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Relational Autonomy and Self-Trust

Traditional autonomy theory, especially as it is deployed in the context of health-care ethics discussions, has focused on specific factors that interfere with autonomy: coercion, internal compulsion, and ignorance.[2] Depending on the circumstances and the severity, the presence of any of these factors may make it impossible, or at least very difficult, for an agent to act autonomously.[3] What traditional accounts tend to overlook, however, is that there is a fourth way in which an agent's autonomy may also be compromised, namely, by the forces of oppression.[4] Oppression may itself involve dimensions of coercion, compulsion, and ignorance, but it functions in complex and often largely invisible ways, affecting whole social groups rather than simply disrupting isolated individuals; as a result, its effects tend to be ignored within the traditional autonomy framework that focuses solely on individuals. Moreover, addressing these features requires changing the broad social conditions that constitute oppression and not merely changing some of the specific circumstances of an individual agent's situation. It is necessary, then, to explore the distinct ways in which oppression may interfere with a person's ability to act autonomously.

To make explicit the role of oppression in autonomy, we appeal to a concept of relational (or contextual) autonomy. We understand relational autonomy to involve explicit recognition of the fact that autonomy is both defined and pursued in a social context and that social context significantly influences the opportunities an

agent has to develop or express autonomy skills. In relational autonomy, it is necessary to explore an agent's social location if we hope to evaluate properly and respond appropriately to her ability to exercise autonomy. Whereas traditional accounts concern themselves only with judging the ability of the individual to act autonomously in the situation at hand, relational autonomy asks us to take into account the impact of social and political structures, especially sexism and other forms of oppression, on the lives and opportunities of individuals. By making visible the ways in which autonomy is affected by social forces, especially oppression, relational autonomy challenges assumptions common to much bioethical literature that autonomy be viewed as an achievement of individuals.

We must, therefore, evaluate society and not just the individual when determining the degree to which an individual is able to act autonomously. Insofar as oppression has reduced or undermined an agent's ability to act autonomously in various contexts, relational autonomy seeks politically aware solutions that endeavour to change social conditions and not just expand the options offered to agents. In particular, a relational view of autonomy encourages us to understand that the best way of responding to oppression's restrictive influence on an individual's ability to act autonomously is to change the oppressive conditions of her life, not to try to make her better adapt to (or simply to manage to "overcome") those conditions privately.

We live in a society complicated by many intersecting forces of oppression. Although we may challenge them and work to reduce their influence, we cannot hope to see their disappearance in the near future. Many members of our society have been damaged to varying degrees by these forces of oppression, and many have diminished ability to exercise autonomy as a consequence of their experiences as members of oppressed groups. Unfortunately, the damage done by oppression may be so deep that the effects can never be completely erased,[5] but reducing oppressive circumstances can increase opportunities to repair some of the damage and prevent its occurrence in future generations. Because oppression is always an impediment to autonomy, any society truly committed to promoting autonomy must work to eliminate the forces of oppression that reduce citizens' opportunities to become maximally autonomous.[6]

Of course, this is not to say that every person who belongs to one or more groups that is subject to oppression is incapable of exercising autonomy or that everyone who belongs to a dominating group is fully autonomous. Rather, it is to make clear that oppression tends to interfere with an agent's ability to develop or exercise autonomy effectively in specific ways. Individual members of oppressed groups are affected to varying degrees by the forms of oppression that are endemic to their society; some manage to overcome the oppressive circumstances of their lives largely unscathed. Furthermore, since there are many intersecting forms of oppression, each person belongs to multiple groups with multiple locations on any map of oppression and may well be privileged in some respects even as she or he is oppressed in others, and this complex positioning may have an impact on the agent's opportunity to develop the abilities needed to act autonomously. Also, the features that support the development of some of the skills necessary to exercise autonomy are products not only of large social forces but also of particular personal relationships; the latter vary significantly from one individual to the next even within the same social groups. Membership in one or more oppressed groups is an obstacle, then, but not an insurmountable barrier to the development of relational autonomy.

Here we focus specifically on one particular dimension of oppression that interferes with autonomy, namely, oppression's effect on self-trust. We argue that an agent requires a certain degree of self-trust to be able to act autonomously; because self-trust is undermined by oppression, oppression reduces an agent's ability to act autonomously. To make our argument more concrete, we review some areas of healthcare where it is evident that the effects of oppression on self-trust interfere with patients' ability to act autonomously, and we consider some of the options available to health-care providers in such circumstances. We discuss a variety of cases, concentrating particularly on problems associated with caring for women with serious addictions, as this is an area where the links among oppression, self-(dis)trust, and autonomy create especially difficult challenges for health-care providers. We explore how health-care providers ought best to respond to these patients. In our view, there is no single solution to this difficulty but a range of responses that must vary with the health needs and the situation of each patient.

We begin by looking at some of the distinct ways in which oppression can limit an agent's ability to act autonomously in order to appreciate how self-trust fits within this complex matrix. First, oppression may involve explicit or implicit limitations on the options available to members of oppressed groups. An important example is the way in which oppression may limit the options that are reasonable for an agent to choose under various circumstances by placing her in a double bind;[7] in such cases, whatever she does, she will suffer. For example, it is not unusual for women who are living with violent partners to feel trapped in those dangerous relationships. They may feel that they cannot leave the relationship because the danger of such action would be too great: generally, the most serious attacks of domestic violence occur when the battered partner attempts to separate. Moreover, separation may bring not only the heightened risk of attack but also harassment, financial difficulties, the risk of losing custody of her children, and for immigrant women the threat of deportation. On the other hand, remaining with the abusive partner clearly represents a serious danger to the woman and her children. Unless she has access to excellent social services for battered women, there may be no safe option available to her. Less dramatic examples of oppression-related double binds involve the ways in which women are often considered suspect as job candidates if they are single and if they are married, if they have children and if they do not, and if they quit their previous job and if they were fired.

Second, and more deeply, oppression may shape agents' values and desires in ways that undermine their capacity for autonomous choice in certain matters. In fact, women's oppression typically involves circumstances in which the agent's immediate interests appear to support her active participation in practices that actually promote her oppression. For example, part of women's oppression is that they are primarily valued (by themselves, as well as by others) in terms of their instrumental role as mothers. Many women who have difficulty in conceiving or maintaining a pregnancy seek medical interventions to circumvent infertility problems, using powerful fertility-enhancing drugs and often surgical treatments in the pursuit of a baby. In so doing, they reinforce the social norms that proclaim the profound importance

of women being able to reproduce. The relentless efforts of so many infertile women to spare no risk or expense to produce a biologically related child help to deepen social expectations about the normalcy of childbearing for all women and to raise questions about the nature of other women who choose childlessness. Whatever their intentions, their participation in practices that take for granted the desirability of biological reproduction helps to further entrench social attitudes about women's fundamental role as mothers.[8]

Our main focus in this article is on two other ways in which oppression can interfere with autonomy. One is that oppression tends to deprive a person of the opportunity to develop some of the very skills that are necessary to exercise autonomy by restricting her opportunity to make meaningful choices and to have the experience of having her choices respected. As Diana Meyers argues, exercising personal autonomy involves certain types of competency that depend on the development of corresponding skills.[9] If an agent is never exposed to an environment that fosters the development of those skills, she will lack the ability to exercise autonomy. Moreover, she will have been deprived of the opportunities to develop the level of self-trust that is necessary for her to gain and use these skills effectively. She may then not be in a position to exercise autonomy even when invited to do so. Hence, it is not sufficient simply to offer a person an uncoerced choice; it is also necessary to ensure that she has had the opportunity to learn to exercise choice responsibly.

