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SELF-TRUST AND REPRODUCTIVE AUTONOMY

by

Carolyn McLeod

Submitted in partial fulfillment of the requirements
for the degree of Doctor of Philosophy

at

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Abstract

In this thesis, I give a theory of the nature of self-trust and an explanation of its role in autonomous decision-making. We tend to think of trust as essentially interpersonal, which casts doubt on the coherence of the concept of self-trust. Drawing on patients' experiences in reproductive medicine, I argue that self-trust is a meaningful as well as a useful concept. I provide autobiographical sketches of a number of women's experiences, supplemented by my own observations made while doing a clinical practicum in reproductive medicine, to illustrate that what many women feel toward themselves in a variety of reproductive health care contexts is analogous to what we feel toward others when we trust and distrust them. I ground my theory of self-trust in an account of interpersonal trust, in which I draw on a number of theories of trust in ethics, especially those of Annette Baier and Karen Jones. The paradigm of trust in those theories is interpersonal, and I describe how self-trust and that paradigm are both alike and unlike one another in the following areas: what it is that we trust about ourselves/others when we are trusting, what kind of mental attitude trust is, and what constitute legitimate grounds for trusting. I use my theory of the nature of self-trust to understand the relation between autonomy and self-trust. I give a feminist analysis of that relation by showing how oppression can be a barrier to self-trust and hence, to autonomy. Lastly, I discuss the practical implications of the value of self-trust for the duty of health care providers to respect women's reproductive autonomy.

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Chapter 1

Introduction:
Self-trust as One Solution to Patient Vulnerability

Lee, a nurse and a counsellor, entered an infertility program feeling confident about where her boundaries lay in terms of how much she was willing to go through emotionally, spiritually, and physically in trying to get pregnant.[1] She left the program feeling powerless, objectified, and as if her identity had been threatened. Those feelings arose, in part, because of how little control she had over who had access to her body. The program she was in utilizes a "team approach" to medicine where patients have no guarantees as to who will be examining them at any point in time and who will be conducting scheduled procedures. Because of the intrusive nature of the physical exams and procedures associated with infertility treatment, the team approach puts the dignity of women at risk. As one woman who went through the same program as Lee commented, you "park your dignity and integrity at the door and pay this price to get pregnant."

With no real relationship with most of the people treating her infertility, Lee had the impression that she "was only another procedure to be done" or a mere "number ... in a blood work report." At no point did she receive adequate attention to her emotional needs, even from the counsellor involved with the program. Moreover, when she tried to advocate for her needs, she was labelled "a problem": another non-compliant patient.

The labelling induced shame about what she described as her "sensitivity" and it also made her worry that she might be abandoned by her care providers. Those feelings, along with being treated as a mere object of medical scrutiny, caused her to lose her sense of who she was and of what she needed. Before entering the program, she had never thought of herself as uncooperative or as someone who tends to create problems where they do not exist, nor had she ever thought of her body as a mere reproductive vessel to which anyone could have access. In the end, Lee was left in an extremely vulnerable position.

After she left the program, Lee wrote letters to two of the physicians with whom she came in contact. Below, I give an excerpt from a letter she sent to the physician who gave her a hysterosalpingogram (HSG)--a procedure determining whether the fallopian tubes are blocked--and who then conducted a hysteroscopy to repair damage to the lining of her uterus which could have been caused by the HSG itself. The excerpt focuses on the events that led up to her hysteroscopy, an experience which Lee herself describes as objectifying. The events are not isolated; rather, they are representative of a larger pattern of unethical patient care.

> When you did the informed consent over the phone, I specifically asked you how many people would be in the O.R. [operating room] suite. You told me there would be three people--the anesthetist, the circulating nurse, and yourself. This was a very important issue for me because of my past history of trauma. I don't know if [John[2]] told you that I originally was

asking for spinal anesthesia because I did not want to be unconscious in this type of situation. After talking with the anesthetist and with you over the phone, I felt reassured that I was heard. I couldn't believe when I was wheeled into the room I counted eight people (men and women) there cleaning instruments, laughing and showing no signs of finishing up before you got started (with my entire lower body fully exposed and my legs in stirrups). I looked at you to help me in this and to try to honor my need for control and personal dignity--and you responded in defense of the staff that were cleaning instruments rather than on my behalf. I still remember crying and begging the anesthetist to knock me out because what I was feeling at that moment was unbearable. I now wish that I had gotten up off the table and left the room. In addition, I was not informed that I would be catheterized as part of the procedure. When I awoke, I had searing urethral pain and knew I had been catheterized, which you confirmed when I asked you later. If I had known this ahead of time, I would have begun a preventive course of Pyridium because I have chronic inflammatory urethritis. I also find myself wondering which of the five extra people in that room actually catheterized me. I guess it wasn't supposed to be an issue because I was unconscious. It was another episode where I felt objectified.[3]

There are a host of ethical problems with this situation, not the least of which are the

attending physician's complete disrespect for Lee's prior requests and his insensitivity to her needs as a woman who had suffered previous trauma. Further, there was inadequate disclosure about the nature of the procedure (i.e., the possibility or the necessity of catheterization). A less obvious problem, perhaps, than the violation of consent and improper consent is that Lee felt she could not get out of that O.R. suite, and, instead, had to ask to be "knocked out" by the anesthetist. She was not forced to stay against her will, but she could not muster the will to leave. She could not trust herself to choose and act in ways that were consistent with maintaining autonomy and a sense of dignity.

The value of the self-trust of patients is never mentioned in discussions about trust in bioethics. At most, those discussions emphasize that the vulnerability of patients leaves them no choice but to trust their health care providers, and hence, it is crucial that they *can* trust them (Rogers 1998; see, e.g., Whitbeck 1995). The vulnerability that Lee felt with her legs up in stirrups on the O.R. table increased exponentially when she discovered that she could not trust her physician. But she was vulnerable as well because she was not in a position to be able to trust herself. In situations of vulnerability, it is important not only that we can trust others, but also that we can trust ourselves to stand up for our own interests and for what we value most. Otherwise, we relinquish our autonomy. Having trustworthy professionals is not the only ethical solution to the problem of the vulnerability of patients. A further solution is respect for patient self-trust.

The focus of this thesis is the undermining of women's self-trust in reproductive health care contexts and how that impacts negatively on their reproductive autonomy--

that is, on their autonomy regarding aspects of their lives that concern reproduction.[4] Factors such as objectification, worry over possible abandonment, and shaming by health care providers can all contribute to a lack of self-trust in patients such as Lee, and, ultimately, to a lack of patient autonomy. So, too, can claims to medical epistemic authority and the dismissal of experiential bodily knowledge in patients. I defend the importance of health care providers attending to patient self-trust as a condition for autonomy, particularly in the context of reproductive medicine. There, the potential barriers to self-trust tend to be greater than in many other health care contexts because of the negative influence that gender oppression and socialization can have on women's reproductive health care choices. My theory of the relation between patient self-trust and autonomy is feminist for I highlight the many obstacles oppression can pose to the ability of patients to trust themselves.

To defend the view that health care providers have a duty to respect patient self-trust, as part of their duty to respect patient autonomy, I need the following: 1) a theory of trust; 2) a theory of how trust can be self-regarding; 3) a theory of where things can go wrong with self-trust (such that patients might lose their autonomy); and, 4) a theory of why, in fact, self-trust is important for autonomy. I develop each of those theories in that order in separate chapters, beginning with chapter 2: a theory of what we trust in others. In a sixth chapter, I give recommendations for how health care providers can preserve or bolster patient self-trust in the realm of decision-making in reproductive medicine. Throughout, my claims are grounded in actual as well as hypothetical cases of patients trusting or distrusting themselves in that area of medicine. The cases are centred around

three reproductive health care issues, namely, miscarriage, infertility treatment, and prenatal diagnosis.

In chapter 2, I offer a theory of trust that can be extended to a self-regarding attitude of trust. I use Mark Johnson's idea that our moral concepts are structured by core cases, or "prototypes," and that we move to less prototypical cases using our moral imagination (1993). Modelling our concept of trust on prototype theory allows us to understand how self-trust is coherent given that we tend to think of trust as essentially interpersonal. One moral philosopher, Trudy Govier (1993, 1998), has theorized about the nature of trust as a self-regarding attitude. In using prototype theory to explain how self-trust could be meaningful, I am expanding on her work.

In discussing the central features of trusting attitudes, philosophers tend to agree on at least one feature: that trust is an attitude about the competence of others to do what we are trusting them to do. Where philosophers tend to disagree is on the issue of the desired motivation of trusted others. The standard answer, given by Annette Baier (1995), is goodwill; in trusting others, we are optimistic that they will act with goodwill towards us. I give a different answer. I argue that trust is an attitude of optimism about someone's moral integrity. Thus, it is a moral attitude, and that makes it distinct from other attitudes, such as confidence and mere reliance. I explain, correspondingly, that distrust is an attitude of *pessimism* about someone's competence and moral integrity.

Self-trust shares with trust the feature of optimism about the moral integrity and competence of the trusted one (i.e., oneself in the case of self-trust), although it is missing the feature of interpersonal relationality which characterizes trust in others. One

might wonder, immediately, how self-trust differs then from self-respect, which on most accounts is an attitude about our moral character and competence. Further, one might ask how it differs exactly from self-reliance and self-confidence, and ask, moreover, how we could ever tell that a person was trusting herself to do something, rather than merely relying on herself to do it or merely confident that she would do it. In other words, how can we distinguish, in practice, between self-trust and certain other self-regarding attitudes? I deal with such issues in chapter 3, where I use some autobiographical sketches of some women's experiences with miscarriage to support a theory of the nature of self-trusting and self-distrusting attitudes.

Things go wrong with self-trust and self-distrust when the subject tends to trust herself too much or too little or when she distrusts herself too much. She will lack autonomy in each case. In general, self-trust supports autonomy, but not just any self-trust will do. Furthermore, too much self-distrust, even if it is justified, can be detrimental to autonomy. Lee may have been experiencing distrust (rather than merely a lack of trust) in her ability to leave the O.R., and if so, she was probably justified given how disempowered she was. Still, her self-distrust would have been an impediment to her autonomy. The question of what makes self-trust and self-distrust justified is the focus of chapter 4.

The position I arrive at in chapter 5, that *justified* self-trust is important for autonomy, raises a number of philosophical concerns. For example, it is unclear what we need to trust well about ourselves to be autonomous. Which moral commitments are we optimistic that we will live up to when choosing and acting autonomously? More

importantly, perhaps, do all forms of autonomy even require such optimism? If that were the case, then all autonomous behaviour would have to have a moral dimension, which is controversial among philosophers, some of whom wish to distinguish moral autonomy from personal autonomy. In other words, they differentiate behaviour in which we act on our own moral sense from behaviour in which we satisfy desires that are non-moral, and they want to describe both types of behaviour using the language of autonomy.

Furthermore, why would trusting ourselves badly diminish our autonomy? It is generally understood in autonomy theory, both in bioethics and moral philosophy, that we can make bad choices and still maintain autonomy. Can we not trust the wrong decisions, then, and still be autonomous? Such issues arise in chapter 5, where I explain the role of self-trust in autonomous decision-making, drawing on patients' accounts of their own experiences with infertility treatment. I also develop a role for self-*dis*trust in autonomous behaviour, and moreover, I argue that the relations among self-trust, self-distrust, and autonomy have implications for how we think about autonomy. In a feminist theory of those relations, autonomy must be conceived differently from how it is traditionally conceived in bioethics and moral philosophy.

What all of these theories mean for the ethical treatment of patients such as Lee is the topic of chapter 6. What should health care providers do to ensure that they are not inhibiting patients from trusting themselves well? Furthermore, where the barriers to patient self-trust are rooted in oppression, what can providers do to try to minimize their negative effects? Lastly, are any broad changes necessary to the way reproductive medicine is conceptualized, changes that would allow for greater self-trust among

patients? I consider those questions in light of various cases involving prenatal diagnosis, and in light of the cases from previous chapters. I recommend, overall, that reproductive medicine be more woman-centred, where "woman" is respected and understood in much of her complexity. When pregnant or during infertility treatment, she has important needs that are not merely physical; not uncommonly, she has suffered some of the severe effects of sexist oppression, including sexual abuse; and, moreover, she often possesses valuable knowledge about her own body. Were respect and attention given to such factors, patients would be less vulnerable to harm in reproductive health care settings because they would be in a better position to trust themselves.

Notes

1. I am using the pseudonym of "Lee" to protect the privacy of this patient, with whom I have been in personal contact. Lee and I connected at a time when she was searching for information as a way of understanding her experience and I was researching this thesis. She shared her ordeal with me and her letters to her physicians, and for that I am truly honoured and grateful. I look forward to working with her in the future on a project we have devised together about the powerlessness and objectification of women in modern infertility treatment.

In her professional capacity as a counsellor, Lee has met other women who suffered what she went through in the same infertility program. Thus, she knows that her experience is not unique. The quotation I give below from another former patient of the program is from one of Lee's letters, as are all of the other quotations in this introduction.

2. John is a pseudonym for the other physician to whom she wrote.

3. This case and the others that occur throughout the thesis are collected by chapter and patient or subject name in the Appendix.

4. Often, the term "reproductive autonomy" is used in the literature to refer to people's civil libertarian rights to access to abortion or reproductive technologies. I am using the

term more broadly to include all choices that concern the reproductive aspects of our lives. For example, the ethical issues I discuss about Lee's case have to do with her lack of reproductive autonomy, as I define that term.

Chapter 2

Prototypical Features of Trust Relations: What We Trust in Others

1. Introduction

My aim in this chapter is to develop a theory of trust that can be used to understand the nature of self-trust. An obstacle to this strategy, the strategy of clarifying the concept of trust first and then extending it to a self-regarding attitude, is that we[1] normally think of trust as relational, in the sense that it occurs between distinct entities in a relationship. Clearly, self-trust is not relational in that sense. Recently, Trudy Govier (1993, 1998) and Keith Lehrer (1997) have done some philosophical work on self-trust, but neither of them sufficiently address the question of whether the extension of the concept of trust to a self-regarding attitude is even coherent. Is "self-trust" a meaningful concept given that trust, as we primarily understand it, occurs within relationships? One theory of concepts that explains how it could be meaningful is prototype theory, which Mark Johnson defends as a plausible theory of moral concepts in *Moral Imagination* (1993). I argue in this chapter that prototype theory is helpful in illuminating how it is that we could conceive of self-trust given the way that we conceive of trust.[2]

On the prototype model of concepts, self-trust is a non-prototypical variant of our prototypes for trust, all of which I argue are instances of interpersonal trust. On Johnson's model, the prototypes of a moral phenomenon, such as trust, form the structure

of our concept for that phenomenon. Before we can understand any variations on the prototypes, we need to understand the prototypes themselves. Hence, to understand the nature of self-trust, we need to comprehend the prototypical sense of trust first. In this chapter, I outline Johnson's theory and illustrate some of the instances of interpersonal trust that form the structure of our concept of trust. Johnson explains that there are important or salient features of the prototypical instances of a particular phenomenon that shape our understanding of those instances as prototypes of that phenomenon. I discuss many of the salient features of prototypical trust relations, drawing on the theories of Karen Jones (1996) and Annette Baier (1995) about what makes an interpersonal relation a trust relation. I modify their theories and defend an original list of the important features of trust that concern what it is that we trust in others.[3] At the end of the chapter, I also discuss briefly the important features of *dis*trust and the issue of whether trust and distrust admit of degrees.

While identifying the key features of trusting attitudes, I distinguish a trust relation from another type of relation with others, namely reliance. Similarly, in the next chapter, I distinguish between the self-regarding attitudes of self-trust and self-reliance (and also between self-trust and self-confidence, and self-trust and self-respect). The claims I make in this chapter about the differences between trust and reliance are motivated by noticeable and morally significant differences between instances of those different phenomena. I demonstrate how those attitudes differ from one another by altering illustrations of prototypical instances of trust such that they illustrate something noticeably different, something I believe we would call "reliance."

2. Understanding Moral Concepts: Johnson's Use of Prototype Theory[4]

According to Johnson's description of how prototype theory applies to moral concepts, we can extend our use of a moral concept to phenomena that do not have all of the characteristics we normally associate with that concept. Self-trust is such a phenomenon: it is missing the characteristic of interpersonal relationality that we normally associate with trust. However, for it to be appropriate to use the term "trust" to describe that self-regarding attitude, the attitude must share a number of the characteristics of trust.

In *Moral Imagination*, Johnson argues against the traditional view in analytical philosophy that what forms the structure of our moral concepts is a stable list of necessary and sufficient conditions. On the traditional model, the list of conditions is meant to act as a guide to our application of a moral concept; we use the concept appropriately only when we apply it to situations where all of the relevant conditions are present. Those conditions are necessary in the sense that they represent inherent features of the moral phenomena to which our concepts refer. So, for example, if relationality is a necessary condition of trust, then it must be an inherent feature of trust, which means that trust is never non-relational. Johnson denies that our moral concepts are structured in terms of necessary and sufficient conditions and that our use of them is limited to cases that satisfy a set of strict criteria. He defends instead a theory of moral concepts in which they have a "prototype structure" and an application beyond standard, prototypical cases.

To say that moral concepts are structured by prototypes is to say that we identify them with certain prototypical instances, which are "clear, unproblematic cases" to which the concept applies and which are central to our understanding of that concept (Johnson 1993, 80). Johnson uses the example of the conceptual category "bird": for some of us, the member "robin" is "cognitively more central to our understanding of [that] category" than other members (1993, 78). The instances which are "cognitively more central," or prototypical, vary depending on the person's physical and social environment.[5] For example, the kind of bird that is perhaps more central to a New Zealander's understanding of bird is a kiwi rather than a robin.

The same person's prototypes can also gradually shift as that person comes to inhabit new physical and social environments. For example, someone who had never before been exposed to a social environment where people ascribe moral worth to animals and who becomes immersed in a sub-culture of vegans and animal rights activists may experience a gradual change in her prototypes for certain moral concepts, such as rights.[6] It may become as natural for her, in other words, to associate rights with animals as it is with humans. However, her prototypes for rights could not vary dramatically from the rights prototypes of members of her dominant culture if she is to continue to communicate about rights in that culture. The variances among prototypes for people living in the same culture cannot be extreme if they continue to be able to understand one another. Since prototypes can vary only slightly among members of the same cultural group, we can therefore speak generally about the prototypes for a phenomenon within a given culture.

The idea that our concepts are structured by prototypes rather than by a list of strict criteria is compelling. To use an example in the moral realm, we do not contemplate what all of the necessary and sufficient conditions are for murder when we think of the concept "murder"; rather, we think of prototypical instances, which for those of us who are continually exposed to American culture, probably resemble the kinds of cold-blooded murders we see in Hollywood suspense films.

When we are faced with problematic, non-prototypical cases, we try to imaginatively extend our moral concepts to them. We assess whether those cases are sufficiently similar to the prototypical cases that the relevant concepts should apply to them as well. Examples of non-prototypical instances of murder might include cases of killing under duress, or of killing beings whose moral status is questionable to us (e.g., some animals). Whether "murder" is really an appropriate description of such cases will depend on their degree of similarity to our prototypes for murder. But to be able to make that kind of comparison, there must be some features of the prototypes that are especially important or salient to us. We could not make judgments about the similarities and differences between cases without a sense of which similarities and differences are relevant, and we would lack that sense if we did not prioritize the features of prototypes. The salient feature of our prototypes for murder, relevant specifically to whether killing under duress is murder, is the feature of the voluntariness of the murderer. The feature relevant to the killing of an animal, such as a seal, is the feature of the moral status of the victim.

Johnson argues that we do prioritize the features of prototypes in terms of their

importance or salience; however, we do not treat the salient features as necessary and sufficient conditions, nor as inherent features of the external things to which our concepts apply. Thus, it is possible, for example, that a murder might occur where the murderer acts under duress. The salient features guide us in the imaginative extension of our concepts, but they do not restrict their extension in the way that they would if they were necessary and sufficient conditions, and they are not fixed in the way that they would be if they were inherent features.[7] Our concepts are more malleable than theories about necessary and sufficient conditions make them out to be.

But are concepts so malleable that *none* of their important features serves even as a necessary condition for the use of those concepts? Johnson's theory is that none of the important features of our moral concepts is necessary *and* sufficient; however, his theory does not preclude that some features may be necessary. Some must be necessary, for at least some concepts, since an event would not count as murder, for example, unless someone died, and a creature would not be a bird if it did not have wings (whether they be vestigial or not). However, we miss the point of prototype theory if we focus on the idea that some of the features of our prototypes might be necessary. What is interesting about that theory is the claim that when we apply a concept to a particular phenomenon, we do not reason from a set of necessary (and/or sufficient) conditions; rather we move from certain prototypical instances to that phenomenon. The move is guided by salient features of the prototypes, but it does not occur simply by reasoning from those features.

There are prototypes for our concept "trust" and features of those prototypes that are salient to us. It is doubtful that we have a single trust prototype as opposed to a

cluster of prototypes made up of relations in our lives in which trust is clearly a factor. Johnson recognizes that for many concepts, there will be more than one "clear case," and hence more than one prototype (see, for example, 1993, 80). For example, there is probably a cluster of prototypes for our concept "animal" that includes instances of domesticated and wild animals, of mammals and reptiles, *etcetera*. When we think of the concept "animal," we do not think of only one animal, but of a number of different creatures that we clearly recognize as animals. In this chapter, I identify some of the kinds of trust relations that generally form the cluster of trust prototypes in Western culture, and then identify the important features of those relations. In chapter 3, I determine whether there is some kind of self-regarding attitude that shares enough of the important features of trust that we would call that attitude "self-trust."

3. Important Features of Trust Prototypes

I want to propose that, generally, our cluster of trust prototypes includes three types of relations, all of which are instances of interpersonal trust. We interpret trust as something that occurs between distinct entities in relationship, but our use of that concept is not limited to relationships between persons. However, in contemplating whether we should be extending the use of that concept beyond interpersonal relations to relations with governments, for example, or with animals, we often assess whether those relations are sufficiently similar to interpersonal trust relations. To evaluate whether we can trust our dog, for example, we decide whether there are features of our attitude

towards our dog that closely resemble features of the trusting attitudes we have toward other people, such as our best (human) friend.[8] Certain interpersonal relations, including close friendships between persons, are exemplars for us of trust relations. They form our trust prototypes and include the following: the child-parent relation, the relation between intimate adults, and the professional-client relation. Characteristically, those relations involve certain kinds of dependency that are indicative of trust (unlike, for example, the relation between strangers). Let me make that point more persuasive using short vignettes that highlight the kinds of dependency that can occur in those relations.

a. Anna is a 9-year-old girl who depends on her father, Stefan, to care for her and to explain things about the world to her. For example, when she does not understand what her class is learning in school, she relies on Stefan to help her. If she does something wrong, she expects him to be able to explain why. Anna's father speaks with authority on lots of different issues, and she always assumes that what he says is insightful.

b. Marie and Josie are lovers and best friends. Above all, they depend on one another to be loyal and honest, as well as emotionally supportive. Both of them believe strongly in the importance of loyalty and honesty in a relationship and that allows them to be optimistic that they will not be disloyal or dishonest with one another. They depend on one another to be honest in particular about their own feelings, and to act in ways that are

appropriate given their feelings. Furthermore, they rely on one another to be understanding about the other's feelings, especially when the other is under severe stress, such as when Marie is fighting with her boss at work, or when Josie has a difficult paper to write for graduate school.

c. For over eight years, Todd has had the same family physician, Dr. Chen. He depends on Dr. Chen to provide him with good medical advice and to perform medical procedures competently. He has gone to Dr. Chen for so long not only because he feels that he can rely on his judgment and expertise, but also because Dr. Chen provides him with a lot of information about the potential harms and benefits of different procedures and treatments. It is important to Todd that he have that information so that he can make informed choices about his own health care.

In each of these vignettes, at least one party in the relationship is depending on the other in a way that suggests that they have a bond of trust. Anna is trusting Stefan's judgment and his concern for her well-being; Josie and Marie are trusting one another to be loyal, honest, and emotionally supportive; and Todd is trusting Dr. Chen to be a good physician. These are clear and unproblematic cases of trust, that is, cases where most of us would not have any difficulty using the concept of trust. They are also instances of types of relationships that are common in our lives, and that, characteristically, have trust as a central component.

The vignettes are not meant to be exemplars of what the different parties to such relationships *should* be able to trust in one another. Different peoples' prototypes or paradigms for trust will differ depending on what they believe to be important aspects of interpersonal relations, where what is important for them will depend, in part, on their past experience in trusting others. For example, if I had been betrayed by a dishonest partner in the past, then honesty in any new intimate relationship may be particularly important for me. I want to use the vignettes to illustrate only the general features of the attitudes of the dependent parties that explain why their relationships are trust relationships. There must be something in common among those attitudes for the vignettes to be prototypical of *trust* and, hence, to form a cluster of trust prototypes.

Trust theories in moral philosophy provide some guidance on what are the common and important features of trust prototypes. Virtually all of those theories focus on interpersonal trust. I seek guidance in this chapter from the theories that I find the most persuasive, which are those of Karen Jones (1996) and Annette Baier (1995). Jones and Baier agree that there are two central components to trust relations: optimism about the competence of the trusted in the domain in which we trust her, and optimism about her goodwill within that domain. Jones adds the component that we expect the trusted other to be "directly and favourably moved by the thought that we are counting on her" (1996, 4). I analyse the theories of Jones and Baier and make substantial revisions to their lists of the important features of trusting attitudes. The list I propose is the following: 1) optimism about the competence of the trusted in the domain in which we trust her, 2) optimism about her moral integrity in that domain, 3) an expectation that

what she stands for in the domain is similar to what we stand for, such that she is committed to doing what we are counting on her to do, and 4) an expectation that her perception of the kind of relationship we have with one another is similar to our own perception of it. I shall describe each of these features separately and defend their importance within our conception of trust.

3.1 The Competence of the Trusted

Baier and Jones agree that a key component of trust is optimism about the competence of the trusted person within a particular domain. In this section, I explain why that feature is important within prototypical trust relations. I make the distinction between kinds of trust where we depend on someone to be competent to do something *for us*, or to have specific concern for us, and trust where we simply rely on someone to be competent in a certain area. I call the former "trust with specific concern" and the latter "trust without specific concern." Normally with both kinds of trust, we rely on the other to have domain-specific skills rather than rely on him to be competent at everything. I argue that one "skill" that the trusters in prototypical trust relations typically depend on the trusted others to have is moral understanding.

