecting participants, I aspired for some variation in participants' age, gender, racial identity, religious and spiritual affiliation, class background, and

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professional experience and expertise. Given the small number of participants, it was not possible to investigate in-depth how these demographic characteristics might influence perspectives of altruism in clinical social work practice. However, participants discussed personal experiences and beliefs related to altruism that were tied to aspects of their identity.

Given the exploratory nature of the study, I used a non-probability and purposive sampling method (Engel & Schutt, 2013). I introduced the study on Facebook and encouraged Facebook “friends” to pass on the information to people they knew who might be interested. I emailed my personal and professional contacts who had interest or knew of other potential candidates for the study. All promotional messages included the eligibility criteria for this study. Per the thesis guidelines, I did not actively recruit members of the Smith College School for Social Work community (i.e. fellow students, alumna, or faculty).

Data Collection

As people showed interest in participating in the study and I confirmed that they met the selection criteria, I sent them an informed consent document that further described the nature of the study, the risks and benefits of participating, and the confidentiality guidelines (*See Appendix A*). After receiving their signed consent, I sent them a demographic questionnaire (*See Appendix B*) to gather preliminary data regarding the participants’ demographic information and professional experience. This questionnaire, based on a survey created by the National Association of Social Workers and the Center for Health Workforce Studies at the University of Albany (CHWS & NASW, 2006), allowed me to report on the diversity of the sample, to look for trends

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within demographic characteristics, and to compare the characteristics of this sample with national data.

Interview guide and measures. I employed a semi-structured interview guide (*See Appendix C*) to use with participants. In the guide, I started by asking participants about their definition of altruism, then stated my definition and asked about discrepancies between the two definitions. Then, I asked more about the participant's perspectives on altruism within the context of clinical social work and the idea of promoting altruism in clinical practice. The questions fit into the following domains: 1) understanding and background regarding altruism in the context of clinical social work, (2) promotion of altruistic activities, (3) perceived impact of altruistic activities, and (4) motivation to engage in altruistic activities and limitations in doing so.

Interview procedures. After receiving the completed questionnaire, I arranged a time for the interview with each person. I interviewed six participants over the phone and seven participants in person, using an audio recorder to capture their responses. Each interview lasted between 45 minutes to an hour. I chose to do semi-structured interviews in order to provide general guidance for participants, but also to allow them to speak freely about the topic areas that were of interest. Because of this format, I was able to probe for respondents' understanding and ask for clarity about their responses (Engel & Schutt, 2013).

Consistent with standards in qualitative research, I completed memos to record my reflections immediately following the interviews. Capturing these initial impressions assisted me in staying true to the participants' experiences and perspectives in the process

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of analysis. I listened to the digital recordings throughout my analysis and transcribed the recordings.

Ethical Considerations

To protect the confidentiality of the participants, I assigned each participant a code number, which I placed on all materials. I stored the transcribed data and the database with responses from the demographic questionnaire in a password-protected file, separate from participants' names and contact information, completed demographic questionnaires, and informed consent documents. All research materials will be stored in a secure location for three years according to federal regulations. In the event that materials are needed beyond this period, they will be kept secured until no longer needed, and then destroyed. All electronically stored data will be password protected during the storage period.

Although there was little foreseeable risk in participating in the study, clinicians I interviewed may have felt some discomfort talking about their personal and professional experiences. However, discomfort was not evident from my perspective; participants spoke freely in response to my questions. The interviews transpired without any interruptions; I did not need to stop the recordings at any point. During the interviews, I tried to communicate curiosity and interest in participants' responses. I tried to maintain a neutral tone while asking the questions, in spite of my bias that I see great potential in healing through participation in altruistic activities.

Data Analysis

In analyzing the data, I considered my research objective (and bias connected to this objective): to investigate clinical social workers' perspectives on altruism in

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individual clients' therapeutic work. Reading through the interviews, I identified patterns in the data and developed a codebook in order to establish themes across different participants' narratives. I employed both *a priori* and structural codes based on my interview guide and I also developed inductive codes that emerged from the data. Because I was not seeking to prove a hypothesis, but rather explore a phenomenon, themes emerged through both coding strategies. I constantly compared newly collected data to support reliability, validity, and reflexivity (Engel, & Schutt, 2013). As I came to conclusions in my analysis, I sought out evidence that negated my theories about the phenomenon. I used peer debriefing as a way of legitimizing my findings and monitoring my bias in the study (Engel & Schutt, 2013).

Data presentation.

In the Findings chapter, I present descriptive statistics for the quantitative data gathered from the Demographic Questionnaires. Then, I provide the qualitative narratives from the interviews, using participants' words to illustrate the themes that emerged across the data. To demonstrate the extent to which a theme is shared by respondents, I present the frequency of concepts across participants. Even if concepts emerged from only one participant, I do present these quotations to demonstrate the range of perspectives regarding a specific thematic area. When discussing the findings, "all" refers to all 13 participants, "most" refers to 9-12 participants, "some" refers to 5-8 participants, and "several" refers to 3-4 participants.

CHAPTER IV

Findings

Introduction

This chapter will present data collected from the interviews that relate to the research objective: to further the understanding of clinical social workers' perspectives on the role of altruism in therapeutic work with their clients. To begin, I will present the demographic information that the participants submitted through their Demographic Questionnaire. I will then highlight the themes that emerged in the study, beginning with the understanding of the phenomenon of altruism, continuing with perceptions of altruism in the clinical practice context, altruism's connection to the therapeutic process, the impacts of engaging in altruistic acts, both positive and negative, and finally, factors that prevent people from engaging in altruistic acts with particular attention given to the experience of depression. I will end the chapter discussing the limitations of this study. As noted in the previous chapter describing study methods, "all" will refer to all 13 participants, "most" will refer to 9-12 participants, "some" will refer to 5-8 participants, and "several" will refer to 3-4 participants.

Demographic Characteristics of Participants

Table 1 contains the demographic information of all 13 participants. All participants confirmed that they are licensed clinical social workers and that they are working with individual clients. I have omitted the participants' zip code information to maintain participants' confidentiality.

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Table 1. Demographic Characteristics of Participants

Characteristic	Clinical Social Workers (n=13)	%
Age		
26-34	2	15.40%
35-44	3	23%
45-54	3	23%
55-64	1	7.70%
65 & over	4	30.80%
Gender		
Female	9	69%
Female, cis	1	7.70%
Male	3	23%
<i>Female combined: n=10, 77%</i>		
Race and Ethnicity		
Caucasian	5	38.50%
White	5	38.50%
White, Irish	1	7.70%
Latino	1	7.70%
No Response	1	7.70%
<i>Caucasian, White, and Irish combined: n=11, 85%</i>		
Class		
Middle Class	8	61.50%
Middle - Upper Middle Class	1	7.70%
No Response	4	30.80%
Religion		
United Church of Christ (UCC)	2	15.40%
Christian	1	7.70%
Loosely Christian	1	7.70%
Catholic	1	7.70%
Non-practicing Catholic	1	7.70%
Unitarian Universalist	1	7.70%
Jewish	2	15.40%
Buddhist	2	15.40%
None	1	7.70%
No Response	1	7.70%
<i>Christian affiliated^a</i>	6	46.20%
Years Practicing		
1-2	2	15.40%
8-11	3	23%
14-15	2	15.40%
25-27	3	23%
35-41	2	15.40%
55	1	7.75

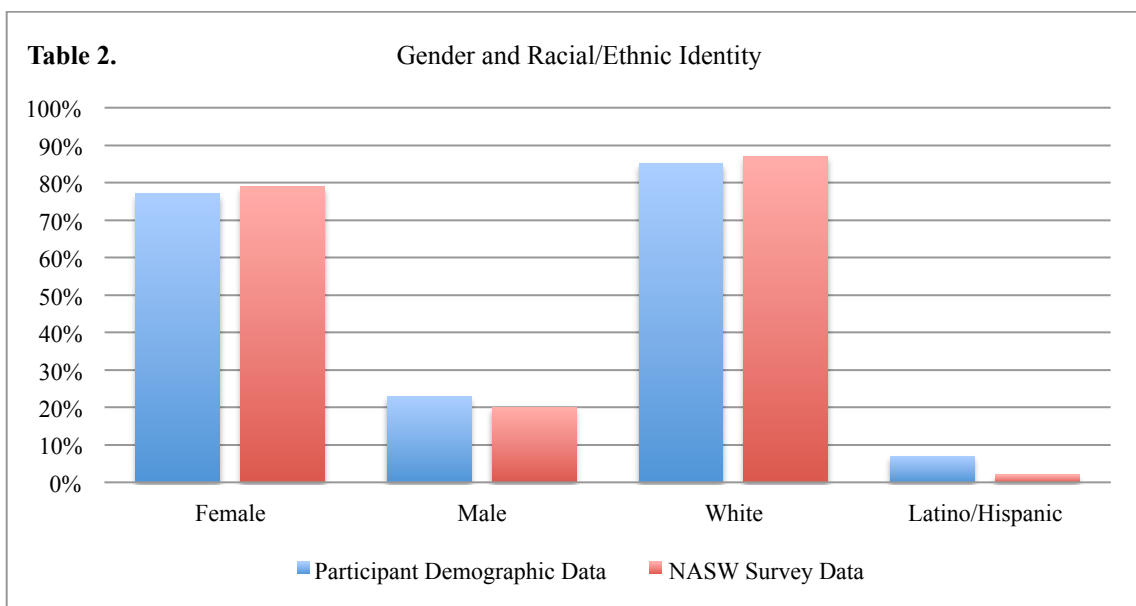
^aCombined the following religious affiliations: United Church of Christ (UCC), Christian, Loosely Christian, Catholic, Non-practicing Catholic

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Four participants described their primary work sector as private not-for-profit, and eight described their primary work sector as private for-profit. Practice areas varied from private practice to community mental health agencies and residential programs.