Lastly, oppression can lead to the internalization of a sense of social worthlessness and incompetence that is translated into a lack of self-worth and self-trust. When a group is oppressed, the society at large operates as if that group is less worthy and less competent than others and devalues its members. Members of oppressed groups may then internalize these attitudes; many are inclined to accept society's devaluing of their personal worth on at least an unconscious level and to doubt their own worth and ability to make appropriate choices.[10] This lack of self-worth and self-trust may be devastating to agents' autonomy competency, interfering with their ability to act according to their own interests at all.

Many feminists have explored the effect of these various aspects of oppression on autonomy, and several have addressed the necessity of having an adequate sense of self-worth. To date, none have focused explicitly on the effect of oppression-related reductions in self-trust on the agent's autonomy.[11] Our aim here is to bring out the significance of self-trust in discussions of oppression and autonomy. We are interested in exploring the ways in which oppression interferes with the development of self-trust and with the fact that reduced self-trust tends to reduce an agent's ability to act autonomously. And we seek to understand the special challenges health-care providers face in caring for patients with the diminished autonomy that is associated with low levels of self-trust.

Self-trust (and its correlate, self-distrust) must be considered when evaluating or promoting autonomy skills because autonomy is dependent on self-trust.[12] Exercising autonomy involves, in part, reflecting on one's beliefs, values, and desires; making reasonable decisions in light of them; and acting on those decisions. It is essential in developing the capacity to be autonomous that the agent trusts her capacity to make appropriate choices, given her beliefs, desires, and values; that she trusts her ability to act on her decisions; and also that she trusts the judgments she makes that underlie those decisions. These include judgments about the values and motivations that lie behind her decisions and about the efficacy of her own decision-making skills. Without trust in these judgments and trust overall in her ability to exercise choice effectively, any agent would have little motivation to deliberate on alternative courses of action.

In recognizing some degree of self-trust to be a precondition of autonomy, we are offering a substantive view of autonomy that builds on existing theories formulated by Paul Benson and Robin Dillon.[13] Autonomy theories can be either substantive or procedural. Procedural accounts require that the agent subject her beliefs, values, and desires to some procedure or method of evaluation and that she act on whatever beliefs or desires satisfy that procedure. Meyers, for example, offers a procedural account in which the goal of the procedure is to determine what the agent *really* believes or desires, and being successful in this process of self-discovery requires that the agent possess certain competency skills.[14] We accept the procedural dimensions of autonomy and believe that self-trust has a role to play within them, but we also believe that an autonomy theory must be supplemented with a limited substantive demand. What distinguishes substantive accounts from procedural theories is that the latter, unlike the former, are "content-neutral"; the procedure of evaluation does not dictate that the agent must *really* believe anything specific about herself or the world to be autonomous. Substantive theories, on the other hand, put restrictions on the kinds of beliefs, values, and desires an agent must have in order to be autonomous. The restriction Benson and Dillon argue for is to have a positive conception of one's own worth and respect for one's capacities. The requirement that the agent value or respect herself puts a limit (albeit a minimal one) on the sorts of beliefs or feelings that she can have about herself if she is to be autonomous.[15] We propose a different, though similar limit in requiring that the agent trust her own judgment. As we explain below, we believe that self-trust is a criterion for autonomy distinct from that of self-respect or self-worth.

The role of self-trust within the procedural dimensions of autonomy includes the following aspects. First, to be motivated to exercise her own choices, the agent must trust her capacity to choose effectively, a type of self-trust that we refer to as Type I. Having this capacity involves having good decision-making skills and also being situated to choose well, meaning that the agent is adequately informed of alternative courses of action and of whatever facts are relevant to her decisions. For her to trust herself to make good decisions, she must trust her competency skills and the accuracy and adequacy of the information available to her. Distrust in these areas inhibits her autonomy because it makes it very difficult for her to formulate decisions about what she should believe or desire and how she should act. As noted, oppression can cause self-distrust in the agent's decision-making skills by depriving her of sufficient opportunities to develop and exercise those skills. People who believe that she is less competent than others by virtue of being a member of a particular social group will deny her these opportunities. Oppression can also limit her knowledge base for making decisions by ensuring that most of the information circulating throughout her society is about the lives of members of the dominant group and the risks or benefits *they* would incur by making particular decisions, such as those about their own health care.

Second, an agent must trust her ability to act on the decisions she makes, a type of self-trust that we call Type II. She may lack this form of self-trust because she lacks the courage to act on her judgments and consequently distrusts her ability to do so. She may also lack it because of conflicting desires that stand in the way of her acting on her judgments. Such desires are commonplace among people who are oppressed and who are attempting to fight their oppression. Their trust in their ability to act on decisions that oppose their oppression can be compromised by the desire simply to get along with others or the desire to experience the benefits of conforming to dominant stereotypes or interests. For example, some women find it very difficult to stick with a decision not to appear unwise or innocent around men in positions of power, who would not pay much attention to them otherwise.

Third, the substantive demand on autonomy concerned with self-trust is that the agent must trust the judgments she makes that underlie her own choices. We call her trust in her own judgment Type III. Judgments that are relevant to her autonomy are, for example, her judgments about the trustworthiness of her own decision-making skills. Whether she trusts or distrusts her evaluations of her own capacities as an agent will depend on her level of self-knowledge, or the degree to which she feels that she understands her own strengths or weaknesses as an agent. Other autonomy-related judgments concern the values that inform her decisions. She must have some confidence in the appropriateness of her values for her to be motivated to make decisions that reflect them. If her values have been shaped by oppression, it will not be easy for her to trust them because they will encourage her participation in practices and behavior that undermine her moral worth and that may cause her severe suffering.

Each of these three different types of self-trust or distrust can be situational or more general, meaning that they can apply only to specific situations or to most situations in which the agent finds herself.[16] For example, most of us distrust our decision-making capacities in at least some situations, in particular, those in which we know that we lack the knowledge required to make an appropriate choice. People trained only in philosophy probably would (and should) distrust their ability to make good decisions in situations in which training in engineering is called for. Type II self-trust is also often situational; for example, whether we have the courage to act on our decisions usually depends on the context in which we have made them. If we lack that courage in *most* situations, our autonomy will suffer, and that happens whenever any of the three types of self-distrust occur generally rather than only situationally. On the other hand, situational self-distrust of any type may be minor and, hence, trivial if it occurs in an area of little importance to the agent. However, if it occurs in an area that relates to how she defines herself or to what she values most, it will be nontrivial in the sense that it will interfere with her autonomy. For example, if she defines herself as a proud lesbian but lacks trust in her ability to act on judgments that reflect that pride in relevant situations, that situational Type II self-distrust will negatively affect her autonomy.