The dependent party of the relationship in each of the vignettes is optimistic that the other possesses some kind of competency. For example, one thing Anna is optimistic about in terms of her father's competence is his ability to make sound judgments about what is morally right and wrong. Josie and Marie are each optimistic that the other is

competent to provide emotional support and to understand what it takes to be a loyal and honest partner. And, lastly, Todd is optimistic that Dr. Chen is competent as a family physician. Todd is expecting Dr. Chen to be competent to perform the medical procedures that are a part of his practice, and to give sound medical advice as well as detailed information about different health care options.

If the optimism about the other's competence in prototypical trust relations were to fade away, then so would the trust. For example, if Todd were to hear that a number of Dr. Chen's former patients were suing him for malpractice and Todd began to seriously doubt Dr. Chen's competence as a physician, then Todd's trust in him would diminish, if not disappear altogether. If Marie were no longer optimistic that Josie understands what it means to be faithful to Marie, then much of her trust in Josie would disappear.

We can trust without expecting others to do something for us, but even there, we are optimistic about their competence. Most of the characters in the vignettes are trusting another person to promote their interests in some way, or to have some specific concern for them. An example of trust without specific concern is trust that another will be conscientious at her work, even though whether she is conscientious or not will have no impact on us. Part of the trust that Anna has in her father is trust of that sort; she trusts him to make considered and insightful comments about a range of issues, that is not necessarily limited to issues relating to Anna's well-being. Often trust that does not demand specific concern occurs outside of a personal relationship. For example, I once trusted Mother Teresa to make truthful statements to others, but I had no personal

relationship with Mother Teresa. In the absence of a relationship, trust of that sort is likely non-prototypical, but where it occurs inside of a personal relationship, it can be prototypical. While trust without specific concern does not necessarily involve optimism about the competence of others to do something for us, it does involves optimism that they are competent to do something (e.g., in the case of Mother Teresa, to know what honesty amounts to).

It is not important in determining whether there is trust in a relationship that the trusted person is *in fact* competent. If Stefan were not competent to make judgments in many of the areas in which he assumed some epistemic authority, but Anna continued to believe that he possessed that competence, she would still be trusting her father. Her trust would simply be misplaced. It would not be misplaced because Anna should have known that her father did not have that competence. It is not necessary in trusting that someone is competent in a certain area that we understand what that person has to do to be displaying that competence. Particularly in trusting professional people, such as plumbers, architects, or physicians, we usually have very little understanding of their area of expertise. Usually we know that they are certified experts in their field, but we do not know what makes them experts. Ignorance about what determines whether the trusted one is competent is a feature of many trust relations (Gambetta 1988; Baier 1995, 117, 186), and it makes the trusting person vulnerable to deception in the form of concealed incompetence.

Optimism about the competence of the other in prototypical trust relations is usually domain specific.[9] Most of the trusting characters in the vignettes are trusting the

other to be competent in specific domains. For example, Todd is trusting Dr. Chen to have expertise in the domain of medicine, while Josie and Marie are trusting one another to be competent about certain aspects of intimate relationships. We tend to think of trust between lovers and between a child and a parent as being more comprehensive than trust in other types of relationships. Often, we assume that it extends to the entire well-being of the trusting person. Still, it is usually not so comprehensive that the one trusting is optimistic that the other is competent at everything. I may trust my mother to be generous and caring, but not trust her to be competent to advise me about my career or to be a competent canoeist. Even Anna, at her age, may recognize that she cannot trust her father to be good at everything. She may have noticed that he has some foibles, such as arriving late for appointments or losing things frequently, which make him untrustworthy in some domains.

Still, one might argue, it is possible to *just trust*, without any consideration for domain. An example would be a child who does not recognize that there are domains in which his parents are fallible. I seem to exclude such instances of trust by describing trust as a three-place relation, of A trusting B to do C in a particular domain. However, that logic of trusting can accommodate cases where we say that a person is just trusting. There, what the person is trusting the other to do drops out of the picture not because the logic of his trust is unique, but because there are so many domains in which he trusts the other that it is too cumbersome to list them all. He may, in fact, trust the other in every domain (in which case his trust would surely be misplaced) or, alternatively, trust her in a range of domains, the boundaries of which may be unclear.

As I shall argue, all three representations of trust in the vignettes involve the domain of moral understanding. Knowing what is morally required in different situations is one dimension of moral competence: the epistemic dimension. Another dimension is acting on what is morally required, that is, being morally virtuous. The latter overlaps with the feature of trust relations that I discuss below: optimism about the moral integrity of the trusted. They both concern the motivation of trusted others, whereas the epistemic side of moral competence concerns only the ability of trusted others to understand and to do what is required of them.

One might wonder what the relevant competency is in intimate trust relations or in friendships. As Jones writes, it is "a kind of *moral* competence. We expect a friend to understand loyalty, kindness, and generosity, and what they call for in various situations" (her emphasis; 1996, 7). However, that statement needs to be qualified. For one thing, in trusting a friend, we can expect her to understand more than just what it takes to be moral in her relationship with us. For example, Josie expects Marie to have some understanding of the stress she is under as a student, which is a type of nonmoral understanding. Secondly, we can trust a friend without trusting her to be loyal or generous. Some friends we trust to be generous and caring; others we trust to be insightful and loyal; *etcetera.*

Like trust in intimate relations, trust in parent-child relations extends into the domain of the moral but is not confined to that domain. Anna relies on her father to make competent judgments on many different issues, whether they be moral or nonmoral. One specific kind of moral competence that she probably expects from him is

the competence to understand the importance of not lying to her or misleading her about what he actually knows. In more sophisticated terms, she is relying on him to appreciate the importance of making responsible claims to knowledge. Other areas where children tend to trust their parents to have some moral understanding are the areas of promise-keeping, of being kind, and of being fair.

We are also optimistic that the professionals whom we trust have at least some moral understanding. We expect them to understand the moral importance of honouring a commitment to perform some kind of service to us, if that is what we are trusting them to do. However, from many of them, we expect greater moral understanding than that. For example, Todd is representative of a growing segment of Western society that trusts physicians to understand the need to respect patient autonomy (along with related issues, such as what counts as justified and unjustified paternalism, and the responsibility of physicians to disclose information to their patients). It is not enough that health care practitioners have the necessary technical skills and scientific knowledge to be competent practitioners. As many of us now presume, they also need to understand the moral significance of attending to the patient's individual concerns and wishes, particularly in situations where they must use their own judgment in deciding how to care for patients.[10] However, even patients who do not assume that physicians should attend to their individual concerns, or should respect their autonomy, still trust their physician to have some understanding of the moral importance of acting in their best interests.

Thus, in all of the prototypical trust relations I have identified, the one trusting relies on the trusted to have some moral understanding, where that feature is part of the

more general feature of optimism about the competence of trusted others to do what we are trusting them to do. Normally that general feature focuses on specific kinds of competencies, and hence, our trust in others is normally domain-specific. Even trust that does not involve specific concern tends to focus on specific competencies. For example, my trust in Mother Teresa extended to her knowledge of the moral importance of being truthful and caring, in particular for people in desperate circumstances; however, it did not extend to her knowledge of the moral dimensions of abortion.

3.2 The Motivation of the Trusted

We want trusted others not only to have the ability to do what we are trusting them to do, but also to have the motivation to do it. Where there is some confusion in modern trust theory is in sorting out the kind of motivation that we expect from trusted others. According to the majority of theorists, including Baier and Jones, the relevant motivation is "goodwill"; however, not all trust theorists agree (e.g., Holton 1994)[11] and some fail to give a clear answer at all to that question (e.g. Govier 1998).[12] It is important not to be ambiguous in answering it, since part of what makes trust unique from other kinds of attitudes, especially mere reliance, is the sort of motivation we expect from those whom we trust. I argue that what we expect is moral integrity, where I interpret integrity in light of recent philosophical advances in theorizing about integrity. Those advances, made by philosophers Cheshire Calhoun (1995) and Margaret Urban Walker (1998), help us, in my view, to better conceptualize trust.

But it cannot only be moral integrity that we demand from trusted others. What moral integrity involves, as Calhoun explains, is consistently doing what "one takes oneself to have the most moral reason to do" (1995, 249). If what another person's view of what he has the most moral reason to do frequently differs from what I would take myself to have the most moral reason to do in similar situations, then I probably will not trust him. I argue that trusting involves an expectation that there is some similarity between what we and the trusted other stand for, morally speaking, in the domain in which we trust her.

I argue, then, that our attitude toward the motivation of trusted others concerns both their moral integrity and what they stand for. I add that it sometimes also concerns their perception of their relationship with us. Sometimes for us to be optimistic that another person will be motivated to honour our trust, we have to expect that she perceives her relationship with us similarly to the way in which we perceive it.

3.2.1 Trust and Moral Integrity

Let me begin by explaining why the relevant motivation in trust relations is moral integrity rather than goodwill. Baier and Jones interpret goodwill loosely to mean caring about the good of others, or having some concern for their welfare (see, e.g., Baier 1995, 102, 136; Jones 1996, 7). Both are imprecise about what that concern amounts to: is it "kindly or benevolent feeling," which is the vernacular sense of goodwill? Is it informed necessarily by considered judgments about the other's welfare? If so, are those

judgments moral judgments? I evaluate each of those ways of defining goodwill in terms of how well they resemble the sort of motivation we expect from trusted others. If what Baier and Jones mean by "goodwill" is a kind of moral, or just, concern for others, then their view is not far off from my own that what we trust in others is moral integrity.

Colloquially, we use the term "goodwill" to mean kindly feeling for others. For kindly feeling to be what we trust in others, it must be enduring to some degree, for we always expect the concern of trusted others to endure at least over the period of time in which we trust them. Could it be true, then, that what we trust in others is reliable kindly feeling? I give two reasons why not: we can trust without expecting others to have kindly feelings for us; and trust can be betrayed when the trusted other is motivated by kindly feelings but does not do the right thing in the circumstances.

We can trust others without being optimistic about their kindly feelings, especially when we trust them without expecting them to have specific concern for us. Whether they have that concern is irrelevant to our trust in them when our trust does not require that they do anything for us. But optimism about kindly feelings may not even be a feature of some instances of trust that do demand specific concern. For example, it is conceivable that a patient could trust a physician to be motivated by a commitment to provide her with good health care without assuming that the physician has kindly feelings for her. Particularly in trust relations between patients and specialists, such as surgeons, kindly feelings need not be a feature of those relations.

But where someone did have kindly feelings toward us that were reliable, would knowing that not be a good reason to trust that person? If Dr. Chen, for example, reliably

expressed kindly feelings toward Todd, could Todd not trust Dr. Chen even without knowing whether he is committed to promoting the welfare of his patients? The problem there is that Dr. Chen could be motivated by those feelings and still betray Todd's trust. Say that not only does Todd trust Dr. Chen to respect his autonomy, but Dr. Chen is also committed to respecting Todd's autonomy (which requires that he disclose information to Todd about his health status and his health care options). If Dr. Chen were to develop reliable and kindly feelings toward Todd, and was motivated because of those feelings to be dishonest with him about his health status, then he would be betraying Todd's trust. There, he would be failing to inform Todd of any potentially serious health problems not because he thinks it is his moral duty to prevent Todd from experiencing distress (Dr. Chen is committed to promoting patient autonomy), but because he has a strong desire not to cause Todd any distress. In that case, Dr. Chen would be acting on kindly feelings without doing what Todd is trusting him to do. Thus, Todd's trust in him could not be grounded in kindly feelings.

Trust is usually incompatible with serious forms of deception unless deception is necessary to shield the trusting person from severe harm. If Todd became clinically depressed and suicidal, then it might be compatible with his trust in Dr. Chen for Dr. Chen to withhold information from him about a serious illness, at least temporarily. However, even when it is not necessary to deceive others to protect their welfare, kindly feelings can encourage deception if those feelings are strong enough. What we want, ultimately, from trusted others is not kindly feelings, but a commitment to doing what is right in the circumstances. In the scenario above, the right thing for Dr. Chen to do, both

from his perspective and from Todd's, is to disclose information to Todd about his health status, since disclosing it is respectful of his autonomy.

But is it not a bit overblown to say that what we want in trusted others is for them to "do the right thing"? It may be that we just want them to make considered judgments in determining how to best serve our interests, rather than have their kindly feelings motivate them in ways that might subvert our interests. Thus, we still might trust their "goodwill," but only if it is informed by their judgment.[13] That idea is compelling, yet there is one aspect of our view toward the motivation of trusted others that it does not adequately clarify. Consider a situation where someone we trust uses his considered judgment to evaluate our interests, but ignores his responsibilities to others in the process. For example, what if Dr. Chen were good at respecting Todd's autonomy, but at the same time, he gave preferential treatment to Todd, even over patients who were suffering greatly and had arrived at Dr. Chen's office first? Most people in Todd's place would be appalled; and they would claim that that is not what they were trusting the other to do. Presumably, then, I have misconstrued Todd's interests by implying that Dr. Chen could satisfy them by simply respecting Todd's autonomy. Assuming that Todd is a decent guy, it cannot be in his interests to have others suffer for his own sake. But even if he were not a decent guy, it would not be in his interests to see his physician treating his patients unfairly; Todd may be disturbed by such treatment, if only because it suggests to him that one day Dr. Chen might treat *him* unfairly. Either way, what Todd is trusting Dr. Chen to do *is* the right thing. He is trusting him to be motivated by judgments that are not merely considered, but that are moral.

The above objections to the idea that we want trusted others to be motivated by goodwill, interpreted as kindly feeling or considered judgment, reveal that what we really want them to be motivated by is moral integrity. We want them to have an enduring commitment to acting in a morally respectful way toward us and we want their actions to be in accordance with that commitment.[14] Having integrity means that your actions are "integrated" with what you stand for, and having moral integrity means that they are integrated with what you stand for morally speaking (Calhoun 1995). When Dr. Chen fails to disclose important information to Todd about his health status, he compromises his own moral integrity, and in doing so, he betrays Todd's trust.

I shall defend the view that optimism about the moral integrity of trusted others is a key feature of trust relations by responding to the following objections. 1) Having that optimism suggests that we require trusted others to be perfect moral agents, which is unrealistic. 2) It implies that we expect them not to be motivated by feelings of affection at all, which seems untrue of many trust relations. 3) The desire to maintain moral integrity sounds too self-centred for what we expect of trusted others, especially when what we expect of them is specific concern for us. 4) And lastly, moral integrity is too sophisticated a concept to be what children trust in their parents or in other adults; however, their trust is a paradigm of trusting.

The first objection, then, is that relying on trusted others to have moral integrity implies that we are expecting them to act as perfect moral agents who never bow to temptation or pressures from others; and that must be too much for what we expect of trusted others. But that objection assumes, without good reason, that the only people

who have integrity are those who act on what they stand for without fail. As Margaret Urban Walker argues, however, we also describe people as having integrity if they "own up to and clean up messes" (1998, 118)--that is, if they take responsibility for failing to fulfill a commitment to us because they were under too much pressure from others or because they experienced some momentary weakness of will. As long as they make amends for whatever problems they caused, we would still say that they had integrity. Walker defines integrity "as a kind of reliable accountability" (1998, 106); it concerns how reliable we are in living up to important commitments, but also whether we are willing to be accountable for failing to meet our commitments on some occasions.

But are people who fail to meet their commitments yet are still accountable for their actions also trustworthy? That might depend on how often they neglect their responsibilities and create "messes" for others. Usually we do not conclude after someone fails to meet a single commitment that she is untrustworthy, unless, perhaps, the relevant commitment is extremely important. However, if someone *regularly* fails to honour her commitments, due to temptation, say, or the pressures of everyday life, then we would say she is untrustworthy, even if she did clean up after herself. We would also say, though, that she lacks integrity. A person with integrity takes her moral commitments seriously, which means that she does not bow to temptation regularly, nor does she regularly make commitments to others that she knows she cannot keep.

Although it is inconsistent with having integrity that one regularly bows to temptation, (i.e., the desire to do something morally forbidden), it is not inconsistent with it that one regularly acts on one's desires, as long as one's desires are compatible with a

commitment to doing what is right. If acting with integrity meant acting solely from that commitment, then it would not be what many people trust in one another. For example, intimate partners, such as Josie and Marie, usually trust that the other will act out of feelings of affection rather than out of moral duty. Yet, it is consistent with a person's having moral integrity that she often acts from feelings of affection, as long as her actions are regulated by a commitment to doing what is right. The idea of that commitment playing a regulative function--limiting the sorts of feelings on which we can act--comes from Barbara Herman (1981). Herman distinguishes between secondary motives, which restrict how we can act, and primary motives, which provide us with the motivation to act.[15] The commitment of a person with integrity to act morally serves as a secondary motive, regulating her conduct, when it permits her to do what she desires to do. When what she desires to do is something immoral, her commitment to doing what is right takes over as her primary motive and prevents her from acting on that desire. It is only when that commitment serves as her primary motive that she is forced to act against her immediate desires, or feelings of affection. At other times, she can act wholly on those desires or affections and still have moral integrity.

Still, one might object to the thesis that we trust others to be motivated by a desire to maintain integrity because, especially if one accepts traditional philosophical accounts of integrity, that view may sound as though we are expecting trusted others to be concerned primarily for themselves. However, we do not expect them to be self-centred, especially those whom we trust to have specific concern for us. Traditional theories of integrity, such as those of Bernard Williams (1981) and Gabriele Taylor

(1985), describe integrity as a virtue of an agent who remains committed to life projects or to whatever values she endorses despite the consequences that might have for others. Those theories suggest, in other words, that integrity is a personal virtue of an agent who is able to maintain an integrated self.[16] However, as Calhoun explains, guarding our integrity involves more than just guarding our selves from disintegration. She argues that integrity must be a social virtue as well as a personal one because a person with integrity is someone who "stands for something," and no one stands for anything only for themselves. They do it "for, and before, all deliberators who share the goal of determining what is worth doing" (Calhoun 1995, 257). Calhoun explains that in taking a stand, we offer to others our best judgment about how we *and* they should live and be treated within our society.

However, standing for something must involve more than just offering our best judgment; and so must integrity, one would think, if it is to count as a social virtue. To fully support her claim about the social nature of integrity, Calhoun needs to emphasize that in taking a stand, we take responsibility for ensuring that what we stand for is preserved or established. That kind of responsibility is "forward-looking," to use a term of Claudia Card's (1996, 25), whereas "reliable accountability" is often merely backward-looking.[17] Since integrity involves responsibilities that move in either direction, a person with integrity cannot be self-indulgent or merely self-protective.

The view that integrity involves forward and backward-looking responsibilities allows us to make sense of how a child could trust in another's moral integrity. One might assume that especially for children younger than Anna (say 5 or 6 year-olds),

moral integrity could not be what they trust in their parents. Since child-parent relationships are clearly among the list of trust paradigms, it may seem that I have it wrong about what the relevant motivation is in trust relationships. However, to be trusting of another's moral integrity, one does not need a sophisticated understanding of the concept of integrity. If children trust that their parents will care for them and will make things right when things go wrong, then they are trusting their parents to fulfill forward and backward-looking responsibilities, and, therefore, they are trusting their moral integrity.

What is most important to us in trusting the moral integrity of others is that they take their moral commitments seriously within the domain in which we trust them. For example, whether my plumber acts with moral integrity in the domain of intimate relationships is scarcely relevant to whether he is trustworthy in the domain of his profession. If I discovered that he cheats on his partner frequently, and concluded that I could never trust him in an intimate relationship, I could still trust him as my plumber--that is, trust that he will act with integrity in conducting his business as a plumber.[18] Nonetheless, as Govier points out, distrust in relationships "often spreads from one context to others" (1998, 147). We often perceive evidence of untrustworthiness in one domain as potential evidence of further untrustworthiness in other domains. Such evidence might cause us to question the moral character of the trusted person by revealing a propensity on his part for moral lapses. Still, we might suspect that propensity to be isolated to specific domains, and thus, continue to trust that person outside of those domains.

Those who act with integrity act on what they take to be the best moral reasons for everyone to act; however, they do not necessarily act on reasons that are morally correct. Calhoun explains that "integrity hinges on acting on one's own views, not the right views (as those might be determined independently of the agent's own opinion)" (1995, 250). As long as our own views express what we *take to be* morally correct, and we act in accordance with them, then we have moral integrity. Even if our own views violate some objective standard of the truth of different moral values, we could still have moral integrity.

3.2.2 What the Trusted Other Stands for

It cannot just be moral integrity that we expect from trusted others, for we care about *what* they stand for, not just about whether they will act on what they stand for.[19] For example, Todd does not trust Dr. Chen simply to act on whatever values Dr. Chen endorses as the right values. Todd expects him to endorse specifically the value of respect for patient autonomy. Similarly, in trusting Josie, Marie does not only care about whether Josie intends to live up to her commitment to Marie; she also cares about how Josie conceives of that commitment. She cares about whether Josie shares with her a commitment to being emotionally supportive, loyal, and honest in intimate relationships. If Marie did not know or suspect that of Josie, then she would not trust her as her lover. In this section, I argue that an important feature of prototypical trust relations is the expectation that what the trusted person stands for, morally speaking, is similar enough

to what we stand for (as far as we know what that is) that we can count on her commitment to doing what we trust her to do.

To trust others, usually we need some sense of what they stand for so that we can know whether they are likely to act in the way that we would expect them to if we were to trust them. The way that we would expect them to act depends on what we perceive to be morally acceptable ways to act. For example, what Josie expects from any partner she trusts is loyalty and honesty because that is what she believes is important in intimate relationships. To say that she simply expects "loyalty and honesty," however, is a bit vague since she might not trust a lover who defines loyalty as avoiding all conversations with people to whom she might be sexually attracted. One needs to know enough about how the trusted other conceives of her moral commitments that one can expect her to behave in a certain way. Since we usually trust others to behave in certain ways only within particular domains, what is most important is that we know where the trusted other stands in the domain in which we trust her.

Is it realistic, though, to claim that, before we can trust in others, we need to have some idea of what they stand for? Do we not sometimes trust without knowing ahead of time that others are committed to acting in the ways that we would want them to in the relevant domain? What about when we accept the help of a stranger when our groceries have fallen all over the street? Some of us seem to be able to trust people in such situations without being aware of what they stand for. However, would we actually trust the stranger if we assumed that he would probably steal our groceries or would beat us over the head while we are bending down to pick them up? No. But how could we

assume anything about where his moral commitments lie if we have never met him before? We could do so on the grounds that it is reasonable to assume that other members of our society share at least some values in common with us. If we could not assume that--either because we knew that our values were very different than theirs or because we were a recent immigrant to this country and were uncertain which values people held in common here--then we would have a lot of difficulty trusting others.

What if someone does not know what she should expect from others, not because of cultural difference, but because she is uncertain about what she stands for? What about young Anna, who might stand for some things, but not enough things that she knows what she should expect from others in many contexts? Would it be possible for her to be trusting, then, in those contexts? Without knowing what she should expect, presumably she would not be able to figure out whether she should trust others given what they stand for. However, if she admired what they stood for generally speaking, she could trust them, even without having any specific expectations regarding their behaviour. Anna could trust her father in that way if she admired him (which she seems to do). By "admiration," I mean simply looking up to the other, which is something a child could do who is even younger than Anna. Small children tend to look up to their parents and rely on them to be caring. What they are expressing is akin to admiration for their parent's values.

Furthermore, an adult who is uncertain in a particular context about what values she should hold could trust someone else whose judgment she admires. A pregnant woman who admires her obstetrician's judgment, for example, could trust him to decide

what is best for her with respect to prenatal diagnosis even if she had no idea what her own values about that option should be.[20] There, she would be trusting her obstetrician, not because what they both stand for is relevantly similar, but because what he stands for is presumably consistent with what she would hope to stand for in that context.

One might object that in the cases I have just given, admiration for the other's value judgment is a consequence of trusting, as opposed to something that makes the trust possible. The child admires her parent's judgment and the patient admires her physician's *because* there is trust in their relationships. However, there is no reason to assume that admiration could not precede trust or that trust and admiration could not develop simultaneously and exist in equal degrees. What I have called "admiration" may grow or diminish alongside of trust in a child's relationship with her parent, for example.

Thus, having an expectation about and/or admiration for what people we trust stand for, morally speaking, is a prototypical feature of trust. One could add that our trust tends to grow or diminish as our knowledge of what others stand for increases. Furthermore, the amount of evidence we need about how similar their values are to our own will likely depend on what is at stake for us by trusting them. For example, there is more at stake in trusting a lover to move in with us than there is in trusting a lover to stay overnight twice a week. Presumably, we would want to know more about the values of the lover in the first case than we would in the second before we would trust that person.

What if we could guarantee somehow that our lover's values were the same as ours without relying on her moral integrity? Could we not, then, trust our lover? In other words, what about abusive situations where someone manipulates another into holding

distorted views about love and loyalty? For example, Marie could coerce Josie into believing that loyalty to Marie should involve never speaking to other women, which allowed Marie to rely on Josie to be committed to loyalty of that sort in their relationship. There, she would not be relying on Josie to act on what she stood for (i.e., act with moral integrity); rather, she would be relying on her to act on what Marie herself stood for. If that were the case, would we still want to say that Marie is *trusting* Josie to be "loyal"?

3.2.3 Trust as Opposed to Mere Reliance

I argue, following Baier, that when we expect others to act in a certain way only because they have been coerced or because they have a disposition to so act, then we are merely relying on them, rather than trusting them.[21] Reliance is an attitude toward another person's competence, where as long as that person is motivated to do what they are competent to do, it is irrelevant to us what kind of motivation they have for acting.[22] Thus, reliance is compatible with sleazy motives (e.g., hostility, hatred), with motives that are morally indifferent (e.g, habit), or with positive motives, including that of moral integrity. Thus, I assume, as does Baier, that trust is a form of reliance. What I call cases of "mere reliance" are cases where we are optimistic that the other will act from a motive other than moral integrity. For example, I might be optimistic that my surgeon will perform my surgery competently not because I feel that he has any moral integrity but because I know that he does not want to get sued. There, the language of trust seems out

of place. It is not out of place because I would necessarily behave any differently with the surgeon who fears social sanctioning, as opposed to the surgeon who acts with moral integrity. I might be willing to put my life in the hands of either surgeon as long as they were equally competent as surgeons.