Participants work with different age groups. Some work with couples, families, groups, and communities as well as individuals.

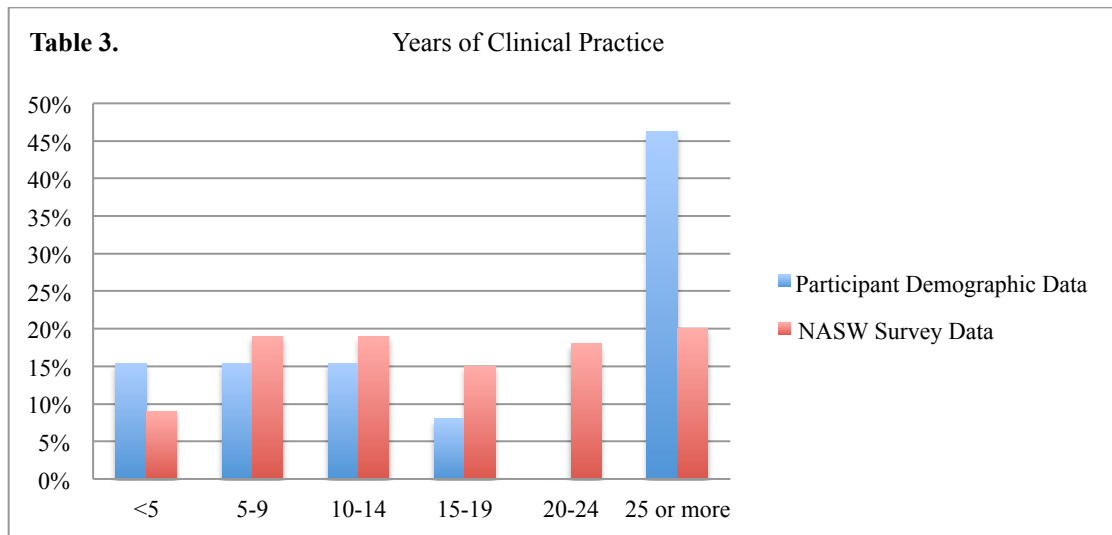
Although this sample does not include much variation in racial and class identities, it does represent voices from varied ages, professional experiences, and religious and spiritual affiliations. Several of the demographic figures may be similar to the demographics of social workers nation-wide. The Practice Research Network collected demographic information from 1,560 regular members of the National Association of Social Workers in 2002 (NASW, 2003). Although their study only captures NASW members, it provides data from a much larger cross-section of social workers with which to compare the data from this study. The following charts show the similarities in the data. (See Tables 2 and 3.)



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This study reflects trends shown in the larger pool of social workers in the NASW survey, showing how the field is dominated by females and White people. This study is lacking a representation of men and People of Color, but is adequately mirroring the current demographics in the field of social work, as represented by the NASW members' demographics.

The following chart (*See Table 3.*) demonstrates some similarities in years of clinical practice between this study and the NASW data.



This study did not have any participants who have been practicing between 20-24 years. The other noticeable difference is that this study has a much higher percentage of participants who have been practicing for more than 25 years. Although the median age for both groups was the same, 50 years old, this study's largest group was those clinicians who have been practicing for more than 25 years. Because of the many years of experience from participants, this sample has a depth of perspectives and examples from many seasoned professionals.

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As this study is qualitative in nature, the goal of these comparisons is not to suggest representativeness or to generalize to the larger population (Engel and Schutt, 2013). Rather, these comparisons are drawn to be responsive to potential concerns regarding the purposive sampling approach I used in recruiting for the study. While the sample does not represent the heterogeneity of perspectives in social work practice, these comparisons suggest that demographic characteristics are somewhat aligned with those characteristics of the social work practitioners nationally.

Primary Themes

The following major themes emerged from data collected from the 13 interviews with clinical social workers.

Understanding the concept of altruism. All of the participants identified that the definition for altruism provided as part of the interview guide was consistent with their understanding of the word: the principle of unselfish concern for others. However, further conversation about altruism demonstrated that several participants were not settled with the meaning of altruism either in general or in the context of their work. One clinician said, “It feels kind of complicated to me, a bit abstract.” Although another clinician agreed with the definition of altruism, she then questioned the discourse around the principle and described how it reflects aspects of the mainstream North American culture:

I think doing things that are for other people are also for us because of the ways that we are connected to each other...Altruism isn't really getting the connection part...I think the word itself and the way it is used speaks a little bit to our cultural framework that separates our common good...I think that we in this

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culture work in this dichotomy: you're selfish or you're unselfish. Unselfish is when you really take other people into account or give to other people. But I think that caring for ourselves and caring for other people can be a part of a whole that's on somewhat of a different level.

Understanding this either/or mentality and the limitations of the language associated with the concept of altruism will be relevant throughout the discussion of the research findings.

The egoism vs. altruism dichotomy. In describing their perspectives on altruism in their clinical practice, participants alluded to various understandings about the intended focus of their clinical work. Several participants described that their work primarily focused on benefitting their individual clients. It is unclear whether or not any of the clinicians felt that the presence of altruism in the therapeutic process would undermine an egoistic framework or their interest in the individual's well-being. They did not comment about whether the attention on the *other* was taking away from the attention on the *self*. It was clear, however, that some participants were open to integrating the focus on the self and the focus on the other in the therapeutic process. Several valued the "interconnectedness" of individuals' healing process and the greater world's healing process. This integration seemed to be manifested in clinicians' own work, support of their clients' work, or collaboration in the following areas: one-on-one conversations, cultivating groups, building connections and networks of support, community organizing and advocacy, political activism, and responding to oppression such as racism, and stigma toward people with mental illness.

Summary. Altruism seems to be a complex principle that may provide an inadequate description of human interactions. It may illicit language about a potentially

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false dichotomy between roles of being a giver and a receiver, being unselfish or selfish. Nevertheless, participants in the study were intrigued by the topic of altruism and it prompted a rich discussion.

Perceptions of altruism in clinical practice. Participants shared an array of perceptions of altruism in their clinical practice. The degree to which altruism was present in participants' practice with their clients varied significantly. Several clinicians described altruism as integral to their work, while others found it irrelevant. Most participants commented in some way how their style of practice or understanding of their clinical role influenced the ways altruism did and did not emerge in their work with clients.

Altruism in the clinical encounter. The heart of the interview was directed toward participants' understanding of altruism in the clinical encounter, specifically regarding clients' engagement in altruistic acts. The findings show a significant difference in the frequency of altruism emerging in the participants' clinical work. Three participants explained that altruism was not relevant in their practice: "I don't think about altruism in relation to my practice. It's not a framework that comes up." Another participant stated that altruism didn't arise as a motivation of clients, "I wouldn't say any of my clients is or has been interested in improving the social world or the environment." Seven other clinicians gave examples of times clients talked about participating in altruistic acts and how those experiences were connected to their therapeutic work, but they did not seem to consider altruism in the lives of their clients or as part of the therapeutic process on a regular basis.

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Three other participants did experience altruism as actively present in their clients' therapeutic process and in their conversations together. "It's a natural part [of the work], it evolves." This participant describes how the clinical work evolves and inspires altruism:

I'm looking at what will help you recover from whatever it is, or heal from whatever it is you are feeling wounded by or hurt by...What will help you achieve the goals you seek to achieve to make your life more fulfilling or meaningful? And then because I think altruism is central to the human condition, particularly for people who are taking care of themselves and others, it will almost always emerge, some kind of altruistic acts will be helpful to the person I'm working with.

He connects his own understanding of altruism being central to the human condition with the extent to which it emerges in his work with clients.

Understanding that altruism emerges to varying degrees within the participants' experiences brings up further questions about how it emerged, what role the clinician had in it emerging, and how the clinicians made sense of their role given their theoretical background.

Perceived role regarding altruism in the clinical encounter. In participants' discussion of their role, some of them used the terms "directive" and "non-directive" to describe their style of working with their clients. Although these terms were not defined within the interview guide, I will operationalize them for the purposes of this analysis and the development of a theoretical framework. The term "directive" will refer to a style that uses the following actions as a way to encourage clients to change the way they

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think, feel, or act: giving explanation, suggestion, or advice; expressing agreement or disagreement, urging, and expressing approval or disapproval. “Non-directive” will refer to a style that does not encourage clients to change the way they think, feel, or act.

