The Harvard Review of Psychiatry
V. 10 N. 1 2002

Shattered Trust: Technical and Moral Lessons from an Interrupted First Visit

During a new patient intake interview Dr. A gently asked her patient, Ms. H, about the possibility that Ms. H's memory of an incident might be distorted. Ms. H expressed anger that her credibility was being questioned, declared that she didn't like Dr. A's "suspicious attitude," and discontinued the session. Dr. A did not know whether Ms. H sort treatment anywhere else. Was there something ethically amiss in Dr. A's "attitude?"

Are there ethical considerations that ought to shape the mindset with which we listen to patients' stories?

"I don't like your attitude,"--so went my mother's frequent refrain during my early adolescence. And clearly Ms. H doesn't like Dr. A's attitude either. I had no doubt my mother intended a reproach; her declaration was not meant to be taken as a neutral report of maternal tastes. My mother was making a *moral judgment* about my attitude. I will not speculate as to whether or not Ms. H was, or thought of herself as, judging the morality of Dr. A's attitude. Rather I am interested in the general question of whether attitudes are the sort of thing appropriately subject to moral assessment, and more specifically, whether Dr. A's "listening attitude," passes moral muster.

If, following the American Heritage Dictionary, we take an "attitude," to be "a state of mind or a feeling: [a] disposition," then there are grounds for skepticism about applying moral categories to attitudes. Typically we think of moral judgments as applying to characters, states of affair and actions. A person can be morally good, a situation morally just and an action morally right. But we post enlightenment liberals get queasy moralizing about thoughts, feelings and purely mental inclinations. In part this unease is the legacy of the struggle for freedom of conscience. We want no authority coercing belief, and moral judgment may serve as the first step in justifying coercion. Nor are we comfortable judging an agent for matters beyond her control, and many believe that we cannot, at least can not very directly, control our thoughts and feelings. Mental health workers have additional reasons for abjuring moral judgments about psychological states, or at least have reasons not to appear as quick to disapprove of psychological states. Forthright moral condemnation or thinly disguised disgust seem neither a prudent career nor effective therapeutic strategy for the psychotherapist. This professional disinclination to moralize about psychological states would also disincline therapists to reflect on the morality of the attitudes they bring to therapy.

Yet we cannot deny that psychological states are often the prelude to action. Our attitudes inform our behavior. Indeed attitudes are only discernible, and therefore only subject to others' moral scrutiny, to the extent that they are made manifest. Action is commonly viewed as the moral object *par excellence*, and so it is the presumed links between attitudes and action that make the former fit subjects for moral assessment. No doubt such assessments must take into account our considerable ignorance regarding the nature of the connections. We know little about which thoughts lead to which actions. But our ignorance is not total. Some psychological states, we are confident, increase the likelihood of some actions. The moral quality of those actions would seem to infect their psychological precursors.

For those moral theories termed "consequentialist," actions themselves are not the primary subjects of moral evaluation.[1] Actions derive their moral value from the outcomes they promote. Actions are right or wrong only insofar as they lead to good or bad states of affairs. On this view, our only grounds for condemning types of actions are their

tendencies to lead to bad outcomes. Still, on that basis we can condemn certain categories of action.

Other moral theories, termed "deontological," take actions to have moral qualities quite apart from any moral assessment of their consequences.[2] These theories, nonetheless, usually allow that consequences, although not completely determinant, do play a role in moral justification. For although actions with strong intrinsic moral qualities can not be morally altered by their consequences, most deontological views concede that the vast array of intrinsically morally neutral acts are to be judged by their intended consequences[3].

In sum, regardless of most theoretical stances, from a moral perspective, both particular outcomes and how they are achieved count. This is the conceptual framework on which most professional codes of ethics are built. Such codes usually include an identification of the goal of professional practice, that is, the kind of outcome that the professional is to aim at or the good that justifies the preponderance of professional activity. But the bulk of the code is made up of constraints on action that may be employed in pursuit of that good. If a code did not consist of constraints, it could merely state the professional goal, argue for the goal's value, and than urge the practitioner to pursue that goal by whatever means are most effective.[4] The question of which means are most effective is a technical, not an ethical, question. Professional ethics is largely concerned with setting the bounds of technique.[5]

But technique is not wholly irrelevant to professional ethics, for often ethical codes disallow using techniques that are ineffective, unsafe, unconventional or even merely less than the most effective technique available. Judging what counts as competence and skilled technique may be technical questions, but the presence of competence and skilled technique are also reasonable *moral* mandates.