Just as it is appropriate sometimes to distrust others, it is also appropriate sometimes to distrust oneself. There are situations in which it is justified for an agent to distrust her ability to act on her judgments. The justification lies in a history of failing to act on the relevant judgments in the relevant situations. Often situational self-

trust and distrust develops, at least in part, through inductive reasoning about past successes or failures at using or attempting to use our various abilities. Depending on the soundness of this reasoning, the agent's self-trust or distrust will be well formed or ill formed. For example, an alcoholic may reason that she can trust her ability to act on her decision to refrain from drinking, but her reasoning may be unsound, based on her past experience, in which case her trust in her ability to refrain is ill formed.

Clarifying how the different types of self-trust develop and the exact nature of self-trust (that is, what sort of mental attitude it is) is not something we can accomplish here, but we make some preliminary remarks about both. First, regarding the development of self-trust, the fact that oppression and self-distrust are interrelated means that self-trust does not always or merely develop through inductive reasoning by the agent. The level of support that the agent receives within her social environment will have a profound influence on her self-trust. That support can exist on two different levels: (1) the agent can be given opportunities to develop and use her various capacities and, through these opportunities, learn to trust her capacities; (2) the agent can receive encouragement from others to trust her own capacities. On the first level, the self-trust is relational in a causal sense; supportive social conditions provide the materials for its development. On the second level, self-trust is relational in a constitutive sense; the agent's trust in herself exists in part because others reinforce that trust in their relationships with her. Our self-appreciation is influenced by the opinions that others have of us, particularly when we are young. It is doubtful that anyone could ever avoid the constitutively relational aspect of self-trust and distrust.

The way in which a particular instance of self-trust or distrust develops will determine whether that trust is informed primarily by beliefs or feelings. The primary influence on self-distrust that arises through inductive reasoning about past failures will probably be a belief, whereas the primary influence on self-distrust that exists because of subtle attempts by others to undermine self-trust will probably be a feeling about our own incompetency. Such subtle attempts, which may not be fully conscious on the part of those who make them, are common in relationships that involve oppression.[17] Oppressed people often receive the subtle (and occasionally not so subtle) message from others that their opinions are not as credible or as important as the opinions of the dominant group. Often the message is vague, and so it produces a vague sense or a feeling in the agent, rather than a belief, that her judgment is untrustworthy.

Thus, self-trust, like interpersonal trust, is an attitude that is shaped by beliefs and/or feelings about the trustworthiness of the trusted. This general description of trust is consistent with the view of many trust theorists, such as Annette Baier, Richard Holton, Karen Jones, and Trudy Govier, even though they differ in their elaborations on the view that trust is an attitude.[18] For example, Jones says that trust is an attitude of optimism about the goodwill and competence of the one trusted, and it involves an expectation that that person will be "directly and favorably moved by the thought that we are counting on her."[19] Holton agrees that it is an attitude that entails assumptions about the future motivations of the trusted person, but he disagrees that it is necessarily informed by a belief about the goodwill of that person. We can infer from where the agreement lies about the nature of interpersonal trust

that the attitude of self-trust concerns the competence of the self and expectations about how one will be motivated to act in the future.

Thus, we can see how self-trust differs from self-worth and self-respect; it is not interchangeable with either of them, although that is how some authors, such as Benson and Dillon, treat those forms of self-appreciation.[20] Self-trust differs from self-worth in being about our competence rather than our worth. It makes sense, for example, to talk about trusting our competence to judge our worth. Self-respect can also be about our competence, but there is a sense in which the positive evaluation it gives of our competence is grounded in our past behaviour.[21] In trusting ourselves, we are optimistic that we will be able to carry that evaluation forward into the future. Thus, one can trust oneself to act in the future in a way that maintains one's self-respect. However, it is doubtful that one could have that trust in the absence of self-respect, and moreover, that one could acquire self-respect regarding one's competence without some self-trust. Those self-regarding attitudes are distinct, yet they are mutually reinforcing.

Some theorists, particularly Holton, argue that we can decide to develop trusting attitudes, whereas we cannot simply decide to believe. These attitudes are constrained somewhat by evidence that contradicts them and by our current beliefs and feelings; for example, we cannot decide to trust a person whom we believe to be untrustworthy. However, outside of some minimal constraints, we can will ourselves to trust. As Holton explains, willed attitudes of trust that are unreasonable, given the evidence and our relationship with the trusted, are ill founded.[22] Likewise, trusting attitudes toward the self can be ill founded; for example, if I develop a trusting attitude toward my ability to take a bobsled down a mountain without killing myself but I have no evidence of my ability to do so, that attitude is unreasonable.

In conclusion, we have reviewed how different types of self-trust can damage our autonomy and explained how they can be related to oppression. Being fully autonomous in our view requires having all nontrivial forms of the different types of self-trust. We recognize that autonomy exists in degrees and that lacking some instances of nontrivial self-trust does not make an agent completely nonautonomous. However, our interest lies primarily in cases in which the agent's autonomy has been damaged severely by oppression-related reductions in self-trust, and we intend to discuss how health-care providers should respond to such patients. In the next section, we explore the influence on health-care provision of the impact of oppression on self-trust and autonomy. At the end of it, we consider cases in which that impact is severe, specifically, among women with addictions.

Responding to the Effects of Oppression on Self-Trust in Health Care

It is at present widely agreed throughout the biomedical health-care community that patients should make autonomous decisions about their health care to the greatest degree possible. There is no clear consensus, however, on how health-care providers are to proceed when caring for patients who are not fully autonomous. We are concerned, specifically, with the question of determining how health-care providers should respond to patients whose autonomy is diminished as a result of their oppressed status.

Typically, the health-care system has responded to patients with reduced levels of autonomy (as identified by the traditional analysis) by exercising paternalism (making decisions on behalf of patients without their full consent). Indeed, exercising paternalism has been customary throughout the history of medicine, even when dealing with autonomous patients. It is only in the past few decades, paternalism has become widely recognized as a direct threat to autonomy; as a result, health-care providers have been formally discouraged from exercising paternalism when dealing with patients who are capable of making autonomous decisions. Nonetheless, a certain degree of paternalism pervades modern practice. Health-care decisions can be exceedingly complex, requiring understanding of a great deal of technical information and careful weighing of options. Even the most independent and self-reliant patient often feels overwhelmed and is inclined to defer to medical authority when facing serious health matters. In such a context, when health-care professionals are faced with patients whose autonomy is suspect for any reason, it may seem appropriate to exercise paternalism to ensure the best possible care for these patients.

Paternalism on the part of health-care professionals is always questionable, however, for it may involve significant distortion of the patient's real interests. The exercise of paternalism is especially problematic when applied to patients whose autonomy is reduced by virtue of their history of oppression. Oppression involves unjust distributions of power, and health-care settings are sites of very uneven power differentials. If health-care professionals, especially physicians, further consolidate their already disproportionate power in relation to patients, especially those from oppressed groups, they exacerbate a problematic power differential and further reduce the already limited autonomy of their patients. Moreover, they are unlikely to be in a position to know what is ultimately in the best interests of patients whose life experiences are very different from their own; hence, they are unlikely to be in a position to exercise paternalism wisely.[23] Other solutions to the problem of reduced autonomy must be found.[24]

The impact of oppression on patients' ability to exercise autonomy can be felt in many different ways. For example, the ability to exercise autonomous choice requires, among other things, access to appropriate information. Competent health-care providers strive to simplify the relevant information and to ensure that patients appreciate the meaningful choices before them, but most shape the decisions their patients will make by tailoring the information to ensure the selection of what the health-care expert considers the best choice for each patient—an indirect form of paternalism. Patients' autonomy is generally reduced to the exercise of "informed choice" in which the information provided is restricted to that deemed relevant by the health-care provider (and by the health-care system, which has determined what information is even available by pursuing certain sorts of research programs and ignoring others). Even in "ideal" cases in which patients have strong autonomy skills and full access to all the available information, it is important to recognize the influence that oppression may have on the information base and, thereby, on the meaningful options available to patients.