Theoretical orientations that correspond with a directive style include but are not limited to behavioral, cognitive behavioral, and solution-oriented clinical practice approaches.

Theoretical orientations that correspond with a non-directive style include but are not limited to person-centered, and psychodynamic approaches (Sommers-Flanagan, & Sommers-Flanagan, 2009). I will use the terms “less directive” and “more directive” because I am only drawing from limited examples of clinicians’ role with their clients and the clinicians likely do not fit entirely into either category, directive or non-directive. This terminology seeks to demonstrate the spectrum of clinical styles.

Client-initiated and less directive. Most participants did not see it as their role to make suggestions to their clients about doing altruistic acts. Some described themselves as not having a directive style, rather wanting to take the clients’ lead. For example, one clinician said:

I wouldn't try to guide anyone toward volunteering or some sort of selfless service because it's a good thing to do. I don't want to put that value out there. I follow their lead...something about making the recommendation feels morally laden. It wouldn't feel authentic for me to guide someone down this path.

She described her perspective, in part, coming from her psychodynamic training: “Other therapists who are more directive or take on a more solution-oriented approach might handle it differently, but my style tends to be more psychodynamically oriented

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and so I'm not so directive in my interventions." This example emphasizes this distinction in therapeutic approaches relating to directiveness.

Client-initiated and more directive. Some clinicians felt comfortable initiating conversations about altruism. For example, one participant stated:

I don't think it's an overt intervention, because I am definitely of the mindset that I'm not here to give advice. It's more like bringing the concept into the room in a subtle way to ponder the subject [altruism] and how it might be beneficial.

Several clinicians described supporting their client's interest and involvement in altruistic acts once the client introduced the subject. One clinician explains his philosophy on altruism being appropriate when client-initiated:

There's an organic process. I'm not necessarily throwing ideas out at the person before they even come in with those things. It's not part of their treatment plan to give back to others. But if I see that within somebody, then of course, I'm going to build on that...I'm absolutely going to say, "Yeah, go for that! That sounds like that would be fulfilling, it would be satisfying."

Collaborative process. One participant described the topic of altruism emerging in the therapeutic encounter without clear initiative from client or clinician. This collaborative process seemed to be connected to his perspective on altruism, "I'm always seeing it as something that is part and parcel of a process of healing and human connection." He described asking clients questions stemming from a positive psychology framework such as:

What has helped them in the past? What have they appreciated? When have they felt cared for? And why was that helpful to them? What would make them feel

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more connected to other people? Or might help them feel better than they're feeling right now?

Although he is not using questions that are directly about altruism, his understanding of the importance of altruism in the therapeutic process comes through in the formulation of his questions.

Clinician-initiated and more directive. As compared to the prior group, others felt comfortable being more directive with their clients by stating the understood benefits of altruistic acts, or by asking questions about clients' interest in the area. For example, one clinician stated how he offered ideas and encouraged his clients toward helping others in the community:

I encourage my clients in slight ways...I don't have any expectations, I just offer the opportunity for helping others. I don't really have a plan or anything, it just comes out...I don't push people, I just ask the questions: "Would you consider going to help other people? Or do something with somebody in your family, or in your community?", "Do you think this would be helpful to you in your recovery?" And they say, "Yes!" And I give them more information and they say, "No!" and I drop it. But I'm always trying to encourage them to help other people as a way of recuperating or healing from their own wounds.

He also highlights that clients may have some enthusiasm as well as resistance to the idea of participating in altruistic acts. This may be due to the issue of timing which will be addressed later in this chapter.

Conceptual Framework. Although these differences in style and initiative may seem subtle in some ways, bringing light to the distinctions may further the

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understanding of altruism in the context of clinical social work. In this study, several participants encouraged their clients to engage in altruistic acts, but only one participant overtly advised his clients to act on behalf of other's welfare. The following diagram illustrates the range of the clinician's styles and approaches to altruism in their work that surfaced in this study. (See Figure 1.)

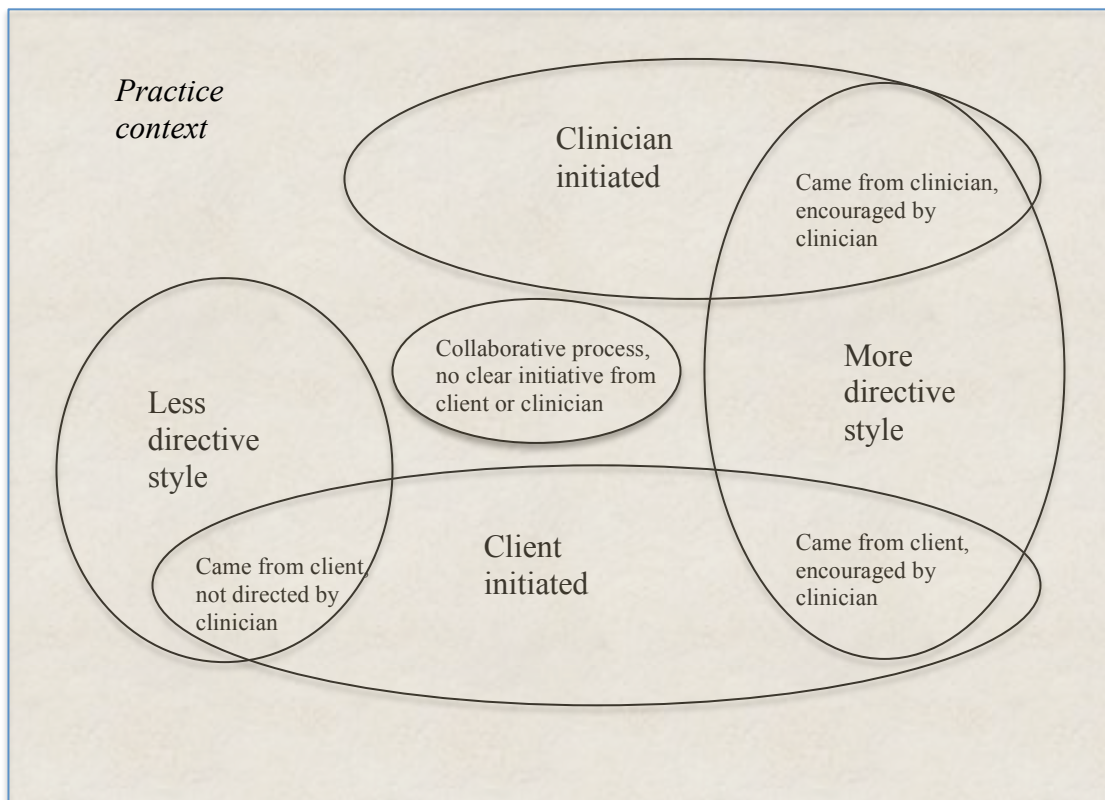


Figure 1. How altruism emerged in respondent accounts of the clinical encounter.

In Figure 1, I propose a theoretical framework to illustrate the different ways that altruism emerged in the therapeutic process across participants' experiences. "Practice Context" serves as the background for this framework, indicating that participants drew from their experiences in a wide variety of clinical social work settings. The foreground of the figure denotes variation in both areas of initiative (Clinician initiated and Client

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initiated) and clinician's style (Less directive style and More directive style). The "Collaborative process" is positioned in the center of the figure, due to its unique position between the client and the clinician's initiative. Given the small number of participants in the sample, this framework is presented as a heuristic to facilitate future research about how the orientation of clinicians and their clients might influence the use of altruism in clinical social work practice.

Figure 1 also demonstrates relationships between the factors of initiative and clinician directiveness. For those clinicians with a less directive style, if altruism emerged, it tended to emerge if the conversation was initiated by the client. For clinicians with a more directive style, altruism tended to emerge through either the client or the clinician's initiative. Participants' style as clinicians, and how they understood their role in the therapeutic relationship, combined with their clients' style and presenting concerns seem to shape the ways altruism emerged in the therapeutic encounter.

Those clinicians who were more direct about encouraging their clients to engage in altruistic acts did so in a variety of ways including encouraging them to get involved in faith-based groups, community organizations, or advocacy groups that were connected to their interests, joining 12-step groups and support groups, getting involved in the peer community, connecting with family members, and even talking to people they saw on the street. Clinicians who work in residential and community settings spoke about the immediate opportunities for their clients to connect with others around them. In these settings, being attuned to the needs of others and helping the greater community seemed to happen more naturally for clients given their context. For some of the clinicians

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working in a more traditional therapy context, examples of altruism in their clients' lives seemed to emerge less freely in the interview.

Summary. Many of the participants took moments during the interview to consider altruism in the context of their work. Several had thought deeply about it and for others it was a new idea. Overall, the interviews revealed that perceptions of altruism in clinical practice varied significantly amongst the group of clinicians. However, the conversation prompted them to comment on their understanding of their role as a clinician.

Making meaning of altruism in clients' therapeutic process. Participants expressed that altruism was related to their clients' therapeutic process in various ways. One participant summarized, "It's all part of the whole fabric of moving forward. If you are moving forward, if you are growing, I feel like altruism is often part of it." Some clinicians identified that "moving forward" included clients' healing and recovery process, and the evolution of their sense of self and identity. However, not all clinicians considered altruism as forward movement for their clients. One clinician made meaning of altruism in the therapeutic process by considering how clients' altruism fit into her clinical assessment and formulation of her clients' concerns.