The multiplicity of psychotherapeutic theories is an obstacle to devising a usefully detailed code of psychotherapeutic ethics for at least two reasons. Firstly, goals are contested (candidates include, among others, patient autonomy, social functionality, self-understanding, contentment, and, what will receive special attention here, realization of the patient's *stated* goal for therapy.) It is difficult to set moral guidelines for a practice whose very purpose is at issue. But even within theories that agree on the goal(s) of psychotherapy, there is often wide disagreement on the efficacy of various means to its achievement. While formally this technical disagreement is no concern of a code of ethics, in practice it means that the moral demand to use skilled technique is an empty piety with no content. Hence psychotherapeutic ethics encounters the difficulties of identifying worthy goals and effective techniques even before arriving at the problems that are the substance of most other codes of professional ethics, namely, *what constraints must we put on effective technique in pursuit of our worthy goal.*

We return to Ms. H and Dr. A. We can finesse the question of the goal that should govern the encounter by getting sufficiently vague and agreeing that the goal of psychotherapy is to "help," the patient. Indeed Dr. A's sole utterance in the first part of the interview is

"How can I be of help to you?" We can leave open what we believe, or our preferred theory asserts, or even what Dr. A thinks constitutes helping the patient. But we must note that the patient states that she wants help in "figur[ing] out what to do" about "this problem." [6] Although she doesn't explicitly say so, the phrase "this problem" must be construed as Ms. H's attempt to refer to her husband's infidelity, or to her feelings resulting from the infidelity. Ms. H is not asking for help in dealing with her *belief* that her husband was unfaithful. The problem, as she presents it, includes her husbands infidelity *as a fact*. One may transform or dissolve that problem by dismissing its factual assumptions, but it is not clear that that is helping Ms. H with *the problem she presented* and sought help figuring out.[7]

So the first question we must ask of Dr. A's attitude is whether it reveals a disposition to help Ms. H with the problem Ms.H presents, or rather does it reveal a disposition to discover some other problem, perhaps a closely related or more fundamental problem, a problem whose solution would dissolve Ms. H's problem, but still not the problem Ms. H claimed to be seeking help with.

For her part, Ms. H clearly sensed in Dr. A a disposition to reconceive her problem, for she accuses Dr. A of assuming that she, Ms. H, is delusional. Ms. H may have gone too far in charging that Dr. A was assuming Ms. H was delusional, but surely it is fair to charge Dr. A with suspecting that Ms. H was delusional. What then are the ethics of such psychotherapeutic suspicion?[8]

There is much to be said against suspicion as a general attitude. Social harmony at all levels, demands fairly high degrees of trust. Imagine the moral quality of our social world if we approached each other suspiciously, doubting each other's reliability as part of an initial stance. Any moral code which aims at the common good would surely strongly endorse trust as a moral value. Moreover, we all like to be trusted, and so Golden Rule type ethics directs us to trust others. It is common to be insulted when one's veracity is questioned, and morality should prima facie frown on insults.

But trust is not an unconditional moral good. Unlike cruelty, which is always morally wrong, there are places for distrust and suspicion in the moral world. More to the point, there are places for them in the ethical discharge of certain roles. We expect jury members to judge the credibility of witnesses. An unsuspicious police detective is more of a joke then a moral exemplar. When Poirot declares that he suspects everyone, we don't feel him morally delinquent. We grant certain social roles dispensation from general moral rules because we believe that the efficient pursuit of the good we charge that role with pursuing is worth the suspension of the rule. Granted, we rarely are prepared to sacrifice everything to efficiency,-- hence the constraints on technique in moral codes. But a trusting attitude is something we often lay aside if it thwarts efficient means to a genuinely good end.

Does psychotherapeutic suspicion, as a professional attitude, receive justification as an efficient means to a good goal? *It would not if the aim is to help the patient realize her stated goals.* As an agent of the patient's explicit will the therapist has no use for distrust

of that will. But servitude to the patient's presenting self-understanding is a cramped conception of the proper aim of psychotherapy, even though it sometimes gets rhetorical support. It would preclude as goals any of the profounder transformations that are traditionally many psychotherapies' stock and trade, transformations that the patient can not explicitly request because the good they represent are not yet realized by the patient. Much of the sort of help that psychotherapies try to provide involve new understandings, new perspectives and new goals. Restricting psychotherapists to only superficial manifestations of a problem seems absurd. It is true that one can not help a patient defeat extraterrestrial aliens by eliminating the patient's belief in their existence, but do we really want to prevent therapists from thinking of the problem as the patients belief that she is in battle with Martians? Do we wish to insist that ethics requires the therapist only focus on a patient's stated problem that the Martians are devilishly clever military tacticians? The therapist's attitude should be one that allows (but doesn't, of course, insist), that the patient's (mis)understanding of the problem may itself be problematic and generate the problem. Some problems not solvable as stated, but can still be helpfully dealt with by disintegrating them. If the goal is "to help," broadly construed, we may admit suspicion as potentially helping.