Specifically, oppression tends to restrict the relevant knowledge base that can be called on for making health-care decisions. It may limit the health-care providers'

ability to appreciate the type of information the patient might need to know in order to choose wisely in her circumstances. For example, the need to arrange for flexible work hours to adapt to a treatment regime may not seem problematic to a physician but may pose an insurmountable barrier to women in certain types of jobs. Furthermore, oppression may limit the knowledge base itself; for example, although heart disease is the leading cause of death in women, many important studies of heart disease have used only male subjects, so there are insufficient data about the effectiveness of prevention or treatment programs for women (e.g., the value of taking a daily dose of aspirin as a preventive measure). Similarly, research into treatment for AIDS has concentrated on the progress of the disease on men; as a result, women must often choose drug regimens whose effects on women's bodies have not been sufficiently explored.[25] In these sorts of cases, relational autonomy helps us to recognize that circumstances may limit the autonomy of all patients who belong to oppressed groups by creating an inappropriately limited knowledge base on which such patients must rely.

These sorts of gaps in available knowledge are problematic in that they reduce the agent's ability to choose well. They also raise issues of trust and of Type I self-trust. These gaps mean that often patients who are members of oppressed groups have particular reason to distrust the information their health-care providers supply. In addition, they mean that patients are limited in their ability to obtain independent and appropriate information on their own. In such circumstances, patients must lack trust in their own abilities to acquire the necessary knowledge to make well-informed decisions. Even a patient who has managed to develop strong autonomy skills will lack Type I self-trust when she must choose in the face of inadequate or skewed data. She may have complete confidence in her own ability to make such decisions, but if she knows that she is making them without adequate data, she will still not be able to fully trust the outcome. Many menopausal women feel precisely this unease as they grapple with the question of whether or not to begin hormone replacement therapy. Although the self-distrust at issue is quite limited in scope and located around a particular range of choices—and, hence, is a relatively benign form of self-distrust—it is still relevant to the autonomy of the agent. In this case, it is a form of well-founded distrust of the results of her own deliberations because of the limitations inherent in the circumstances in which these decisions are made. Oppression is relevant here because the data needed to make health-care decisions are often particularly limited for members of oppressed groups; as a result, patients from these groups find that they must often distrust the knowledge base they need to rely on and that distrust will affect their confidence in many sorts of health-care decisions they are required to make.

In such circumstances, autonomy is compromised. Paternalism is not any more reliable, however, since health-care providers will face the same limits in knowing what will best meet these patients' needs. Thus health-care providers have a responsibility not to take over decision making from patients but to ensure that patients understand the limits of the knowledge the former can provide. Moreover, health workers should appreciate their collective responsibility to work toward filling in these important knowledge gaps.

Yet more complex questions arise when we consider cases in which patients

choose medical procedures that seem inseparable from their oppression. In these cases, patients who are aware of the ways in which socialization may have shaped their values and desires to conform to oppressive stereotypes will again find it difficult to trust their own deliberations. They will lack Type III self-trust insofar as it concerns the values and desires that inform their decisions. For example, the decision about whether or not to use hormone replacement therapy at menopause is further complicated by factors other than inadequate and inconsistent evidence. There is also the fact that women are encouraged to use such treatments to continue to look young; in doing so, they are participating in the norms of a culture that prefers its women young and beautiful. Of course, hormone replacement therapy is seldom a straightforward, single-dimension decision; women are also encouraged to use it to reduce their risk of heart disease and osteoporosis and now, it is suggested, of Alzheimer's disease. The multiple dimensions of such decisions mean that many factors must be taken into account, making such decisions especially difficult and complex for many women. Those who find that maintaining a youthful appearance is an important consideration are in a particularly awkward position. They may well have excellent reasons for wanting to continue to look young for as long as possible: their careers and romantic possibilities may well depend on appearing youthful, and their own aesthetic sensibilities may also be an issue. The problem is that cultural attitudes that consistently value young (looking) women over older women are oppressive to every woman. To devalue women who clearly have reached a certain maturity is to devalue important aspects of all women's lives. It reflects a value system that cares more about women's appearance than their wisdom or experience; in such a system, women are valued more for their ornamental role than for their personhood. Women who are aware of this cultural prejudice against aging women, yet who feel a strong desire to look young, will find themselves uncertain about their own motivations to use hormone replacement therapy. They may also lack a form of Type II self-trust, one relating to their ability to act on their judgment that in making choices that affect themselves, they should be respectful of their own personhood. They may distrust this ability because they are confused about whether choosing hormone replacement therapy is consistent with that judgment.

Similar problems are associated with the use of cosmetic surgery to better meet society's beauty standards. As more women make the effort to fit these norms, the pressure grows on other women to overcome their natural "handicaps" and adapt to the expectations that apply to women. In such ways, the evaluation of women by external standards of appearance becomes ever more normalized, further contributing to the oppression of all women by overshadowing efforts to recognize them in other terms.[26] For women to participate in this value system is to reinforce it rather than challenge it; their compliance helps to perpetuate its oppressive power.

This issue is made especially problematic because it is an area where women have reason to distrust their own value schemes. Some of the operative values are part of a cultural worldview that is oppressive to women in general and tends to be especially oppressive to women who belong to marginalized groups, including disabled women, lesbians, women of color, and poor women (since the norms promoted are those of young, affluent, slim, fit-looking, white women). Women whose positive evaluations of their own bodies are not attached to these exploitative social

values may find it very difficult to identify or maintain their own value schemes in light of the availability of "cures" for certain body shapes, such as small breasts and large tummies, which are treated as subjects for invasive medical responses. Their difficulty in maintaining their own value systems suggests a lack of Type II trust in their ability to act on decisions that reflect those systems or a lack of Type III trust in their own evaluations of their values. Cosmetic surgeons effectively reduce many women's body parts to material for surgical manipulation, invoking technologies otherwise reserved for healing serious illness and conveying the sense that such deficiencies are important enough to warrant dramatic solutions. At the same time, they join their medical colleagues in acting as authorities for women on the health of their bodies. The multiple messages involved make it hard for many women to trust their own evaluations of their values regarding body shape and size when those evaluations are at odds with sexist beauty norms.

Health-care providers have a responsibility, then, to refrain from encouraging such use of medical resources and to refrain from promoting the youth and beauty their procedures may engender. They need to reflect on their role in a culture that cares more about the superficial aspects of women's appearance than their characters or talents. If they wish to promote the autonomy of patients who seek these procedures, they should not simply respond to informed requests for surgical "corrections" but, at least, also encourage their patients to consider the forces that lead to these choices, as well as alternative responses.

