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# The Psychotherapist as Moralist

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# THE PSYCHOTHERAPIST AS MORALIST

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*"The analyst respects his patient's personality; he does not try to mould it according to his own personal ideas; he is satisfied when instead of giving advice he can obtain his results by arousing the patient's own initiative."* (Sigmund Freud)

The death of consensus is a fact of the contemporary human condition. The field of psychotherapy exemplifies this. Nevertheless, if we set aside those therapists who have succumbed to the simplistic allurements of a Skinnerian type behaviorism, we can expect that the opening citation from Freud will probably win very general acceptance. No good psychotherapist should go about imposing his own personal ideas, especially his own moral ideas, on his patients. And the patients should feel confident that the therapist will not be insinuating his personal moral expectations in the name of therapy.

This would be all well and good if it were not impossible. Whatever his conscious intentions, every therapist, to some degree and quite unavoidably, communicates and imposes his own moral and even religious valuations on his patients. It is the contention of this article that this is so, and that therefore it would be well for the therapist to recognize his actual role as ethicist and moral counselor and learn to perform it less badly or even well. He may, and, indeed should, revere the ideal contained in the above quotation from Freud, but he must acknowledge the reality of the influential value-communication that transpires in multiple and subtle ways between him and his patient.

First of all, then, let us elucidate what morality is so that we, praiseworthily, might know what we are talking about. Secondly, it will be argued that the therapist is inescapably involved in the moral condition of his patient. And finally, some conclusions will be offered to assist with the moral aspect of counselling.

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### The Meaning of Morality

One reason why therapists may feel that they can prescind from moral questions is that they are unclear about the meaning of the term *moral*. This is entirely understandable, albeit regrettable. It is part of the human problem that the terms we most use are the terms we most abuse. False meanings and connotations easily attach to words as they pass through the vagaries of human discourse. The term "moral" is widely used and abused. In common parlance and in technical scientific, social, and philosophic literature, the term appears with no consistent meaning.

To some people, moral means uncompromising, absolute principles. To others it relates to one's religious teachings. It is also used to signify the ideal as opposed to the hard, practical realities. And in a way that is relevant to psychology and psychotherapy the term moral suffered grievously in the school of thought known as Positivism. Positivism was not just one of those philosophies whose ideas passed harmlessly from journal to tome with little impact on the concrete world of the living. Positivism was not just a school but a climate-setter. In its climate, many critical categories of Western thought took shape.

It was Positivism, for example, that encouraged the idea that objectivity was linked to being value-free. This idea spread with epidemic force through even those sciences that should have been concerned with the discovery and elucidation of operative value assumptions and judgments. Instead, the chimeric ideal of "value-freeness" hung over important developmental periods of such disciplines as sociology, education, political science, and psychology. Psychotherapy did not escape the infectious assumption that good, scientific practice necessitates a clean break from the realm of moral evaluation. Since they grew up in these shadows, it is easy to understand the uneasiness and caginess of the therapist when they discuss the morality question vis-a-vis their practice. In the name of objectivity and good science, morality is treated as though it

were not there. But it is there a it is intrinsic of personal existe and well eing.

So wha oes moral mean? Bri y, moral m s human . . . in the normativ sense of that term. Human be used descriptively, or norm vely. For example, it is hum to be selfish. This is descripti people are often that way. No tively, however, it is not huma o be selfish. People should not that way. The study of morality, then, is the study of what people should and should not be if they would be truly human.

The moral question arises because, as Nietzsche says, man is a valuing animal. However controlled he may be by nner and outer determinisms, he is not entirely programmed. Rather, his agony and his dignity is found in his capacity to select among the many values that compete for his attention and selection. Of course, not all values are moral values. For example, there is value in being able to do mathematics, or in being able to dance or play music. But these values are not moral values because you can lack them without being less human. A clumsy person might be truly human, as might a student who fails in mathematics. However sad it is to lack beauty or agility or particular intellectual skills, it is not of itself dehumanizing. We can have some of the values, and not others and still be thoroughly human and moral.

