Ethics column- Trauma and an Ethics of Responsibility

Danny Taggart*

"How was I (how are any of us) to do other than that which we, at that time, actually do?"
George Saunders, Lincoln in the Bardo

Clinical psychology's focus on trauma as one alternative to a biological pathogenesis of mental illness requires a recognition that often psychiatric diagnoses act as 'discursive fig leaves' covering up child adversity and resultant trauma. It has been suggested that some mental health services could be restructured to better take account of the specific needs of abuse survivors, utilizing principals of a Trauma Informed Approach (TIA, Sweeney, Clement, Filson & Kennedy, 2016). TIAs are based on the principal that for people seeking help for problems arising from relational abuse, there are risks that the helping system will enact procedures that have parallels to the experience of original trauma (Bloom & Faragher, 2010). TIAs advocate service structures and treatment plans that engender trust and safety at all levels for clients (Sweeney et al., 2016).

With this in mind the question I would like to consider is, what are the ethical implications of TIAs for clinical psychologists and how are they distinct from our current operational ethical frameworks? As I have outlined before in CPF, I have multiple interconnected perspectives on the subject of trauma (Taggart, 2016) and as such I want to present an argument that considers the tensions between our disciplinary knowledge as an empirical science and a broader philosophical examination of the ethics of human relationships. In order to do this we need to first turn to the ethical foundations of clinical psychology as a discipline, considering how it is equipped to manage a shift in emphasis towards trauma informed approaches.

The Code of Ethics and Conduct for psychologists in the UK (2009) locates its ethics broadly within the "British eclectic tradition" which points to the use of moral principles as guidelines rather than directives, or 'should' rather than 'must.' It also highlights the work of Immanuel Kant, specifically his Categorical Imperative often summarized as "Do unto others as you would be done by." This sounds like a good place to start regarding human relationships and the code goes on to suggest that if "moral judgments are to retain some objectivity…they must be based on rational principles which serve as criteria" (p4). So, the code is emphasizing the importance of universal moral principles based upon treating others as oneself would want to be treated, located within rationally based structures that can guide practice by clinicians using their judgment in specific circumstances. To many this will read as so self-evident that it can be considered to be what Bourdieu (1977) refers to as a 'doxa', a taken for granted assumption that is deeply embedded in our social and cultural understandings. Another component of ethics in modern healthcare positions the clinician as less a practitioner guided by an ethical philosophy and more a purveyor of technical services in a marketplace and engaging in a transaction with a patient as consumer (Dyer, 1998). This

approach is more common in the US but is increasingly present in how we talk about mental health services in the UK with a 'patient choice' agenda at the heart of many policy developments (Carter & Martin, 2016).

What I want to do here is to temporarily disrupt these assumptions about a rational approach to ethics and a transactional understanding of what passes between us and our clients, not to fundamentally challenge their usefulness, but rather to ask whether we need a distinctive approach if we are conceptualizing some clients as survivors of trauma rather than suffering from a psychological disorder. This disruption is important because if we stop considering clients as suffering from a psychological disorder and instead think of them as having been in relationships that have caused interpersonal injuries, then our role as psychologists also in relationship with them becomes more pressing. The question of how we can avoid a recreation of an abusive relational pattern, no matter how unintentional, becomes of central importance. I propose that forming relationships as psychologists with trauma survivors in a qualitatively different way from that of the relationship(s) where the original harm was caused is more complex and fraught than we might sometimes think. To facilitate a temporary disruption of the doxa of our taken for granted ethical framework I will turn to a different approach to ethics, one that radically rejects the rational and market based approaches outlined above, and which was developed by the 20th century continental philosopher Emmanuel Levinas.

An Ethics of Responsibility

Levinas was born in Lithuania in 1906 to Jewish parents. His philosophy is steeped in both the Jewish Talmudic tradition and secular continental philosophy (Critchley & Bernasconi, 2002). In his early career he was influenced by the phenomenological psychology of Edmund Husserl and studied under Husserl's student Martin Heidigger. In the 1930s Heidigger became involved with the rising National Socialist movement in Germany and provided intellectual support for Aryan supremacy. During the war Levinas lost much of his Jewish Lithuanian family to the holocaust and was himself a prisoner of war, caught while working for the French resistance (Hand, 1989). Aspects of his subsequent philosophy were characterized by a response to a rejection of Heidigger's concept of Daesin, and it's emphasis on Being, which he saw as tacitly endorsing ethnic supremacy, the horrors of Nazism and its implications for future human relations. In his book Totality and Infinity (1969) Levinas argued that ethics is 'first philosophy', a responsibility to the Other (a way he denotes another person) that precedes any capacity for thought or reason, and most controversially the privileging of the good over the true.

A departure from a purely rationalistic ethics

Such a challenging and opaque ethics of responsibility to the Other is important for clinical psychology's approach to trauma in two central ways. The first is that procedural, rationalistic ethics are insufficient in preventing terrible things from happening and from understanding their consequences. There were laws, social norms and rules that were at first gradually dismantled and then ferociously destroyed by the rise of fascism in Germany. The limits of rationality that Levinas pointed out can also be understood in

relation to the occurrence of trauma. Taking, for example, childhood sexual abuse; there can be nothing reasoned about why such crimes occur, they are by the very nature of the harm they do anti-rational. Therefore, while rationality has an important place in investigating the harm this abuse causes, it is unlikely on it's own terms to be able to fully or even nearly comprehend the phenomenological experience of being 'in it'. Engagement with the irrational is therefore a key requisite for entering into the subjective world of abuse victims, a process referred to by the philosopher Matthew Ratcliffe (2012) as a form of "radical empathy" that recognizes that the phenomenology of "mental illness" means changes in the form of experience and not only the content. I would argue that this radical empathy is necessary to understand the 'out of this world' experiences of many trauma survivors. What may be required of us as clinical psychologists in these cases, akin to astronauts tethering themselves to a docking Space Station in order to launch into space exploration, is that we harness ourselves to a grounding psychological theory but then allow ourselves to enter into the different atmosphere of a traumatised person's experience in order to properly comprehend the distinctive space, time reality that they occupy.