Understanding altruism in the healing process. Some of the participants saw a clear connection between altruism and their clients' healing process. This clinician who has worked many years with clients who have mental illness, touches on the ways altruism can cultivate the development of self worth, an important aspect of healing:

It [altruism] is part of a healing process. Whether or not it's stated directly, it's helping them find a sense of worth. It feels to me like it's integral to their welfare.

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And integral to them understanding that while their mental illness has a place in their life, it is not their identity. If they happen to be an artist or a poet, it's not because they are mentally ill...it's because they have that gift. And they can use that gift. So they are more than the sum of their parts.

Others commented on the ways participating in altruistic acts can cause a shift for clients, particularly for those who have been consumers of mental health services and identify with the label of “patient” whether self-imposed or imposed by others. “When people are coming from a place of vulnerability and being on the end of the person receiving the support...to be on the opposite end, to be the one providing support to others in some way, it can be really balancing and healing.” This clinician highlights the value of role reversal in a client’s healing process.

Desired Outcomes. Some participants did not have particular treatment outcomes in mind regarding altruism in their clients’ lives while others expressed the desired outcomes of participating in altruistic acts. Examples of desired outcomes included: personal fulfillment, developing one’s character, learning to look beyond one’s self, building meaningful relationships, having new experiences, outlooks and perspectives, improvement in one’s mood and getting “unstuck.” One participant shared her hopes for her clients: “I would want everybody to have that kind of joy. To take those kinds of risks—because sometimes it's a risk to be altruistic, particularly if it's about advocacy in the face of prejudice.”

Personal and global healing. Another participant commented that he desired a helpful outcome not only for his client, but also for the greater community. This connection between an individual’s participation in altruistic acts and the impact on the

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greater community did not emerge often throughout the interviews. However, the following statement expresses one participant's understanding of altruism's role as both integral to the clinical encounter as well as in the world:

We have lots of different drives, aspects to being human, but two major ones are aggression and altruism. And so we know that aggression has been with human beings throughout history, and we know that we are all capable of it. And I feel the same way about altruism. Altruism is like the antidote; it's what connects us to other people. When we are being selfless, or we are being other-directed, embracing empathically other people. And so I feel like the more we can stimulate a sense of altruism, the less the aggressive side of human nature manifests itself. It leads us to lead better lives, have better life societies....it's probably how we've made progress in the world, the altruistic side of human behavior has helped us to rise above the aggressive side.

This participant provides an example of the aforementioned integration of egoism and altruism.

Understanding altruism in clinical formulations. Several participants were clear that choosing to be altruistic ought not be interpreted as an inherently positive part of someone's healing process. Instead, they described approaching the topic of a client's involvement in altruistic acts with curiosity. Altruism's connection to aggression came up with another clinician in this context. She was giving the example of one of her teenage clients who has been engaged in animal rights activism:

That's one way of managing your aggressive impulses...to in fact become very peace-loving and very kind. Bending over backwards. I'm just wondering when I

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hear her, how she's contending her own aggressive impulses...it's probably a very effective way through this concern for animals. I try to think of it as a defense. You can think of something as a defense and you can think of something conflict-free, that this is just an interesting choice and she feels strongly about it and it doesn't have any basis in her development. Maybe it's part of growing up these days, maybe it's something personal to her? I don't know.

This clinician demonstrates how she considers her client's involvement in altruistic acts in relationship to her ego functions, object relations, and other psychological development. Understanding her client's activism becomes part of her clinical formulation:

I listen with interest and I wonder why it's so important to her. And I wonder what is it about her that embraces this so fiercely. What makes her so concerned about animals and vulnerability? And what is it about her history and her present relationships with her parents...I don't know what the roots of it are for her. I'm not taking it at face value; I'm wondering why she's so fierce about this.

Rather than deeming altruistic tendencies as helpful to the therapeutic process as other participants had, this clinician considers her client's altruism as a reflection of the client's life experiences, relationships, and mental status.

Summary. These clinicians have made meaning out of altruism in clients' therapeutic process in various ways. Some clinicians understood it primarily to be helpful to clients in their healing process. They mentioned ways that altruism helped clients in their recovery, personal development, and identity formation. A few clinicians mentioned altruism in the clinical sphere having an impact on the greater community.

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Finally, one clinician described the potential in considering a client's relationship to altruism as part of the clinical formulation process.

Altruism as a clinical tool. In addition to asking participants about their general understanding of altruism in clinical work, this study prompted participants to discuss the possibility of employing altruism as an intervention or a clinical tool. Among those who experienced altruism emerge in their practice, some felt comfortable categorizing altruism as an intervention. One participant specified, "'Intervention' is a very subjective term and it is socially constructed in different ways." She did feel comfortable "stretching" the word, intervention, to include altruistic acts. Whether or not participants used this term, some discussed their understanding of altruism's use as a clinical tool and the circumstances in which participating in altruistic acts could be helpful to their clients. Participants also described circumstances in which using altruism as a clinical tool would be contraindicative to the therapeutic work.

Context regarding altruism as a clinical tool. Participants described circumstances in which participating in altruistic acts could be relevant to clients' therapeutic process: "when someone feels hopeless and bored and is open to giving to others and to the world," and "when a client has empty time, is disconnected from others, or feels stuck."

Several participants discussed the importance of considering how altruism fits into their clients' treatment goals. One participant clearly defined the parameters of altruism as a clinical tool in this way: "When it's part of a clinical plan, then it's appropriate." Another participant who works with children and families explained that participating in altruistic acts could be appropriate "whenever one of the goals is building

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strong attachment.” She continued to say, “You could really tie it into anything, including working on self-esteem, self worth, depression or any kind of mood disorder.”

Another participant explained the importance of reflecting on her clients’ perspective and background when considering altruism as an intervention. “I think you have to know a lot about the person you're working with and know about their values. I would want to be very careful that it wasn't me putting my values on them.” She thinks when clinicians are considering using altruism as a clinical tool that they should explain to their clients how participating in altruistic acts could be beneficial in their healing or growth.

Caution regarding altruism as a clinical tool. Several participants expressed caution regarding altruism’s use as a clinical tool. One participant explained when to refrain from using altruism as a clinical tool based on the extent clients are getting their needs met:

If you have a client who feels that their needs have been ignored, and they're coming in to you and one of the things you start saying is, “What about going out and helping others?” and they are saying, “You're not hearing me and I haven't gotten any of my needs met and you're trying to tell me—you're not here to talk about my needs? You want me to think of somebody else's needs?” If their life story was that they were forced to think of somebody else's needs, and their needs never got attuned to, I think it's counterintuitive to therapy to do an intervention at that point in time. It would be a further extension of “my needs are not the ones that matter, others are” and that is not therapeutic.

This clinician contributes that not only should clinicians consider how altruism could

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play a part in a client's treatment plan, and reflect on the client's values regarding altruism as others have mentioned, but that clinicians also ought to consider what kind of a message they are sending their clients when they discuss altruism within a clinical encounter. Although she is warning that clinicians should consider how clients negotiate their needs and other's needs, she eludes that using altruism as an intervention could be appropriate at some point with such a client. She goes on to say:

If clients feel that they are allowed to have needs of their own, that it's ok, and they are allowed to meet their own needs, and that reaching out to others is not at the expense of their own, then I think altruism would be wonderful. But if a person hasn't gotten there yet, I think you are continuing the cycle.

She warns how the clinician could become another object in a person's life who is not attuned to or supportive of the client's needs.

Timing and level of stability. Others cautioned that altruism may be more or less relevant to clients depending on circumstances in their lives. "Why would we not want to encourage people to give the things they have to give? The only answer is that in some way, this is not the time; this is a time that would be more detrimental than helpful." As illustrated by this participant, some respondents expressed that introducing altruism as a clinical tool is "all about the timing." Participants mentioned the following scenarios when altruism as a clinical tool would not be appropriate: when a client is in acute crisis, when a client feels very vulnerable, and when a client is emotionally or mentally unstable. Below, one respondent explains the need for stabilization prior to a recommendation for altruistic activities:

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If you've got someone who doesn't have a certain level of stabilization, sending them off to embark on something new, before they have their basic ability to ground, and regulate, I think is setting them up for negative experiences. Once you know them enough and you know they can handle new experiences, unpredictability, uncertainty, and things that may not fit their expectations and their hopes without getting triggered and sent over the edge, then it's time to go down this route.

This clinician echoes the importance of knowing clients well when considering altruism as an intervention. She goes on to say that clinicians ought to hold off on introducing new experiences to their client until the person has a “more stable and constant view of self...Transitions in and of themselves, for those who have a trauma history, can be triggering.”

In addition to stabilization, some clinicians named other indicators that altruism may be an appropriate intervention. For example, one participant identified signs that her clients were ready to participate in altruistic acts: “They developed new friendships, they had some kind of social grounding, gotten some kind of a job.” Another clinician felt that his clients needed to be sharing with him that they were increasing their social interaction before he felt they were ready to “make the next step”: “You have to be able to interact with others before you'll be altruistic.”