What is the difference, then, between such cases? According to Richard Holton, we are not trusting others when we expect them to act out of selfishness or out of duress because we would not feel betrayed if they were to fail to do what we were relying on them to do, whereas we would feel betrayed if we had been trusting them to do it (1994, 65, 66). The feeling of betrayal is the expected emotional response to broken trust (Baier 1995, 99), but when we rely on someone to act in certain ways because of external factors influencing her behaviour or because of her reliable dispositions, we do not feel betrayed if she acts any differently. For Holton, what is unique about trust, compared to mere reliance, is that when we trust, we adopt a stance in relation to the other that involves a readiness to feel betrayal.

However, I disagree with Holton that a stance of readiness for the possibility of betrayal is what alone distinguishes trust from mere reliance. The response of betrayal is a negative moral assessment of behaviour, relevant specifically to when a person fails to honour a commitment that we had been trusting her to meet. If she does not do what we were trusting her to do through no fault of her own, then we would not say that she has betrayed us. Since betrayal has a moral element to it, it is an appropriate response only to the behaviour of someone whom we were trusting to act morally. Thus, what makes trust different from reliance is not merely, or even ultimately, that the emotional response

of betrayal is unique to broken trust. Trust and mere reliance are distinct because we expect trusted others, unlike those on whom we merely rely, to be motivated by a moral commitment.

We can be unaware that someone intends to act out of sleazy motives and still be trusting her, rather than merely relying on her. Our trust would simply be misplaced. Where the trusted one lacks integrity and relies, as Baier writes, on the "successful cover-up of breaches of trust" to keep the trust relation going, there is trust in the relation but it is "morally rotten" (1995, 123).[23] Not all trust theorists agree on that point, however. Both Jones and Judith Baker (1996) suggest that trust requires not merely optimism that the trusted person will be concerned for our welfare, but *actual* concern on her part for our welfare. Jones argues that when the trusted person relies on the concealment of breaches of trust, the trusting person's relation to her is one of reliance, but not trust (1996, 19). Similarly, Baker claims that trust, like friendship, is a relation that one party can destroy by being deceitful even if the other party is not aware of her deceit (1996). Jones and Baker are focusing here on a specific way in which we use the term "trust." We often say that trust is missing from a relationship when one party is deceiving the other successfully. But do we really mean that there is no trust left of any kind in the relationship? Surely we would still say that the duped party is trusting the other party. There is such a category as misplaced trust, and because Jones and Baker do not make room for it, their theories are unconvincing.[24]

One could also trust and be wrong about there being similarities between what the trusted other stands for and what one's self stands for, or would hope to stand for. In

order for trust to thrive, it is important only that one's expectation about those similarities persists, and moreover, that one remains optimistic about the moral integrity and competence of the trusted one.

3.2.4 The Trusted Person's Perception of our Relationship

There is one further feature of our attitude toward the motivation of trusted others, a feature relevant specifically to certain kinds of trust relations, and that is that we expect trusted others to perceive the kind of relationship we have with one another similarly to the way in which we perceive it. If they conceive of our relationship differently than we do, then they may not welcome our trust. Adding that feature takes care of the problem of unwelcome trust, and it concerns our attitude specifically toward *whether*, as opposed to *how*, trusted others will be motivated to act.

Jones discusses the problem of unwelcome trust in "Trust As an Affective Attitude" (1996). Partly in order to solve it, she adds to her theory that trust involves the "expectation that the one trusted will be ... favourably moved by the thought that we are counting on her" (1996, 4).[25] Adding that expectation to account for unwelcome trust is redundant, I suggest, once we acknowledge the expectation about the trusted person's perception of our relationship. Moreover, adding it excludes, as I argue, the real possibility that we could have trust that is not necessarily unwelcome, but where the trusted other is not moved by the thought that we are counting on her.

When trust is unwelcome, according to Jones, trusted others are not objecting to

our optimism about their competence or about their goodwill. Nor would they be objecting to our positive attitude toward their moral integrity, or about the fact that we admire what they stand for. What they object to, specifically, is our expectation that they do something for us. Jones interprets that as an objection to the expectation that they be favourably moved by the thought that we are counting on them. However, adding that expectation as a feature of all trust relations is problematic because we do not always count on trusted others to do something for us. Moreover, even when we do rely on them to have specific concern for us, we might not expect them to acknowledge our trust and to be favourably moved by it. On my theory of trust as optimism about another's moral integrity, one could merely expect the other to be moved by his moral commitments, rather than by the thought that we are counting on him.

Thus, the problem of unwelcome trust is only relevant, potentially, to cases where we are trusting others to have specific concern for us. Let us consider that kind of trust in more detail. How does optimism about moral integrity translate into an expectation, in some cases but not others, that the trusted one will behave in a certain way toward us? It does if the moral commitments on which we are expecting her to act require her to promote or respect our interests. While some moral commitments demand that we respect the interests of everyone (e.g., our duty not to commit murder), others require only that we behave in a certain way toward people with whom we have a special sort of relationship. Although I may have a duty to be honest on some level with everyone, for example, I am not morally required to be as honest about my feelings with everyone as I might be in an intimate relationship. Similarly, I am not morally obligated to be as

concerned for the welfare of others as I ought to be for my own family members and close friends. The moral commitments relevant to the trust in prototypical relations tend to be commitments of the sort that require us to behave in certain ways only toward people with whom we are in certain kinds of relationships. Often what we trust in parents, lovers, and professional people is that they do something for us that they would not do for just anyone. That is, we trust them to act on commitments that are "relationship-specific."

Where unwelcome trust is a problem specifically is when we expect others to have what I shall call *special* concern for us. Where we trust others to have specific concern that they are committed to having toward everyone, unwelcome trust should not be an issue. However, if we trust them to have special concern--that is, trust them to do only what they are committed to doing in certain kinds of relationships, then our trust could be unwelcome. It would be unwelcome if we were expecting the trusted person to interpret the relationship she has with us differently from the way in which she interprets it. For example, if a student trusts his teacher to be emotionally supportive in the way that a parent would, but the teacher does not think of (and does not want to think of) her relationship with the student as a kind of parent-child relationship, then the student's trust would be unwanted. By trusting his teacher in that way, however, the student must be expecting her to think of their relationship as more like a parent-child relationship than a teacher-student relationship. Without that expectation, he could not be optimistic that she would be emotionally supportive in the way that she would with her own child.

Thus, to deal with the problem of unwelcome trust, it is important to recognize

that an important feature of trust relations that involve special concern is an expectation that the trusted one perceives her relationship with the truster similarly to the way in which he perceives it. He wants her, specifically, to conceive of their relationship as the kind that requires her to act on the relevant commitment. That feature is not present in all trust relations, but it is a feature of the prototypical relations I have illustrated in this chapter.

4. Degrees of Distrust and Trust

Before concluding this chapter, let me discuss briefly the main features of distrust and the issue of whether we distrust and trust others in degrees. I shall argue, following Jones, that we are distrustful not when we merely fail to be optimistic about the competence or motivation of others, but when we are *pessimistic* about their competence or motivation. Since pessimism and optimism admit of degrees, we can have degrees of trust and distrust in others.

In deciding whether to trust others, we have two main concerns: whether they are competent to do what we would be trusting them to do and how they would be motivated to do it. We want them to be motivated by moral integrity, assuming that for them to act with integrity would mean that they fufill certain moral commitments, which may or may not require them to have some specific concern for us. We do not trust others unless our attitude toward their competence and moral integrity is an attitude of optimism.

But a lack of optimism about someone's competence and/or moral integrity does

not signal distrust, necessarily. Consdier an example of someone asking me whether he can borrow my truck. I might fail to be optimistic about his ability to drive the truck without distrusting him to drive it if I am simply unaware of whether he is competent to do so. I also might not be optimistic that he would be careful with my truck and return it to me when he says that he will, but not go so far as to distrust him. I simply may not know him well enough to know how he would be motivated to act if he were to borrow my truck.

To be *dis*trusting of others, we need to be pessimistic about their competence and/or about whether they will be motivated in the right way (Jones 1996, 7). Pessimism about one or the other--competence or motivation--produces distrust in situations where one might have been trusting. As Jones writes, pessimism and optimism are "contraries but not contradictories; between them lies a neutral space" (1996, 16). Distrust does not occupy that space. It is a response not of indifference or agnosticism, but rather of pessimism toward the trustworthiness of another in a particular domain.

Since we can be pessimistic or optimistic about the competence and motivation of others to varying degrees, we must be able to distrust or trust them to varying degrees. Alongside total optimism and total pessimism lies more than neutral space; there is also space filled with different degrees of optimism and pessimism.[26] We may only be somewhat optimistic, for example, that the stranger who helps us to pick up our groceries will act on a commitment not to harm us. In the absence of good evidence that he will act in that way, we may only trust him partially.

Our attitude toward the trustworthiness of the stranger may be best described as

partial optimism *and* partial pessimism. If we did not trust him completely, our behaviour around him would be somewhat guarded, suggesting not only that we feel somewhat optimistic about his motives, but also that we feel somewhat pessimistic about them. One can be hopeful and yet at the same time slightly cynical about the trustworthiness of others. Someone who is generally distrustful of lawyers would feel that way, for example, if she were forced to consult a lawyer and decided to try to be optimistic about her lawyer's moral character. Her attitude towards her lawyer would be an attitude of qualified trust and distrust.

Trust and/or distrust of varying degrees do not exhaust all of the attitudes we can have toward the trustworthiness of others. Another attitude, one Baier (1995) discusses, is "anti-trust," where we actively or willfully resist adopting an attitude of trust toward others. Anti-trust can be a political stance directed toward members of privileged groups who tend to exploit members of one's own social group, in part, by encouraging their trust and then abusing it. Anti-trust is an important topic, but since it bears little relevance to self-trust, I do not discuss it in depth in this thesis.[27]

5. Conclusion

I have described four important features of prototypical trust relations that concern what we trust in others. One of those features is relevant specifically to the trust that occurs in those relations where the truster expects the trusted person to have "special concern" for her. That feature is the last of the following features of a trusting attitude:

optimism about the competence of the trusted in the domain in which we trust him; optimism about his moral integrity in that domain; an expectation that what he stands for is relevantly similar to what we stand for, or would hope to stand for; and an expectation that he perceives the kind of relationship he has with us similarly to the way in which we perceive it. Those features are common among the attitudes of the trusting parties to the relationships that form our prototypes for trust. A further prototypical feature which I identified in this chapter is that trust occurs between two persons in relationship. Our trust prototypes are all alike in being instances of interpersonal trust.

The question now is whether there is a self-regarding attitude that sufficiently resembles our trust prototypes that we would call it "self-trust." Is there such an attitude, one that shares enough of the prototypical features of trust to qualify as a non-prototypical variant of trust? In chapter 3, I argue that there is, and I develop an account of that self-regarding attitude.

Notes

1. I assume that the "we" applies only to those of us in Western culture, and that the way "we" understand trust reflects the dominant uses of that term in "our" culture. There may be subcultures in Western society that interpret the concept of trust differently; and how it is interpreted in Western culture may overlap significantly with how it is understood in other cultures. However, I shall not explore those possibilities here. I focus on common understandings in the dominant culture, without precluding alternative uses.

2. Prototype theory is not an uncontroversial theory of concepts (see, e.g., Griffiths 1997, 176-179), but it does seem to cohere with a popular theory of moral and emotional learning, which I support in chapter 4, as a theory of how we learn to trust. In that

chapter, I defend the view that trust is an emotional attitude, and as such, it is a learned and habitual response to certain types of situations. We learn how to give appropriate emotional responses through association with what Ronald de Sousa calls "paradigm scenarios" (1987). Along with teaching us how to have the appropriate emotions, the scenarios demonstrate the use of our emotion concepts. If we learn through paradigm scenarios how to use the concept of trust, then it makes sense that the concept itself would be structured by something similar to prototypes.

3. In chapter 4, I describe an important feature of trust that does not concern what we trust in others, namely, our vulnerability while trusting.

4. Johnson did not invent prototype theory, but he did invent the theory about how it applies to *moral* concepts. Prototype theory was developed by cognitive scientists, in particular Eleanor Rosch and colleagues (see Johnson 1993, 261, ftn. 2).

5. That is something that Johnson does not emphasize enough. For example, he does not explain with the bird example that the prototype "robin" is culturally specific.

6. It is crucial that our prototypes for some moral concepts are adaptable to our environment because of the instrumental nature of some moral phenomena, such as trusting. The reliability of our trusting attitudes may shift as our circumstances change, in which case we may need to refine our prototypes. Trust prototypes are not static and neither are paradigm scenarios for trust, as I explain in chapter 4.

7. The explanation Johnson gives for how we pick out the important features of the prototypes and why those features are not inherent features is too complicated to outline here (see 91-98). Roughly, he gives what resembles an evolutionary reason for why some features are important to us. They are features that we need to focus on if we are to get by in the world successfully. In other words, rather than being essential features of moral phenomena, they are instrumentally significant features given the nature of our interactions with our social and physical environments (Johnson 1993, 93).

8. Still, for some people, it may be easier or more natural to trust a dog than to trust any human. For example, a child who has been neglected or physically abused may find it easier to trust dogs before people.

9. See, for example, Jones (1996, 19). Baier is able to explain this aspect of our trust relations by describing trust using the "model of *en*trusting" (1995, 101). She argues that when trusting others, we *entrust* them with the care of something we value, which means that we must be trusting them in a specific domain (i.e., the domain of caring for things of that sort). Since the entrusting model would probably not fit many instances of self-trust (often, with self-trust, we are not entrusting ourselves with something), I shall not explore that model here.

10. Some theorists have argued that the use of discretion is common in medical practice (see Whitbeck 2499), because often there is no set procedure for practitioners to follow. (And, hence, some claim that medicine is an art, rather than a science; see, e.g., Elliott 1998). Patients trust that where practitioners are not constrained by strict standards of care that their actions are guided by a moral understanding of what is in their patient's best interests and/or by an understanding of their patient's individual interests and concerns.

11. See section 3.2.3, on "Trust as opposed to Mere Reliance," for a discussion of Holton's position.

12. Govier's book, *Dilemmas of Trust* (1998), is confusing on the topic of the motivation of trusted others. For example, Govier writes that when we trust someone, "we believe in his or her basic integrity; we are willing to rely on him or her," (91) and that when we trust ourselves, we have a firm belief in our "own good character and good sense" (95), or at least a "positive sense of our own motivation" (99). So do we want the trusted one to act with integrity, then, with good sense, with any kind of positive motivation, or with any motivation compatible with relying on someone?

13. There is some evidence in Baier's work that she would accept such an interpretation of goodwill. In *The Tanner Lectures*, she discusses the importance of using our judgment in expressing our goodwill; "for, as Aristotle emphasized, judgment must continually be used when we aim at contributing to someone's well-being" (1992, 118).

14. Still, as I explain below, the actions of trusted others can be motivated wholly by kindly feelings or feelings of affection, as long as those feelings are in accordance with the commitment to doing what is right.

15. Marcia Baron borrows the primary/secondary motive distinction from Herman and argues that the Kantian good will is structured in such a way that the agent's sense of duty often plays a regulative function, as the agent's secondary motive (1995, 129). In borrowing that distinction myself from Kantian theorists (i.e., Baron and Herman), my intention is not to suggest that the "commitment to act morally" that regulates the actions of a person with moral integrity is equivalent, necessarily, to a Kantian sense of duty. It could just as easily be equivalent to an Aristotelian sense of virtue, or, presumably, to a care ethicist's sense of moral responsibility.

16. What it means to have an integrated self on these theories differs. Calhoun explains how it differs among the theories of Bernard Williams, Gabriele Taylor, Lynne McFall, and Jeffrey Blustein (236-252).

17. It is backward-looking in the sense that we are assuming responsibility for our causal role in creating a certain state of affairs. For a more detailed account of the distinction between forward and backward-looking responsibilities, see Card (1998, especially 25-

29).

18. In proposing that integrity could be domain-specific, I am not denying that it concerns the integration of our selves. I am simply denying that a person with integrity has to be integrated in every domain of his life. I find the view that integrity involves complete integration too strict. Still, I would accept that someone who takes his commitments seriously only in one domain, particularly one that is relatively minor compared to the domains in which he usually maneouvres, is someone whom it would be inappropriate to say has integrity.

19. My inspiration for including this feature comes from Eva Hoffman's autobiography, *Lost in Translation: A Life in a New Language* (1989), where she illustrates the importance of having some idea of what the trusted other stands for. Hoffman emigrated from Poland to Canada when she was thirteen years old, and later lived in the United States. She focuses in her book on the difficulty she had in expressing her thoughts and feelings in a new language and in interpreting the thoughts and feelings of others who lived in a different language and culture. Her inability to understand well the feelings and thoughts of North Americans made it especially difficult for her to establish trusting relationships with them:

> What do they think, feel, hold dear? It's harder for an outsider to make these distinctions anyway, and particularly important to make them--for it's only when you can identify where a person stands that you can establish genuine trust (196).

20. I do not pretend that it is a typical scenario where a woman allows her physician to decide for her because she admires what he stands for. A number of women in prenatal care may agree to what their physicians recommend because it seems easier to agree than disagree. In other words, agreeing is the path of least resistance.

21. Baier writes that when one relies on someone's "dependable habits, or only on their dependably exhibited fear, anger, or other motives compatible with ill will toward one," one is not trusting, but merely relying on them (1995, 98, 99).

22. I am drawing here on interpersonal prototypes for reliance. We also may have reliance prototypes that are non-interpersonal, which we use when we conceive of ourselves as relying on a theory, for example, or as relying on the weather.

23. Baier also thinks that trust can be morally rotten if the "truster relies on his threat advantage to keep the trust relation going" (1995, 123). However, as I argued above, if someone manipulates another person into doing what he is relying on her to do, then he is simply relying upon her, not trusting her.

24. One reason why one would not want to negate that category is that, without it, we would not be able to explain the fact that some forms of uncooperative social behaviour such as "[e]xploitation and conspiracy ... thrive better in an atmosphere of trust" (Baier 1995, 95). One method for ensuring the continuation of the oppression of a particular social group is to ensure that its members are convinced of the trustworthiness of their oppressors. The trust that they are encouraged to have makes them vulnerable to further oppression.

25. She also adds that feature in order to solve another problem, which is that we can rely on someone to be benevolent and competent without trusting her; we only trust her, according to Jones, once we expect her to be moved by the thought that we are counting on her (1996, 10). Below, I disagree with Jones on that point.

26. Whatever geographical metaphor we use to represent the connections among attitudes of optimism, pessimism, and indifference, it must allow for combinations of partial optimism and partial pessimism. The metaphor of a continuum, with total optimism and total pessimism at either end, will not do because it is too linear.

27. Where it might have some relevance to self-trust is in the following sort of case: a privileged white male deliberately fails to trust himself to think intelligently about issues of race and gender.

Chapter 3

What We Trust or Distrust about Ourselves

1. Introduction

A number of philosophers have discussed or mentioned self-trust in their work, including Keith Lehrer (1997), Trudy Govier (1998), and Allan Gibbard (1990). None of them have taken seriously the worry that self-trust might not exist because trust might be purely relational, in the sense that it never occurs outside of a relationship between two distinct entities. Part of my aim in this chapter is to take that worry seriously. I argue that there is such a thing as trusting oneself.

In the previous chapter, I interpreted the concept of trust using prototype theory and argued that interpersonal relationality is an important feature of that concept because all of our prototypes for trust are instances of interpersonal trust.[1] But according to prototype theory, conceptual categories can allow for phenomena that do not share the same features as the prototypes for those categories. Hence, there could be trust even where there are not two persons in relationship. I argue that although the attitude toward the self to which "self-trust" refers is not identical to the attitude of the truster in prototypical trust relations, it does share most of the important features of that attitude.

I identified the important features of trusting attitudes in chapter 2, and also discussed some important features of distrusting attitudes. I argued that trust in

prototypical relations is an attitude of optimism about the competence and moral integrity of others in certain domains, and involves expectations about what they stand for in those domains and how they perceive their relationship with us. Since a phenomenon could be missing some of the prototypical features of trust and still be a "trust" phenomenon, distrust cannot simply be the absence of one of those features. Rather, it differs from trust in that the distrusting person feels pessimism, rather than optimism, about either the competence or the motivation, or both the competence and motivation of another person. In other words, he is pessimistic that he could trust that person to be competent to do what he would be trusting her to do and/or he is pessimistic that she would be motivated in the right way to do it.

In this chapter, I illustrate what self-trusting and self-distrusting attitudes are using autobiographical sketches of three women's experiences with miscarriage. I propose that the terms "self-trust" and "self-distrust" are helpful in explaining some of the different responses these women had to what went on in the time surrounding their miscarriage. It is common after miscarriage that women feel pessimistic about their competence in a number of areas, such as in knowing what it takes to act responsibly during pregnancy, in understanding and expressing their own emotions, and in carrying a pregnancy to term. All of the different ways that a woman who has miscarried can lose appreciation for her own competence are lumped together in some of the literature on miscarriage as low "self-confidence."[2] I argue that "self-distrust" is different from a lack of self-confidence and describes more accurately some of the pessimistic self-regarding attitudes that the women whose stories I use developed after their miscarriage.

Moreover, I explain how those attitudes were influenced by ideological norms in their society, and in later chapters, describe in more detail how an agent's socio-political environment can undermine her self-trust. The importance of noticing that some of the women's attitudes are instances of self-trust or self-distrust rather than instances of self-confidence lies in the unique role that self-trust plays in autonomous decision-making. By noticing how their socio-political environment influences those attitudes, we become aware of some of the ways in which that environment can have an impact on autonomy.

The scope of this chapter is limited to two main issues: 1) whether the terms "self-trust" and "self-distrust" have some application to people's lives; and 2) what it is about the self that people trust or distrust. What exactly does what we trust or distrust in ourselves have in common with what we trust or distrust in others? Which characteristics of the self do we trust or distrust when we are self-trusting or self-distrusting? Those questions are different from questions about what might constitute grounds for thinking that we can trust ourselves or not in a particular domain. The latter concern our justification for assuming that the characteristics that make us trustworthy to ourselves are present or absent, but exploring that issue would take us beyond the topic of what those characteristics are in the first place. I discuss the issue of justification in chapter 4.

Questions about what we trust or distrust in ourselves are also separate from questions about what kinds of mental attitudes self-trust and distrust are. I reserve discussion of that topic also for chapter 4, where I argue that they are emotional attitudes, characterized by patterns of salience (de Sousa 1987, Jones 1996), as well as patterns of

behaviour (Campbell 1997). There, I distinguish a self-trusting attitude from a belief about one's own trustworthiness; and I develop a theory of what I call the "skill" of trusting well or self-trusting well. That skill can be nurtured or lost depending on the agent's social environment, and it is essential for autonomous decision-making, as I shall argue in chapter 5.

2. Three Women's Accounts of Miscarriage

In this section, I give excerpts from three women's accounts of their miscarriages and highlight the aspects of their accounts that reveal how they felt toward themselves before and after the miscarriage. Below, I argue that some (but not all) of the self-regarding attitudes they express are instances of self-trust and self-distrust. Two of the stories are from *Hidden Loss: Miscarriage & Ectopic Pregnancy* (Hey *et al* 1996), and the other is from the documentary film, "Unsung Lullabies" (Leaney & Silver 1995), in which a number of women and men explain the emotional impact of miscarriage on their lives.

Case 1

> Janet miscarried her first child at seven and a half weeks gestation. In order to conceive the child, she had "charted and monitored [her] cycle with great care until the exact moment" that she knew she could get pregnant. Because she had used a natural method of contraception in the

past, she was already very familiar with her cycle. When she got pregnant, her charts showed it, and her GP accepted her charts as evidence (Hey *et al* 1996, 42).

Here is an excerpt from what Janet writes about the miscarriage: "Every morning the bleeding stopped and every afternoon it started and on the Wednesday we went back to our doctor. He felt, palpated, and prodded and questioned that I had ever been pregnant at all: 'You told me you were pregnant and I believed you.' And I, knowing that I had been pregnant, started to doubt myself and my knowledge of my body. I felt concerned for the doctor, that he felt he had made a mistake, and it was my fault. You are very willing to believe that everything is your fault.... I was afraid that the whole episode had just been hysteria, and he (the GP) was thinking 'neurotic woman' ... [she then explains that she had an ultrasound which confirmed that she had been pregnant] ... I had known that I was pregnant, and I had doubted it, doubted me, doubted this little baby's existence because some forms of knowledge are seen as more valid than others" (Hey *et al* 1996, 44, 45).

It is common for women in *Hidden Loss* to say that they had known they were pregnant but their doctors doubted it. Pregnancy tests early in the first trimester can be unreliable[3]; Janet had two of them before her ultrasound and both were negative. Her doctor assumed that she was having a late menstrual period.

The attitudes toward herself that Janet expresses in her story have to do with her knowledge of her pregnant state. Before her physician questioned that knowledge, she was certain that she possessed it; she mentions "knowing I had been pregnant," and "my knowledge of my body." In claiming that knowledge, she was assuming some expertise on her part in recognizing changes in her body, particularly changes that occur in pregnancy. When her physician denied that she had ever been pregnant, she began to doubt the reliability of her knowledge claim. She did that for two reasons. One was that she may have been wrong to assume that she had the expertise to make that claim in the first place; as she said, she "started to doubt ... [her] knowledge of [her] body." That doubt arose because her physician contradicted her and she assumed that his expertise was greater than hers. That assumption was influenced, as Janet herself reveals, by an ideological norm favouring knowledge that is grounded in technical scientific evidence rather than in non-technical evidence that cannot always be verified using standard scientific methods (the former are the "forms of knowledge [that] are seen as more valid than others"). For a while, Janet accepted that her physician had greater expertise than her because he was trained to access evidence of pregnancy that is technical, whereas her expertise was largely informed by experiential evidence. Although she did have some technical evidence, drawn from her basal temperature charts, much of the information on which she relied came from her own bodily experience.

