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Psychotherapy as Cultivating Character

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Duff R. Waring argues that, in some instances, psychotherapy should be viewed as healing (or alleviating) mental disorders and also as cultivating good character in patients (Waring 2012). In these instances, psychotherapists should understand their patients as having character faults that are manifested as mental disorders, as having nascent virtues they can build on during therapy, and as moving toward goals that can be specified in terms of both improved mental health and greater moral virtue. Waring's discussion is deeply illuminating, but it suffers from a major difficulty: the failure to take adequate account of the differences between the perspectives of third-party observers of therapy and of psychotherapists as participants in therapy.

Waring uses the example of a thirty-five-year-old man with a serious anger management problem. The man simmers with hostility, periodically erupts in violence at slight provocation, has obsessive thoughts of hitting others and being hit, feels persecuted by the world, takes great offense at minor slights, drinks to excess, and is twice divorced by women who became alarmed at his drinking and violence. The man feels shame and guilt about his behavior, and he suffers from chronic self-loathing and episodic depression. According to Waring, the man displays both mental disorders and moral flaws, both personality disorders and character faults. Moreover, the same patterns of behavior, emotions, and thinking are evidence for both the mental disorders and the moral flaws. In terms of mental disorders, he might fit the criteria (depending on further details) for Antisocial Personality Disorder, Borderline Personality Disorder, Impulse Control Disorder, Substance Abuse Disorder, and some type of Depressive Disorder. In terms of morality, we can say he lacks the virtues of self-respect, self-love, self-control, empathy, respect for others, and responsibility.

Likewise, the aims of therapy can be specified as simultaneously moral and mental health matters. In terms of mental health, the goals are to remove or alleviate his mental disorder and, more positively, to help him improve his skills in controlling his anger (and drinking), to increase his self-esteem, to improve his ability to relate with other people, and to exercise greater personal autonomy. In terms of morality, the goals center on moral self-development by increasing his self-control over his anger and drinking, his self-respect and self-love, his capacities for empathy and his ability to respect others, and his acting with greater moral responsibility.

Finally, the process of moving from problems to goals is a shared therapeutic activity that builds

on and expands the patient's autonomy, and simultaneously a shared moral endeavor that builds on and improves the patient's nascent virtues in the direction of greater virtue. In understanding this process and its aims, we need a theory of virtue ethics that is psychologically realistic, especially in understanding moral goals in terms of what is morally satisfactory rather than ideally good, and that celebrates moral diversity in how the virtues are implemented in good lives. To this end, Waring invokes and insightfully applies Christine Swanton's ethical theory (Swanton 2003).

Waring is recommending what I call an integrated moral–therapeutic perspective: morality and psychotherapy are overlapping and interwoven rather than mutually exclusive (Martin 2006). In particular, the same features of the man's behavior, emotions, and cognition can be viewed through the lenses of health and morality. The situation is in some respects like looking at the familiar duck–rabbit drawing so as to see it as a duck or as a rabbit. For example, just as the same dot in the drawing can be seen as the eye of a duck or the eye of a rabbit, so the man's violence can be seen as part of a moral fault or mental disorder. Again, just as the two interpretations of the dot are semantically connected via "eye," the moral and health perspectives have some direct overlaps; for example, the terms "self-respect," "self-esteem," and "self-love" all convey both healthy and morally appropriate self-regard.

Waring's Janus-faced vision (to switch metaphors) is far too rich to be worked out in a single essay. Not surprising, his essay leaves open a great many details about how morality and mental health perspectives fit together, including exactly how many types of cases he would apply his outlook to. He also blurs the issue in places, as when he invokes Louis C. Charland to support his approach. Charland claims that Antisocial, Borderline, Histrionic, and Narcissistic Personality Disorders are "moral and not medical" matters, and he challenges whether psychotherapists have any special expertise in dealing with them (Charland 2004, 71). This is not Waring's view, as I understand him, for he seeks to dissolve Charland-type dichotomies.

I see one large gap in Waring's discussion. In my view, he is insufficiently sensitive to the complications in applying his integrated moral–therapeutic perspective to the special role of psychotherapists. Much of his discussion fits how third-person observers might reasonably think about psychotherapy. Psychotherapists, however, are not observers. They are participants. They are also professionals who have special roles and responsibilities that center more directly on healing rather than moral cultivation (even though, again, I agree that their work has both implications). This role modifies and restricts how they employ the virtue–ethics language that is appropriate for observers.

We need not return to myths of "value-neutral therapy" to appreciate that some explicit uses of moral language are inappropriate during therapy, or at least during some stages of therapy. Imagine a psychotherapist saying to a patient: "You have several very serious character faults or vices. You lack the virtues of self-control, self-respect, empathy, and respect for other people. You feel guilt and shame because you actually are guilty and shameful in your conduct. We need to work together to help you become a morally better person. One of my contributions will be to educate you about morally appropriate ways of thinking, feeling, and behaving. Working together, we can improve your character."

Although such language might be suitable for a third-person observer, it might be therapeutically self-defeating for psychotherapists to use. It might also be morally self-defeating, insofar as the therapy contributes indirectly to moral improvement. Therapists need to establish and maintain a caring, supportive, autonomy-respecting relationship with patients, which can be more important than the specific techniques and theories they employ (Frank and Frank 1991, 40–3). To maintain that relationship, therapists are trained to be largely nonjudgmental. Doing so often requires avoiding the language of vices and faults, which can push psychodynamic buttons that interfere with the relationship.

At one point, Waring might seem to touch on the issue I am raising. In a footnote, he distinguishes between encouraging a patient to accept

responsibility for changing a moral disorder (future-oriented responsibility) versus blaming them for being responsible for causing and having the disorder (past-oriented responsibility). In doing so, he notes that a patient might not be fully blameworthy for causing the disorder, and instead the patient's specific disorder and failed moral vision might be attributable to bad upbringing. Yet my concern is different. Even if patients are blameworthy by an observer for the origin and manifestations of their violent behavior, the special role of the therapist typically requires avoiding blame—to help. The same, I might add, can be said of friends, lovers, and spouses in providing support.

I am not suggesting that explicit moral language is never appropriate during therapy. I am only saying that the moral language appropriate for third-person observers needs to be filtered through the prism of therapy. Positive moral language might be quite appropriate in promoting therapeutic goals, as when therapists convey hope about the future, praise patients for their courage and for accepting responsibility, and urge patients to love and respect themselves. Of course, much depends on nuance and context, and therapists are trained to be attuned to how patients can misinterpret even positive moral language. Exactly when virtue–ethics talk is therapeutically helpful during therapy, and when it is best left for third-party observers, needs to be studied empirically.

Finally, it might be objected that in contrasting the perspectives of psychotherapists with those of third parties I have neglected what most interests Waring: the perspective of the patient. In reply, although Waring says he is interested in "the efforts that patients make," he is equally interested in "a concerted effort by the therapist and patient to replace character faults with character strengths or virtues." If anything, the objection raises further questions about whether Waring intends for therapists or patients to initiate moral language.

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