In other cases, health problems are even more directly related to the patient's oppression. For example, both poverty and stress, two conditions highly correlated with oppression, are associated with countless illnesses and are inevitably aggravating factors in any illness. Moreover, many health problems are far more common in members of oppressed groups than in the rest of the population; for example, AIDS is more common among the poor and lupus is more common among people of African descent in North America than in the population at large. Aboriginal women die of cervical cancer in Canada at many times the rate of white women, and suicide has reached epidemic proportions in some native communities in North America. Although women tend to outlive men in much of the world, their lives are plagued by more chronic and debilitating illnesses. Furthermore, one of the characterizing features of oppression is that members of groups subject to oppression are highly vulnerable to violent attacks; women, for example, suffer disproportionately from the effects of domestic and sexual violence, and disabled women in particular experience an exceptionally high rate of attack. These correlations are inseparable from the oppressive conditions that affect disadvantaged populations. As we have noted, such experiences undermine the autonomy of members of oppressed groups in multiple ways; in particular, systematic abuse often interferes with an agent's sense of self-trust, as we discuss below.

When patients appear in the health-care system with conditions in which their oppression seems to be a contributing factor, then, it is not sufficient simply to try to correct the immediate damage, for that leaves the underlying contributing factors intact. It is important for patients—and others—to understand the social and political dimensions of their condition. To restore their sense of self-trust, those who have been assaulted need to appreciate that this violence is part of an endemic pattern and not a consequence of their own behavior; those suffering from nutrition-related disorders because of their low incomes need to appreciate the role that poverty (and not necessarily incompetence) plays in limiting their access to a nutritious diet; and those with poorly understood illnesses should understand that there has been inadequate research into such conditions as lupus that primarily affect disadvantaged populations. This knowledge should help patients feel validated in their legitimate claims for care and should help them to avoid blaming themselves for the conditions in which they find themselves. It may help strengthen the patients' trust in their ability to recognize their need for help and give them guidance on how to pursue both personal and political strategies to improve their situation. Such guidance may require directing patients toward self-help activist groups that will promote a sense of empowerment and build skills and forms of self-appreciation that are necessary for autonomy, including self-trust.

Identifying ways in which health-care providers can promote the autonomy of patients with certain oppression-induced problems, as well as seriously low levels of autonomy, can be exceedingly difficult, however. We now consider some of these difficulties when dealing with a group whose members have faced especially serious problems in developing the conditions necessary for autonomy— women with serious addictions (i.e., addictions to dangerous quantities of such harmful substances as heroin, crack cocaine, alcohol, and solvents). Most of these women tend to have several problems in exercising autonomy. The first and most obvious is one recognized by all autonomy theories: addictions are a form of compulsion, so by their very nature, they interfere with autonomy. This feature in itself makes treatment of serious addictions a significant problem for those committed to respecting autonomy.

The compulsive nature of addiction may make it very difficult, for example, for an addict to make a voluntary (let alone an autonomous) choice to enter a treatment program. Hence, the question arises, when faced with an addict with a low level of autonomy who does not wish to seek treatment or who denies that she has a drug problem, should providers be permitted to get her into treatment by deceiving her somehow or by simply forcing her? Despite the fact that addicts have low levels of autonomy, methods that involve force or deception to admit them for treatment are problematic for several reasons, most notably because the treatment that follows is likely to be ineffective. The general consensus in the field of addiction treatment is that many of the addict's beliefs and attitudes must change if she is to modify her behavior, and this change will not occur in treatment if she is there unwillingly.[27] Hence, whatever the ethical arguments are about coercion in such cases, there is a strong pragmatic case against coercing any addict into treatment.

Whatever account of autonomy we might choose, then, there are good reasons to doubt that women with serious addictions are fully autonomous and also good reason to refrain from forcing them into treatment. We believe, though, that there is an even deeper concern that emerges when we adopt the perspective of relational autonomy—the fact that the autonomy of women with serious addictions is undermined not only by the compulsive nature of their addiction but also by the ways in which their personal history has inhibited their ability to acquire the conditions necessary for autonomy. Many women with serious addictions have experienced se-

vere violence or abuse. A strong correlation between women's addictions and their abuse has been proven in various studies (most but not all of which focus on alcoholic women). Brenda Miller and her colleagues discovered that compared to nonalcoholic women, it is more common for female alcoholics to have suffered childhood sexual abuse, emotional abuse by their fathers and spouses, and spousal physical abuse.[28] One study found that 74% of alcoholic women have experienced sexual abuse, compared to 50% of nonalcoholic women, and a similar difference in percentages was found for physical and emotional abuse: 52%, compared to 34%, for physical abuse; 72%, compared to 44%, for emotional abuse.[29] Moreover, the experiences of female alcoholics with different forms of abuse tend to be more frequent and more severe than their nonalcoholic counterparts.[30] For illicit drug use, one study found that teenaged girls who reported a history of sexual or physical abuse used drugs more frequently than other girls.[31]

What makes most forms of violence or abuse examples of oppression is that they are so systemic that they could be defined as social practices.[32] This definition is appropriate given that these forms of oppression occur in a social environment that makes them permissible, either explicitly or implicitly.[33] The emotional, physical, and sexual abuse of women are not isolated problems that concern only individual women; they are political issues because they are encouraged by sexist stereotypes of women as inherently more passive and vulnerable than men, as primarily sexual objects, and as caregivers as opposed to care receivers.[34]

Most forms of abuse tend to have a negative impact on the abused person's level of self-appreciation. Different kinds of abuse can prevent the development of or can destroy existing self-trust of all the three main types, resulting in the diminished autonomy of the agent. Emotional abuse during childhood, as well as during adulthood, that involves continual criticism and labeling the victim as worthless and incompetent can damage all types of self-trust. Experiencing frequent criticism for her opinions and choices can cause the agent to seriously distrust her decision-making capacities, to lack the courage to act on her own decisions, and to distrust her judgment overall. Predominantly physical forms of abuse can also damage self-trust, mostly because the victims often blame themselves for the anger or sexual desires of their abuser. Victims of incest often think that they somehow provoked their abuse, either because that is what their abusers tell them or because blaming themselves seems to offer a way of reasserting control by allowing them to believe that the abuse will stop if they behave differently in the future.[35] When the abuse continues, they are likely to begin to profoundly distrust their judgment and decision-making capacities because every decision they made about what they needed to do to avoid the abuse turned out to be wrong. Hence, their self-trust of Types I and III will be damaged as a result of the abuse. Some empirical support for these claims can be found in a small study by Doris Brothers, which shows that the greatest problems relating to trust caused by incest and rape lie in the victim's trust in themselves.[36] These problems may not only relate to Types I and III self-trust; in some cases, they may also concern the agent's trust in her ability to act on her judgments, trust that she may lack because of having been threatened with harm or violence if she were to alter her behavior or report her abuse to anyone.

Rather than blaming themselves for the abuse, some victims alternatively block

it out of their minds, sometimes by retreating to a fantasy world. One survivor of incest explains that "I hid myself; I became invisible. I did whatever I could do with my mind to leave the situation."[37] It is not uncommon for incest survivors who used this method to forget about what happened to them until years later. Their trust in their ability to accurately recall memories of their abuse years later may diminish because of disbelief on the part of others who are close to them and because of a societal acceptance of "false memory syndrome."[38] As Sue Campbell argues, those who have encouraged the acceptance of this so-called syndrome, in particular the founders of the False Memory Syndrome Foundation, have succeeded in making it more unlikely than it was in the past that people will believe the testimonies of incest survivors.[39] The so-called syndrome implies that incest survivors, most of whom are women, are "bad rememberers,"[40] and it encourages them to distrust their memory to a degree that could seriously limit their autonomy. Someone who believes that she is a bad rememberer will have difficulty in trusting her capacity to reflect rationally on her beliefs. This capacity is a necessary decision-making skill, and it relies on the memory of the agent. Reflecting on and evaluating our beliefs often involves determining whether our memory of the situation in which we formed them is consistent with the beliefs themselves. Those who are taught to distrust their memory will lack a form of Type I self-trust that is necessary for autonomy.