Specific conditions may also require careful consideration for the use of altruism as a clinical tool. For example, two participants discussed timing for their clients who have a history of substance use. “They need to be strong in their sobriety before they can go out and help other people. They've got to be in their recovery stage.” Both mentioned

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Alcoholic's Anonymous (AA) and other similar programs that teach service to others as an integral part of recovery. "They take everybody and everybody can contribute." One clinician commented on how one of his clients was proud of being of service to others, a value he ascribed to from being a part of AA. However, he continued to be in denial about his substance use and his focus on his altruism served as a distraction from his recovery. This circumstance shows the adverse affects of using altruism as a clinical tool at the inappropriate time.

Summary. Participants openly explored the idea of altruism as a clinical tool and gave a variety of input into the parameters of its use. Several clinicians thought altruism could be helpful in addressing a range of mental health concerns. Others cautioned about the importance of clinicians and clients attending to the client's needs sufficiently before attending to another's needs. Participants named level of socialization, sobriety, and readiness for new experiences as important aspects of stabilization that would need to be assessed before using altruism as a clinical tool.

Promise and peril of altruism as a therapeutic tool. Although the interview guide did not prompt participants specifically to share about how altruism has impacted them in their personal life, most participants commented on this in some way. For example, one person said, "It makes me feel more alive, and I benefit greatly from being engaged with acts of altruism." And another clinician said, "It's almost like you get a little shot of endorphins." Those participants who saw the therapeutic potential of altruism gave testaments to the significance it can have in people's lives.

Altruism can be a way to get unstuck and be able to really open your eyes a little bit and realize that there is a world out there and there is connection and that even

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when you may not feel at your best, you can somehow connect with others. I think if it's not a negative interaction, but a healthy interaction, it can be reparative, it can be restorative, and it can help get them outside of themselves from that stuck, depressed place.

For this participant, her spirited explanation seemed to come not only from witnessing altruism in her clients' lives, but also from her own personal experiences engaging in altruistic acts. In the data, there seems to be some overlap in participants' personal beliefs about altruism and its presence in their clinical work. However, the specifics of this relationship are not clear because not all participants spoke about their own personal experiences with altruism.

Impact on clients. However, as requested in the interview guide, participants spoke in depth about altruism in the lives of their clients. Most participants shared that their clients experienced some benefit from participating in altruistic acts. One participant described, "It broadens their horizons in all kinds of ways and introduces them to new social networks...It's contributing to their own evolution, growth, and empowerment." Another clinician explained that when her clients help others, they feel better about themselves as well as the world they are living in. In turn, "that decreases the sting of the stigma and the injustices that people are experiencing." Some participants commented on how they have observed altruism improving clients' mood and defending against the worsening of isolation, and despair.

Alleviating depression. Several participants shed light on the reasons they understand that altruism is so relevant to depression, a topic that came up often

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throughout the interviews. One clinician shared the progression of impacts altruism could have as a therapeutic tool:

Reaching out and focusing on others can be helpful as a distraction from the despair or the problems in your own life, a recognition that people are out there struggling, you're not in it on your own. And sometimes, even though we don't feel like we're in control and we don't have much to offer, we actually are and others are very appreciative of receiving some help from us. And that in and of itself can be a way to combat the exacerbation of depression.

Others commented on how participating in altruistic acts can help shift the focus away from what is exacerbating the client's depression and "keep the ball rolling" in therapy. Several participants made connections between altruism, compassion, and one's sense of self. They commented on how depression tends to cause people to turn inward and is often an experience of having low self-esteem and a decreased sense of self-worth and self-efficacy. Altruism conversely, causes people to turn outward. "When you help somebody else, it puts you in touch with something positive about yourself, or strength, there's something you have to give that maybe you forget when you are struggling with depression."

Several participants framed altruism as having the potential to provide clients with new opportunities to strengthen their sense of self and their purpose in the world.

When they give, something inside them says, "I am good." It's an authentic voice from inside them. And it establishes a groundwork for hope, for realizing that they are so much more than their mental illness. All of us are so much more than

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the things we have to deal with. So they get an insight into the core of who they are and it grounds them in a way that very few other things can ground them. The “authentic voice” the participant describes here may be referring to what Melanie Klein calls the “internal object.” This psychic entity is “part of the world lodged within” that “exerts a characteristic influence on the individual’s way of experiencing life, and crucially affects relationships with others” (Likierman, 2001, p. 110). Applying object relations theory to this example implies that the experience of giving for clients, and all people, may shape the internalized object toward an association with goodness. It is likely that people’s internalized object can be shaped in different ways by altruism, but there were no other such examples within the data.

Mutual aid. Several participants commented on the unique experience of clients participating in altruistic acts that connect them with others who have experienced similar hardship.

I've personally experienced and witnessed others getting more out of their acts of altruism that are somehow connected to the harder times that they've gone through themselves than acts of altruism that have nothing to do with it—but not to say there isn't value in both...If someone is providing support to you and they have some semblance of life experience that they can draw from that bring up, "ok, you get it." You didn't walk in my shoes and go through exactly what I went through, but we had similar enough experiences that I can trust on a gut level that you know what I'm talking about...that's just really meaningful to humans.

Several other participants agreed that participating in mutual aid is often the “most helpful” to the people they work with. By engaging with others who have had similar life

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experiences, they inherently have something to give: their story, their understanding, and their compassion. One participant explains why these exchanges are powerful:

Because then they both validate their own experience, and they become present to somebody else in an arena where that other person understands them. They can give to others in a community where they know that gift is going to be appreciated.

Participants mentioned various kinds of group involvement that facilitated this type of giving and receiving in clients' lives: support groups for survivors of natural disasters, AA and other 12 step groups, support and advocacy groups for people who have mental illness. The topic of altruism via participating in mutual aid came up in the context of clinicians talking about engaging in these kinds of groups with their individual therapy clients, or within the context of a residential or community setting. Most participants referenced mutual aid within some sort of structure or program, but one participant noted that it can also emerge between people without being a part of a group. One clinician specified that participating in altruistic acts is especially empowering to those clients who have endured trauma in that they can experience taking action, have a renewed sense of control, and help change other's lives by sharing their story of resilience. However, another clinician warned that for survivors of sexual abuse in particular, as well as others who have endured trauma, sharing about their experiences with others can "reawaken the experience" for them in a way that could be re-traumatizing.

Positive impact is not universal. In addition to discussing these benefits, most participants gave examples of situations in which participating in altruistic acts was not

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beneficial and could be potentially harmful for their clients. Several clinicians explained that participating in altruistic acts would not be therapeutic for clients who like to take care of others, and sometimes will take care of the others at the expense of her own needs. For clients with this leaning, the therapeutic work would explore the client's difficulty of being on the receiving end of help rather than encouraging them to continue giving to others. One clinician explained how many of her clients find themselves in helping roles with their families and coworkers. "It can be a very restrictive role for them. Sometimes the work [in therapy] involves helping them try to expand the kind of role they can have in their relationships."

One clinician gave the example of a client she works with who comes from an alcoholic family in which she took on the role of being the "good kid" among her siblings:

She attended to everyone's needs and prioritized other's needs above her own. She has been "successful" in the world with her job—she takes on things, she takes initiative, bosses love her; but it is really taking a toll on her. She is exhausted, depressed, anxious. It's hard for her to attend to her own needs. I think a lot of people struggle with that.

In this example, the client's altruistic tendencies have negatively impacted her mental health. Another participant gave an example of the way altruism could negatively impact the therapeutic process: "For some clients, the focus on others who are vulnerable has been more of a defense that prevents them from paying attention to themselves. It prevents them from working through their own stuff..." This example demonstrates some parameters around a more egoistic focus in the clinical work.

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Preventative factors. Participants gave a variety of examples of the limitations present in clients' lives, including factors associated with aspects of people's sociocultural location, that could prevent them from engaging in altruistic acts. Two participants mentioned the costs of volunteering such as spending money on transportation and spending valuable time: "If there's so much pressure on them to get a paid job, it can be hard to see that doing a volunteer job without a pay check would be worth their time." One participant mentioned the pressure clients can feel in the jobs they already have and feeling they need to "work all the time" in the capitalist economic system. Another participant named clients' immigration and documentation status as factors that could impact the accessibility of participating in altruism in an institutional setting. Others mentioned preventative factors such as poor health, addiction, developmental trauma, and severe mental illness. Cultural factors including clients' understanding of work, helping behavior, and gender roles were also mentioned. Several participants commented on how there could be any range of factors that prevent people from engaging in altruistic acts.

Fear and Vulnerability. However, several participants specifically connected altruism with the fear of experiencing vulnerability in one's self and in others: "Why would you want to make yourself more vulnerable? You've been through enough." Participants named various fears that clients have associated with participating in altruistic acts: "fear that what I think might be helpful will not be received as helpful," fear of something going wrong, and if so, a fear of retaliation. Participants explained that clients' comfort with being altruistic likely depends on how safe they experience the world, the nature of the relationships they have had and the kinds of traumas they have

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endured. One clinician who works with children who have a trauma history explained that for her clients, “a lot of times the fear originates at home.” She described their experiences:

Kids who have been traumatized don't want to be any more vulnerable than they already are. Because [when you are helping other people] you are...putting your heart out there and you could get rejected. They might think, “I am going to protect myself no matter what.”