It is an entirely different story, however, if someone claims to be good at justice but poor at veracity. It is more than somewhat regrettable if a person is splendidly courageous but distinctly prone to murder. Moral values pertain to a realm of value that is constitutive of human personhood. They are not optional. Moral values are essential to and constitutive of our humanness and of our personhood. When moral values are at issue, our humanity is at issue. The moral question is utterly serious.

When a moral value is rejected with some degree of freedom the pain of guilt is experienced. Guilt is a ripping and tearing experience in which the guilty agent knows that what he does is in radical confrontation with what he is. Action and being are at odds. What one does contradicts and rejects what one is. Human behavior should enhance the process of humanization. Guilty behavior thwarts that process.

An example might alleviate the abstractness of this description. Some primitive peoples studied by anthropologists punish incest by making the incestuous pair eat from the trough of hogs. The example, however offensive to our delicacies, is a remarkable symbolization of what we mean by guilt. The offending couple is seen as having acted in a beastly and inhuman way. By way of retribution and to dramatize their guilt, they are made to eat in a beastly and inhuman way. In various ways, the liturgies of guilt that are part of every culture attempt to demonstrate this same point, that the penitent has acted in a way that is incompatible with what he is.

Guilt, of course, can be either healthy or neurotic. (Therapists who are only aware of sick guilt, take heed!) Just as a malfunctioning censoring or warning device might sound an alarm when no cause is present, a disturbed person may experience guilt for activity which is only imagined or which is mistakenly felt to be immoral. The goal of therapy in such cases is obvious, however difficult it may be to achieve.

On the other hand, guilt can be a normal, healthy reaction to clearly immoral activity. Therapy here, of course, does not consist in disguising this normal reaction or by branding it a neurosis.

Part of the Freudian legacy to psychotherapy (to which even non-Freudian therapists are perhaps unwitting heirs) is the tendency to see normal and abnormal as existing on a qualitatively undifferentiated continuum. Therapists should examine their professional consciences on this, particularly with regard to the guilt question. It is good therapy as well as good logic to make distinctions where there are differences. And real guilt is not identical with neurotic guilt.

It should, of course, be noted and granted that healthy guilt with which a person does not know how to cope, can become neuroticizing. But it could be no less neuroticizing to cater to the illusion that all guilt is sick or unreal. (How a therapist could purport to deal with a guilt problem of any kind without entering the field of ethics is s ething we will retur to mo r tarily.)

loral values, then, ar the distin ively human value People ma vary immensely in etermining what is moral and w t is immoral but they do not va in considering the moral ques to be one of utmost gravity. he behavioral contradiction moral values induces the bas human phenomenon of guilt. uilt is a painful and, indeed, ntolerable experience. We withdraw from it as we do from a hot object accidentally touched, immediately and instinctively. The withdrawal from guilt is achieved either by behavorial reorientation or by rationalization and self-deception. But withdraw we must. No one can think of himself comfortably as evil.

As a result, every man is a moralist, or, if you will, an ethicist. (The two terms are, for all practical purposes, synonymous.) The task of ethics is to determine true human values and to discern which attitudes, actions, and omissions are moral or immoral. Scientific ethics goes about this task systematically by developing a methodology that is as thorough and as sensitive as possible. The ultimate goal of ethics is to determine what humanness means. And since we are not automatically good or bad, the challenge of ethics is addressed to every man and i this sense every man is an ethicist.

People get their ethical answers in various ways. Authority figures are a prime source . . . parents, churches, peers. Persons who are

more secure and reflective might reach ethical conclusions more independently, through personal discovery experience, and analysis. Religious persons might seek moral enlightenment from mystical communion with God. But for the most part, people take moral instruction from the group and the authority figures thereof. How psychotherapy relates to all of this is a matter that can now be discussed.

**Morality and Psychotherapy**

Carl R. Rogers, in his *Client-Centered Therapy* writes:

> "As we listen to recordings of therapeutic interviews, and study the transcribed material, it is very evident indeed that therapy has much to do with what is perceived as 'good' or 'bad,' 'right' or 'wrong,' 'satisfying' or 'unsatisfying.' It somehow involves the value system of the individual, and changes in that system. This is an aspect of therapy which has been little discussed, and thus far barely touched from a research point of view."