Janet also questioned her claim to be pregnant because she wondered whether it could have been motivated by "hysteria." That is, perhaps it was prompted by an obsession she had with wanting to be pregnant, and because of that obsession, she had

deceived herself about whether the evidence pointed, in fact, to a pregnancy. As soon as she suspected that her claim was false, Janet began to feel guilty because she had persuaded her doctor to believe that she was pregnant and had therefore, caused him, perhaps, to make a mistake. Her guilt arose, then, because she knew that someone else, namely her physician, had been relying on her to give him accurate information.

Janet did not feel guilty because she had known when she made the claim to be pregnant that it might be false, but had encouraged her physician to believe it anyway. There is no indication in her story of a conscious intention to deceive, but every indication that she had truly believed she was pregnant and that there was sufficient evidence to support her claim. In other words, she thought that she was making a responsible claim to knowledge, that is, a claim motivated by an honest and rigorous assessment of the evidence.[4] She felt guilty not because she had known all along that her intentions were suspect, but because she later worried that that was the case.

Below, I argue that Janet trusted her judgment that she was pregnant before her physician questioned that she was; and, after he questioned it, she distrusted that judgment. I explain how her attitudes toward her own expertise, or judgment, are similar to the attitudes of trust and distrust in the expertise of other persons.

Case 2

> In her second pregnancy, Sheila had a miscarriage at eleven weeks gestation. She writes that at the first sign of trouble, "I knew immediately that I would lose the baby. It was the first moment after the full-term

pregnancy and 11 weeks of the present pregnancy that I felt scared that something could go, and in fact now was going, wrong. The possibility of problems had never before occurred to me. I knew things could go wrong in pregnancy but I felt I was the <sic> one of the lucky ones who would sail through it with very little alteration from the norm .... I was totally shattered. I was someone whose life revolved around bodily activity. I had worked hard to gain control in body action, to be aware of how my body moved and reacted to stimuli. I was fit and healthy. Now I felt I had lost all control of my body. I kept bleeding and there was nothing I could do about it. It was the first feelings of guilt (feelings that were to remain with me for a long time)--that I of all people should be experiencing something other than a normal pregnancy. 'Pregnancy is not an illness'; you should be able to continue as before with slight limitations. I, who enjoyed fitness and activity, was now faced with terrible guilt. Had I brought on this miscarriage myself? Oh, why had I been so selfish to go away the weekened <sic> before? I had felt the need for a break so had naturally gone to the mountains. I must have overstrained myself--it was my fault. If only ..." (Hey *et al* 1996, 21).

I want to highlight three different positive attitudes Sheila had about her own abilities that were destroyed as a result of her miscarriage. One is about her ability to "sail through" her pregnancy without experiencing any problems, another concerns her ability

to control her "body action," and a third is about her ability to act responsibly during pregnancy.

Sheila was so optimistic that she would experience a "normal" pregnancy that she did not even consider the possibility that she would not. She knew that problems could occur in pregnancy, but did not appreciate that they could occur in *her* pregnancy. She ignored that possibility and assumed that she would be "one of the lucky ones." That sort of attitude is understandable given the cultural messages that women tend to receive about pregnancy in Western society. As the writers of *Hidden Loss* point out, "[t]he literature ..., our mothers, and shared collective common sense make it seem that having a baby as the result of being pregnant is as automatically guaranteed as rain in June" (1996, 127). However, in reality, miscarriages occur in over 50% of all conceptions.[5] There are a number of reasons why our society tends to ignore the high rate of miscarriages.[6] One concerns the cultural construction of femininity as a characteristic of childbearing women. Painting a rosy picture of childbearing, or at least avoiding discussion about what often goes wrong in pregnancy, may be crucial for persuading women to accept the social role of childbearer. Since the female gender is defined in terms of that role, women who miscarry are "failures as women," which also might explain why many people around them do not want to acknowledge their miscarriage, and why the women themselves might not want to acknowledge it publicly.

People may avoid discussing a woman's miscarriage not only because they suspect that it is an embarassing topic for her, but also because the event of her miscarriage may not have any emotional significance for them. It could even lack

emotional urgency for the woman who miscarried, especially if she never knew that she was pregnant. However, often the woman is the only one for whom the miscarriage was (and continues to be) profoundly emotionally significant. If she miscarried before she was "showing,"[7] she may have been the only person to have fully acknowledged the fetus's existence and to have developed an emotional connection with it. For those who never established such a connection or who did not even know that she was pregnant, the fetus's death will likely hold little, if any significance. Still, one might think that others could sympathize with the woman if they knew what emotional impact a miscarriage can have on women. But how are they to know that, given how women's experiences of miscarriage tend to be ignored in our society?

Sheila was unprepared for the possibility that she would miscarry and was also unprepared to deal with what went on in her body during the miscarriage. She responded with shock to her miscarriage because she had been confident that she could sail through a pregnancy. That confidence was shattered as a result of her miscarriage. She was unprepared for how her body reacted during the miscarriage because she had learned that by maintaining a high level of fitness, she could control how her "body moved and reacted to stimuli." She lost that control during the miscarriage. As she said, "I kept bleeding and there was nothing I could do about it"; "I had lost all control of my body."

It is important to appreciate that Sheila's attitude about her ability to control her "body action" is distinct from her attitude toward avoiding problems in her pregnancy. She did not assume that she would avoid any problems because her control over her body was so great that she could prevent problems from occurring. There is no indication in

her story that she felt that she had that much control over her body. Thus, her attitude about her bodily control was not what made her unprepared for the possibility of miscarriage; rather, it only made her unprepared for dealing with the uncontrollable bleeding during miscarriage.

A third self-regarding attitude of optimism in Sheila's story was her attitude toward her commitment to caring for herself and her fetus and toward her capacity to know what that would take. That she knew what it would take is revealed by her remark that "'[p]regnancy is not an illness'; you should be able to continue as before with slight limitations." She must have accepted that advice about pregnancy, for it had influenced her decision to go hiking in the mountains and influenced how much she exerted herself on the trip; earlier on in her story, she explains that she had taken it easy by reducing her pace and carrying less weight than usual (Hey *et al* 1996, 21). She had purposefully done what she thought she needed to do to be responsible, and therefore, she must have been committed to acting responsibly. Initially she assumed that she was not failing to live up to that commitment by going hiking, but her view of that plan changed after her miscarriage. She had been selfish to go on the trip and felt guilty for doing so. She had broken a commitment to care for herself and her fetus, and had been wrong to assume that she knew how to act responsibly in pregnancy; she concluded that she must have overstrained herself while hiking and had subsequently caused her own miscarriage. Like Janet's guilt, Sheila's guilt was a response, in part, to a failure to do what others (e.g., her potential future child) were relying on her to do.

Sheila's guilt may seem completely unreasonable, particularly to those who know

that it is highly unlikely that her hiking was the cause of her miscarriage. However, it is important to interpret her guilt against the background of pronatalist norms that require women to go to extreme and often unnecessary lengths to care for their children or their offspring, and which presume that it is simply second-nature for women to know how to care for them. Those norms imply that by virtue of being a woman, Sheila should have known how to protect her fetus and should have ensured its protection. What Sheila interpreted as guilt may have partly been shame in her own shortcomings as a woman and as a mother, revealed to her as a result of her miscarriage. Below, I explain that both her feelings of guilt and Janet's may have been mixed with shame.

As I argue below, in her complex response to her pregnancy and miscarriage, Sheila expressed self-trust and self-distrust in her attitudes about behaving responsibly in pregnancy, self-confidence and a lack of self-confidence in her attitudes about sailing through her pregnancy, and self-reliance and a lack of self-reliance in her attitudes about her ability to control what goes on in her own body. In chapter 2, I contrasted trust with reliance, and here I add the further contrast of trust as opposed to confidence.

Case 3

> Anna had a positive pregnancy test at six weeks gestation, but the day after the test, she started bleeding severely and had a miscarriage. As a result of the miscarriage, she suffered a lot of emotional confusion. She had a loving partner who was deeply concerned about what she was going through, but who did not seem to be able to help her to get through it.

"I found it really difficult to express just how difficult I was finding it emotionally after the miscarriage, and ... I guess partly because I didn't know anyone else who'd miscarried and I felt sort of like, well, it was only six weeks. It wasn't like I'd lost, ... lost a baby or that I'd had a stillbirth or something like that, .. and you know that maybe I shouldn't be as upset as I was" (Leaney & Silver 1995).

Often, there is pressure on women not to grieve after a miscarriage because many people around them do not view their fetus's death as an event that warrants profound grief. That view is reflected in the kinds of responses that people often give to women when they miscarry. An example is that the miscarriage was a "blessing in disguise; the baby would have been deformed" (Hey *et al* 1996, 129). Miscarriages are often interpreted as "blessings" not only when the fetus might have had an abnormality but also when the pregnancy was unwanted and the woman was trying to decide whether to terminate it. It is a blessing that she did not have to make what for her might have been a difficult decision. However, even when women have miscarriages in unwanted pregnancies, they can experience the death of the fetus as a significant loss, and be confused or even offended when others suggest that they should be relieved about the outcome.[8] Whenever women feel incredible sadness over a miscarriage, but others respond as if there is little to be upset about, the women can experience profound confusion about their feelings and, in particular, about whether the intensity of their feelings is warranted.

Anna felt a kind of "emotional incompetency" when it came to dealing with her

miscarriage. As she said, she "found it really difficult to express just how difficult [she] was finding it emotionally after the miscarriage." There are two reasons why she might have felt that way. One is that she may have thought that most people would be unsympathetic to her feelings if she were to try to articulate them, and the other is that she was simply having trouble articulating them. She may have thought that people she knew, including her partner even, could not be truly sympathetic because none of them had ever experienced what she was going through (as far as Anna knew). For instance, her partner never experienced what it was like to have their "child" inside of him. Others also might be unsympathetic because, "well, it was only six weeks," and "it wasn't like I'd lost ... a baby." Anna may have been imagining that people around her were interpreting her miscarriage as a relatively insignificant event, and that encouraged her to try to interpret it that way as well.

However, Anna must have been confused about how she was feeling, rather than just concerned that others would be unsympathetic. She was somewhat persuaded by the view that the death of her fetus did not warrant profound grief, but she was experiencing that level of grief nonetheless. That must have made her confused about whether her feelings were warranted, and perhaps even uncertain about whether they were caused by her fetus's death. She may have been thinking that if its death was insignificant, then it could not have been the event that triggered those feelings. They must have been caused by something else, in which case they were not feelings of grief over the death of a fetus. They could have been feelings of anger over how others treated her after the miscarriage (perhaps she assumed that they blamed her for it), they could have been feelings about an

imagined death of an imaginary entity that had greater moral or personal significance than her fetus, or they could have been caused, of course, by abrupt hormonal changes.

The two reasons why Anna may have found it difficult to express her feelings could be interconnected. More specifically, she may have been confused about her feelings and about the occasion that produced them *because* of the lack, or presumed lack, of sympathy from others for those feelings. Sue Campbell's theory of feelings explains why that may have been the case (1997). Campbell argues that until others give "uptake" to our feelings, that is, until they recognize them as the same sorts of feelings that we do, then usually we cannot be certain about what they are feelings *of*, or of what their content is. She argues that feelings are individuated (that is, their content is defined) collaboratively through their expression. Their individuation depends both on how the person with those feelings interprets the occasion the significance of which she is trying to express, and on how the people to whom she expresses its significance interpret that occasion. If someone with whom she shares her feelings does not see how the occasion warrants the kinds of feelings she is claiming to have, then she may become confused about what those feelings are about (Campbell 1997, 109, 110).

Campbell's theory is helpful in understanding the enormous difficulty that women, such as Anna, have in sorting out their feelings surrounding a miscarriage when those feelings clash with the way their society expects them to react emotionally to miscarriage. Their emotional turmoil is no coincidence, given that most people around them may not acknowledge their feelings or may even deliberately try to discourage them out of an interest in perpetuating our society's rosy view of childbearing. Using

Campbell's theory, we can account for the kind of emotional confusion that comments such as "it was a blessing in disguise" or "it could have been worse: you could have lost a baby" can cause for women who have miscarried. Those women need listeners who will give uptake to their feelings, rather than demand different feelings. Those are people who have some understanding of the various kinds of emotional significance that miscarriage can have for women.[9]

Although Anna's ability to understand her feelings by clarifying the significance of the event that caused them may be dependent on sympathetic listeners, one can still refer to *her* competency in that area, and of whether she trusts or distrusts it. One could assume about that competency that it is relational in the sense that one's ability to exercise it depends on whether one has opportunities for collaboration with sympathetic others. It is a competency that can manifest itself only if those opportunities exist. Below, I call that competency a form of emotional competency; and I explain that Anna distrusted it in the domain of her miscarriage.

3. Important Features of Self-Trust and Self-Distrust

First I shall focus on the attitudes I identified above as self-trusting and distrusting attitudes; and I shall explain why we would conceptualize them as forms of trust, or distrust. They include Janet's attitudes toward her own judgment that she was pregnant, Sheila's attitudes toward her commitment to act responsibly in her pregnancy, and Anna's attitude about her emotional competency in the context of her miscarriage.[10]

I structure this section by going through each prototypical feature of trust and distrust, and identifying whether each is present in the above attitudes. I argue that all are present in some form or other, except the features that concern the relationship between the truster and the trusted.

Interpersonal trust and self-trust are importantly similar in that when we trust others, we are trusting them to have certain competencies and to live up to their commitments to us, and when we trust ourselves, we are trusting our own competency and commitment. One unique aspect of self-trust is that the self-truster is the one trusting as well as the one trusted. To be the one trusting, she must be optimistic about the competency of the trusted (i.e., herself) and the commitment she has to do what she is counting on herself to do. To also be the one trusted, she must take some responsibility for exercising that competency and for meeting that commitment.

3.1 The Competence of the Self

The women's attitudes which I identified as trusting or distrusting attitudes all concern different competencies that the women possessed (or wished that they possessed) within particular domains. For example, Janet's attitudes of optimism and pessimism had to do with whether she was competent to recognize when she was pregnant. Before her physician doubted her, she felt that she had the expertise to determine on her own whether she was pregnant given her knowledge of her cycle. Her optimism about that expertise mimics the optimism of the characters in the vignettes in

chapter 2 who are optimistic about the epistemic powers, or judgment, of the trusted (they are Eva, a 9-year old girl who trusts her father's judgment, and Todd, who trusts his physician's judgment). In particular, like Todd's attitude about the expertise of Dr. Chen, Janet's attitude is domain-specific. Her optimism and pessimism about her own judgment extend in her story only to judgments about changes in her body, particularly changes that occur in pregnancy.

The attitudes of Sheila and Anna are also directed at domain-specific skills, or competencies. Sheila was optimistic before her miscarriage that she was competent to understand what it would take for her to act responsibly in her pregnancy. Her attitude focused on the epistemic dimensions of her moral competency, as do the trusting attitudes of Josie and Marie, the characters from chapter 2 who trust one another in an intimate relationship. Their trust depends, in part, on their optimism about one another's moral competence, but not necessarily on whether they are correct about that competence. Similarly, although Sheila was not wrong that she was competent to understand what it would take to act responsibly in her pregnancy, she could have been wrong and still have maintained her attitude of self-trust. That attitude would simply have been misplaced. If she were to lose her optimism about her moral competence in the domain of her pregnancy (which she did), then her self-trust in that domain would disappear. Once Sheila decided that her miscarriage was her fault, she began to feel pessimistic about her prior moral understanding, and consequently distrusted that understanding as it related to her pregnancy.

The relevant competency with Anna's negative attitude is her ability to identify

and articulate her own feelings. She was pessimistic that she possessed that competency in the domain of her miscarriage, but not necessarily pessimistic that she possessed it in other domains. That competency is probably one dimension of "emotional competency," where another is having the ability to understand or at least be sympathetic to the feelings of others. Intimate partners often trust one another to have both dimensions of emotional competency, which is the case with Josie and Marie. By trusting one another to be emotionally supportive, they are trusting that the other is competent to be sympathetic toward the feelings of the other. They are also trusting one another to be able to express their feelings clearly, since each trusts the other to be open and honest about her feelings and to act appropriately given their content. Their trust in one another's emotional expression has the same object as Anna's pessimistic attitude toward herself.

3.2 The Moral Integrity of the Self: Feelings of Shame and Guilt

It would be difficult to establish that the women were trusting themselves in the relevant domains unless their attitudes concerned not only their competence, but also their moral commitment to act in a certain way. I argued in chapter 2 that what distinguishes trust from mere reliance (where trust itself is a form of reliance) has to do with the sort of motivation one expects from trusted others. One expects them to act with moral integrity. When one is merely relying on others, one expects them to be motivated by habit, selfish desires, or some threat of harm, rather than by a commitment to doing what is right in the circumstances. I argue in this section that the women's

attitudes were focused on a commitment to doing what is right. That is, their attitudes shared with attitudes of interpersonal trust or distrust the feature of optimism or pessimism about the moral integrity of the trusted one. I explain that for them to have been trusting or distrusting themselves, their optimism or pessimism did not have to be conscious. And, furthermore, I claim that one source of evidence (although not a conclusive source) for whether they had been trusting themselves is their emotional response when their trust was (supposedly) broken. The expected response to broken self-trust, I argue, is guilt or shame.

Because the women's attitudes were self-regarding, it is important to demonstrate not only that the women were optimistic or pessimistic that they would act on a commitment to be moral, but also that they took some responsibility for living up to that commitment. Those who take such responsibility allow their moral commitments to regulate their primary motives for acting. In chapter 2, I distinguished between primary and secondary motives, and explained that a person with moral integrity is someone whose commitment to doing what is right acts as a secondary motive, regulating her conduct. Sometimes when it serves that function, the agent is introspecting her primary motives (i.e., the motives she has for acting) to confirm that they are consistent with her moral commitments.

But a person can act with moral integrity without engaging in introspection if she already knows that what motivates her to act is consistent with a commitment to doing what is right. Often reflecting upon those motives "would be otiose and leave unchanged our intellectual and practical attitudes" towards them, as Lehrer suggests (1997, 4). That

leaves room for the possibility of unconscious trust, which is common in interpersonal relations, and would be common with self-trust, if such attitudes exist. An example, involving interpersonal trust, is that often we do not put conscious effort into our trust in friends or lovers for it just seems obvious to us that they are trustworthy (Baier 1995, 99).

When we trust ourselves without conscious effort, one source of evidence for whether we are, or were, optimistic about our competence and commitment to do something is the way that we would respond to our failure to do it. For example, if I had been optimistic that I would live up to a commitment to care for my dog, Fergus, but failed to live up to it because I was too lazy to walk him regularly or because I sometimes forgot to feed him, one would expect that I would feel guilty or even ashamed. One assumes that the appropriate emotional response to a failure to live up to a commitment when one could have acted otherwise is guilt or shame. Moreover, if I had been counting on myself to be competent to care for Fergus but cared for him incompetently--by feeding him the wrong food, for example--then I would also feel guilty or ashamed. I would feel badly that I had counted on myself, and had others count on me (especially Fergus), to do something that I was not actually competent to do.

In the literature on emotions, shame and guilt are distinguished from one another by associating guilt with our actions, and shame with our nature (see especially, Bartky 1990 and Deigh 1983). We feel the betrayal[11] of broken self-trust more deeply when we respond with shame, for in our minds the betrayal represents not only a wrongdoing on our part, but a shortcoming, or a flaw in our character (Bartky 1990, 87). Since wrongdoings usually reflect badly on our character, shame and guilt often accompany

one another. Moreover, as Sandra Lee Bartky notes, "the boundaries between them tend to blur in actual experience. Psychological studies have shown that most people are hard put to state the difference between shame and guilt, nor can they easily classify their experiences under one heading or the other" (Bartky 1990, 87, 88; see ftn 23, citing Miller 1985). Thus, although the women in the cases above described their feelings over the disappointment of their self-trust as guilt, they may, in fact, have felt shame as well.

Thus, if it is true that we can trust ourselves, then when that trust is broken, we will feel guilty and/or ashamed, whether our trust is conscious or not. That emotional response is consistent with the expected emotional responses to broken interpersonal trust by the truster and the one trusted. What we expect from the truster when interpersonal trust is broken is that she feels betrayed. What we expect from the trusted, that is, the one who broke the trust, is guilt or shame, since those emotions are appropriate for someone who has betrayed another. When we trust ourselves, we are the one trusted and therefore the one responsible for honouring the trust. When we fail to meet that responsibility through some fault of our own, we feel guilty or ashamed because we have betrayed ourselves.[12]

However, a response of guilt or shame alone does not confirm that one had been trusting oneself, since it alone does not establish that one had been optimistic that one would act with moral integrity. There are three reasons why it does not confirm such optimism. First of all, although shame and guilt are negative moral assessments we make of our behaviour or of our nature when we fail to live up to certain standards, we may experience those emotions without accepting the relevant standards. We could have

internalized the standards without actually endorsing them (see Bartky 1990). For example, what spawned Sheila's guilt, in part, may have been the internalization of the standard that she drastically alter her normal behaviour in pregnancy because it is a disease-like state. Sheila does not endorse that particular view of pregnancy, but the pervasiveness of it in patriarchal society may have invaded her psyche, nonetheless. Similarly, Janet did not accept the standard that technical, scientific evidence is inherently superior to experiential evidence, but still, that societal epistemic norm may partly explain her guilt about claiming to be pregnant, without much technical evidence, when, in fact, she might not have been pregnant. Guilt and shame that arise in response to internalized standards that we do not endorse do not reveal that we had been optimistic about acting with moral integrity, since integrity requires that we act in accordance with standards that we accept. To establish that those emotions are evidence of such optimism, one would have to have good reason to suspect that we did endorse the relevant standards and were committed to living up to them.

Secondly, we may experience guilt or shame about violating a particular standard even if we did not accept it at the time that we violated it, but did so later on and wished that it had been guiding our behaviour. Consider the example of someone who frequently told lies in the past exaggerating his successes, but who never believed that those lies were really morally problematic. If he now accepts that they are, he will probably feel guilty or even ashamed about having told such lies. But his shame or guilt would not reveal that he had been optimistic in the past that he would act on a commitment to refrain from telling lies about himself.

Lastly, it is possible that even if we had accepted a standard at the time that we violated it and now feel guilty or ashamed, we might not have been optimistic that we would live up to that standard. Consider the example of someone who has always agreed that she ought to take good care of her body. On New Year's Eve, she makes a resolution to quit smoking, but she does not really take seriously the possibility that she will quit because she knows how difficult that would be. There, she is merely *hopeful* rather than optimistic that she will live up to her commitment to take better care of herself, and she will probably feel guilty or even ashamed when she has her first cigarette after the holiday. She was merely hopeful, but one would not go so far as to say that she was trusting herself to quit smoking.

Thus, guilt or shame alone does not establish whether we had been optimistic that we would live up to a particular standard. Establishing that requires that one produce further evidence, such as evidence that our past behaviour is consistent with a sincere attempt to meet the relevant standard, and that in all likelihood, we would openly endorse that standard.

Can we demonstrate, then, that the women's self-regarding attitudes focused on whether they would live up to certain moral commitments and would, therefore, act with moral integrity? First we need to determine what the relevant moral commitments might be. What would it mean for the women to exercise the competencies on which their attitudes focus and act with moral integrity at the same time? After answering that question, we need to establish that they were, in fact, optimistic or pessimistic that they would act with integrity, and that they took some responsibility for acting in that way.

But we also need to show that by striving to fulfill the commitments on which their attitudes focus, the women were displaying a social virtue. As I argued in chapter 2, the virtue of integrity is social because it involves "standing for something," which requires that one take on forward-looking responsibilities for ensuring that what one stands for is preserved or established, not only for one's own sake, but also for the sake of others. With self-trust, we take on responsibilities for ourselves by standing up for what we need and value most, and/or responsibilities for the welfare of others who are relying on us or trusting us. To be morally responsible for ourselves, we must fully appreciate our own worth as moral agents, which requires that we attend to our own needs and desires. There are social elements to doing so, including sending the message to others that no one should compromise her own worth. Furthermore, self-trust motivates us to meet moral commitments to other people. It is the appropriate response to trust from others that we welcome, for to honour their trust, we must be optimistic that we will act competently and with moral integrity in doing what they are trusting us to do.

Let us consider Janet first and determine which moral commitment she could have been living up to while making knowledge claims about her own body. A plausible candidate is the commitment to making responsible claims. That is, she could have been striving to be a responsible epistemic agent, one who has no intention of deceiving others or herself by making false or exaggerated claims. She would have been attempting to emulate such an agent not only for her own sake, but also for the sake of others, in particular her physician, who was relying on her to give him accurate information about her pregnant state. Thus, in being committed to epistemic responsibility, she would have

been optimistic about exhibiting a social virtue. Responsible epistemic agents are committed to making statements that are not simply convenient or useful, but true. Someone who admits that her claims are made solely out of convenience, simply to serve her own interests, could hardly call them "knowledge claims." Being responsible epistemically requires assessing the available evidence carefully and also recognizing the limits of one's knowledge (i.e., recognizing that how much one knows is limited by whatever one has actual evidence to support).

But how we understand epistemic responsibility is determined not merely by the bounds of evidence, but also by what counts as evidence, which is often partly a political issue. In some contexts, dominant groups gain the power that knowledge brings by ensuring that what is deemed to be "evidence" is whatever they have expertise in assessing, and by controlling who develops that expertise.[13] That is, sometimes, they exact limits on who gets to be epistemically responsible by promoting a narrow conception of evidence. As I have mentioned, Janet does not endorse the dominant conception of evidence in medical contexts, and hence, the standard of epistemic responsibility she may have been living up to in claiming to be pregnant must have been a revised version of the dominant standard.

Janet was committed to making responsible knowledge claims and felt that her claim to be pregnant was responsible before her physician doubted its truth. When he said, "You told me you were pregnant and I believed you," he was suggesting that she had been irresponsible in making that claim. What he probably meant was that she had been careless in recording her temperature on her charts. The other evidence she had of

pregnancy--her experiential evidence--he probably did not take seriously from the beginning. That evidence did not save her, then, from being labelled irresponsible by him once he suspected that her technical evidence was unreliable. By responding to her physician's comment with guilt feelings (and perhaps also with shame), Janet revealed that she had at least internalized (but had not necessarily endorsed) the constraint that she strive to make responsible claims. As I argued above, she may have been responding to the dominant constraints on evidence at that point, even though she never actually believed in that conception of evidence and may have been striving to meet a standard of epistemic responsibility that is compatible with an alternative conception of what counts as evidence.