Not all survivors of incest and other forms of abuse suffer from diminished self-trust and autonomy. Many of them have resisted the label "passive victim," preferring to define themselves as survivors who have succeeded in developing their own coping strategies for abuse.[41] Not all coping strategies lead to survival, however; abused women who cope with their abuse by becoming severely addicted to harmful substances are not yet survivors.[42] Although using these substances may have been the only strategy available to them in the short term, prolonged and severe substance use puts them at risk of serious health problems and may worsen whatever psychological problems they developed as a result of the abuse.[43] Furthermore, prolonged use inhibits their ability to adopt less harmful coping strategies.[44] Before the term "survivor" can be accurately applied to addicted women who suffered abuse, they need to receive treatment for their addiction that addresses not only their addictive behavior but also the abuse and its psychological effects.

Effective women-centered treatment must attend to the fact that many female addicts probably have diminished self-trust and, hence, reduced relational autonomy because of experiences with abuse that typically undermine self-trust. Those who care for these women face the dual tasks of helping them to break free of their addictions, as well as improving their low levels of relational autonomy by helping them to build higher levels of self-trust. These tasks in most cases will be inseparable, which makes the latter essential in addiction treatment for women. Studies have shown that for addicts who lack confidence in their own abilities, increasing that confidence increases their chances of successful recovery from drug or alcohol addiction.[45] One study performed at the Amethyst Women's Addiction Centre in Ottawa, Canada, revealed that women whose self-esteem and assertiveness skills increase during treatment are more likely to curtail their drinking.[46] Being assertive or confident to express your own opinions and feelings has a lot to do with trusting your own judgment about their accuracy and relevance in discussions with others.

Thus, improving assertiveness usually requires improving self-trust; if the former is essential in addiction treatment for women, the latter must be as well. It stands to reason that if an addict continues to have a psychological problem such as low self-trust that diminishes her autonomy, her ability to succeed at the extremely onerous task of quitting a serious drug habit will be inhibited.

Our analysis of the importance of discussing relational autonomy in the context of treatment for women with addictions and histories of abuse provides an additional, and powerful, argument against coercing these women into treatment. Forcing them into treatment that will probably be ineffective (since coerced treatment typically is ineffective) will have the likely consequence of further undermining their already limited autonomy. Imposing treatment will increase the powerlessness of these addicts because all that it achieves is a further reduction in their decision-making power. Taking this power away from them in the context of treatment for their addictions could only be justified if the intent and the most probable consequence of doing so would be to improve their level of autonomy in the long run. Ineffective treatment would not have this consequence, and thus, for addicts with low self-trust, it is especially urgent that means other than coercion be sought to encourage them to escape from the compulsive nature of their addictions.[47]

For health-care providers to have any effect on whether addicts seek treatment, it is important that providers develop trusting relationships with them.[48] In the absence of such relationships, addicts are unlikely to listen to encouragement from providers or will interpret their encouragement as an attempt to harm or humiliate them. Gaining the trust of patients requires that providers honestly display moral concern for their well-being and competence in addressing their health-care needs.[49] Addicts who are members of oppressed groups may have good reasons to doubt that providers will have either of these qualities, reasons that may relate, for example, to the fact that various health-care professions have tended to ignore the health-care needs of members of oppressed groups. It is important for providers to strive to overcome barriers to trust in their relationships with these addicts by showing them that they are morally concerned for their welfare and are committed to providing whatever help they can. Yet, a delicate balance is called for. Providers should not expect or encourage addicts, in particular those with abusive histories, to trust them before the addicts have any evidence of their trustworthiness.[50] The root of many female addicts' problems lie in having trusted someone whom they should have been able to trust but who instead betrayed them severely.

The ability of providers to address the health-care needs of addicts with diminished self-trust and relational autonomy is largely determined by the availability of forms of treatment that are compatible with their needs. Many feminists have argued that traditional forms of addiction treatment, like Alcoholics or Narcotics Anonymous are male-biased,[51] and the American Medical Association (AMA) has agreed with them.[52] Some feminists have argued in favor of approaches to addiction treatment that are feminist or, in other words, that see oppression as a relevant factor in their addictions.[53] We agree with this position and would add to it that feminist approaches should be informed by a theory of self-trust that is feminist or, in other words, that explains how oppression could be relevant to self-distrust.[54] These programs must pay attention to the ways in which different forms of oppression, in particular violence and abuse, can undermine self-trust; more positively, they also must develop ways to promote self-trust.

The environment and some of the group sessions in existing feminist programs seem to promote self-trust to some degree already. Many women who have been through the Amethyst program say that they feel more confident about their own judgment (and therefore have built greater Type III self-trust) because of the "egalitarian" environment at the center. There women are comfortable in expressing their own opinions because they know that others will listen to them and take them seriously, an experience that some Amethyst clients have never had before.[55] Amethyst also conducts a special session on sexual abuse; one woman reports that from this session she learned that having been abused was not her fault and that knowing this has given her "the strength and courage [she needs] to be a survivor."[56] Gaining that strength and courage probably translated into greater Type II and Type III self-trust; learning about the dynamics of abusive relationships can help abused persons realize that what they were led to believe or feel about their own judgment was unfounded and that they should be more confident about acting on their judgments.[57] As well as giving them the opportunity to explore these dynamics, it may also be helpful for women with low self-trust to explore how oppression may have shaped their values and to consider whether adopting nonsexist, nonracist (and other antioppression) values would make them more comfortable with their decisions. Another helpful method for improving self-trust might involve giving women educational and employment opportunities that allow them to develop autonomy skills and prove their competency to themselves. Most female addicts have lacked these opportunities in the past to a greater extent than male addicts.[58]

Because oppression is morally objectionable and its continuing existence threatens to undermine the ability of its victims to develop self-trust, feminist treatment centers should also work along with other groups to try to eliminate oppression in the lives of female addicts. For some addicts, however, oppression may have undermined their self-trust in such a profound way already that removing oppressive forces from their lives would have little effect. As Susan Babbitt argues in *Impossible Dreams*, feelings of incompetence and worthlessness can be so internalized that improvements to one's social environment would do little to change them. One form of self-distrust that may be extremely difficult to dislodge is Type III distrust in the agent's judgments about her own decision-making capacities. Even if she has been very successful in using these capacities in the past, if she distrusts her judgments about them, she will be inclined to interpret each success as a fluke. No matter how hard she reasons about their origin, she could interpret every good decision she makes in this way. When psychological damage caused by oppression is that severe, it may be unreasonable to expect addiction counselors to heal it. Still, it is possible, though certainly not guaranteed, that a supportive and loving environment in group sessions where people trust one another will heal such damage. What addiction counselors can do is figure out what sort of group dynamics can have that effect and try to reproduce them in future group sessions. What they need to do minimally is to understand the depth of the problem, lest they blame the clients for their own sense of frustration from ineffective treatment.