On these grounds skepticism regarding the patient's account of her problem seems an obviously justifiable therapeutic tool. But we incur moral hazards with a willingness to substitute the therapist's understanding of the patient's problem for the patient's statement of the problem. One hazard is that this substitution provides the therapist the opportunity to *impose* her world view on the patient. The therapist can in effect say "my values and/or sense of reality in this matter are superior to the patient's and so I shall try to replace hers with mine." This appears to violate the long prized liberal value of autonomy. To avoid this distasteful, illiberal implication of therapeutic suspicion, an alternative justification for substituting the therapist's understanding of the patient's problem for the patient's statement of the problem might go as follows: "I, the therapist, am merely seeking to help discover/construct the patient's true understanding, deepest values, real self, etc., and thereby help the patient replace her presenting problematic self with a better, truer, but yet unmanifested self." This second characterization claims that therapeutic suspicion is in the service of patient autonomy. But it is in the service of the autonomy of a patient not necessarily fully present at the outset of therapy.

This move saves "autonomy" but at the price of the patient's personal identity. Indeed it is a rather vacuous nod to the value of autonomy. The therapist can claim to be enhancing the patient's autonomy, but the claim requires that the therapist grant herself the authority to determine who the patient really is.

It is morally better, I think, for a therapist to go another route. There should be an honest and open declaration that the therapist questions the patient's conception of the problem and value of the goal she seeks help in achieving. The therapist should either suggest an alternative understanding and goal, or suggest a collaborative exploration of alternative understandings and goals. Perhaps alternatives can be agreed on early, or there can be an agreement to start the process with no mutual goal and common understanding beyond the

therapist's good will commitment to employ the therapy to benefit the patient. The suspicious attitude, in other words, is acknowledged at the outset. There is no pretense that the therapist is necessarily in league with the patient's stated will..

Such an approach allows a suspicious attitude but pulls most of its morally objectionable teeth. The therapist has no hidden agenda, is employing no unconsented to techniques, nor misrepresents her, the therapist's, goals. If the patient chooses to continue the therapy thereafter, any therapeutic manipulation the patient is subject to, is manipulation she has agreed to endure, which hardly counts as manipulation at all. We find police detectives occupational suspicion morally acceptable not only because we judge it an important means to a goal we endorse, but also because the detective is known to be suspicious.

The ethics proposed here would have Dr. A, upon being accused by Ms. H of assuming that Ms. H is delusional, say something in the spirit of, " Of course your husband may, as you believe, have been having an affair, and perhaps I can help you deal with that situation. But we also ought to look at the possibility that you are mistaken in that belief and that the mistake is caused by the discontinuation of your medication, for it is my professional experience that such discontinuation can contribute to the formulation of false beliefs, and I would be irresponsible and false to your best interests if we did not investigate that possibility."[9]

This approach, which I tout as the morally sound employment of suspicion, may be a technical fiasco. Although his role as a police detective should have put his interviewees on notice that he was suspicious, even Detective Columbo was at pains not to prematurely reveal his particular suspicions. He wanted to flush out suspects, not frighten them away. And candid suspicion as an opening therapeutic attitude might frighten away patients. But it might not. The very candor of the therapists' doubts may lessen their threat. Indeed the term "suspicious," with its ominous connotations for the target of the suspicion, may be a misnomer for the attitude I am suggesting. Perhaps "skeptical," or even, "epistemically open and flexible," better captures the proposed attitude. The therapist should begin uncommitted to any viewpoint. This does not mean that she listens to her patient without context, assumptions, hypotheses, and a host of cultural, intellectual and emotional inclinations.[10] (A starting inclination may very well be "the patient is accurately representing 'the facts'.") It does mean that she is prepared to take different perspectives if the evidence suggests that those different perspectives will help her help the patient. Indeed it is her ability to take various perspectives, including perspectives that her training has made available to her, that in part constitutes the therapist's professional expertise.[11] It is one of the reasons the patient sort out the therapist in the first place. Understanding the patients perspective is not equivalent to restricting oneself to the patient's perspective.

What is the alternative to perspectival flexibility that permits skepticism of the literal truth of the patient narrative? A dogmatic commitment to see things as the patient currently reports them to be, that is, to adopt the patient's theory as the only morally permissible

one? But such a naive acceptance of one's interlocutor's viewpoint is not even a general requirement of conversational good will. Perhaps ethics does not demand that you always voice your doubts and disagreements in conversation, but it does not preclude respectful, sensitively worded dissents or alternative takes. Sometimes friendly support calls for an empathetic ear, a comforting mirror of the speakers feelings and judgments. We should not dismiss the moral value of empathetic listening as an activity. But it is perverse to elevate it to sole paradigm of ethical listening. To do so would be to assert that there is only one morally acceptable response to all narratives--their recapitulation. But some of the best dialogues, in moral as well as practical and intellectual terms, involve responses that challenge, reverse, reinterpret and even refute the others, as well as one's own, previous understandings. None of this can happen if all skepticism, all "suspicion," is drained from the listening. Surely the ethically best listening practice of the therapist shouldn't be narrower than that of general conversationalist.[12]

We have been discussing whether suspicion, even if it is an effective therapeutic tool, is an ethically impermissible attitude for the therapist, and concluded that it is not. No ethical constraint derived from non technical considerations prohibits therapeutic suspicious listening. If, however, such an attitude is technically deficient, the ethical requirement to use good technique might disallow it.