However, Janet's guilt does not confirm that she endorsed any standards of epistemic responsibility at the time that she claimed to be pregnant. She may have only realized after her physician suggested that her claim was irresponsible that she should have been committed earlier on in her interaction with her physician to making responsible claims to knowledge. However, there is evidence in her behaviour while she was attempting to discover whether she was pregnant that the commitment to being epistemically responsible was guiding that attempt and that she endorsed that commitment. The evidence is that she "charted and monitored [her] cycle *with great care* until the exact moment" that she knew she could get pregnant (my emphasis). That she took great care reveals that she was committed to acting responsibly, and moreover, that she probably had been optimistic, rather than merely hopeful (but never actually serious) about being a responsible knower. In other words, she was optimistic that she

would act with moral integrity. Once her physician's comment caused her to suspect her true motives for claiming to be pregnant, she began to feel pessimistic about whether she had, in fact, acted responsibly in making that claim. She was pessimistic not merely because the claim might not have been grounded in any "real" evidence, but also because she may have been "hysterical" in making that claim. Hence, it may have been inconsistent even with the evidence she valued and had available to her.

For Sheila to act with moral integrity while exercising the competency on which her attitudes focus would involve her acting on a commitment to behave responsibly in her pregnancy. That responsibility is clearly social as well as moral for it concerns her well-being as well as the well-being of her fetus. The "terrible guilt" Sheila felt after the miscarriage because she thought she had caused it by overstraining herself on the hike, suggests that she may, in fact, have been committed to fulfilling that responsibility. Further evidence of that commitment lies in her plan to exert herself less than usual on the hike. Her view that she should limit herself slightly informed her commitment to protect herself and her fetus and that commitment was guiding her behaviour. Thus, Sheila must have been optimistic that by going hiking she was acting in accordance with her moral commitments in pregnancy. That is, she must have been optimistic that she was acting with moral integrity. After the miscarriage, her optimism disappeared and was replaced by pessimism about her true motives for making the trip. She assumed that she had been motivated by selfishness rather than by a desire to act in a way that was consistent with her moral responsibilities.

The kind of commitment Anna was striving to live up to is the commitment to

understand her emotions and to act appropriately given their content. Her commitment is probably the same as one of the commitments of Josie and Marie to one another (the characters from chapter 2): Josie and Marie trust not only that each other is competent to express her emotions clearly, but also that she is committed to expressing them clearly and to acting in ways that are consistent with her emotions. That Anna was struggling to "express just how difficult [she] was finding it emotionally after the miscarriage" reveals that she was committed both to understanding her emotional response to her miscarriage and to acting in appropriate ways given that response. She wanted to *express* her emotions clearly, which means she wanted her behaviour to communicate *those* emotions, that is, to be suitable behaviour given what those emotions were. Like Josie and Marie, Anna and her partner were probably committed to having an emotionally healthy relationship, which means that Anna probably felt obligated to settle her emotional confusion not only for her sake, but also for her partner's sake. Thus, in all likelihood, her commitment to exhibiting emotional competence in the domain of her miscarriage was guiding her behaviour; and to honour it, she would have been exhibiting a social and a moral virtue. She was taking some responsibility for living up to that commitment, but was having little success, and therefore felt pessimistic about whether she was competent to live up to it.

Thus, like individuals who are trusting or distrusting others, the women in the cases were optimistic or pessimistic about whether they would live up to, or had lived up to, a moral and social commitment to act in a certain way. Their attitudes were focused not only on one of their competencies within the domain of pregnancy and miscarriage,

but also on their moral integrity in that domain. Because those attitudes were directed at themselves (they were the one trusted as well as the one trusting), they also must have taken some responsibility for honouring their commitment. If they were fulfilling that responsibility, then their commitment must have acted as their secondary motive, that is, as a motive regulating their primary motives to act. I have argued that there is some evidence in their stories that their moral commitment was performing that regulative function. Moreover, I argued that it could have been performing that function even if the women were not consciously aware of it.

3.3 The Expectation About What I Stand For

Thus, the women's attitudes had two of the important features of prototypical trust: optimism about the competence of the trusted and optimism that she will act with moral integrity. Another important feature is the expectation that what she stands for is similar enough to what we stand for that we can trust her to be committed to doing what we are trusting her to do. We do not trust her to have that commitment simply by being optimistic that she will act with moral integrity; for she could act on a different moral commitment and still maintain integrity. However, as I argue, with self-trust, we *do* trust ourselves to act on certain moral commitments simply by being optimistic about our moral integrity. That optimism entails the expectation that the commitments that the one trusted (i.e., ourselves) will act on will be our own.

However, most self-trusting attitudes do focus on our future behaviour,[14] and so

do we not need to expect, when trusting ourselves, that we will be committed in the future to the same values that we now hold and that are relevant to our trust in ourselves? If that were true, we would have to be questioning our commitment to those values, and that in itself would reveal that we are not truly committed to them. One's endorsing or being committed to a moral value, such as social justice, presupposes one's having an expectation that one will hold that value in the future. If a young person claimed to stand for social justice and to oppose capitalist values, for example, but at the same time, he expected that when he got older he would probably vote for a right-wing political party just like most of the adults he knows, then we would question his commitment to the values he claims to hold. Moral values, then, are distinct from preferences, for we often expect that when we have a certain preference (e.g., a preference for jogging), unlike when we are committed to a moral value, we might give it up at some point.

Since being optimistic about our moral integrity means being optimistic that we will act on our own moral commitments, and being committed to certain moral values entails the expectation that we will hold those values in the future, it would be redundant to add to a description of self-trust that focuses on our future behaviour the expectation that we will hold certain values in the future.

But even though we do not expect our moral values to change in the future, they might change nonetheless. When we revise moral commitments that we had been trusting ourselves to have in the future, do we betray ourselves? That issue is complicated by the fact that some feminist philosophers, such as Susan Babbitt (1996), Margaret Urban Walker (1998), and Claudia Card (1996), have argued that acting with

integrity sometimes *requires* that we revise our commitments, rather than strive to meet commitments that are no longer appropriate given new circumstances or relationships we find ourselves in, or new knowledge we have gained about people's needs (including our own). If that is true, then we do not betray our optimism that we will act with moral integrity when we revise our values and act on new values instead of those that we had been trusting ourselves to promote. But the fact that we had been trusting ourselves to act on *those* values suggests that we do betray ourselves.

The best response to that apparent paradox, in my view, is to acknowledge that when we revise our values in ways that are compatible with maintaining integrity, and, consequently, we fail to meet our earlier commitments, we may cause some harm or disappointment to others, but we do not betray *ourselves* as a result.[15] If we were trusting ourselves to live up to responsibilities that are primarily other-directed, then we may disappoint the relevant others. But if we have revised our commitments and no longer care about our earlier commitments, then why would we be betraying ourselves if we do not live up to them? Consider someone who trusted herself always to put her family commitments before her commitments to close friends or even to intimate partners (those whom she would not classify as family). She had been taught that the family was sacred and that the unity of it should not be sacrificed for any reason. But at some point, she realizes that this view of family is simply false. She then prioritizes her commitments differently and begins to act, in some circumstances, on commitments to friends, where those commitments conflict with family obligations. Her family might be hurt or disappointed as a result; but surely she has not betrayed herself.

3.4 The Relational Features of Trust

The features of our trust prototypes that I have not yet discussed in relation to self-trust are the following: the expectation that the trusted person's perception of the kind of relationship we have with one another is similar to our perception of it, and the fact that there is a relationship between us and both of us are persons. I argued in chapter 2 that it is important to include the feature about the trusted one's perception of our relationship in a description of trust where the trusting person is optimistic that in his relationship with the trusted, she will live up to a moral commitment that requires her to behave in a certain way only toward people with whom she has a special kind of relationship (such as a friendship, or a love relationship). For the trusting person to have that optimism, he must expect that the trusted one perceives the kind of relationship they have with one another as the kind that requires her to fulfill that commitment. That expectation is not a feature of trust that is self-regarding since there is no issue there about what kind of relationship exists between the truster and the trusted. Similarly, the feature of interpersonal relationality is irrelevant to self-trust.

However, as I argued above, whether self-trust is a genuine form of trust does not necessarily hang on whether it is missing one or two of the important features of trust prototypes. Yet I also acknowledged that some of the important features of prototypes could amount to necessary features of the phenomena which those prototypes depict. Thus, the feature of interpersonal relationality, for example, may be a necessary or an especially important feature. But since many of us already use the term "trust" outside of

personal relationships, it is doubtful that interpersonal relationality carries such importance. For example, sometimes we speak of trusting in governmental institutions. Thus, trust must be coherent in the absence of interpersonal relationships.

Although self-trust is not relational in the sense that it occurs within a relationship, it is relational in the sense that it can be fostered or undermined through our interactions with others and through our broader social and political environment. If something is relational in the second sense, then it is socially constituted. I have demonstrated in the cases of Janet, Sheila, and Anna that their self-trusting and distrusting attitudes have that characteristic.

Thus, given the similarities between the women's self-regarding attitudes and attitudes of interpersonal trust and distrust, it is appropriate to extend the concepts of trust and distrust to them. Before I review those similarities, let me briefly explain the differences between self-trust and certain other self-regarding attitudes, namely self-reliance, self-confidence, and self-respect.

4. Self-Trust and Other Forms of Self-Appreciation

According to my theory of trust, when we are optimistic that we are competent to do something and will do it with moral integrity, we are trusting ourselves. On the other hand, if we are optimistic that we are competent to do something and will do it out of habit or fear, we are merely relying on ourselves. I argued in chapter 2 that trust differs from mere reliance in that when we rely on others to be motivated not out of moral

integrity, but out of habit or out of a desire to avoid social sanctions, we are not trusting them. What is unique about self-confidence, compared to self-trust and self-reliance, is that when we are confident that we will act in a certain way, we cannot imagine acting any differently (Luhmann 1988, 97). In other words, the self-confident person merely *expects*, rather than is optimistic, that she is competent to do something and will be motivated to do it. There, I am interpreting "expectation" differently from even enormous optimism by assuming that the latter, unlike the former, still implies an awareness of the possibility of disappointment. In this section, I distinguish self-trust from other forms of self-appreciation and identify the other self-regarding attitudes that Sheila had besides her self-trust and self-distrust.

An important difference between Sheila's attitude about "sailing through her pregnancy" and her self-trusting attitude is that she merely expected to avoid all problems in her pregnancy, but did not necessarily expect to act responsibly. Her expectation about sailing through is revealed by her comment that "[t]he possibility of problems had never before occurred to me." She did not expect in the same way to act responsibly, since she was consciously regulating her behaviour by a commitment to act in that way (e.g., that occurred when she decided to carry less weight than usual on her hike). The former attitude is an attitude of confidence as opposed to trust. In being self-confident, as Niklas Luhmann observes, "you do not consider alternatives" (1988, 97). You do not appreciate the risk that you may act differently and consequently disappoint yourself and others, whereas in trusting yourself, you appreciate that risk but are committed to trying to avoid it. If you fail to meet that commitment, you feel guilty or

ashamed, whereas if you fail to act as you had been confident that you would, the emotional response one would expect is shock or surprise. Sheila's response when she discovered that her pregnancy would not run smoothly was shock.

The response to ill-deserved self-confidence may sometimes be mixed with guilt or shame, and, hence, it may be difficult to distinguish from a response to broken self-trust. We may feel guilty or ashamed upon discovering that our self-confidence was ill-deserved because we may realize then that we should have been committed to being more honest with ourselves, and with others, about our level of competence.

Sheila's attitude about her ability to control her "body action" was probably an attitude of mere self-reliance. It is doubtful that she was trusting herself to have that control, since it is hard to imagine what moral commitment she could have been living up to while exercising it. Her attitude could possibly have been an attitude of confidence, but it is more likely that it was an attitude of mere reliance, since it is plausible to assume that it was grounded in a fear of losing control. Sheila may have what our society labels "the superwoman syndrome," which women can develop in response to societal pressure to excel in their careers while at the same time accepting most of the responsibility at home for child care and domestic work (Hey *et al* 1996, 140). Some women who have all of those responsibilities find that they can cope only if they are optimistic about being in control over virtually every aspect of their lives. They live at least under the illusion of complete control--hence the term "superwoman syndrome." Sheila's desire to have control over her body may be a symptom of that so-called syndrome.[16] She may strive to maintain control over her "body action" only

because she feels that if she were to lose control in one area of her life, the rest of her life would fall apart.

Let me explain briefly how self-trust differs from one other form of self-appreciation, namely self-respect. One might expect there to be little difference between the two given that self-respect concerns our moral character or integrity, which is also true of self-trust (if I am right about the nature of it). But only one type of self-respect actually involves the appraisal of our character--what Stephen Darwall calls "appraisal self-respect"--whereas another involves simply recognizing that we are beings with moral worth who deserve to be treated respectfully--what Darwall calls "recognition self-respect" (Darwall 1995). It is appraisal self-respect that overlaps significantly with self-trust. The former targets our moral character and the competencies we develop as a result of that character (Darwall 1995, especially 187).[17] Thus a physician, for example, could respect herself for having personal and professional integrity and for being competent to care for her patients. She could also trust herself in that regard.

How, then, does self-trust differ from appraisal self-respect? The main difference is that when we respect ourselves because of our moral integrity, we are optimistic that we have that integrity, whereas when we trust ourselves, we are optimistic that we will *act* with moral integrity, not merely that we possess it. Furthermore, an important feature of self-trust which self-respect lacks, and which I focus on in the next chapter, is vulnerability. That we are optimistic in trusting ourselves not only that we possess integrity, but that we will act with integrity, explains why we are vulnerable in trusting ourselves, but not in respecting ourselves. Thus, in important ways, those two attitudes

are distinct. Nonetheless, they are closely related to one another, for they are mutually reinforcing. Those with appraisal self-respect, or optimism about their moral integrity, are more likely than others to have self-trusting attitudes. Similarly, those who have self-trust are more likely to prove their integrity and competence to themselves and, therefore, to build appraisal self-respect.

5. Conclusion

That the women's self-regarding attitudes which I identified as trusting or distrusting attitudes share most of the important features of interpersonal trust or distrust reveals that there are such attitudes as self-trust and self-distrust. The features of Janet and Sheila's optimistic attitudes that parallel the important features of our prototypes for trust are the following: optimism about their own competence in a particular domain, and optimism that they will act with moral integrity in that domain, where the latter presumes an expectation that the moral values they will hold in the future will be relevantly similar to the values they hold now.

The women's negative attitudes toward themselves were similar to interpersonal distrust in that they were attitudes of pessimism about whether the women could trust, or should have trusted, their own competence in a particular area, and in some cases, also pessimism about whether they would act with moral integrity. Those attitudes arose not simply because of how the women perceived their own competence or moral integrity, but because of how others perceived or would likely have perceived their behaviour, and,

moreover, because of certain ideological norms in our society. Therefore, those attitudes were "relational," in the socially constituted sense.

Notes

1. Prototype theory states that we understand concepts in terms of prototypical instances of the phenomena to which our concepts refer, rather than in terms of necessary and sufficient conditions. So, for example, when we see some type of bird, we conceive of it as a bird because of its similarity to our prototypes for bird (which for some North Americans may include, say, robins and bluejays), not because it satisfies a set of necessary and sufficient conditions for being a bird.

2. See, for example, Hey *et al* (1996, 142) and Rajan and Oakley (1993, 85, 86). The literature on women's own experiences of miscarriage is relatively sparse in comparison to the literature on other areas of women's reproductive lives (e.g., abortion and infertility treatment).

3. That depends on what kind of test is performed and when it is performed. Blood tests are more sensitive in detecting the pregnancy hormone than urine tests, and modern urine tests will not detect it at all before four weeks gestation. Also, if a woman has what is called a "missed abortion," where the pregnancy has ended but there was no immediate miscarriage, the pregnancy test may come back negative even though an ultrasound would show some pregnancy tissue. (Source: Dr. Bruce Dunphy, reproductive endocrinologist, IWK-Grace Health Centre.)

4. I say more below about what makes a knowledge claim responsible or irresponsible.

5. That is a conservative estimate from *Unsung Lullabies* (1995). Rajan and Oakley estimate that about 80% of pregnancies end in miscarriage (1993, 75).

6. One reason cited in the literature is the inhibitions people have in our culture in discussing death (Rajan & Oakley 1993, 75, 81). Most people may be even less comfortable in acknowledging the death of a fetus than they are with the death of a child or an adult because there are no socially sanctioned rituals in our culture for honouring the importance that a fetus (or potential future child) may have had in people's lives. There are no established rituals, such as attending a funeral service or sending flowers to the woman who miscarried and/or to her partner.

7. A miscarriage is defined as a pregnancy loss that occurs prior to 20 weeks gestation (*Unsung Lullabies* 1995). Most women will not have been showing before they have a miscarriage. Any fetal death after 20 weeks gestation is called a stillbirth.

8. I am drawing here on my own experience with having a miscarriage in an unwanted pregnancy. That experience is under-represented in the literature on miscarriage, which focuses predominantly on the experiences of women in wanted pregnancies.

9. As Campbell explains, "uptake in collaborative individuation" can be "facilitated by ... overlapping biographies [or] personal knowledge" (1997, 108). The best listeners for women who have miscarried will usually be people whose biographies or personal knowledge overlap with the women's experiences of miscarriage--that is, listeners who themselves have had miscarriages or who have intimate knowledge of what women can experience emotionally after a miscarriage.

There is some evidence in a study by Lynda Rajan and Ann Oakley that women who have miscarried benefit emotionally by having access to sympathetic listeners (1993). Rajan and Oakley did a randomized controlled trial of providing social support to women who had suffered previous pregnancy losses and were currently pregnant. The kind of support offered was the opportunity to talk on a regular basis with a midwife, who understood what women can experience emotionally when they miscarry. Rajan and Oakley found that there was an appreciable difference in the emotional health of the women who received the social support in comparison to those who did not.

Rajan and Oakley emphasize that women who have miscarried should have the opportunity to talk with someone who has expertise in counselling women about miscarriage. However, it is also important that primary health care providers have some training in responding to the emotional needs of those women. Otherwise, those care providers may cause harm by responding in uneducated ways to the emotional aspects of women's experiences with miscarriage.

10. I reflect on how we would conceptualize Sheila's other attitudes toward herself in the last section of the chapter.

11. We might feel the betrayal even when we are not actually betrayed. I explain in chapter 4 that trust can be merely disappointed rather than betrayed, but even with disappointed trust, we often suspect betrayal and, consequently, we may develop feelings of betrayal.

12. I have some discussion of the plausibility of the notion of self-betrayal in chapter 4 (section 2).

13. Anne Fausto-Sterling makes a similar claim in her work on scientific theories about sex differences (1985). She points to the political motivations of scientists who are members of dominant groups to explain why they ignore perfectly good evidence in testing their results. Their political agendas shape what they deem to be actual evidence.

14. I do not want to exclude the possibility that we could be trusting ourselves in the present moment to behave in a certain way. For example, Janet could have been trusting herself *while* she was claiming to be pregnant that her claim was responsible.

15. But we might betray others as a result, as I explain in chapter 4. Self-trust and interpersonal trust are asymmetrical on the issue of whether revising one's values can lead to the betrayal of trust.

16. Calling it a syndrome is not entirely appropriate since the name suggests there is something wrong with the women rather than with the society that pressures women to take on so much responsibility, in particular for child care and domestic work.

17. Not just any competency is a proper object of self-respect, according to Darwall; the relevant competencies must reflect our moral character. It is not clear that all of the competencies we can trust ourselves to have would fit that description. For example, if I trust myself as a tree-planter to be competent and committed to planting trees properly, my competency alone may not stem from my moral character. I may be competent because I am physically capable of planting trees well.

Chapter 4

Where Things Can Go Wrong: Unjustified Trusting and Distrusting

1. Introduction

In earlier chapters, I outlined the features of interpersonal trust that concern what we trust in others. I argued that self-trust is a form of trust that shares many, but not all, of those features. It involves optimism about the competence of the trusted one (i.e., oneself) and optimism about one's moral integrity. One key feature I have not yet discussed, which is relevant to self-trust as well as interpersonal trust, is vulnerability. In trusting ourselves or others, we incur vulnerability; for trust is a form of dependence. If things were to go wrong while trusting, that is, if the trusted one were to fail to honour our trust, we would be disappointed, and perhaps even seriously harmed. It is essential, then, that we are able to discriminate between people or situations that merit trust and those that merit distrust. In this chapter, I explore some of the conditions that make trust, or distrust, justified. Moreover, I distinguish between trusting attitudes that are justified and those that are "well-grounded." The latter are always successful in targeting a trustworthy person, whereas the former do not guarantee that success. In other words, trust can be justified without it being well-grounded.[1]

My primary aim in this chapter is to develop a theory of what it means to trust oneself well, meaning in a justified way. One of the harms to which one is vulnerable in

trusting oneself is a loss of autonomy, as I argue in chapter 5. Not all forms of self-trust are important for autonomy: for example, self-trusting attitudes that are unjustified can be detrimental to it. Sometimes, justified self-*dis*trust can preserve our autonomy, although too much self-distrust, of any kind, is a barrier to autonomy. In chapter 5, I argue that people who are autonomous possess the "skills" of trusting and distrusting themselves well (i.e., they are able to develop justified self-trusting and self-distrusting attitudes). In this chapter, I defend an account of those skills.

What it means for self-trust to be justified, or unjustified, is no different, I assume, from what it means for interpersonal trust to be justified. Hence, my discussion here centres around trust generally, rather than self-trust specifically. How we interpret the justification or well-groundedness of trust depends on what kind of mental attitude it is (i.e., whether it is a belief, an emotion, a disposition, etc.). Thus, I also give a theory of the nature of trusting attitudes, and there, again, I assume that self-trust and interpersonal trust do not diverge from one another. The only issue relevant to this chapter where they might diverge is the degree of vulnerability one incurs with self-trust compared to interpersonal trust. Since we have more control over our own behaviour than over the behaviour of others, it may seem that we cannot be as vulnerable in trusting ourselves as we are in interpersonal trust relations. I give reasons for rejecting that second point; I argue that self-trust can entail as much vulnerability as interpersonal trust.

Rather than provide a fully detailed theory of when it is justified to trust or distrust (which would take us beyond the scope of this thesis into complex debates in epistemology), I focus instead on what has been missing thus far in the literature about

the justification of those attitudes. One thing missing is an account based on the processes of coming to trust, or distrust, someone. I argue that trust and distrust are justified when the processes that form and sustain them are reliable, and that they are unjustified when those processes are unreliable.[2] Moreover, I claim that the sequence of processes responsible for justified trust and distrust are inevitably social in nature. The justification of those attitudes depends, in part, on the reliability of the social feedback we receive to them. I propose that being able to trust well, or to form justified trusting attitudes, requires at a minimum that one be raised in a social environment that provides some opportunities for acquiring self-knowledge. Fewer of such opportunities exist for people who are oppressed or abused, compared to those in more supportive social relations. Oppression and abuse are often the causes of why things go seriously wrong with self-trust as well as with interpersonal trust.

2. Self-Trust and Vulnerability: The Unique Harms of Betrayal

In the introduction of this thesis, I mentioned that it is important to be able to trust others and to trust oneself in situations of vulnerability.[3] However, we also incur vulnerability *by* trusting because the trusted one may not honour our trust. My main purpose in this section is to argue that vulnerability to unfulfilled trust is as much a feature of self-trust as it is of interpersonal trust.

Vulnerability is closely associated in our minds with potential betrayal; we think of trust as something that engenders vulnerability because it can be betrayed. One might

wonder whether we could ever betray ourselves. I argue that we can, and for many of the same reasons that we might betray others. Trust can also be disappointed as opposed to betrayed, although I argue the harms of betrayal are usually greater. Betrayal can engender or perpetuate low self-respect, and it can damage our ability to trust ourselves and others in the future. If we distrust ourselves too much, we also incur the risk of diminished self-respect. Hence, we are vulnerable to some degree in distrusting ourselves as well as in trusting ourselves.

In distinguishing interpersonal trust from mere reliance in chapter 2, I argued that the reason why a sense of betrayal is an appropriate response to broken trust is that with trust, as opposed to mere reliance, we expect the other to act with moral integrity. Normally, betrayal occurs when the other fails to act from that motivation. But she could, instead, fail to honour our trust because her circumstances prevent her from acting with integrity, or because integrity requires that, in response to changes to her circumstances, she revise her moral commitments. In either case, she disappoints our trust; but she does not necessarily betray it. Since we tend to associate "broken" trust with betrayal, neither would it seem appropriate to say that she has "broken our trust." We could *feel* that she has broken or betrayed it, but we would be wrong in that assumption. Someone could feel betrayed but not *be* betrayed.

We often feel betrayed when someone we were trusting has to revise his moral commitments and forego doing what we were trusting him to do. For example, if I was trusting my partner Andre to keep his promise to spend a weekend with me, but suddenly his work becomes hectic and he cannot get away, I might feel betrayed by him, even

though I might not have been betrayed. If his integrity demanded that he prioritize his commitment to work above his commitment to me, and, furthermore, if he makes amends for the "mess" he causes in our relationship, then he has acted with moral integrity. Making amends is important since having integrity entails being accountable for failing to meet one's commitments (as I argued in chapter 2). Andre has not betrayed my trust if he has acted with moral integrity, for that is how we expect trusted others to act. Trust is a moral attitude; so if I had been expecting Andre to act immorally by putting his commitment to me before any commitments to anyone else, no matter how his circumstances might change, then I was not trusting him. I was merely relying on him to act out of intense feelings for me, perhaps, or maybe out of some threat I had issued to him.

But what if Andre cannot make amends for the mess he causes by cancelling our weekend together? Sometimes when the circumstances of the trusted person stand in the way of his honouring our trust, he cannot *be* accountable for failing to honour it. What if Andre and I had long been planning a special event for the weekend that would be impossible to reschedule? In that case, Andre may not be able to make amends for missing the weekend, which suggests that he does betray my trust, although presumably he maintains his integrity, since he seems to do what integrity demands. But does he really do everything that integrity requires of him? If integrity is about being accountable, must Andre not lose at least a bit of it if he cannot make amends to me? It is plausible to assume that my response to his behaviour might have some bearing on whether his integrity remains intact. What if I am being unreasonable, though, in not

allowing Andre to make amends? Questions of that sort are often difficult to answer, and as a result, it is often difficult to draw a clear line between when trust is betrayed and when it is merely disappointed.[4] Sometimes, we are confused about what someone needs to do to maintain his integrity, and about whether we should relieve his guilt or shame if he fails to do what we were trusting him to do.