In this example, although the fear of rejection may be preventing clients from participating in altruistic acts, it is also a factor that is important in their ability to maintain a sense of safety and protection, something that this clinician wants to honor in her work with her clients.

Preoccupation with the self and life stressors. Other participants also spoke about honoring their clients' therapeutic process and meeting them “where they are at” regarding their focus on self and focus on others. Participants described that clients were often “caught up in their own distress,” focusing on their pain and negative experiences or feeling like, “everyone else has abused me.” One participant could imagine her client saying, “I didn't get what I needed from the world, why should I give back?” In the following example, one clinician explains her understanding of how this type of preoccupation with one's own suffering can prevent clients from acting on behalf of other's welfare:

People don't engage in altruistic acts because sometimes people have a lot of problems and they can't even think beyond the moment. They don't even have the capacity to do anything but stew in their own juices. They can't even enjoy the

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beauty of a flower. They are too consumed with their own preoccupations and stress to do anything other than lick their wounds and try to calm themselves down.

The idea that people lack the capacity to consider others because of their internal issues and life stressors came up often in the interviews.

Depression. Some participants focused on the experience of depression as an internal issue (often related to environmental stressors) that can prevent clients from participating in altruistic acts. For example, one participant said, “It [altruism] requires that you engage in the world, engage with someone in a relationship. When you are quite depressed, you don’t want to engage with any one...it shuts you down. It’s hard to be open to relating at all.” Participants tended to connect depression with a focus on the self and altruism with a focus on others:

They have to get out of themselves, I guess [to participate in altruistic acts].

When somebody is self-absorbed, for whatever reason, like a severe depression, they’re very much in their heads, and they can’t even see around themselves. So how would you even want to reach out to others and give back to them? You might not even think you have anything to offer.

Participants expressed that depression is not only limiting in the ways it impacts people’s mood and energy level, but also in the profound ways it impacts the person’s sense of self. They explained that clients may not be able to focus on others or consider the ways they could be of help because of a profound experience of worthlessness; they may not be able to see themselves as agents of change, or as people who can be of service to others.

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Depression and access to the therapeutic qualities of altruism. As noted above in the section about the *Impact on clients*, participants commented on the ways altruism can prevent the exacerbation of depression, and improve one's mood, perspective on life, and self esteem. However, this section about preventative factors has also shown that some participants understand depression as a condition or experience that *prevents* people from engaging in altruistic acts due to having a low mood, lack of energy, low self esteem, and experiences of hopelessness. Thus, the data regarding depression in this study presents a paradox. As one participant aptly stated, "The problem is the solution, or the solution is the problem, they are very close to each other."

Summary. Participants responded that participating in altruistic acts could have both positive and negative impacts on clients' therapeutic processes. The use of altruism as a clinical tool seems to depend greatly on whether or not taking on a helping role benefits the client, and the degree to which clients are having their own needs met. Participants mentioned the importance of having access to groups and settings where clients could be of service to others who have had similar experiences. Particular attention was given to the experience of depression. Participants collectively identified that participating in altruistic acts can alleviate depression but that depression itself can also prevent people from being able to be altruistic.

Limitations

These findings have the potential to spark new conversations about altruism in the context of clinical social work, however, there are several limitations of the study to keep in mind. Limitations are present in the following areas: diversity within the demographics of the sample, perspective, researcher bias, and generalizability.

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Demographic diversity. Although I made an effort to ensure heterogeneity in the sample, the data reflect a limited sociocultural and geographic landscape. Due to my recruiting strategies, the participants are all in some way linked to someone I know, may share cultural affiliations, and may have participated in communities and organizations I have been a part of. Many of my personal and professional contacts share aspects of my identity as a young, White, European American, queer woman who has lived her whole life in the United States, coming from a Protestant Christian, upper-middle class background. Participants may share a set of biases particular to cultures and social networks within which I am connected.

Dominant cultural perspective. Although the sample reflected demographics of social workers nation-wide, the lack of representation of People of Color significantly limits the study. Although the 11 participants who identified as White or Caucasian do not represent a homogeneous perspective, given their many differences of life experiences as well as other demographic characteristics such as religious affiliation, they are all in some way participants in a dominant cultural perspective. Readers should keep in mind that the findings of this paper reflect a primarily dominant White perspective. Participants shared about many experiences working with clients from all kinds of racial and ethnic backgrounds. The one participant who identified as Latino described working with almost all Spanish-speaking clients, most of whom are Puerto Rican.

Researcher bias. My identity and life experiences shape my interest in the principle of altruism as well as my bias in the research process. For example, growing up within a United Methodist church community, and continuing to be active within progressive Christian circles has instilled in me the value of service. This cultural

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influence largely prompted my investigation into the topic of altruism and it also informs the meaning I assign to the concept. Because of my positive experiences giving and receiving acts of service, I have developed a bias that I had to keep in check throughout the research process. Other cultural influences that have influenced my understanding of altruism, my bias, and topics related to this thesis include: participating in mutual aid groups, working as a full-time volunteer, and living within a residential therapeutic community working alongside adults with mental illness. I may have explored topics more closely related to these experiences or “listened for” themes that resonate with my own experiences.

In the process of the interviews a few participants commented that I was “getting at” something. They were picking up my bias that was present perhaps in the questions themselves, or in the ways I asked the questions. By asking, “Have you ever considered proposing altruistic acts in your practice with your clients?” it is understandable that participants might have interpreted the question as somewhat of a suggestion. In the process of analyzing the data, I may have been looking for evidence that supported the benefits of altruism and searching for reasons altruism ought to be brought up “in the room.” However, I took steps to counter my researcher bias by taking memos after the interviews, and reviewing my code book with my peers and my research advisor. I have kept my own assumptions and preconceptions in mind while exploring the data and continued to return to the data to confirm if my conclusions were present in the findings.

Perspective. This study served as a way to start exploring the phenomenon of altruism in clinical work. Hearing clinicians’ perspectives served as the beginning of an exploratory process that will hopefully invite other perspectives in the future. Although

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hearing about clients' experiences through the lens of the clinician is valuable, it is inherently limited because it is a second-hand account that does not capture the unique voices of the clients themselves. It is somewhat ironic that this study is so one-sided in this way given that clinical work itself is not one-sided, but involves relationships and participation from both clinicians and clients.

Generalizability. The size of the sample limits the generalizability of these findings. Although one of my primary findings pertains to the clinician's role regarding altruism in the clinical encounter, and I was able to demonstrate a spectrum of understanding in this area based on the 13 participants responses, each person had his or her own understanding. There is much variation in experiences and perspectives on this topic. Further studies could reach more clinicians, accessing a greater amount of data that could better illustrate the approaches to altruism in the clinical sphere.

The sample reflected variation in practice modality, i.e. individual therapy, work with individuals in the context of a program, and work with individuals in the context of a community. The responses of the participants were appropriately influenced by the contexts in which they worked. The study did not specify that participants comment only on their work with individuals, so they also spoke about their experiences working with families, groups, and communities. This array of modalities within participants' experiences reflected the many ways in which clinical social workers practice and brought depth to the exploration of this topic. Consequently, this study does not represent any one modality, but rather a view into clinical social workers' experiences in general. The results of this study are not generalizable to a specific clinical context. More focused research could explore this phenomenon within a given practice modality.

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Summary. This study represents a predominantly White sample that in part reflects the researcher, but also the national demographic statistics of social workers. It also represents the dominant perspectives of providers and allows for clinicians to speak on behalf of their clients' experiences, which is potentially problematic. These factors as well as issues of researcher bias and generalizability constitute the limits of this study and inform directions for future research.

Conclusion

The 13 participants shared a range of responses regarding altruism in their clinical work. Some of the clinicians viewed participating in altruistic acts as a therapeutic intervention while others did not see altruism as a value to be discussed or proposed in their work with clients. Participants' responses seemed closely tied to how they perceived their role as a clinician. I developed a theoretical framework (*see Figure 1*) to illustrate connections between the clinician's level of directiveness and initiative around altruism within the clinician's practice contexts. The ways and degree in which altruism emerged varied significantly in the participants' experiences, bringing up questions for further study.

Although some of the participants spoke freely about the power that participating in altruistic acts can have, no one mentioned any type of guidelines specific to altruism in the therapeutic context; participants seemed to be guided by their own principles and use of clinical judgment. Participants discussed the importance of timing and stability regarding the use of altruism as a clinical tool, but did not agree about the appropriate circumstances or level of readiness necessary for using altruism as a tool with clients.

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Most clinicians mentioned the experience of depression at some point in the interview. Some brought it up as a limitation, a reason people would not be able to engage in altruistic acts, while others described altruism as an antidote for depression, that those who have depression would benefit from engaging in altruistic acts because it could alleviate their depression. This paradox, in addition to other topics, will be important areas for further exploration.