It is at least remarkable that something as basic and as important to a patient as his value structure could be "thus far barely touched from a research point of view." And yet, who would dispute Rogers' observation on this point? If this phenomenon were to be researched, one thing that would command attention would be the role of the therapist in affecting evaluational change. Only a therapist who is beguiled by his own non-directive rhetoric would believe that he has had absolutely no directive input in this development.

Part of the difficulty here is that psychiatry which has been so attentive to the subjective experience of subverbal and subconscious experiences has had too little to say about the subverbal, subliminal, and subconscious *communication* of these experiences. And yet there is a growing appreciation abroad today, which is being fed by a variety of disciplines, that any conversation is filled with communicatory symbols only some few of which are words. This would seem to be especially true in the deep intimacy of psychotherapeutic conversation.

We can pursue this point by viewing first of all the nature of the client-therapist relationship, the authority status of the therapist in our culture, and the peculiar insecurities generated by the valuational upheavals of contemporary society.

Psychologist Joseph Nuttin was expressing what should be obvious when he wrote in his *Psychoanalysis and Personality* that:

> ". . . the therapist's treatment is not simply the application of a technique; it establishes between the therapist and the patient a personal relationship which plays an essential part in the actual process of treatment, and for this reason the *whole personality* of the therapist, with his life-conception and his whole way of looking at things, exerts an unavoidable influence on it."

Nuttin elaborates on this by noting, "the discovery, in many different countries, that in a great number of cases of loss of psychic balance, the heart of the trouble has been found to be bound up with the problem of the *meaning* and *content* of life." It should be obvious that this concern is also a moral concern. It should be obvious too that the patient, given



tensions that brought him into therapy, will have his antennae highly sensitized to all signals related to this accute personal and moral need.

To speak of the meaning of life, of course, is to speak of something that cannot entirely be verbalized. In such an experience of meaning, there is much of the ineffable, the felt, the imagined, and the hoped for. Abraham Maslow speaks of the communication of the ineffable:

> "... Poetic and metamorphical language, physiognomic and synesthetic language, primary process language of the kind found in dreams, reveries, free associations and fantasies, not to mention pre-words and non-words such as gestures, tone of voice, style of speaking, body tonus, facial expressions — all these are more efficacious in communicating certain aspects of the ineffable."

How could a therapist silence all the signals of meta-communication and implicit conversation? How could he turn off his "pre-words and non-words?" It seems likely that he could not do so. It seems that something like "transference" (without insisting on a Freudian definition of that term) always takes place in therapy. At least, it would be difficult to find a therapist who would deny that a deep, close, multi-level relationship develops in any extended therapy. Such a relationship could not be had without a good deal of communication on matters of basic concern. Otherwise the requisite trust could not be generated!

Also relevant to the communication between patient and therapist is the authority status of doctors in our society. A doctor today is, as he was in many primitive societies, something of a priest. People naturally attribute "sacredness" to whatever touches the ultimates such as life and death. These matters of ultimate concern are within the province of doctors. The signs of their sacred status are many. Doctors seem naturally to evoke the confidence and trust that is traditionally reserved for "holy men." They have an insist on titles. Special vestments are associated with the popular image of a doctor. And policemen give to doctors the traffic enforcement courtesies customarily reserved for the clergy. These men who preside at the sacred events of birth and death are not without a sacerdotal aura.

If this is so, the doctor, and particularly the therapist, should know that people attribute to him authority that is not limited to the technicalities of medicine. By culture they are atuned to expect of him priestly tasks, not the least of which is moral instruction. Priests are figures of direction, not of non-direction. The doctor may as well know that divestiture from priestly status is not easily achieved.

A final factor relevant to client-therapist communication is the revolution in values that is taking place today. Values previously enshrined in consensus are now challenged even by the very authority figures who used to uphold them. Persons who would retain older standards of morality often find themselves what sociologists call "a cognitive minority". Given the human need for social support in knowing as in living, cognitive

minorities are usually shrill and nervous.

This problem can take another form as it does with persons who, caught in the maelstrom, are constantly shifting their moral stances. Years ago one would have to look back several generations at least to find substantially different view of what makes for the good life. Today many persons find themselves in serious disagreement with their own moral views of just a few years ago. This can be highly unsettling. Many patients in therapy today have been shaken by one of these experiences. It can increase their need for moral guidance and moral dependency.