As with interpersonal trust, with self-trust we are vulnerable to changes in our circumstances that convince us to reorder our commitments and act on commitments other than those we had been trusting ourselves to meet. But there we are not vulnerable to the betrayal of ourselves, specifically. I explained in chapter 3 that we do not betray trust in ourselves when we revise our values in ways that are compatible with maintaining our integrity. Thus, on the issue of when betrayal can occur, interpersonal trust and self-trust are asymmetrical.

One area where the theoretical distinction I have made between betrayed trust and disappointed trust may not be applicable is where trust is cultivated in people who have shown little evidence of integrity in the past. One of the ideas for which Mahatma Gandhi is famous is that trust can breed trustworthiness; by cultivating trust in others, we can elicit trustworthy behaviour from them, even if they have a history of acting without integrity.[5] When I am optimistic that a trusted person will act with moral integrity, I am expecting her to act on certain moral commitments, or values, as I argued in chapter 2. When my trust in her is cultivated, I may have little to no evidence that she even holds the relevant values. That is especially true where the other is a child who does not yet have a developed system of moral values. Alternatively, it may be clear that the person

in whom we cultivate trust is committed to certain values, including the values we are trusting her to promote, but she is generally untrustworthy because of the weakness of her will. In that case, if she does not live up to our trust, she fails to act with moral integrity.[6] But given that we had little evidence that she would ever honour the kind of trust we placed in her, it seems strange to say that our trust is betrayed, or that we are justified in feeling betrayed. Thus, it seems possible for trust to be merely disappointed, even though the other does *not* act with moral integrity.

The distinction between betrayed trust and disappointed trust is therefore kind of blurry. Nonetheless, it exists, and exists roughly between cases where trusted others fail to act with moral integrity, and where they maintain their integrity but do not do exactly what we were trusting them to do. Similarly, with self-trust, that distinction is not clear-cut, and cultivated trust is a possible exception to it. For example, I could cultivate trust in myself in a domain where I know that I suffer from weakness of will, and if I fail to honour my trust, I may only disappoint myself, rather than betray myself. Also, when my circumstances change and I revise my commitments, sometimes I am confused about whether the revision is justified, and whether I should let myself off the hook for the harm I may have caused by failing to act in accordance with my trust. I may be especially concerned about that harm if most of it is borne by others. In the end, I might feel that my trust was betrayed, even though it may only have been disappointed.

Some might question, however, whether we could ever "betray" ourselves, a worry that might arise because of the close association in our minds between betrayal and deception. One of the most common ways for another person to betray us is by

deceiving us about whether he would act with moral integrity in doing what we were trusting him to do, about whether he was competent to do it, or about both his competence and his motivation. In discussions of betrayal in the context of self-trust, the issue arises of whether *self*-deception is a real phenomenon. Much philosophical debate has been devoted to that issue, for it seems paradoxical for someone to play the roles of deceiver (believing that X) and the role of deceived (believing that not-X) simultaneously. I find the most persuasive theorists in the debate to be those who explain how self-deception *is* possible, where the most common explanation is that there are different levels of consciousness or there are subsystems in the mind, the contents of which can conflict (see, especially, Johnston 1988, Rorty 1994, 1988). Since self-deception is a frequent occurrence in the lives of many of us (Rorty 1994), it seems that it must be real, and hence, that it must be possible to betray ourselves through self-deception.

We can also betray ourselves if we fail to act with moral integrity because of weakness of will or insensitivity. We may trust ourselves to attend to certain needs of our own or of others, but when it comes time to fulfill those needs, we are too weak-willed or too insensitive to attend to them properly. In either case, self-deception would never enter into the picture if we had been intending all along to live up to our trust and we never try to kid ourselves about whether we had the opportunity to live up to it (i.e., never try to deceive ourselves into thinking that we could not possibly have acted on the relevant moral commitment, given our circumstances).

The harms we are vulnerable to when our trust is betrayed, or when it simply

feels betrayed, are greater than when we acknowledge that our trust was merely disappointed. We tend to feel the harms of betrayal even when our feelings of betrayal are unjustified. One of those harms, one that is unique to betrayal, is diminished self-respect. We can lose self-respect as a result of feeling betrayed, either by others or by ourselves, because the betrayal implies that we are not worthy of respect. Betrayal by others can impact negatively on what Darwall (1995) calls "recognition self-respect," that is, the respect we have in acknowledging ourselves as beings with inherent moral worth who deserve to be treated respectfully by others. Betrayal by the self, on the other hand, can damage "appraisal self-respect," which is our respect in our own moral character (Darwall 1995), respect that is called into question by a failure to act with moral integrity.[7]

Feelings of betrayal can also interfere with our ability to trust well in the future. They may cause us to question that ability, making it more difficult for us to trust again. Furthermore, serious forms of betrayal, particularly betrayal by an abuser, can actually damage our ability to trust well, rather than simply induce us to doubt it. As Judith Herman explains, the trauma of abuse often shatters whatever sense the survivor had of the world as a safe place, that is, as a place with trustworthy people in it (1992, 51, 52). Consequently, she may not know any longer where trust, and distrust, are appropriate. On the other hand, those who suffered abuse early in life may never have developed the ability to trust, or distrust, well. Without those skills, they are at serious risk of further abuse. As Herman notes, "[t]he risk of rape, sexual harassment, or battering, though high for all women, is approximately doubled for survivors of childhood sexual abuse."

Herman cites the work of Diana Russell, who found that two-thirds of women who experienced such abuse in childhood were subsequently raped (Herman 1992, 111; Russell 1986).

Abuse can also interfere with one's ability to trust oneself. Trudy Govier refers to a small study by Doris Brothers which showed that the greatest problems relating to trust caused by incest and rape lie in the survivor's trust in herself (Brothers 1982; Govier 1993, 99-101). With damage done to her ability to trust others well, the survivor will likely distrust that ability (which is a form of self-distrust). With her whole world in pieces, she also may distrust her capacity to cope with events or decisions in the future. Furthermore, she may distrust her own perception of the kinds of signals her behaviour is sending to others. It is common for people who are abused to blame themselves for their abuse either because their abusers encourage them to do so, or because blaming themselves is viewed as a way of "reasserting control" (i.e., they believe that they can prevent further abuse by behaving differently in the future; see, Govier 1993; Lepine 1990; Dominelli 1989).

The harms of trusting oneself too little, or of distrusting oneself too much, are severe. Perpetual self-distrust reinforces low levels of self-respect, and it also inhibits autonomous action, as I argue in chapter 5. Thus, vulnerability accompanies self-distrust as well as self-trust. Among oppressed people, the harms of self-distrust are encouraged by oppressive social stereotypes. For example, the stereotype of the inferior intellectual capacity of white women and of people of colour of both sexes can encourage them to be distrustful of their ability to be responsible epistemic agents. It can promote pessimism,

specifically, in their epistemic competence.

Interpersonal distrust also carries with it potential harms arising as a result of oppression. Some of those harms themselves are interpersonal: when distrust is either ill-deserved or well-deserved and the source of it is discrimination, or a reaction to discrimination, it prevents the development of healthy relationships. Furthermore, interpersonal distrust that goes wrong or is ill-deserved can harm the individual who is distrusted. Since trust is an attitude of optimism about a person's moral integrity, trusting must be a sign of respect for others. We do not trust merely for instrumental reasons, contrary to the view of some moral philosophers, such as Diego Gambetta (1998) and Russell Hardin (1996). Their trust theories imply that trust is just another mechanism, like a contract, for furthering our self-interest. On my theory, trust may have instrumental value, but it is also an indication of respect. When we distrust others who deserve to be trusted, we are displaying disrespect.

Thus, getting things wrong when trusting or distrusting can be harmful; and the trusters are not necessarily the only ones who suffer the harm. I have argued that we are vulnerable in many of same ways in trusting ourselves as we are in trusting others. In both cases, we are vulnerable to disappointed trust and to betrayed trust, where the potential harm of betrayal, or of perceived betrayal, is greater. When the betrayal itself is exceedingly cruel, such as in cases of incest or rape, it can cause pervasive damage to the survivor's perception of herself and of her social world.

One might accept that with self-trust, we are vulnerable in the ways I have discussed, but object that we are never *as* vulnerable as we are in trust relations. One

might agree with Govier who writes that,

> With self-trust, the predictability of success [i.e., of our trust being honoured] or failure may be greater: we should know better what is going on because it is, after all, our own self that we are trusting. That is not to say, obviously, that our self-knowledge is perfect. Risk remains: we are vulnerable to our own failings" (1998, 95).

Govier is assuming there that we are better knowers of the self than of others, and, therefore, that we are less vulnerable to getting things wrong with self-trust. However, some of the reasons for believing those epistemic claims are dubious. Traditionally, philosophers (most noteably Descartes) thought that introspection was an infallible, or nearly infallible route to self-knowledge. Since it is not a route we can take in understanding the mental attitudes of others, and we do not have an equally clear and accessible route to understanding their attitudes, then, presumably, we are in a better position to know ourselves. However, Hilary Kornblith has given us good reason to doubt the perspicacity of introspection. He argues, convincingly, that even with our causal proximity to our mental attitudes, introspection is insufficient "to ground claims to self-knowledge" (1998, 55). It does not allow us to rule out psychological conditions that are undetectable introspectively and that promote self-misunderstandings (1998, 55). Those conditions include paranoid personality disorder, as well as being "emotionally well-adjusted," which, as Kornblith claims, tends to involve "a degree of optimism [that] can, on no reasonable construal, be justified by the facts" (1998, 58). Those kinds of conditions can occur in mild or severe forms (thereby, causing mild or severe forms of self-misunderstanding) and some of them are widespread. Moreover, they can distort not

only our introspection, but also our "external" perception of ourselves. Perceiving, or observing, our own behaviour is an alternative route to self-knowledge.

Nonetheless, Govier might be right that with self-trust, "we should know better what is going on." Kornblith does not endorse skepticism regarding the self and does not exclude the possibility that we could know ourselves better than others. We may have good evidence that we are not suffering from the kinds of psychological conditions he lists. We could rule out severe paranoia, for example, if we were "experiencing no difficulties at work or ... have good relationships with others" (Kornblith 59). Since we are in a better position to gather such evidence about ourselves, we are generally in a better position to know ourselves well than to know others. Notice that the evidence relevant to our self-understanding that Kornblith emphasizes does not come from introspection alone, nor from the mere perception of our own behaviour. Rather, it comes, partly, from outside of ourselves. To know ourselves well, we rely on feedback from others about what our selves are like. How good their feedback is influences how well we can know ourselves. Those who often get unreliable feedback, such as people who are abused or oppressed, are in a worse position to obtain self-knowledge than others.[8] Still, those abused or oppressed often have at least some sources of reliable social feedback, which may put them in a better position, generally speaking, to know themselves than to know others.

However, whether we trust or distrust well does not depend only on the kind of social feedback we receive about ourselves. As I discuss below, how well we trust or distrust, in ourselves or in others, is influenced as well by the paradigms for trust we

learn from others. Oppression may distort those paradigms in ways that can make it more likely that we get things wrong with self-distrust than with distrust in others, for example. Hence, it is not obvious that most of us are more likely to get things wrong with interpersonal trust or distrust than we are with self-trust or self-distrust. Furthermore, in either case, we may experience the same degree of harm if we do get things wrong, as I established above. Whether we trust ourselves or trust others to do something important to us, often we put ourselves at risk for the same amount of harm or disappointment. Thus, there are at least two distinct senses in which we may be as vulnerable in trusting ourselves as we are in trusting others.

The importance of getting things right with self-trust lies primarily in the relation between self-trust and autonomy. I argue in chapter 5 that justified attitudes of self-trust are crucial for autonomy. Thus, the ways in which oppression and abuse can interfere with getting things right with self-trust and self-distrust have severe consequences for our autonomy.

3. The Nature of Trusting and Distrusting Attitudes: Patterns of Salience and Behaviour

For the task of explaining when it is justified to trust oneself or to distrust oneself, we need a clearer understanding of what kinds of mental attitudes trust and distrust are. I argue that they are emotional attitudes with cognitive components that are not reducible to beliefs. Moreover, they are normally constituted, in part, by "patterns of attention and tendencies of interpretation" (Jones 1996, 4), which means that they draw our attention

toward certain features of the world, and influence how we interpret different features. Identifying those patterns allows us to explain why the attention of those who are trusting is directed away from evidence disconfirming the trustworthiness of those whom they trust. However, as I illustrate, it is possible to be trusting even though one's attention is focused on contrary evidence.[9] In such cases, one's trusting attitude is revealed mostly by one's behaviour. Thus, there are patterns of behaviour as well as attention, or salience, that characterize trusting and distrusting attitudes.

My account of the nature of those attitudes draws upon the work of a number of theorists writing on trust and/or the emotions. One of them is Karen Jones, who recognizes that trust is constituted in part by patterns of attention, although she does not acknowledge its patterns of behaviour (1996). Like Jones, I rely on the theory of emotions as perceptual attitudes developed by theorists such as Ronald de Sousa (1987) and Cheshire Calhoun (1984). I also draw on a theory developed by Sue Campbell (1997), who establishes the importance of highlighting the behavioural dimensions to our emotions.

I defend those theories of emotions only insofar as they help us to understand certain features of trust and distrust. Let me emphasize that by arguing that those attitudes have perceptual and behavioural dimensions, I do not presume to be giving a complete theory of what it means to say that they are emotions. A complete account would explain what, aside from those dimensions, gives trust and distrust the identity of emotions (e.g., some kind of physiological change in the agent).[10]

On the perceptual model of emotions developed by de Sousa and others, emotions

are a "species of determinate patterns of salience," or attention (de Sousa 196). They control our patterns of attention because, like sensory perception, they are "informationally encapsulated," meaning that they are attuned to a limited range of information and, to a large degree, are "cognitively impenetrable" to information that lies outside of that range (de Sousa 152, 195). The information to which they make us attuned is information that tends to make them justified. When we experience an emotion, we are resistant to evidence suggesting that it is unjustified or irrational, given our circumstances.

To illustrate how that model works, consider the emotion, fear. When we sense the presence of something we fear, such as a snake, we are alive to information that confirms the continued presence of the snake, and also to information confirming that the snake is truly harmful to us. We tend to ignore or deny evidence that the snake is no longer present, or was never actually present, or never actually posed a threat to us.[11] But our resistance to evidence that makes our fear unwarranted, or no longer warranted, is not "limitless" (Jones 1996, 16). Our emotions are not completely impenetrable to rational persuasion. If enough counter-evidence exists regarding the presence or threat of the snake, then at some point we will accept that evidence and our fear will diminish, and perhaps even disappear altogether. The intensity of our emotions lessens, on the perceptual model, as we begin to notice information that is not "encapsulated" within them.

But what if we accept the evidence that the snake has disappeared or was never harmful to us, but we continue to behave as though we are very afraid of the snake? Our

patterns of attention might change upon accepting that evidence, while our patterns of behaviour do not. Would we still say, then, that our fear has lessened? Probably not. A behavioural model of emotions emphasizes that emotions can manifest themselves primarily in our behaviour, in which case, to know that they exist, we must analyse our behaviour (Campbell 1997).

On both the perceptual and behavioural models of emotions I am describing, emotions are cognitive in the sense that they represent emotive properties of objects in the world or of states of affairs (i.e., properties of those objects or states that tend to elicit certain emotions within a given culture). Thus, trust understood in terms of those models is a cognitive emotional attitude. If it were non-cognitive, it could not be evaluated in terms of whether it is well-grounded or justified. Trust is well-grounded, as I argue, if it accurately represents the property of trustworthiness in the trusted person. It is justified if it is formed and sustained by reliable psychological processes. Trust-forming processes are reliable if they tend to produce attitudes that accurately represent people as trustworthy.

To evaluate how accurately our emotions represent the world, we first have to identify their objects (e.g., the trusted person in the case of trust or self-trust). As Sue Campbell writes, "in some cases, it is the actions of the subject of the emotion that establishes who or what [the object of that emotion] is" (1997, 77). Where emotions are primarily behavioural, we need some understanding of the typical patterns of behaviour that are associated with those emotions to know which objects they target. For example, to know that a person is displaying fear towards a snake, as opposed to some other

creature or thing, we need to know what kinds of behaviour are indicative of fear and then study where that person's "fear" behaviour is directed.

The characteristic patterns of response of different emotional attitudes are learned through association with what de Sousa calls "paradigm scenarios." Those scenarios are clear cases where it is appropriate to have the relevant emotion. As de Sousa explains, they involve a "situation type," which identifies the characteristic objects of the relevant emotion, and a set of "normal" responses to that type of situation (1987, 182). For example, a paradigm scenario for envy in our culture is having someone else receive a reward that one had coveted for oneself. There, the situation type is the other person getting the reward, and the normal response is envy. That response is not merely perceptual, however; it is characterized by certain patterns of behaviour (e.g., congratulating the person who won in a half-hearted way, or avoiding contact with him altogether). Thus, we learn to associate outward as well as inward responses with certain situations based on their resemblance to the situation types of our paradigm scenarios. After a while, those responses become habitual.

As we learn the paradigm scenarios for different emotions, we probably also acquire the prototypes for our concepts of them. The theory of emotional learning through paradigm scenarios seems to support the use of prototype theory in thinking about the structure of emotion concepts. The latter is a theory I used in earlier chapters as a way of understanding the extension of a concept (e.g., trust) to a phenomenon that shares many but not all of its important features (e.g., self-trust). With paradigm scenarios, we learn how to use the emotion concept as well as how to have the relevant

emotion. Like prototypes, the scenarios guide us in identifying situations where a particular emotion is present, or where it would be an appropriate response. If the emotions are learned through such scenarios, then it seems sensible to assume that prototypes, or "paradigms," structure our concepts of them.

In situations that only partially resemble the situation types of our paradigm scenarios, we must modify our habitual responses so that our attitudes will accurately represent their objects. We can refine our paradigm scenarios at the same time because those scenarios are not static (de Sousa 1987). But knowing when to refine them or when to modify our habitual responses is a skill in itself. Having that skill or ability is crucial in knowing how to have emotions that are justified, that is, that reliably depict the way the world is. We do not acquire that knowledge simply by being familiarized with paradigm scenarios.

For some people, it is important that they have the opportunity to experience new scenarios. People raised, for example, in sexist or racist environments, are usually taught sexist or racist paradigms for different emotions. For example, some women in our culture learn that the situation types that warrant shame include situations where they are sexually abused by men, or, alternatively, where they experience intense sexual pleasure. To end sexist oppression, it is important to liberate women from those types of scenarios.

Thus, according to the theories of emotions I have described, emotions are learned by association with paradigm scenarios and are constituted, in part, by patterns of behavioural and perceptual response. Because emotions have those patterns, they fall into the category of "attitudes," where an attitude is a posture or stance one takes before

the world. de Sousa describes attitudes as "perspectives" on the world, but that view is too narrow since it excludes attitudes that are behavioural (1987, 156). Usually one's whole posture reveals one's attitude, and adopting the same attitude as someone else involves assuming a posture in relation to the world that is similar to hers. That is, one must perceive the world and actively engage with it in a similar (although not necessarily in the identical) way that she does. That seems to be true, at least, of emotional attitudes, for unless we take a similar stance as someone experiencing a particular emotion, we will not share the emotion with her. If what she is experiencing is thrilling for her, her simply telling us that it is thrilling will not make us find it thrilling (de Sousa 1987, 156). We will not find it thrilling until we adopt a posture in relation to it that resembles hers.

Why, then, accept that *trust* is an attitude that is emotional and is characterized by behavioural and perceptual patterns of response? First of all, as Jones argues, the view that it has distinctive patterns of attention allows us to explain why someone genuinely trusting is resistant to counter-evidence.[12] I add that a behavioural model helps us to explain that as well. Judith Baker illustrates that feature of trust with the following example: a friend of mine has been accused of a crime, and there is substantial evidence to support the accusation. But "what others regard as evidence against her isn't considered by me as evidence at all... I believe that there is an explanation for the alleged evidence, for the accusation, which will clear it all up" (Baker 1987, 3). What I believe is that my friend is innocent, and my trust in her sustains that belief because it focuses my attention on certain aspects of her character and explanations of her behaviour that tend to confirm her innocence. But it may control my attention by first controlling my

behaviour, that is, by ensuring that I do not even look at the evidence against her, or do not search for that evidence myself. Thus, distinctive patterns of attention *and* behaviour can explain why someone trusting does not acknowledge contrary evidence.

Secondly, the model of trust as an emotional attitude with perceptual and behavioural dimensions allows us to understand the reaction that people commonly have to the following kind of case. I am worried that Bob will not honour my trust in him, and so I maneuvre myself close to Bob and monitor his behaviour, in an attempt to ensure that he honours my trust. Most people would say that trust is missing from my relationship with Bob, or that at least there may not be enough of it, depending on how much monitoring goes on. The reason for that reaction is that monitoring and maneuvring is inconsistent with the kinds of behavioural responses we normally associate with trust. Furthermore, it suggests that I, the person doing the maneuvring, am ever watchful for or anticipating evidence of untrustworthiness. Hence, I cannot be trusting much, since I am so alive to information that would make trust unjustified. A view of trust where anticipating such information and behaving in those ways reveals a lack of trust explains, therefore, our reaction to those kinds of cases.[13]

Thirdly, highlighting the behavioural dimensions of trust and distrust, in particular, is important for interpreting the following sort of situation.[14] My family physician has an excellent reputation and seems to have provided good health care to me in the past, but he has always made me feel slightly uneasy. As a result, my behaviour around him has always been guarded. I do not believe he is untrustworthy; in fact, I believe he is probably trustworthy given the evidence available to me. Consequently, I

do not search for a different physician.[15] Although my attention there is focused mostly on evidence of his trustworthiness, it seems inaccurate to say that I trust him. As most of us would want to be able to say, my unease around him and guarded behaviour translate into a distrusting attitude. That makes sense only on a behavioural model of trust and distrust.

Based on the three scenarios above, we can conclude that interpersonal trust fits a behavioural and perceptual model of emotions. Since we could replace each of those scenarios with examples involving self-trust or distrust, self-trust must fit that model of emotions as well. For example, we tend to think of someone who is self-trusting as someone who is resistant to counter-evidence; she is not easily swayed by the opinions of others who might question her abilities (Govier 1993). But where someone is continually anticipating that she will "screw-up" or is behaving in ways that reveal serious doubts about her own abilities, we recognize her as a self-distrusting person. Furthermore, someone could express self-distrust in her behaviour, but not have her attention focused on her perceived inadequacies. For example, a student might speak hesitantly in class and apologize for her written work, yet not assume that she is incompetent academically (Bartky 1990). Her behaviour indicates that she is ashamed and distrustful of her academic ability, but the limits of that ability are not necessarily the focus of her attention. She may actually do well academically and be as conscious of that fact as everyone else. Nonetheless, her behaviour reveals a lack of self-trust in that domain.

Jones uses an example similar to the example I used of my family physician to argue that trust is neither a belief about someone's trustworthiness, nor is it constituted by

a belief (1996, 24). In my example, if we were to suppose that my unease around my physician amounts to a belief in her untrustworthiness, we would have to accept that forming beliefs is possible in the face of what the agent acknowledges to be substantial counter-evidence. The preponderance of argument in the literature on beliefs opposes that view. We do not, and cannot, have beliefs without regard for what we perceive to be evidence for or against them.[16] But while forming beliefs in the absence of such regard may be impossible, the case of my unease around my family physician suggests that the opposite is the case with trust and distrust; we can have those attitudes while acknowledging the existence of contrary evidence.

Other cases where trusting attitudes "leap ahead" of the evidence are cases where trust is cultivated.[17] As I suggested above, it is possible to cultivate trust where there is little evidence of trustworthiness, and substantial evidence of untrustworthiness. If a small amount of evidence exists in support of a particular stance, such as trust, we can place ourselves in a position where we can focus mainly on that evidence in order to cultivate something like trust. For example, I myself might be a bit scattered and, therefore, unreliable in meeting commitments to myself; but I know that I mean well and I want to be more responsible in the future. To cultivate trust in myself, I could focus on my good points and place myself in an environment where others reinforce them rather than remind me constantly about how scattered I have been. But even once I reposition myself to cultivate self-trust, I do not become oblivious to the presence of counter-evidence. Thus, my trust does not amount to a belief in my trustworthiness, since my situation is not amenable to the formation of such a belief.

A further point, one establishing that trust is not constituted entirely, but only in part, by a belief in someone's trustworthiness, is that one can have that belief without having the trusting attitude. I might believe that someone is trustworthy, but never have trusted her and never have considered trusting her, since she tends to operate in domains with which my life does not intersect. For example, from everything I have heard about Simone, she is a trustworthy heli-ski instructor; but since I have never considered heli-skiing as a hobby, I have never assumed the need to trust Simone as an instructor. In fact, I have never assumed the need to trust her for anything, since I am not even friends with Simone.[18] Hence, my belief about her trustworthiness does not amount to a trusting attitude towards her. The belief and the attitude are separate.

Thus, trust and distrust, either in the self or in others, are not beliefs; rather, they are emotional attitudes with behavioural and perceptual dimensions, and also with a cognitive dimension. Let me point out, briefly, that they can be cognitive even though they are not constituted by a belief because attitudes can have cognitive components that are non-propositional.[19] Even as non-propositional attitudes, however, trust and distrust can be *grounded* in beliefs about people's trustworthiness or untrustworthiness. As de Sousa describes, there are types of emotions that can be founded on beliefs or not, "depending on the context" (1987, 137). Trust and distrust seem to fall into that category. For example, in the context of my relationship with my family physician who makes me feel uneasy, my distrusting attitude is not founded on a belief. However, in the case of Simone, if I changed my mind about heli-skiing and decided to take lessons from her, my trust in Simone as an instructor would be grounded, at least in part, in a belief

about her trustworthiness.