Treating any patient whose autonomy and self-trust are reduced because of her

oppression is a complex matter. It must begin with understanding the political nature of oppression and recognizing the importance of finding ways to empower patients by helping to restore their autonomy, in addition to dealing with their physical symptoms. Much of this work is beyond the scope of health-care providers; it requires broadscale social and political change. Health care by itself cannot, of course, correct all of the evils of oppression. It cannot even cure all of the health-related effects of oppression. If health-care providers are to respond effectively to these problems, however, they must understand the impact of oppression on relational autonomy and make what efforts they can to increase the autonomy of their patients and clients. We have argued that this work must include efforts to help patients develop or strengthen their trust in themselves.

Notes

1. We wish to thank the editors, Catriona Mackenzie and Natalie Stoljar, for their very insightful and detailed comments on an earlier draft of this article. Their guidance has been invaluable. Much of our thinking on relational autonomy emerged through Susan's participation in the Feminist Health Care Ethics Research Network, supported by a Strategic Research Network Grant from the Social Sciences and Humanities Research Council of Canada. Carolyn completed her work on this article while on doctoral scholarships from the Social Sciences and Humanities Research Council of Canada and the Izaak Walton Killam Memorial Foundation.

2. We focus specifically on the ways in which autonomy is used in discussions of health-care ethics. We concentrate, particularly, on the approach of Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics*, 4th ed. (New York: Oxford University Press, 1994), because it is widely seen as the most influential account in the discipline.

3. For example, Beauchamp and Childress say: "We analyze autonomous action in terms of normal choosers who act (1) intentionally, (2) with understanding, and (3) without controlling influences that determine their action" (ibid., p. 123). They do not dwell on the nature of such "controlling influences" but cite examples that deal with compulsion and coercion.

4. For analysis of the concept of oppression, see Iris Marion Young's *Justice and the Politics of Difference* (Princeton, N.J.: Princeton University Press, 1991).

5. This is a central issue in Susan Babbitt's *Impossible Dreams: Rationality, Integrity, and Moral Imagination* (Boulder, Colo.: Westview, 1996).

6. For further development of this argument, see Susan Sherwin, "A Relational Approach to Autonomy in Health Care," in *The Politics of Women's Health: Exploring Agency and Autonomy*, The Feminist Health Care Ethics Research Network, coordinator Susan Sherwin (Philadelphia: Temple University Press, 1998).

7. See Marilyn Frye's *The Politics of Reality: Essays in Feminist Theory* (Freedom, Cal.: Crossing Press, 1983).

8. See Susan Sherwin, *No Longer Patient: Feminist Ethics and Health Care* (Philadelphia: Temple University Press, 1992).

9. Diana Tietjens Meyers, *Self, Society, and Personal Choice* (New York: Columbia University Press, 1989).

10. See Paul Benson, "Free Agency and Self-Worth," *The Journal of Philosophy* 91 (1994): 650–668; Robin Dillon, "Toward a Feminist Conception of Self-Respect," *Hypatia* 7 (Winter 1992): 52–69; and Babbitt, *Impossible Dreams*.

11. In "Self-Trust, Autonomy, and Self-Esteem," *Hypatia* 8 (Winter 1993): 99–120, Trudy Govier draws a connection between self-trust and autonomy, but she does not explore the impact of oppression on self-trust, as we do later.

12. The relation works the other way as well: developing self-trust requires some degree of autonomy. If we are not autonomous beings, we cannot know that the reasons we have for believing or feeling that we are competent and that we have good judgment relate to our own successes rather than successes for which we are not responsible. In *Self-Trust: A Study of Reason, Knowledge, and Autonomy* (New York: Oxford University Press, 1997), Keith Lehrer agrees that autonomy is necessary for self-trust, but he fails to see that the opposite is also the case. He argues that trusting ourselves involves knowing that we prefer and accept things that are worth accepting and preferring. He points out that if every evaluation we make is "imposed or fortuitous," we not only do not know that we are the ones preferring and accepting what is valuable or correct but also we cannot even trust our own judgment about what is valuable or correct in the first place (see especially p. 95).

13. Benson, "Free Agency," and Dillon, "Toward a Feminist Conception."

14. See Meyers, *Self, Society, and Personal Choice*, especially part 2.

15. Benson, "Free Agency," p. 664.

16. Govier explains in "Self-Trust, Autonomy" that self-trust can be merely situational. She contrasts situational self-trust with what she calls "core" self-trust (pp. 112–114).

17. For discussions of the subtle workings of oppression, see Sandra Lee Bartky, *Femininity and Domination: Studies in the Phenomenology of Oppression* (New York: Routledge, 1990), especially "Shame and Gender," pp. 83–98, and Robin Dillon's "Self-Respect: Moral, Emotional, Political," *Ethics* 107 (January 1997): 226–249.

18. See Annette Baier, *Moral Prejudices: Essays on Ethics* (Cambridge, Mass.: Harvard University Press, 1995), p. 10; Richard Holton, "Deciding to Trust, Coming to Believe," *Australasian Journal of Philosophy* 72 (March 1994): 63–76; Karen Jones, "Trust as an Affective Attitude," *Ethics* 107 (October 1996): 4–25; Trudy Govier, "Is It a Jungle Out There? Trust, Distrust and the Construction of Social Reality," *Dialogue* 33 (1994): 237–252.

19. Jones, "Trust as an Affective Attitude," p. 4.

20. For example, in "Self-Respect," Dillon argues that an important part of self-respect is "appreciating" (or trusting) our capacity to live up to expectations we have set for ourselves. Benson discusses the feeling free agents have of being "worthy to act," and at least part of what he means here is that they have trust in their "competen[cy] to answer for [their] conduct" ("Free Agency," p. 660).

21. Determining whether in fact self-trust and self-respect are distinct is more complicated than these comments suggest. The issue is complicated because the philosophical literature refers to different forms of self-respect (and they are reviewed by Dillon, "Self-Respect," pp. 228–232). Self-trust would have to be distinguished from each of these forms.

22. Holton, "Deciding to Trust," p. 71.

23. See Sherwin, *No Longer Patient*.

24. Of course, we recognize that some exercise of paternalism will be appropriate on occasion, but only in very limited circumstances. We do not want to deny the need for paternalism in classic cases of emergency care, for example. We do want to insist, though, that oppression should never be taken as license to presume consent that would not be presumed of other patients in comparable emergency situations.

25. See Anna C. Mastroianna, Ruth Faden, and Daniel Federman, eds., *Women and Health Research: Ethical and Legal Issues of Including Women in Clinical Studies*, 2 vols. (Washington, D.C.: National Academy Press, 1994).

26. The use of cosmetic surgery to promote oppressive norms is not restricted to gen-

der norms. Cosmetic surgeons also help transform people of Asian or African origin so that they appear more Caucasian, a more highly valued look in many parts of the world.