CHAPTER V

Discussion

Introduction

This study has shed some light on altruism and the field of social work by introducing the perspectives of clinical social workers and discussing the phenomenon of altruism as a therapeutic tool. It is unclear why this topic has not been previously explored, but participants generally found the ideas to be valuable to consider and to discuss. This study found that altruism can be a complex concept for some and that it may not be the best way to describe people's interconnectedness in the world.

This study suggests that the clinician's role regarding altruism in the clinical context is tied to therapeutic style and theoretical framework. This study contributed evidence that acts of altruism can be therapeutic, especially when clients engage in altruistic acts in which they can connect with others who have had similar struggles in life. The study also provided examples of how acts of altruism can be harmful when not initiated under the appropriate circumstances. Participants gave differing examples of such circumstances, but highlighted the importance of timing and having stability in one's life before engaging in altruistic acts. These findings lead to questions for further study, and implications for social work education, practice, and growth in the field in general.

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I will begin this Discussion with directions for new research that could bring greater breadth of perspective to the discussion about the use of altruism as a clinical tool and perhaps establish greater clarity regarding the findings of this study. I will then discuss research and practice implications for two of the main themes that emerged in this thesis: the use of altruism as a clinical tool and clinicians' understanding of their role regarding altruism in the clinical sphere. I will then conclude with my recommendations for clinical social workers to cultivate critical consciousness regarding altruism in their work and for the field of clinical social work to consider the limitations of the egoism vs. altruism dichotomy.

Expanding the Knowledge Base

Incorporating diverse perspectives. The limitations of this study, including the homogeneity of the sample, indicate the need for new research that could expand the knowledge base regarding the topic of altruism in clinical social work. Since this study represents primarily White, middle class perspectives, more qualitative studies could focus on other perspectives by interviewing people within subsets of the clinical social worker population (i.e. clinicians of a certain ethnicity) to incorporate more voices into the exploration of altruism in the clinical encounter.

As presented in the *Demographic characteristics of participants* section, the sample of this study is representative in many ways of the demographics of social workers nation-wide, according to the NASW (NASW, 2003). However, a much larger study would be necessary to test if these findings are generalizable to the national population (Engel & Schutt, 2013). A larger quantitative study could also explore how elements of clinical social workers' identities (i.e. race, religion or spirituality, age,

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gender, mental health status, ability, geographic location, etc.) influence their attitudes and experiences regarding altruism in their work.

Incorporating the client's voice. It will be important to gain a more complete understanding of the phenomenon of altruism in the context of clinical social work by hearing clients' perspectives. One avenue of research could be measuring therapy outcomes for clients who have used altruism as a clinical tool. Studies could compare perspectives of clients who have engaged in altruistic acts as a part of their therapeutic process versus those who have not. These studies could also explore the extent to which altruism emerged through a collaborative process, whether initiated by the client or by the clinician. Also, further research could explore how intersubjectivity, personal values, and cultural background of both clinicians and clients influence the ways altruism emerges in clinical encounters.

In this study, participants made generalizations about their clients' experiences that may be contested by people who have lived those experiences. For example, several participants commented that when clients are over-stressed or depressed they do not have the internal capacity to consider others or to act on behalf of another's well-being. This perception may ring true for some people who are stressed or depressed, but it may not at all for others. The explanation of such experiences would likely be more nuanced and personal coming from the client's own voice. More research from the client perspective could also de-center the clinician as the expert on this topic and put greater value on the perspectives of mental health care consumers.

The Use of Altruism as a Clinical Tool

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Clinicians who felt it was appropriate to discuss altruism in the clinical encounter gave a wide variety of responses to when and how they thought participating in altruistic acts could be beneficial to their clients. Social workers may benefit from having a better understanding of the particulars of using altruism as a clinical tool through the development of some sort of framework that illustrates: When is participating in altruistic acts most beneficial to people?, What types of activities are most beneficial given a person's circumstances? What types of resources and supports does the person need to have in place? How is stability determined?, etc. The topics explored in this thesis could generate some areas of inquiry for such a framework, but it would need to be supported by further empirical studies.

Opportunities for future research. This study demonstrated a diversity of approaches for the use of altruism as a clinical tool. However, it did not demonstrate the therapeutic outcomes or explore the parameters of those approaches in depth. The size and introductory nature of this study does not allow for practice implications beyond the clinician's own exploration of the topics above. Further research is necessary to develop the specific practice implications of this phenomenon.

Likewise, further research is necessary in exploring the paradox regarding altruism and depression. This study found a curious connection between these phenomena: that depression could limit a person's capacity for altruism and yet altruism could alleviate a person's depression. There are likely important treatment implications related to this connection, especially given the prevalence of depression amongst client populations. But first, the nature of their relationship ought to be explored through further research.

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Clinicians' Role Regarding Altruism

One reason this topic has not yet been explored may be because clinical social workers have not understood their role to include introducing the therapeutic qualities of participating in altruistic acts or encouraging their clients to act on behalf of others' welfare. I developed a theoretical framework to help conceptualize how altruism emerges in the clinical encounter (*See Figure 1.*) This framework shows the significance of the clinician's perspectives on taking initiative and being directive related to how altruism does or does not emerge. Some participants mentioned factors that influenced their style of working with their clients, such as having psychoanalytic training. However, there was insufficient data to support any conclusions about the connections between the factors that developed a clinician's style and the emergence of altruism in their clinical work. Future research could explore how clinicians perceive altruism in their work based on their theoretical background and type of social work education. Future studies could also explore the influence of clinicians' practice context, another factor that was relevant but under-explored, in relationship to the emergence of altruism in the therapeutic process.

Cultivating Critical Consciousness

Implications for clinical practice. Given the extent to which clinicians' beliefs and values regarding altruism seems to come "into the room," as shown by the participants' examples in this study, and it would be appropriate for social workers to reflect on their own understanding of altruism. Some clinicians were quite comfortable talking openly with clients about the benefits of altruism while others were opposed to bringing topics related to altruism into their work with clients, feeling it was morally

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laden and inappropriate in the clinical sphere. Many of the participants had not previously considered altruism in the context of their practice. Some were unsure of altruism's place within the therapeutic context while others were quite confident in their position on the matter. These discrepancies allude to varying degrees of personal and profession reflection, and therefore, awareness on the part of the participants.

Critical reflection would assist clinical social workers in evaluating the promise and peril of altruism in their practice. Clinicians could begin by considering how they understand altruism in the context of their work. For example, do they perceive altruism similarly to any of the participants of this study? Is it an imposed value, an essential part of the human experience, or something different all together? To what degree are they open to altruism having a role in clinical work and why? Clinicians would also benefit from considering the following topics related to their work with clients: comfort level talking about topics related to altruism or values in general; curiosity about clients' altruism as part of the clinical formulation; potential positive and negative outcomes of clients participating in altruistic acts given their unique circumstances.

Implications for social work education. Social work schools have the potential to provide opportunities for students to examine their own understanding and experience of altruism. Instructors could ask students how their own altruism has or has not influenced their decision to become social workers. This type of inquiry could be important in cultivating social workers' critical consciousness regarding their identity as helping professionals (Sakamoto & Pitner, 2005). It could also help students build awareness about the power differentials inherent in a service provider/service consumer relationship.

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Implications for the field of clinical social work. While several participants had already put a great deal of thought into altruism in the context of their practice, the majority of the participants had not. Given this discrepancy, I would suggest that educational institutions and leaders in the field of clinical social work explore the ethic of service on a deeper level. This study raises the question: What is the meaning of service, not only in clinical social workers' life and work, but also in their clients' lives and in their therapeutic work together? Social workers could also reflect on how the well-being of the individual is connected to the well-being of society and discuss the ways this connection can be present within the context of clinical social work.

Expanding on the egoism vs. altruism dichotomy

The insights collected in this study imply that the *egoism vs. altruism dichotomy* could be understood as a form of splitting: the focus is either all on the self or all on the other. As three participants alluded to, perhaps the Western, individualized cultural framework seeks to separate the self from the other, and when we use language such as “selfish” and “selfless” we maintain this separation. It is as if the *self* is defending against the *connection to the other*; society is using language and cultural norms to resist the reality of our connections to one another on this planet.

Examples of this type of splitting emerged in the data. Participants discussed how clients try to take care of themselves by being self-centered or selfish. They also talked about clients *defending against* focusing on themselves or taking care of themselves by participating in altruism. This type of black-and-white thinking is perhaps limiting for both the client and the clinician in the therapeutic process. It would be interesting for clinical work to explore this *egoism vs. altruism dichotomy* and the reasons why people

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might be finding themselves on either side of the dichotomy. The field of social work could also challenge the *egoism vs. altruism dichotomy* and further explore the integration of care for the self and care for the greater community.

Conclusion

Given that social work is a helping profession and altruism is perceived as helpful by some clinicians, it is relevant that clinical social workers consider altruism in their practice. Considerations could include: how altruism relates to theoretical understandings of clinical work and how clinicians' perspectives on altruism influence their work and their understanding of altruism's therapeutic potential. The study also prompts the field of social work to consider its construction of egoistic clinical practices and its participation in the egoistic vs. altruistic dichotomy. Future research has the potential to explore these considerations in a more systematic way, enhance the social work profession, and potentially employ the therapeutic use of altruism for individuals and their communities.