Whether suspicion is always, sometimes, or never good technique is largely an empirical question beyond the ken of ethical analysis. Dr. A's suspicious attitude certainly wasn't successful. Whether that failure was just bad luck or faulty technique is for other commentators to assess. Dr. A may have made a technical mistake, and if any ethical wrong was done, it is due completely to this technical one.

[1] See John Stuart Mill's Utilitarianism [1863, Anchor Books, 1973] for a classic exposition of a consequentialism. Peter Singer in Practical Ethics [1979, Cambridge University Press] provides a contemporary version. Samuel Scheffler's Consequentialism and its Critics [1988, Oxford University Press] provides good critical discussions.

[2] Immanuel Kant's deontological moral theory is perhaps the best well known. See his Groundwork of the Metaphysics of Morals [1785, Harper Torch, 1964] More recently , D.W. Ross provided a very different deontology in The Right and the Good [1930, Oxford University Press].

[3] One complexity of consequentialist theories I will ignore in this discussion concerns the role of actual consequences versus the role of intended consequences in judging the moral quality of an action.

[4] Not quite. It might also have to defend the goal's value relative to other possible and competing goals. Giving these other goals their due is another way, besides side constraint principles, of generating moral constraints on professional practice

[5] I am using the terms "technique" and "technical" to refer very broadly to all matters that relate means to ends, without evaluating the ends themselves or evaluating the means apart from their relations to the particular ends in view.

[6] This is a quote from Dr. Engel's description of the patient's account, which presumably stays very close to Ms. H's actual words.

[7] My discussion presumes that there is a literal meaning that can be attributed to Ms. H.. How one confidently knows anyone's literal meaning, indeed whether literal, or any meanings even exist, is theoretically controversial. (See W.V.O. Quine's Word and Object [1960, MIT Press]) But without wading into those controversies, my discussion proceeds on the basis of "folk" linguistic theory, of the kind that allows courts to convict people of perjury and libel, and leads most of us to recognize when we have been blatantly lied to, and, more to the point, to recognize when someone is questioning our truthfulness.

[8] My use of the phrase "psychotherapeutic suspicion" may bring to mind Paul Ricouer's characterization of psychoanalysis as belonging to "the school of suspicion." [Freud and Philosophy, p. 32, Yale University Press, 1970] These are related but not identical things. I want to refer primarily and simply to a therapist mindset that is alive to the possibility that the patient might not be telling the truth. Ricouer's account of psychoanalysis emphasizes the centrality to its practice of the premise that the initial patient story is filled with distortions. But, even if "suspicion," however characterized, is a fundamental technique in any or all psychotherapeutic approaches, we are still left with the central question of this discussion: is it a morally sound technique. If not, its indispensability doesn't save it, but rather damns the whole approach. Of course, my simpler notion of "suspicion" may seem oversimple, in that it treats as unproblematic the notion of "telling the truth." I take no philosophical position here on a theory of truth or meaning. See note 7.

[9] I am not recommending the above speech, which, from a technical viewpoint, is likely quite clumsy, or worse. Rather I offer the speech as representing an attitude, which could be expressed in a variety of verbal forms. Of course, as I go on to concede above, any expression of this attitude might be a technical blunder

[10] It is now a commonplace in a variety of philosophical traditions, that all perception and observation depends on non-universal conditions and presuppositions that create context. See Martin Heidegger, Being and Time [1927, SUNY Press, 1997] and Thomas Kuhn, The Structure of Scientific Revolutions [1962, University of Chicago Press]).

[11] I take Joel Greifinger to be arguing ["Therapeutic Discourse as Moral Conversation," Communication Review Vol. 1(1), 1995] that the goal of psychoanalysis is to impart to the patient the ability to apply to herself the flexibility to take new perspectives the better to reflect on her experiences; to make one auto-suspicious, so to speak, in order to arrive at better self understandings. Greifinger claims instilling this mindset in the patient to be a substantial moral goal for the therapist to aim at. I am making the considerably more modest claim that employing this mindset is a morally acceptable technique for "helping," the patient.

[12] There has been a good deal of work the on ethics of dialogue. The conditions under which speaking and listening take place, and the forms they take, from Plato, where the topic is implicit in his depiction of Socrates' practice, to Habermas' ruminations on the "ideal speech" situation, have been the subjects of many moral analyses.