27. See James Foulks, "Should the Treatment of Narcotic Addiction be Compulsory?" *Annals of the Royal College of Physicians and Surgeons* 13 (July 1980): 232–239. Theorists about addiction treatment tend to focus now on ways to enhance the motivation of addicts to enter into treatment on their own. See Mark Schuckit, *Drug and Alcohol Abuse: A Clinical Guide to Diagnosis and Treatment*, 3rd ed. (New York: Plenum Medical Book Co., 1989), p. 263, and W. R. Miller, "Increasing Motivation for Change," in *Handbook of Alcoholism Treatment Approaches: Effective Alternatives*, ed. R. K. Hester and W. R. Miller (New York: Pergamon, 1990), pp. 67–80.

28. See B. A. Miller, W. R. Downs, D. M. Gondoli, and A. Keil, "The Role of Childhood Sexual Abuse in the Development of Alcoholism in Women," *Violence and Victims* 2 (1987): 157–172; W. R. Downs, B. A. Miller, and D. M. Gondoli, "Childhood Experiences of Parental Physical Violence for Alcoholic Women as Compared with a Randomly Selected Household Sample of Women," *Violence and Victims* 2 (1987): 225–240; and B. A. Miller, W. R. Downs, and D. M. Gondoli, "Spousal Violence among Alcoholic Women as Compared to a Random Household Sample of Women," *Journal of Studies on Alcohol* 50 (1989): 533–540.

29. S. S. Covinton and J. Kohen, "Women, Alcohol, and Sexuality," *Advances in Alcohol and Substance Abuse* 4 (1984): 41–56.

30. Ibid.; Miller et al., "Spousal Violence."

31. M. Bayatpour, R. D. Wells, and S. Holford, "Physical Violence and Sexual Abuse as Predictors of Substance Use and Suicide among Pregnant Teenagers," *The Journal of Adolescent Health* 13 (March 1992): 128–132.

32. See Young, *Justice and the Politics of Difference*, p. 62.

33. Ibid., p. 61.

34. Abuse or violence experienced by men who are not members of marginalized groups is not inherently political. Although their abuse may cause similar psychological damage as that motivated by oppressive social stereotypes, the underlying causes of the damage in each case differ.

35. See Govier, "Self-Trust, Autonomy"; William May, "The Molested," *Hastings Center Report* (May–June 1991): 9–17; Diane Lepine, "Ending the Cycle of Violence: Overcoming Guilt in Incest Survivors," in *Healing Voices: Feminist Approaches to Therapy with Women*, ed. Toni Ann Laidlaw, Cheryl Malmo, and associates (San Francisco: Jossey-Bass, 1990), pp. 272–287; Lena Dominelli, "Betrayal of Trust: A Feminist Analysis of Power Relationships in Incest Abuse and its Relevance for Social Work Practice," *British Journal of Social Work* 19 (1989): 291–307.

36. See Doris Brothers, "Trust Disturbances in Rape and Incest Victims," Ph.D. dissertation, Yeshiva University, New York, 1982; cited in Govier, "Self-Trust, Autonomy," pp. 99–101.

37. Lepine, "Ending the Cycle of Violence," p. 284.

38. For a definition of this syndrome, see Sue Campbell's "Women, 'False' Memory, and Personal Identity," *Hypatia* 12 (Spring 1997): 51–82, especially pp. 69, 70.

39. Ibid., p. 74.

40. Ibid.

41. See Dominelli, "Betrayal of Trust," p. 303.

42. It is important to point out that it has not been shown that all women who have addictions and have been abused develop their addiction after their abuse. Their addiction may have come first, and it also may have been a factor in their abuse. Female alcoholics, for example, may be more susceptible than other women to sexual abuse because they tend to be seen as "sexually loose" (Miller et al., "Spousal Violence," p. 538).

43. This point is made by Colleen Hood, Colin Mangham, and Don McGuire, "Detailed Analysis of Literature Pertaining to Substance Use and Mental Health," draft prepared for *Health Canada* (March 1995), pp. 21, 24.

44. Ibid., p. 59.

45. Stanton Peele, "What Works in Addiction Treatment and What Doesn't: Is the Best Therapy No Therapy?" *International Journal of the Addictions* 25 (1990–1991): 1409–1419; Amethyst Women's Addiction Centre, "Here's to You Sister. Creating a Women's Addiction Service: Amethyst's Story" (Ottawa: Amethyst Centre, 1997).

46. Ibid., p. 26.

47. The connection between autonomy and self-trust may not be relevant to all addicts because not all of them suffer serious problems with autonomy or self-trust. Among those who do not are most coffee drinkers, smokers, and people who have fairly mild addictions. Lack of autonomy is not a serious issue for people whose addictive behavior does not impair their ability to perform daily tasks.

48. See Sissela Bok's reply to a letter to the editor by Dr. Quentin Regestein on Bok's article, "Informed Consent, Deception, and Discovering Drug Abuse," *Journal of the American Medical Association* 268 (12 August 1992): 790, 791.

49. See Caroline Whitbeck, "Trust," *The Encyclopedia of Bioethics*, 2nd ed. (New York: Macmillan, 1995), pp. 2499–2504.

50. See Lepine, "Ending the Cycle of Violence," especially p. 275.

51. This criticism is described in Iris Marion Young, "Punishment, Treatment, Empowerment: Three Approaches to Policy for Pregnant Addicts," in *Expecting Trouble: Surrogacy, Fetal Abuse, and New Reproductive Technologies*, ed. Patricia Ann Poling (Bloomington: Indiana University Press, 1992), pp. 109–134; J. Yaffe, J. M. Jenson, and M. O. Howard, "Women and Substance Abuse: Implications for Treatment," *Alcoholism Treatment Quarterly* 13 (1995): 1–15; and Ann Abbott, "A Feminist Approach to Substance Abuse Treatment and Service Delivery," *Social Work in Health-care* 19 (1994): 67–83.

52. AMA, "Legal Interventions during Pregnancy: Court-Ordered Medical Treatments and Legal Penalties for Potentially Harmful Behavior by Pregnant Women," *Journal of the American Medical Association* 264 (28 November 1990): 2663–2670.

53. Among these feminists are Abbott, "Feminist Approach to Substance Abuse Treatment"; Young, "Punishment, Treatment, Empowerment"; and the authors of Amethyst Centre's "Here's to You Sister."

54. There are already at least two feminist programs in Canada—the Amethyst program in Ottawa and the Matrix program in Halifax. Both offer services for promoting self-esteem and dealing with sexual and other forms of abuse, and as we discuss below, these services may help their participants develop greater self-trust.

55. Amethyst Centre, "Here's to You Sister," pp. 6, 24.

56. Ibid., p. 35.

57. However, some female addicts should not be encouraged to feel more confident about at least certain aspects of their judgment during treatment. Whereas many female addicts were abused themselves, some also participated in abuse, as the following statistics reveal: over 95% of child sexual abusers are men (Dominelli, "Betrayal of Trust," p. 299), but almost 50% of child physical abusers are women, and a relevant factor in a large percentage of child physical abuse cases is alcoholism; see Linda Gordon, *Heroes of Their Own Lives: The Politics and History of Family Violence, Boston 1880–1960* (New York: Viking, 1988), pp. 173–175. Addiction counselors face the challenge of encouraging some women to increase their trust in their own judgment without letting them off the hook for having exercised very bad judgment in the past.

58. Judith Grant, "The Women and Substance Abuse Project: The Invisible Problem," Final Report submitted to Health Canada, Moncton, New Brunswick, February 1997, p. 8.