4. Resistance in the Literature to Theorizing about Justification

Whether trust or distrust is grounded in a belief or not, it is unjustified unless it takes into account a variety of factors about the circumstances of the trusting person. Rarely do trust theorists say or imply any more than that about the justification of trust and distrust. They assume that the factors relevant to their justification are too numerous and can interact with one another in too many ways for it to be reasonable to give generalizations about when those attitudes are justified.[20] Hence Baier assumes, for example, that "the appropriateness of trust, of sustaining trust ... [must be] judged case by individual case" (1995, 181).[21] For similar reasons, Jones declares a reluctance to generalize about justification, although she hints at a generalization, namely, that whether trust and distrust are justified depends on whether reliable processes produced them. I take her hint as instructive, but argue that the way she expresses it could mask the social nature of those processes.

It is true that, normally, the factors relevant to the justification of trust and distrust are too numerous to give an exhaustive account of those factors and of how they might combine together in a given situation to make trust or distrust justified or unjustified. But the idea that we need to know what all of those factors are and how they might interact with one another before we can give an account of justification is dubious. Only internalist theories of justification require that we identify all "justifiers," to use a

term of Goldman's, referring to all "facts or states of affairs that determine the justificational status of a belief [or attitude]" (1999b, 274). Internalist theories demand that we be able to give explanations for why our attitudes are justified. For us to be able to do that, there must be some constraints on what qualify as justifiers, for if there were an unlimited number of them, we could never provide the necessary explanation (Goldman 1999b, 274). However, introducing such constraints is often unreasonable, since usually a large amount of what we have learned in the past is relevant to the justification of our attitude. That is certainly the case with trust and distrust, for a lot of prior knowledge and experience goes into trusting and distrusting well. Thus, it seems fruitless to strive for an internalist theory of trust and distrust, which is what Baier and Jones seem to do. Instead, we should aim for an externalist theory.[22] Where justification is external to us, it does not require that we understand the reasons why our attitudes are justified. Reliabilism is an example, for it assumes that reliable processes may generate attitudes which are justified without the subject knowing exactly what those processes are and why they are reliable.

Psychological processes generating trust and distrust can be reliable only if they identify and combine together the many justifiers in ways that tend to produce accurate representations of people as trustworthy or untrustworthy. Given how complicated those processes would normally have to be, they must proceed, in part, unconsciously. Below, I describe in very general terms what those processes involve; but first I review some of the factors defined in the literature as relevant to the justification of trust and distrust, and the factors that are relevant according to my own theory of trust from chapter 2.

As our trust prototypes reveal, and as many trust theorists suggest, both the character and competence of the trusted person are relevant to whether our trust is justified, and so is the domain in which we trust that person. On my trust theory, what is relevant specifically about the trusted person's character is whether she possesses moral integrity and whether she holds certain moral values. It is also important that she conceive of her relationship with us similarly to the way in which we conceive of it.

Evidence of character and competence in the trusted person may lie, as Govier explains, in our past experiences with that person, in second-hand reports about her, and also in her social role (1998, 122). A person's social role may even be relevant, either directly or indirectly, to whether she trusts or distrusts herself. For example, a health care practitioner may assume that she is untrustworthy in a particular domain because it extends beyond the role she has been assigned in her profession; or, alternatively, she may distrust herself because of how others treat her in that role. For example, a nurse who is treated as a dispensable and subordinate member of a health care team may distrust her own ability to do her job well, or she may distrust her judgment about how patients should be cared for.

According to Jones, Baier, and Govier, the political climate or political structure of our society is also relevant to whether we should be trusting (Jones 1996, 20; Baier 1995, 105; Govier 1998, 137-138). What is important about that structure to many of us is how we are positioned within it. For example, in sexist societies, women are so positioned as to be under the continual threat of rape or sexual assault. For them to learn to trust and distrust well in that kind of climate means that they learn to take that threat

into account while trusting or distrusting others. Ideally, their paradigm scenarios for trust become nuanced in response to it, in which case it is more likely that they will be cautious in trusting men, particularly in situations where they are most vulnerable to attack, such as when a male stranger offers to drive them somewhere or when they are at rowdy parties with men who are intoxicated.

Political climate can also be relevant to self-trust. For example, whether I feel I can trust myself as a middle-class white woman to understand what it is like to live as a poor black woman in our culture may depend on whether the dominant culture is classist and racist. If it is, there will be structures in place to maintain my privilege that I might suspect are largely hidden from my view. In that case, I may feel that I cannot trust myself to make a responsible knowledge claim about the lives of people subordinated by those structures, given where I am socially positioned in relation to them.

According to Jones, a further variable determining whether our trust is justified is whether we are good "affective instruments," that is, whether we tend to be good at trusting or distrusting in the relevant domain. If we are not, then,

> ... we should distrust our trust, or distrust our distrust, and demand a correspondingly higher amount of evidence before we let ourselves trust or distrust in the kinds of cases in question. Consider responses to physicians. We can imagine someone with a tendency to find authoritative and avuncular physicians trustworthy and physicians who acknowledge the tentativeness of their diagnoses and the limits of their art untrustworthy. Given how sexism shapes what we take to be signs of competence, we should be wary of our tendency to trust when an etiology of that trust tells us it is as likely to be caused by mannerisms of privilege as by marks of untrustworthiness (Jones 1996, 21).

Jones calls that criterion an "agent-specific" criterion. It is something the agent can evaluate by questioning the social norms that influence her trust, or distrust (as in the example Jones gives), and/or by acknowledging how successful the agent has been in the past in trusting people who deserved to be trusted, or distrusting those who are, in fact, untrustworthy. For example, someone who has frequently been betrayed in the past by intimate partners should have some distrust for his trust in that domain, and should seek more evidence in the future about the trustworthiness of potential partners.

Despite her intention to resist generalizing about justification, Jones implies a certain generalization with her agent-specific criterion. There, she hints that a person might be justified in trusting if she is a reliable truster; that is, if she tends to accurately assess the factors relevant to whether she should be trusting. Taking that hint from Jones, I argue that what makes an attitude of trust or distrust justified is whether the processes that form and sustain it are reliable. However, describing that factor as *"agent-specific"* implies that the reliability of those processes might be causally reducible to the agent, meaning that the agent alone determines their reliability. Yet, as Jones's own example about physicians suggests, the reliability of trust or distrust-forming processes may depend, in part, on the agent's socio-political environment. If that environment is characterized by sexist norms that shape the agent's perception of who is trustworthy and who is not, then she is less likely to develop reliable attitudes of trust and distrust.

Alternatively, Jones may have meant by an "agent" someone who is represented in all of his complexity as a relational being, profoundly influenced by his social environment. In that case, Jones does not exclude the causal role of the agent's social

environment in determining the reliability of his trusting and distrusting attitudes. Still, the term "agent-specific" is ambiguous given that in much of traditional Western philosophy, the agent is portrayed, not in all of his complexity, but as an atomistic entity.

5. A Feminist, Social Theory of the Justification of Trust and Distrust

To trust ourselves well, we need self-knowledge or to know that we are not self-deceived about our own competence and integrity; and to trust others well, we require knowledge of our own ability to assess the trustworthiness of others. Self-knowledge and self-deception are both partly social in nature. We cannot have self-knowledge independently of certain kinds of social relations, and hence, the reliable processes that sustain justified trusting and distrusting attitudes must themselves be partly social. Those processes include comparing and contrasting paradigm scenarios for trust and distrust to the world, modifying our habitual responses, and taking into account the social feedback to those responses. As I argue, unless some of that feedback is itself reliable, we will not be in a good position to detect distorting influences on our trusting and distrusting attitudes.

One potential source of distortion for trust and distrust is self-deception. In deceiving ourselves, as Amelie Rorty proposes, we place ourselves "where patterns of salience are likely to deflect attention away from what we do not wish to see" (Rorty 1994, 218). We are motivated by such a strategy, but usually not on a conscious level.[23] Whether we could even *be* motivated on that level is called into question by the paradox

I outlined above of being the deceiver (believing that X) and the deceived (believing not-X) simultaneously. Where self-deception is unconscious, the evidence of it lies in our behaviour and in the inconsistencies between it and what we consciously believe or intend to do. Consider Rhonda, who is self-deceived about her sexuality. She might claim to be heterosexual, while her behaviour clearly reveals that she is lesbian (she is constantly flirting with lesbians, is visibly turned on sexually by women but not by men, etc.). If she were to admit to possibly being a lesbian, then, perhaps, she would not self-deceived about her sexuality; she would merely be confused about it.

Usually when we deceive ourselves in profound ways, people around us respond to the inconsistencies between our behaviour and what we claim to believe or desire. Their responses suggest to us that we are self-deceived; but sometimes they prevent us from noticing our self-deception. For example, friends of Rhonda's who are homophobic may be aware of the inconsistencies in her behaviour surrounding her sexuality, but never challenge her to account for them. They may even actively reinforce her self-conception as a heterosexual woman. That possibility explains why Rorty refers to self-deception as a "co-operative process" (214). As she states, "[i]t works through sustaining social support" (Rorty 215).[24]

We could be mistaken about our competence and integrity, or about our ability to assess the competence and integrity of others not because we are self-deceived, but because we merely lack self-knowledge. Above, I outlined Kornblith's argument that there are psychological conditions, prevalent in the population, that can interfere with the attainment of self-knowledge by perpetuating mistaken and self-deceptive attitudes about

the self. However, in a social environment where we have the resources to detect such conditions, we can be in a position to know ourselves well. Hence, the pursuit of self-knowledge must be social, rather than the private pursuit of an introspective agent.

Thus, in developing trusting or distrusting attitudes, we need to rule out self-deceptive or merely mistaken attitudes about our competence and integrity or about our assessments of the trustworthiness of others; but we cannot do that without reliable social feedback. If the feedback we get only diminishes rather than enhances our self-knowledge, we will not be able to trust ourselves or others well. Fortunately, that feedback comes in a variety of forms, especially in democratized countries where the media and other sources of information are not as censored as they are elsewhere. The feedback does not have to come from real, live people; often, we receive it through literature or film, for example. If we have access to progressive literature and films which are critical of the status quo, then we can become aware of the influence of negative social norms on our trusting and distrusting attitudes (e.g., the norm to which Jones refers about the trustworthiness of avuncular physicians).

However, the most common source of feedback to which we respond when forming those attitudes is the feedback we get when they are misplaced. With distrust, much of that feedback is indirect. That is, we usually decide whether to be distrusting depending on how successful we have been in the past in trusting. Often, we know of that success because trusting attitudes which are mistaken tend to run smack against the world--that is, we experience immediate harm or disappointment in ways that make it clear to us how those attitudes were misplaced and how we should form them differently

in the future. On the other hand, we rarely discover whether distrusting attitudes are mistaken, since the harms to which they make us vulnerable tend not to be immediate. Thus, knowing when to distrust someone involves being attentive to the reliability (or unreliability) of our past trusting attitudes.

Let me clarify and elaborate on my theory of the justification of trust and distrust using an example involving self-distrust. Eve distrusts her ability to make sound moral judgments about her prenatal care. Whenever her obstetrician seeks her informed choice for any aspect of her care (such as an ultrasound, antibiotics for a bacterial infection, or the mode of her delivery), Eve feels that any decision she would make would probably be a bad decision, both for her and for her fetus. Her self-distrust is manifested in her behaviour--mostly in the continual demands she makes of her obstetrician to tell her what he would do in her circumstances. Whenever he answers that question, she defers to his judgment. She does not even contemplate whether his judgment is consistent with how she conceives of her responsibilities in pregnancy, since she does not trust her own judgment about what those responsibilities require of her.

On my theory, whether Eve's self-distrust is justified depends on how that attitude was generated. If it was generated by psychological processes that tend accurately to represent her level of competence and her commitment to acting with moral integrity, then it is justified. On the other hand, if it was produced by processes that tend to create inaccurate representations, it is unjustified. Below I consider a variety of scenarios in which Eve's self-distrust might be justified or unjustified, as well as well-grounded or not well-grounded. But first, I want to make a few quick points about this

account of the justification of her attitude. One is that the processes relevant to its justification are not only the processes that created the attitude. For her self-distrust to be justified, reliable processes would have to be *sustaining* it as Eve receives further evidence or feedback about whether she should be distrusting herself. Second, the reliability of those processes, overall, may be domain-specific, for it is possible that Eve's self-distrusting attitudes tend to be reliable, or unreliable, in some domains but not in others. The relevant domain in the example would probably be situations in which Eve is required to make important moral decisions about her own welfare and the welfare of those close to her. Third, it is possible that the processes which produced Eve's self-distrust are only somewhat reliable, or somewhat unreliable. We can trust, or distrust, in a qualified way, and sometimes we are justified in doing so. Processes that form and sustain trusting or distrusting attitudes are partially reliable if they only tend to produce accurate representations of people as trustworthy or untrustworthy some of the time, or if they only somewhat resemble processes that are deemed reliable without qualification. The degree to which someone is justified in trusting cannot be equivalent, however, to the degree to which she is justified in distrusting; where they are of equal degree, the only attitude she is justified in adopting is one of neutrality.

I shall sketch the boundaries of where Eve's self-distrust could be justified or not, leaving open the possibility that her attitude might fall inside of those boundaries as an attitude that is partially justified or partially unjustified. Let us begin with the boundaries determining where her self-distrust is unjustified--that is, where the processes responsible for it are unreliable. Her attitude would be unjustified if Eve has not engaged in the

kinds of processes that would tend to give her well-grounded attitudes of self-distrust. As I argued above, such processes would include some consideration for the reliability of past self-trusting attitudes. We must attend to the social feedback to our self-trust in determining whether to be self-distrustful. If Eve's distrust were generated by processes in which she ignores the relevant feedback, then her attitude would be unjustified. That would not preclude Eve from being highly competent in making moral judgments, nor would it preclude her from being incompetent in that domain. What it would mean, simply, is that she is not always a reliable self-distruster in that domain.

Alternatively, the processes which generated Eve's self-distrust may be unreliable because the kind of social feedback she tends to receive about whether she should be self-distrusting in the kind of situation she is in presently reinforces mistaken attitudes of self-distrust. The explanation for that feedback may be that people in her community (including Eve herself, perhaps) have been taught paradigm scenarios for trust and distrust that make it appropriate for women to distrust their ability to make sound moral decisions, and hence appropriate for them to defer to the judgment of others (namely men). In other words, those scenarios may be shaped by sexist stereotypes, such as the stereotype that women are not as competent as men in making judgments about serious moral or political issues.

Given that a sexist community may actually have deprived Eve of the ability to make sound moral judgments, it is possible for her self-distrust to be unjustified (because the feedback to it is unreliable), and at the same time, well-grounded (i.e., an accurate reflection of Eve's (in)competence.) Eve may never have had the opportunity to improve

her moral judgment because she was, and still is, bombarded with the kind of sexist feedback I have just described. There, the relevant feedback is unreliable if it assumes that Eve is incompetent by virtue of being a woman and it is simply false that most women are incompetent in making moral decisions. There, Eve's self-distrust would be unjustified; yet, it would still be well-grounded because Eve does not possess the relevant competency. It is important to emphasize that the evidence for her lack of competency could not be superficial. Sexist stereotypes can cause some women merely to doubt competencies that they do, in fact, possess. For Eve's attitude to be well-grounded, she must actually be incompetent, either as a result of sexism or for some other reason.

Now consider what would make the processes that produced her self-distrust reliable. Eve could be incompetent in making difficult moral decisions while the feedback she receives to her self-distrusting attitudes *is* reliable in confirming her lack of competence in that domain. In that case, her self-distrust would be well-grounded as well as justified. The feedback to her attitude could be reliable and, at the same time, motivated by sexist stereotypes if those stereotypes were so damaging that they impeded the development of decision-making skills in most women. Whether sexist feedback, or feedback influenced by other forms of oppression, is reliable depends on the severity of the impact of oppressive norms and stereotypes.

Eve's attitude could also be justified without it being well-grounded. Say that she tends to have reliable self-distrusting and self-trusting attitudes, generally speaking, which means that she tends to have the social resources she needs to obtain self-knowledge and tends to use those resources wisely. However, in this particular case,

there is someone or something in her social environment manipulating her perception of her situation. Certain people (e.g., her partner or her physician) might be ensuring that she perceive only evidence of similarities, rather than differences, between her situation and situations in the past where she formed reliable self-distrusting attitudes, and unreliable self-trusting attitudes. There are various films where that kind of scenario is played out. For example, in *The Truman Show*, everyone in the protagonist's social world collaborates to deceive him about the nature of his experience. Similarly, in *Gaslight*, a man nearly convinces his wife that she is crazy by so controlling and orchestrating her life that she is cut off from anyone who could confirm her perception of it (Benson 1994, 655). It is possible that some deception of that sort is going on in Eve's case, and, consequently, that she distrusts herself in a situation where she would otherwise trust herself. However, if, in developing that attitude of self-distrust, she engages in the reliable processes that normally generate her self-distrusting attitudes, then her self-distrust may be justified, even though it is not well-grounded.

From a feminist perspective, whether it is reliable to trust or distrust in exceptional cases resembling *The Truman Show* is not particularly interesting. What is interesting is how systemic forces of oppression can influence when it is reliable for someone to be trusting or distrusting. Reliability is a relative term, indexed to a set of "normal" conditions, that is, conditions where one can expect a particular event to occur, or, as in the cases I am describing, expect an agent to be able to develop a particular attitude.[25] Implicit in my discussion of the boundaries of justification for Eve's self-distrust is a certain understanding of what the "normal" conditions are, for someone like

Eve, to develop justified attitudes of self-distrust (e.g., I presumed that the kind of deception she faced in the last scenario made her situation "abnormal"). In the rest of this section, I illustrate how "normal" conditions for the reliability of trust and distrust can vary depending on the agent's socio-political position.

Often, reliability in trusting and distrusting is understood only in relation to the privileged case, so that the "normal" conditions are interpreted as conditions where those attitudes are reliable primarily for the privileged.[26] To see why that understanding of reliability is problematic, consider again Jones's example of avuncular and authoritative physicians. By Western standards, those physicians are generally deemed reliable. They are thought to be more trustworthy than physicians who are somewhat hesitant in giving diagnoses, or who are open about the limits of their knowledge of how to care for patients. But there are good reasons for thinking that avuncular physicians are not as trustworthy for minority groups as they might be for privileged patients. Most physicians are in a better position, generally speaking, to understand the health care needs of the privileged compared to the oppressed. They themselves usually live privileged lives, which shelter them from the kinds of social and environmental constraints on health that many oppressed people face (e.g., barriers posed by poverty, pollution, violence, racism, ableism, etc.). Moreover, the knowledge of physicians of how to treat medical conditions that manifest themselves in unique ways among minority groups (e.g., women) is often vague or incomplete, since members of those groups tend to be excluded or under-represented as subjects in medical research (Baylis, Downie, & Sherwin 1998). With those gaps in the knowledge of physicians about how to care for those patients, the

patients are probably best served by physicians who are honest about the limitations to their art. The gaps narrow considerably for patients who are privileged in multiple ways (e.g., by class and gender), and hence, avuncular physicians are probably reliable for them most of the time.

Whether it is reliable to trust in oppressive environments can differ for the oppressed compared to the privileged for a number of reasons. Like in the above example, the circumstances may be such that it is unsafe for those who are oppressed to be trusting, yet safe for the privileged. An example, relevant specifically to gender oppression, is a crowded subway. Most men can reliably adopt a trusting posture on a crowded subway, whereas most women must be continually alive to the possibility that a man will try to grab them in a seemingly innocent way. Reliability is also relative to one's socio-political status where the available social feedback is less reliable for people who are oppressed than for the privileged. An example is an academic environment where instructors tend to be encouraging of the academic abilities of male students, and less encouraging of those abilities in female students. There are studies which show that such behaviour by instructors is common--for example, that they tend to reinforce the view that men's critical or analytic skills are strong, whereas those of women are relatively weak (see Bartky 1990, 90-93). In classrooms where many of the men possess those skills, but so do many of the women and to similar degrees as the men, the reliability of the feedback by the instructors will tend to vary along gender lines. As a result, it will be easier for the men than for the women to trust themselves to perform well academically in that setting.

When sexist feedback in classrooms or elsewhere impedes the development of certain skills in women, and enhances their development in men, it will be more reliable for women to distrust themselves than for men in situations requiring those skills. Things can go badly, particularly with self-trust and self-distrust, not only when those attitudes are unjustified, but also when people are frequently justified in distrusting themselves. Oppression can have that effect not only by depriving people of the opportunity to learn various skills, but also by frequently placing them in double bind situations. Oppressed people tend to face such situations disproportionately compared to the privileged (Frye 1983). To give a broad example, they are frequently in the position where resisting their own oppression would be consistent with maintaining their integrity, but it would also put them at grave risk of serious harm. Because double binds are inherently difficult to get out of, distrusting oneself to do so with one's moral integrity intact is usually more reliable than trusting oneself. Hence, self-distrust may be justified in more situations for the oppressed than for the privileged.

I have argued, then, that in contemplating the reliability, or justification, of trust and distrust, it is important to index reliability to a set of conditions that are normal given how the agent is socio-politically positioned. The criterion of whether the processes sustaining an agent's trust or distrust are reliable might, therefore, be better described as "group-specific," rather than "agent-specific." This version of reliabilism, which I have defended as a way of understanding the justification of trust and distrust, is social as well as feminist.[27] It is the latter because it is sensitive to the ways in which oppression can interfere with one's ability to trust in others and in one's self.

6. Self-Trust and Self-Distrust as Skills

I have argued thus far that the conditions under which trust and distrust are justified are conditions under which the agent can reliably trust and distrust. I have understood the processes that produce justified trusting and distrusting attitudes in light of a theory I developed about the nature of those attitudes and the way they are learned. I have described them as emotions, but now I want to consider whether it makes sense to call them skills, or abilities. We sometimes refer to trust or distrust as skills, particularly when someone does not trust well, in which case we might say of him, "he really doesn't know how to trust others." Not knowing how to do something means that one lacks the ability to do it (Millikan 1998). In this section, I explain that it is consistent with my theories of the nature of trust and distrust and of their justification to call them skills, or abilities. I argue in the next chapter that among the many skills needed for autonomy are the skills of trusting and distrusting oneself well.[28]

To say that trust and distrust are "skills" is to put them in a certain category of dispositions. My theory of how we learn those attitudes by developing habitual patterns of response implies that they are already dispositional. Habits are a kind of disposition, for they allow us to predict how someone is likely to behave depending on her circumstances (Ryle 1978, 346). Dispositions are "inference tickets," to use a term of Gilbert Ryle's, for they conform to law-like generalizations about people's behaviour. Ryle focuses on two main types of dispositions, namely, what he calls "capacities or skills" compared to "tendencies or habits" (1978, 353-357). He claims that trust falls into

the second category, but not the first; for him, it is a habit but not a skill (356). I argue that it can be both.

According to Ryle, one factor distinguishing a tendency from a skill is that the latter, unlike the former, is a success term. Someone who has a skill can "bring things off, or get things right," but someone who merely has a tendency does not necessarily get anything right (Ryle 356). Adjectives such as "'obstinate,' ... 'fanatical,' ... 'child-like'" can describe tendencies, but not skills (Ryle 356). Similarly, they can qualify the disposition of some people to trust others or themselves, but not qualify that disposition in others. Some of us trust and distrust and often "get things right," meaning that often we are accurate in representing people as trustworthy or untrustworthy. Hence, on the above criterion, the disposition can be either a skill or a tendency.

To define someone's disposition to trust or distrust as a skill is not to imply that she *always* gets things right, or that she is always accurate in representing people's trustworthiness or untrustworthiness. In some situations, she may not exercise the skill, and in others, she may exercise it in ways that are flawed. The flawed exercise of a skill occurs when one is deceived or mistaken about the degree to which one's current situation sufficiently resembles situations in the past in which one was able to manifest the skill. Like reliable processes, skills are indexed to a set of normal conditions, which are the conditions under which they were learned and have been used successfully. As I argued above, the conditions under which people can trust well tend to vary depending on their socio-political position. Those who have that skill will tend to develop, under "normal" conditions (i.e., normal for them), attitudes of trust and distrust that are

justified. Where the exercise of their skill is flawed, their attitudes may be justified but not well-grounded (e.g., if they were deceived in a *Truman Show*-like situation). Where the exercise of it is successful, the resulting attitudes will be well-grounded.

Another way that Ryle distinguishes a skill from a tendency is that skills "have methods," whereas tendencies only "have sources" (356). Hence, it is appropriate to ask how someone manifests a skill, but not how he displays a tendency. We would only ask *why* he displays the latter in the hopes of determining its source. For example, we might ask how someone is scaling a mountain, since mountain-climbing is a skill, but we would only ask why that person desires to scale the mountain, since the desire is a tendency. It makes sense to ask how someone trusts or distrusts well because there are various processes, as I outlined above, for forming justified attitudes of trust and distrust. My theory of their justification specifies a method for developing those attitudes, which is to modify behavioural and perceptual responses in light of the available evidence, including the social feedback to those responses.

One might object that exercising a skill using a method suggests something active, whereas developing an attitude seems passive. But we cannot be passive in developing justified attitudes of trust and distrust, especially given the behavioural dimensions of those attitudes. While forming them, we actively engage with the world in modifying habitual patterns of behaviour. Thus, we can make sense of the idea that in developing those attitudes, we are doing something active, as though we were exercising a skill.

Like all skills, the skills of trusting and distrusting well develop only in social

environments where one has the opportunity to learn them. People who are oppressed or abused are less likely than others to be given to such opportunities. Oppressed people are often taught paradigm scenarios for trust and distrust that inhibit them from trusting and distrusting themselves well. As I mentioned above, many survivors of childhood incest tend to be bad trusters and distrusters in adulthood. Also, people who are abused later in life can lose the skills of trusting and distrusting the self and others well as a result of the abuse.

Thus, trust and distrust can resemble skills or abilities enough that it makes sense to place them in that category of dispositions. We can say of someone who trusts or distrusts well that she tends to "get things right," and we can ask how she does that. Also, we can identify a method for exercising that skill. The skills of trusting or distrusting the self or others manifest themselves under certain social conditions, the nature of which can differ for members of different socio-political groups. Those who have those skills will develop, under "normal" conditions, justified attitudes of trust and distrust.