<u>The dehumanization implicit within categorisation</u>
Levinas argues that the thrust of much modern Western thought, and this is particularly true of psychology, is to denote the Other according to what can be reduced, measured, defined, grouped together and categorized (see Davies, 2015 for a sociological examination of this in psychology). In the process of categorization, a necessary reduction and objectification occurs and this leads to something of the essential 'otherness' of the person being lost. Levinas argues that it is this losing sight of the quasi-indeterminate nature of the Other (Hutchens, 2004) which starts a process of dehumanization. For him, it is only through an ethics of responsibility to the Other- to consider them in all of their strangeness without attempting to reduce down for easier analysis that we can truly be practicing ethically. While this is hard for a discipline like psychology founded on principles of measurement, delineation and categorization, I argue that considering this approach may lead to some useful ideas for working with trauma.

Much trauma happens at the margins of our society. It is those of us already marginalized and disadvantaged who are most likely to suffer further abuse (as way of example, consider the Adverse Childhood Experiences study that show increased risk of sexual exploitation and abuse in adulthood for women abused in childhood; Hillis, Anda, Felittli & Marchbanks, 2001). From this perspective, the process of psychological categorization can be understood as a form of silencing and masking. In reducing down the story of the trauma survivor to a psychological construct we risk being complicit in it's denial (Herman, 1992). What an ethics of responsibility might offer would be a move away from deductive reasoning; "How does this person fit into my preexisting categories?" Instead we might be more interested in how that person's irreducible perspective challenges us to reform our own preexisting categories. This flips the idea of working within a model on its head and requires us to truly start inductively from the person.

Conclusions:
As can be seen, the ethics outlined by Levinas is no soft liberal humanism, it is a stern rebuke to the egocentricity that psychology has done much to promote. It is a reminder of our ultimately social nature and the ethical primacy of our responsibility to others. It is therefore with some trepidation that as clinical psychologists that we approach his work and consider how we can introduce it in our practice. However while demanding, I think there are helpful markers that we can use to step towards an ethics of responsibility without fully dislodging ourselves from the comforts of a more rationalistic, procedural ethics. Perhaps we can begin by asking different questions in our work with trauma survivors. For example, a Levinisian question might differ from a Socratic one by not seeking to explore the 'irrationality' of the Other's thoughts in order to help them correct it, but rather to recognize their inherent foreignness and to use questioning as a form of social intercourse that can communicate a curiosity about and value for their irrationality in how it differs from our own. In this sense it is less conformist and more pluralistic, and thus enables a privileging of the survivor's perspective as being a necessary, idiosyncratic and adaptive one in what they have had to do to survive. Indeed, attention to the micro-differences and more structural variations in perception can allow us as Ratcliffe (2012) puts it to 'do phenomenology' in our therapeutic work with trauma survivors.

Finally, to return to the title quote, Levinas argues that before we can be free to choose to do differently we first have to face up to our responsibility to the Other. In working with trauma survivors it may be that we can only free our own thinking and make different choices through the task of enabling their liberation. It is through straining to see them as they truly are, not how we think they should be or how they are alike us or others, that we can both be liberated from the tyranny of reductionism that enslaves us as clinicians and fundamentally misrepresents them as survivors.

*Acknowledgement and thanks to Dr Peter Appleton who has engaged with me in conversations and preparatory work that contributed significantly to this paper

References

Bloom, S. and Farragher, B. (2010), Destroying Sanctuary: The Crisis in Human Service Delivery Systems, Oxford University Press, New York, NY.

Bourdieu, P. (1977). *Outline of a Theory of Practice*. Cam- bridge: Cambridge University Press.

British Psychological Society (2009). *Code of Ethics and Conduct*. Leicester: Author.

Carter P & Martin G. Challenges facing Healthwatch, a new consumer champion in England. *International Journal of Health Policy Management.*

2016;5(4):259-263.

Critchley, S. and Bernasconi, R. (2002) *The Cambridge companion to Levinas,* Cambridge University Press.

Davies, W. (2015) *The Happiness Industry.* Verso Books, UK

Dyer A. (1988) *Ethics and Psychiatry: Toward a Professional Definition.* New York: American Psychiatric Press.

Hand, S. (1989) *The Levinas Reader.* Blackwell, Oxford.

Herman, J. (1992) *Trauma and Recovery.* Basic Book, USA.

Hillis, S. Anda, R. Feletti, V. Marchbanks, P. (2001) Adverse childhood experiences and sexual risk behaviours in women: a retrospective cohort study. *Family Planning Perspectives,* 33 (5), 206-211.

Hutchens, B. (2004) *Levinas: A Guide for the perplexed.* Continuum UK

Levinas, E. (1969) *Totality and Infinity: An essay in exteriority.* Alphonso Lingis, Pittsburgh.

Ratcliffe, M. (2012) Phenomenology as a form of empathy, *Inquiry, 55 (5), 473-495.*

Saunders, G. (2017) *Lincoln in the Bardo.* Random House.

Sweeney, A. Clement, S. Filson, B. Kennedy, A. (2016) "Trauma-informed mental healthcare in the UK: what is it and how can we further its development?", Mental Health Review Journal, Vol. 21 (3), 174-192.

Taggart, D (2016) Notes from the underground: some reflections on clinical psychology's role in responding to historical and institutional childhood sexual abuse. *Clinical Psychology Forum,* 286, 6-9.