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Appendix A: Informed Consent



Consent to Participate in a Research Study

Title of Study:

Is there room for altruism in individual psychotherapy?: An exploratory study of the perspectives and experiences of clinical social workers

Investigator:

Leslie Hammer
Smith College School for Social Work

CODE # _____

Introduction

- You are being asked to be in a research study of the experiences of clinical social workers regarding altruism, the principle of unselfish concern for others, in work with individual clients.
- You were selected as a possible participant because you are a practicing licensed clinical social worker.
- Please read this form and ask any questions that you may have before agreeing to be in the study.

Purpose of Study

- The purpose of the study is to explore the perceptions of clinical social workers in promoting altruism as a part of their clinical practice. The results of the exploratory study may shed light on how social workers perceive the role of altruism and have potential implication for new types of clinical interventions and further research.
- This study is being conducted as a research requirement for my master's in social work degree.
- Ultimately, this research may be published or presented at professional conferences.

Description of the Study Procedures

- If you agree to be in this study, you will be asked to be interviewed individually for 45 minutes to an hour. The interview will be audio recorded, and either in person, via Skype, or over the phone.

Risks/Discomforts of Being in this Study

- The study has little foreseeable risk but I will be asking you to discuss your clinical practice, which may evoke strong feelings. Feel free to decline to answer any question, or even end the interview early if the discussion causes you discomfort.

Benefits of Being in the Study

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- The benefits of participation are having an opportunity to reflect on your clinical practice and explore the idea of altruism in clinical social work.
- This research may benefit the field of social work by identifying *how* altruism is used as part of psychotherapeutic practices and the rationale for its use or omission. This information may influence new areas of social work research and practice.

Confidentiality

- Your information will be kept confidential. I will be the only person who will know about your participation. The interview will take place over the phone, via Skype, or at a public library or another public place of your choice that provides privacy. *In addition*, the records of this study will be kept strictly confidential. I will be the only one who will have access to the audio recording. Recordings will be destroyed after the mandated three years. They will be permanently deleted from the recording device.
- All research materials including recordings, transcriptions, analyses and consent/assent documents will be stored in a secure location for three years according to federal regulations. In the event that materials are needed beyond this period, they will be kept secured until no longer needed, and then destroyed. All electronically stored data will be password protected during the storage period. I will not include any information in any report I may publish that would make it possible to identify you.

Payments/Gifts

- You will not receive any financial payment for your participation.

Right to Refuse or Withdraw

- The decision to participate in this study is entirely up to you. You may refuse to take part in the study *at any time* up to April 1, 2015 without affecting your relationship with the researchers of this study or Smith College. Your decision to refuse will not result in any loss of benefits (including access to services) to which you are otherwise entitled. You have the right not to answer any single question, as well as to withdraw completely up to the point noted below. If you choose to withdraw, I will not use any of your information collected for this study. You must notify me of your decision to withdraw by email or phone by April 1, 2015. After that date, your information will be part of the thesis and final report.

Right to Ask Questions and Report Concerns

- You have the right to ask questions about this research study and to have those questions answered by me before, during or after the research. If you have any further questions about the study, at any time feel free to contact me, 617-983-6020. If you would like a summary of the study results, one will be sent to you once the study is completed. If you have any other concerns about your rights as a research participant, or if you have any problems as a result of your participation, you may contact the Chair of the Smith College School for Social Work Human Subjects Committee at (413) 585-7974.

Consent

- Your signature below indicates that you have decided to volunteer as a research participant for this study, and that you have read and understood the information provided above. You will be given a signed and dated copy of this form to keep.

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Name of Participant (print):

Signature of Participant: _____ Date: _____

Signature of Researcher(s): _____ Date: _____

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Appendix B: Demographic Questionnaire

This questionnaire is based off of a survey created by the National Association of Social Workers and the Center for Health Workforce Studies at the University at Albany (CHWS & NASW, 2006).

Questionnaire

CODE # _____

Please respond to the following questions as you feel comfortable. Your responses will be kept confidential.

I. Background

1. Age:

- 25 & under
- 26-34
- 35-44
- 45-54
- 55-64
- 65 & over

2. Gender: _____

3. Racial and/or ethnic identity: _____

4. Religious and/or spiritual affiliation: _____

5. Socioeconomic status and/or class identity: _____

6. What formal education programs have you completed? Please mark all that apply.

Social Work

Other

- | | |
|--------------------------------|-------------------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/>Associate Degree |
| <input type="checkbox"/> | <input type="checkbox"/>Bachelor's Degree |
| <input type="checkbox"/> | <input type="checkbox"/>Master's Degree |
| <input type="checkbox"/> | <input type="checkbox"/>Doctoral Degree |
| <input type="checkbox"/> | <input type="checkbox"/>Other: _____ |

7. Are you licensed in clinical social work?

- No
- Yes

If yes, in what state(s)? _____

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Years practicing as a licensed clinical social worker: _____

II. Social Work Practice

8. What best describes the sector of your primary and secondary employers? *Please mark one for each employer.*

- | Primary | Secondary |
|--------------------------------|------------------------------------------------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/>Private for-profit (includes private practice) |
| <input type="checkbox"/> | <input type="checkbox"/>Private not-for-profit |
| <input type="checkbox"/> | <input type="checkbox"/>Federal government |
| <input type="checkbox"/> | <input type="checkbox"/>State government |
| <input type="checkbox"/> | <input type="checkbox"/>Local government |
| <input type="checkbox"/> | <input type="checkbox"/>Military |
| <input type="checkbox"/> | <input type="checkbox"/>Other: _____ |

9. Zip code of primary work setting: _____

10. Do you work in a specific social work practice area (i.e. addictions, school social work, medical social work)? If so, please describe:

11. Do you work with a specific population (i.e. homeless persons, adolescents, Asian Americans, LGBT, etc.)? If so, please describe:

12. Do you currently work with individual clients?

- Yes
- No

Thank you for taking the time to fill out this survey. Please return it to me via email.

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Appendix C: Interview Questions

Interview Guide

CODE # _____

Introduction:

Thank you for participating in this study! My research seeks to explore altruism in the context of clinical social work. I am specifically interested in learning about your thoughts about how altruism relates to your practice with individual clients and to the field of clinical social work.

I will record this interview in order to capture your responses and facilitate additional analyses for this study. I will not share the recording with anyone.

Do you have any questions about this study before we begin?

Do I have your consent to record this interview?

(Ok, great. *start recording here. Interview #__ on date of...*)

Interview Questions:

Defining Altruism

1. We all have different definitions of altruism ...what does altruism mean to you?
2. Given that there are different definitions...I'd like to make it clear what I mean when I use the word. So, for the purposes of this study, I define altruism as the principle of unselfish concern for others. When I say altruistic acts, I am referring to actions that are intended to benefit the welfare of others. Such actions include but are not limited to: giving of one's time, work, or resources, listening, providing services, caring for other people, advocating for other people, volunteering with an organization, working on behalf of the greater community. (Does this make sense to you?)
Would you say that this is consistent or different than how you think about altruism?
How come?

Altruism in practice of clinical social work

3. Tell me about how you see altruism in your practice as a clinical social worker.
4. What types of personal and professional experiences have informed your perspective regarding altruism in your practice as a clinical social worker?
5. What are your thoughts regarding talking to clients about participating in altruistic acts, or activities that benefit the welfare of others?
6. Have you proposed altruistic acts in your practice with individual clients?

If not, Why not? (skip to 7.)

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If so, Can you describe your experiences in proposing altruistic acts with individual clients? (honor confidentiality...)

Probes:

- Is this common? Have you had different experiences?
- (If haven't already...)Tell me about the types of altruistic activities you have proposed to clients.
- What motivates you to propose these kinds of activities?
- Do you consider this kind of recommendation as an intervention?
- What do you see as the desired outcome for recommending altruistic acts in your practice? What are you hoping for your clients?

7. Please describe how participating in altruistic acts has or has not impacted your clients.

(positive or negative or neutral...for whom?)

8. I'm wondering about clinicians proposing altruistic acts as a way to augment therapy versus clinicians proposing altruistic acts as an intervention within the therapy. Under what circumstances do you think it is appropriate to suggest altruistic acts as an intervention?

If you don't think it is appropriate: How come?

9. From your perspective, what do you think would motivate clients to engage in altruistic acts?

10. What do you think would prevent clients from engaging in altruistic acts?

Wrap up:

Do you have any final thoughts?

Do you have any questions?

Thank you for your time

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Appendix D: Approval Letter from the Human Subjects Review Committee



School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950 F (413) 585-7994

January 22, 2015

Leslie Hammer

Dear Leslie,

You did a very nice job on your revisions. Your project is now approved by the Human Subjects Review Committee.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Congratulations and our best wishes on your interesting study.

Sincerely,

A handwritten signature in black ink, appearing to read 'Elaine Kersten'.

Elaine Kersten, Ed.D.
Co-Chair, Human Subjects Review Committee

CC: Marsha Pruett, Research Advisor