In summary, it would be well for the therapist to remember that, whatever the psychiatric specifications of a particular case, the patient is a moral being seeking like all of us a fuller appreciation of his human and moral meaning. Given the nature of human relating, the therapist is speaking in subtle but influential ways to the moral questions of the patient. Therapy does not take place in a moral vacuum. Both he and the patient should know this.

### Conclusions

1. The therapist should recognize that non-directive counselling (this concept is variously nuanced and described in the different schools) is still an ideal. The goal must still be, in Freud's words, to "obtain . . . results by arousing the patient's own initiative." A certain mature autonomy in valuing is the mark of a healthy personality. *Non-directive counselling at its best is less directive counselling.* But without the ideal of non-directiveness, the moral influence of the therapist would be even more imposing.

2. Since the therapist is to some degree a confessor, he should know what the years have taught Catholic confessors. One mark of the good confessor is *flexibility*. A confessor is taught that he may not, implicitly or explicitly, impose his own more rigorous view on an issue where expert moralists are at odds. The confessor may feel that "the opinion favoring freedom" is disastrously wrong, but he may not impose his more rigorous stance if respected moralists find solid reasons for freedom. *Ubi dubium, ibi libertas* (Where there is doubt, there is freedom) was the wisdom behind this position. The practice of the Catholic Church also reflects this wisdom. The Church has not attempted to commit herself infallibly on any particular issue of morality. The reason for this is that moral judgments of particular issues must be based not only on a relevant wisdom of revelation and traditional principles, but also on the moral meaning of the concrete circumstances of every case. It would take divine foreknowledge to assess in advance the moral meaning of every human situation. No one less than God could attempt to do this, nor has the Church attempted to do it. (Quite typically and consistently, *Humanae Vitae* was published with an admission of its fallibility.)

There are many seriously disputed issues of morality today where powerful reasons and expert authority is found on both sides of the dispute. A therapist with illusions of infallibility on these issues is just what a patient does not need. ("Notes in Moral Theology," by Richard Mc Cormick, S.J. and Robert Springer, S.J. appears semi-annually in *Theological Studies*. If a therapist wants to know where ethics is today, he could begin with these Notes.)

3. The psychotherapist has a lot to teach the professional ethicist. A good deal of ethics involves moral principles. Few if any of these principles are self-evident. They are rather a distillation of what much empirical evidence has shown to be truly human and truly moral. Further evidence can confirm, amend, or even disprove moral principles. The history of ethics witnesses this. Therapists have some of that evidence. Carl Rogers says: "My views regarding the meaning of the good life are largely based upon my experience in working with people in the very close and intimate relationship which is called psychotherapy." Things about human life will be learned in therapy that will not be learned in a library. The professional ethicist should hear those things. And the therapist should learn to respect his own experience of what is good even when that experience clashes with what moralists have taught him in the past. The therapist should be in constant conversation with the moralist and he should know that he does not come to that conversation empty-handed.

4. Since moral value communication unavoidably transpires in a psychotherapeutic context, a further conclusion suggests itself. At times a therapist may have to disqualify himself from the treatment of a certain patient. If patient's moral and religious values are totally opposed to that of the therapist to the point where the therapist sees them as nearly absurd, the therapy will probably generate more problems than it solves. Ideally any therapist could treat any patient. Unfortunately, the ideal is not always identical with the real. If the therapist can completely conceal his own value orientation (or indifference) he could, of course, treat any patient. To do this, however, he would have to conduct the therapy from another room and in silence, and this, obviously, presents other problems.

All of those who enter the world of moral counselling, the therapist, the social worker, the moralist, the clergyman, etc., are treading upon holy ground. They enter in a serious way into the sanctuary of human personhood. When we have done our best here, we remain unprofitable servants. There is a consoling story of a good, old priest who had helped many with his counselling and preaching. When he was reminded of this upon his deathbed, he replied with smiling wisdom: "I thank God I have done so little harm!" Would that all of us who treat of the morals of men could merit such an epitaph. ✠