7. Conclusion

I began this chapter by arguing that we are vulnerable not only while trusting others but also while trusting ourselves, and that we are even somewhat vulnerable in distrusting ourselves. Hence, we need to be skilled at determining which circumstances merit our self-trust, or self-distrust, and which do not. I have developed a theory, hinted

at by Jones, that the justification of trust and distrust in the self and in others depends on the reliability of the processes that produce those attitudes. Those processes cannot be reliable independently of a social environment that promotes self-knowledge, as opposed to self-misunderstanding. They are more likely to be unreliable in oppressive or abusive environments compared to more supportive environments, since the former tend to encourage mistaken or self-deceptive attitudes about one's own competence and integrity, and they tend to educate people in paradigm scenarios for trust and distrust that perpetuate sexism or other forms of oppression.

My theory of the justification of trust and distrust included a theory of the nature of those attitudes. I argued that they are emotions with perceptual as well as behavioural dimensions. Their behavioural component, in particular, allows us to make sense of the notions of trusting and distrusting well as skills. Someone has those skills, if, under "normal" conditions, she is able to develop justified attitudes of trust and distrust, which she could do only if she knew how to perform the processes that generate such attitudes. Whether she is able to perform those processes successfully, however, will depend on the nature of her social environment.

Notes

1. And as I explain in section 5, it is also possible for trust, or distrust, to be well-grounded without it being justified.

2. Here, I am influenced by the reliabilist epistemology of Alvin Goldman (1970, 1992; see, also 1999a, where he mentions the implications of a social epistemology for reliabilist theories, 129-130).

3. However, trust is not relevant only to those kinds of situations, as I suggest in this section (e.g., some instances where a parent cultivates trust in a child may be related solely to the moral education of that child, rather than to the vulnerability of the parent).

4. Drawing that line is also difficult with trust that is unwelcome. When someone does not welcome our trust and so does not act in accordance with it, does she betray that trust or merely disappoint it? That would depend, it seems, on how accurate her perception is of the nature of our relationship. As I have argued, trust is unwelcome when the trusted one does not perceive her relationship with us as the kind that requires her to fulfill the responsibility that we are trusting her to fulfill. But she could be wrong about the nature of our relationship. Through her own behaviour and the expectations she has encouraged us to have, she could have unwittingly established a kind of relationship with us that she might think she has avoided. In that case, if she does not satisfy our trust, she betrays it, even though it was unwanted.

5. Govier discusses this idea, an idea about what H.J.N. Horsburgh calls "therapeutic trust," in *Dilemmas of Trust* (1998, 170-174). She cites the works of Gandhi (see, especially, ftn 8, 225).

6. That would not necessarily be true in the former case because if the trusted person does not hold the relevant values, it cannot violate her integrity for her to fail to act on them.

7. I discuss Darwall's distinction between recognition and appraisal self-respect in chapter 3, section 4.

8. Oppressive or abusive environments, which inhibit self-knowledge, usually inhibit knowledge of others as well. Those who do not know themselves well because they have been coerced into believing that they are inferior beings do not know others well in thinking that they are inherently superior.

9. There, our attention on such evidence may be momentary or it may continue for a long period of time. If we are deeply self-deceived about whether we have a trusting attitude toward someone, we may continue to focus on evidence of her untrustworthiness, while displaying trusting behaviour toward her.

10. Behavioural and perceptual dimensions alone do not explain why an attitude is emotional, for one could have behavioural and perceptual attitudes without experiencing a particular emotion. A common answer to the question of what determines the identity

of emotions is some kind of physiological change or "disturbance" (Griffiths 1997). Unless we accept that what makes certain attitudes emotional is the "feelings" they embody (both figuratively and literally), then we "take the feeling out of feelings" (to quote Charlie Martin; personal communication). However, it is a mistake to assume that the feelings are *merely* physiological changes and do not "embed" any form of cognition (Campbell 1998, 71). Nonetheless, they tend to be portrayed in that way even within so-called "cognitivist" theories of emotions (e.g., Lyons 1980, Davis 1988), where the cognitive component of an emotion tends to be separated out from the feeling component, thus leaving the question unanswered of how a feeling could be about anything (Campbell 1998, 71). It is inevitable that many cognitivist theories would divide those components, since many of them describe the relevant cognitive acts as propositional attitudes, which admit of truth or falsity, whereas feelings are not attitudes to which most of us would ascribe truth values (Campbell 1998, 71, 72). There is an alternative, however, to a cognitive model that is propositional, and that is a model where emotions have a non-propositional cognitive dimension, a dimension representing the relation of the subject not to a proposition, but to something like an experience of being in the world (see Campbell 72-74; Bartky 1990; Dillon 1997). My theory of trust as an emotional attitude endorses that alternative (an alternative where trust represents our experience of being in a world with people who exude competence and moral integrity).

Different theories in philosophy of emotions identify emotions not only in terms of cognitive acts and physiological changes, but also in terms of the biological and/or social origins of emotions. For example, de Sousa suggests that we can identify emotions by the functional role they play in our evolution (1987, 190-203). However, he also defends a theory of emotional learning that gives our emotions a strong social dimension. I support that view and illustrate it with examples of how emotions can be learned in ways that perpetuate oppression. I do not deny that they have an innate, or biological component as well as a social component, but neither do I support any particular theory of their biological origins. It would be consistent, though, with what I argue about trust as an emotion that the *capacity* to learn how to form certain emotions, such as trust and fear, is innate.

11. Alternatively, when a snake is actually present, an overall fear of snakes could cause us to deny its presence. We might be so fearful of snakes that we cannot bring ourselves to accept that a snake is close by. In that case, it seems appropriate to say that a disposition to fear snakes is controlling our attention in ways that allow us to justify our lack of occurrent fear.

12. See Jones (1996, 16-17). That resistance itself is a source of vulnerability while trusting. As Jones writes, "[t]rust ... opens one up to harm, for it gives rise to selective interpretation, which means that one can be fooled, that the truth might lie, as it were, outside one's gaze" (1996, 12). A trusting posture, directing one's gaze toward certain kinds of information, makes one vulnerable to deception, since it makes it difficult to detect deception and easy to be mistaken about the factors relevant to whether one

should be trusting.

13. However, such behaviour may be compatible, as I imply, with partial trusting, depending on how much monitoring and maneuvring goes on.

14. The situation is modelled on an example taken by Jones from Patricia Greenspan's *Emotions and Reasons* (1988; Jones 1996, 23-24).

15. It is commonly understood that we can have emotions that conflict with our beliefs about the nature of our situation. Paul Griffiths illustrates that phenomenon by stating that "[t]he fear of earthworms and the conviction that earthworms are harmless commonly co-occur. The judgment supposedly underlying the fear is one we would hotly deny making" (1997, 28, 29).

16. In "Deciding to Trust, Coming to Believe," Richard Holton argues that trust is not a belief, since one can decide to trust, but not simply decide to believe (1994).

17. See Jones (1996, 22). The reason why we would want to cultivate trust is to elicit trustworthy behaviour. We may desire for someone to become more trustworthy simply because we are in a position of having to trust him or, rather, because it would enhance his self-respect. Cultivating trust can actually be a duty. Parents, for example, ought to cultivate trust in their children as a way of encouraging them to become trustworthy agents.

18. It is important that I have never felt the need to trust Simone, because if I had, I may have a dispositional attitude of trust towards her. I could still have a trusting attitude towards Simone even without trusting her occurrently. For my argument to work (my argument that trusting is a distinct from a belief in someone's trustworthiness), I need to separate out any kind of trusting attitude, dispositional or occurrent, from such a belief.

19. That is, an attitude can be representational without being propositional. For a discussion of non-propositional attitudes or states and their justification, see "Are 'Old Wives' Tales' Justified?" by Vrinda Dalmiya and Linda Alcoff (1993).

20. See, for example, Jones (1996, 20). Also, in her chapter on "Reasons for Trust and Distrust," Govier lists the factors that bear upon someone's trustworthiness or untrustworthiness, but does not give a theory about when trust, or distrust, might be justified (1998, 119-138).

21. However, it is not obvious here what Baier means by "appropriateness." She may mean only moral appropriateness rather than epistemic "appropriateness," given that her work tends to focus on what makes trust "morally rotten."

She does generalize about when trust is morally rotten in a way that resembles my

generalization for when trust is justified. It is morally rotten, she claims, if it is sustained by processes that involve deception; that is, if its continuation depends upon "successful cover-ups of breaches of trust" (she adds that neither can it rely upon "successful threats held over the trusted," but as I argued in chapter 2, such threats preclude trust, in the first place; 1995, 123). For her, trust is not morally decent unless it is formed in the absence of deception; for me, trust cannot be justified unless it is formed by reliable processes. Since she provides only a negative condition for when trust is "appropriate," her view, unlike my own, does not allow us to say when, in a positive sense, it is "appropriate," or justified, to trust, or distrust.

22. However, I do not deny that there are some problems with externalism. A significant problem arises in trying to identify which processes are reliable. I give a partial "contextualist" solution to that problem (see Annis 1993); that is, a solution where reliability is defined in terms of certain contextual factors. My externalist theory of the justification of trust and distrust focuses on how reliability in trusting and distrusting varies depending on the socio-political position of the subject.

23. Mark Johnston argues that self-deception does not even occur on an intentional level, but rather on what he calls a "sub-intentional level" (1988).

24. Also see William Ruddick (1988), and Rom Harre (1988).

25. A standard objection to reliabilist theories of justification is that it is impossible to define reliability, and the "normal" conditions to which it is indexed, in a non-arbitrary way (Pollock 1986, 118-120). For example, in the last scenario involving Eve, where I have said that her self-distrust is justified, it seems equally plausible to say that the processes responsible for her attitude are unreliable. It is tempting to say that although normally those processes are reliable, they are unreliable in circumstances involving deception. However, it is equally tempting to insist that they are reliable even in such circumstances, given that normally they produce attitudes that are well-grounded. How can we decide, then, non-arbitrarily which description of those processes to accept? Answering that objection demands a lot of epistemological work. I attempt merely to demonstrate here that an adequate answer must attend to the various ways in which reliability is relativized to the socio-political position of the agent.

26. I speak generally of "the privileged" and "the oppressed" in this section, where I assume that the people who will fall into those categories will vary depending on the nature of the example about the reliability of trust and distrust. For instance, in examples illustrating how sexism influences the reliability of those attitudes, men are the privileged and women are the oppressed. Still, I am generalizing in my use of those categories, since people from different socio-political groups can experience the same form of oppression in different ways.

27. For that reason, specifically, it differs from Goldman's reliabilism, which does not have a feminist element to it.

28. Diana Meyers argues that autonomy requires a "repertory of skills" (1989). I add self-trust to that repertory.

Chapter 5

The Importance of Getting it Right: A Feminist Theory of the Relation Between Autonomy and Self-Trust

1. Introduction

When we trust ourselves, we are optimistic that we will act competently and in accordance with a moral commitment. The commitment might simply be to stand up for what we value most or it can be directed specifically at the welfare of another. In trusting oneself, it is possible to get things wrong, since self-trust is an emotional attitude that is cognitive, meaning that it represents the world in some way, and it can do that well or badly. Our self-trust is not well-grounded--that is, it represents the world inaccurately--if we are wrong about being competent in our present circumstances to do what we are trusting ourselves to do and about being committed to doing it with moral integrity. Getting things wrong while trusting ourselves can cause harm or disappointment to ourselves and others when we fail to meet our moral commitments. Getting things wrong in distrusting ourselves can cause harm to us, for it can reinforce low levels of self-respect and prevent us from seizing new opportunities. I have argued that oppression and abuse can be a barrier to the formation of well-grounded attitudes of self-trust and self-distrust. Those who are oppressed or abused are especially vulnerable to the disappointment or harm that comes with trusting or distrusting oneself badly.

In this chapter, I want to focus on why it is important to gets things right with self-trust and self-distrust. The importance lies in the connection between trusting oneself well and being an autonomous agent. Autonomy is a property of agents who are acting in a particular way (or a property of actions insofar as they are committed by agents who are acting autonomously). To possess autonomy, agents must reflect on what they truly believe and value, and act accordingly. They must be competent and committed to engage in such reflection and to act on the results. Moreover, as Trudy Govier argues (1993), they must have a positive attitude toward their own competency and commitment. That is, they must trust themselves to make an autonomous decision. As Govier astutely remarks, that attitude is "not to be taken for granted: [it] can be put in question by challenges--either from other people or from the course of events" (Govier 1993, 112). In this chapter, I expand upon and refine her theory that self-trust is essential for autonomy. I add to it a feminist analysis of the challenges that many people face to their potential to be self-trusting. Moreover, since I interpret self-trust as a moral attitude towards the self (unlike Govier), I argue that the autonomy it promotes must have a moral dimension. In my view, all autonomous action has that dimension, and thus, self-trust is crucial for all autonomous behaviour.

Furthermore, I consider whether just any agent who trusts herself is autonomous. Govier mentions that those who trust themselves too much are not autonomous (1993, 115). I specify what "too much" means by arguing that to be autonomous, one must have the skill of trusting oneself well--that is, the ability to develop justified self-trusting attitudes--and one must exercise that skill the majority of the time.[1] It is also important

for autonomy that one have the skill of distrusting oneself well. Attitudes of trust and distrust are justified if the psychological and social processes generating them are reliable, in the sense that they tend to produce well-grounded trusting and distrusting attitudes. Autonomy demands that one often have reliable self-trusting and self-distrusting attitudes, but not necessarily that one gets things right all of the time.

Any agent who is non-autonomous in developing self-trusting attitudes also lacks autonomy. On my theory of self-trust and autonomy, the relation between them is not unidirectional, but reciprocal. I maintain, along with Keith Lehrer (1997), that autonomy is important for self-trust, although the reasons I give are different from Lehrer's. I also interpret what "autonomy" means and what the conditions are that promote it differently than Lehrer.

The value of autonomy itself, apart from its relation to self-trust, can be explained, partly, in terms of the disvalue of exploitation, oppression, and abuse. Those who lack the skills necessary for exercising autonomy are especially vulnerable to the subtle workings of oppression and to other forms of injustice. Thus, an ethical principle of respect for the autonomy of others has emancipatory appeal,[2] particularly in contexts where there is a heightened threat of abuse or coercion. However, autonomy is not about the mere absence of threats to the self. As I argue, following writers such as Diana Meyers (1989) and Robert Young (1989), autonomous agents have goals which they set for themselves and which give their lives some purpose.

Despite its emancipatory appeal, the ideal of autonomy is contentious in feminist circles. Feminists have argued that it reinforces masculine ideals of independence and

self-interest, and that it is built on a conception of the self as presocial, that is, a self "untainted by socialization" (e.g., Pateman 1988; Benhabib 1987, 1992; Jaggar 1983).[3] That conception is absurd from the perspective of many women, who tend to experience themselves in ways that highlight the degree to which their selves are shaped by multiple (and often competing) social and political forces.

Feminist criticisms of the autonomy ideal are mostly directed toward liberal conceptions of autonomy. In response to those criticisms, some feminists philosophers have developed alternative, "relational" conceptions. Feminist relational theories of autonomy emphasize the role of social and relational aspects of persons not only in interfering with their ability to be autonomous, but also in engendering that ability (Mackenzie & Stoljar 1999; Sherwin 1998). On those theories, the skills necessary for autonomy are relational, meaning that they are fostered, or undermined, depending on the agent's social environment. I have argued that the skills of trusting and distrusting oneself well are relational, for they are learned best in social environments that support the agent in acquiring self-knowledge. My theory, then, in this chapter can be situated within the frame of feminist relational autonomy theory.

I structure this chapter in the following way. First, I explain the contribution of feminist relational approaches to contemporary autonomy theory and offer some feminist criticism of the standard approaches to autonomy in bioethics and moral philosophy. Second, I use cases in reproductive medicine involving women and men who have undergone infertility treatment to illustrate the importance of self-trust for autonomy, and how oppression can interfere with self-trust in ways that inhibit autonomy. Third, I give

reasons for thinking that all autonomous behaviour is moral behaviour (in the sense that the agent is acting in accordance with a moral commitment) and hence, that self-trust can be the self-regarding attitude motivating such behaviour. Last, I explain why the self-trust that promotes our autonomy must be reliable most of the time, and must also be formed autonomously. I argue that the skills of trusting and distrusting ourselves well are necessary for autonomy because of the importance of self-knowledge for autonomous decision-making. In that final section, I describe in more detail what I mean by "autonomy," and I defend a substantive account, that is, an account that places some restrictions on the kinds of beliefs, values, and desires on which an autonomous agent can act.

2. Standard Versus Relational Theories of Autonomy: How the Former Pathologize the Non-Autonomous Subject

Feminist critiques of traditional autonomy theory tend to characterize autonomy as individualistic. That characterization is not entirely fair, for many of the theories of autonomy in mainstream moral philosophy and bioethics acknowledge that autonomous behaviour is consistent with maintaining personal relationships (see, e.g., Beauchamp & Childress 1994, Dworkin 1989). Those theories accept that autonomous agents may act on an interest to improve relations with others or to support the needs of others as well as their own. What the standard theories do fail to recognize is the full extent to which social and political relations can impact, both negatively and positively, on one's ability to make autonomous decisions, whether or not those decisions benefit others or (merely)

oneself. Hence, those theories are not properly characterized as "relational," as I defined that characteristic of autonomy theories above. In this section, I describe how the standard theories interpret the basic conditions for autonomy as well as the potential obstacles to those conditions. The theories in moral philosophy, in particular, tend to assume that the sources of non-autonomous behaviour lie mainly in individual pathology and explicit coercion. Feminist relational theories, on the other hand, acknowledge oppression as a substantial threat to autonomy. Drawing on the relational theories mainly of Susan Sherwin (1998) and Catriona Mackenzie (1999), I explain how oppression poses that threat; and why, then, supportive social relations are needed for autonomy.

Standard theorists of autonomy in bioethics and moral philosophy do not all agree on the conditions necessary for autonomy. Without presuming agreement among them, I construct a list of conditions that draws together their many contributions to contemporary autonomy theory. Broadly speaking, those conditions include that agents are able to make choices based on their own desires, beliefs, and values, that they can act on those choices, and that the desires and values informing their choices are uninfluenced by forces "alien" to the self.

To be able to choose based on our own desires and values, bioethicists argue that we must have "decisional capacity," or "competence," as well as an adequate understanding of our options (Beauchamp & Childress 1994; Faden & Beauchamp 1986). We have decisional capacity if we are capable of understanding options and of evaluating them in light of our own belief and value systems. But to be in a position to exercise that

capacity, we must be adequately informed. In settings where it is unlikely that we would have the relevant information ready at hand, such as a health care setting, it is important that someone disclose information about our options to us. Most bioethicists acknowledge that inadequate disclosure and poor communication by health care providers is a potential obstacle to understanding. They also tend to highlight the "limited knowledge bases" of some patients (see, e.g., Beauchamp & Childress 1994, 158). For many bioethicists, as well as mainstream moral philosophers, ignorance is a primary obstacle to autonomy.[4]

Bioethicists tend not to specify which desires and values of our own should inform our choices. However, it cannot be that just any desires and values will do since some of them may conflict and some we may hold only fleetingly. An adequate theory of autonomy must explain, in particular, how we sort through incompatible desires, values, and beliefs when choosing autonomously. We do that, according to many moral philosophers, by reflecting on our desires and values at a "second-order level," and by acting on whichever desires and values we "identify with" at that level (Christman 1989, 7; see, e.g., Dworkin 1989, Frankfurt 1989). Someone who acts on her first-order desires or values without identifying with them, or without willing them as her own, does not act autonomously. She is what Harry Frankfurt calls a "wanton": someone who is not concerned about "whether the desires that move [her] to act are desires by which [she] wants to be moved to act" (1989, 68). Wantonness, weakness of will, as well as brainwashing and post-hypnotic suggestion are the main obstacles to identification according to standard theories of autonomy in moral philosophy.

Some moral philosophers, such as Young (1989) and Meyers (1989), argue that it is crucial for autonomy that the subject decide in accordance with a "life plan."[5] Autonomy is about self-direction, but we cannot be self-directed unless some sort of plan is guiding our action.[6] What should explain, in part, why we identify with certain desires and values is that those desires and values further our life plan. Meyers explains that life plans conducive to autonomy can be continually under revision and ill-defined with respect to some areas of the person's life (1989, 49). Young, on the other hand, argues that to have the type of plan needed for autonomy, the agent must have brought "the entire course of his life into a unified order" (1989, 78).[7] Young labels a person "anomic" who falls to organize his life and the maxims guiding his behaviour in a unified way.

It is not sufficient for autonomy, however, that we are in a position to make choices that reflect our own life plans as well as beliefs and values with which we identify. Another important condition is that we are free to act on the choices we make, as opposed to choices made for us by others. Thus, moral philosophers acknowledge that coercion, for example, is an obstacle to autonomy (see, e.g, Dworkin 1989, 61), and bioethicists emphasize that an important condition for autonomy is "voluntariness" (e.g., Beauchamp and Childress 1994; Faden & Beauchamp 1986). The latter rightly insist that patients' decisions must be voluntary, meaning free of coercion and manipulation. However, bioethicists tend to define coercion so narrowly that it includes only explicit forms of coercion which are directed "toward (or away from) one of [the patient's] options" (Sherwin 1998, 26). They, along with most moral philosophers, do not

acknowledge that coercion can be more subtle and have a broader target, such as the patient's appreciation for her own competence in making decisions. One would have to conclude, on most of the standard theories, that the patient who is influenced by social norms and stereotypes that challenge her decisional capacity is not coerced; she is simply weak-willed.

Undermining a person's appreciation for her decisional capacity often amounts to coercion for the following reason. Coercion occurs, as Richmond Campbell explains, "when I so manipulate your circumstances that you have fewer options than before, and the best of them, X, which is what I want you to do, is one you would not have chosen in the prethreat situation" (1998, 185). If I so manipulate you that you do not feel capable of making many decisions on your own, then the best option for you will probably be to defer to my authority. Doing otherwise *confidently* is no longer an option, and therefore, in an important sense, your options have decreased. I have coerced you if deferring to me or if what I choose on your behalf is not what you would have chosen in the "prethreat situation." The "I" in that scenario can be the entire institutional structure of a society and the social norms and stereotypes embedded within it. There does not have to be a conscious, deliberate agent doing the coercion.

A third broad condition for autonomy appears in the work of some moral philosophers, namely Young (1989) and John Christman (1989, 1991). They argue that the manner in which the goals and second-order desires and values of agents are formed is also relevant to whether those agents are autonomous. Young, for example, argues that the path to autonomy lies in becoming aware of whatever forces might be

influencing one's second-order desires and values in ways that make them alien to the self (82, 83). He focuses almost exclusively on forces of alienation that are rooted in the self, such as neuroses and self-deception.

Standard theories of autonomy in bioethics and moral philosophy have contributed greatly to our understanding of autonomy; yet at the same time, they have misled us about what the primary obstacles are to autonomous behaviour. I agree that all of the conditions above are necessary for autonomy, but disagree that more often than not, their absence can be explained by some pathology or weakness of the agent. For most moral philosophers, the paradigms of the heteronomous subject are "the neurotic," "the anomic," and "the wanton." They pathologize that subject by depicting her as pathologically weak-willed, self-deceived, or simply pathological. Moreover, they reinforce that impression by narrowly defining the external sources of heteronomy and restricting them, beyond cases of explicit coercion, to such unusual cases as brainwashing and post-hypnotic suggestion. Bioethicists also give a narrow description of those sources, although they do often blame physicians for limiting the autonomy of patients. The external barriers to autonomy which they ignore, along with most moral philosophers, are oppressive and abusive social environments.

Any adequate theory of autonomy must account for the ways in which oppression and abuse can interfere with the various conditions necessary for autonomy. Some feminist theorists of relational autonomy, such as Sherwin (1998) and MacKenzie (1999), explain how oppression can form a barrier to each of those conditions. First of all, it can inhibit the ability of agents to choose well by hindering the development of the

skills they need to make choices in light of their own beliefs, values, and life goals. As Meyers explains, autonomy demands a set of "coordinated skills," including the skills of "discern[ing] the import of felt self-referential responses [i.e., one's attraction or repulsion to different options]," and of resisting unwanted pressure from others (1989, 81, 84). The formation of such autonomy skills can be blocked or delayed because of the influence of oppressive stereotypes that target the (in)competence or worth of members of oppressed groups. One such stereotype is the "inferiority of women's autonomy" (Meyers 1989, 142). As Meyers emphasizes, a stereotype of women in most patriarchal cultures is that they are dependent on the approval of others and are disinclined to make choices that further their own interests.[8] But women whose behaviour fits that stereotype are not inherently non-autonomous; many of them have been taught to "over-identify with others' interests and to neglect their own" (Meyers 1989, 143). Some may not even have learned how to discern what their own interests are by evaluating their "self-referential responses." Standard theorists of autonomy seem to assume that such skills of discernment and reflection are innate. That may be true of them to some degree, but it is also true that they can be enhanced or diminished depending on the subject's social environment (Meyers 1989). In cultures that promote sexist stereotypes about women's diminished capacity for autonomy, women have less opportunity than men to fully develop those skills.

Oppression is also a factor at the level at which choices are made because it can ensure that members of oppressed groups are not situated to choose as well as members of privileged groups, having less of the information they need to make autonomous

choices. Sherwin makes that point in the context of health care delivery, where the information available to patients is limited to whatever research has been conducted and, often, to whatever individual health care providers can imagine is relevant to their patients (1998, 27). However, rarely does medical research cover gender-differences, for example, in the manifestation, prevalence, and treatment of different illnesses, for (to make matters worse for women) that research is often performed primarily on subjects who are male (Baylis, Downie, Sherwin 1998, 238). Consequently, the information derived through medical research does not put women in as good a position as men to choose autonomously in many health care contexts.

Furthermore, patients depend on individual providers to inform them of the benefits and harms associated with different procedures; and yet, often, what constitutes a harm or a benefit is relative to one's social position. The social positioning, in particular of patients who experience multiple forms of oppression (such as racism, poverty, and ableism) tends to differ dramatically from that of health care providers (Sherwin 1998, 27). Their difference in standpoint may pose a barrier to effective communication, and, ultimately, to patients' receiving the information they need to make decisions that further their own goals and interests.

Secondly, oppression can interfere at the level of the agent's ability to act on the choices she makes. When the relevant choices oppose her oppression, she may lack the courage to act on them or have lingering desires, with which she does not fully identify, that conflict with those choices. For example, like most other women, she may have been taught to believe that a woman's greatest asset is her looks. After years of going to

great lengths to conform to society's beauty standards for women, she decides to throw out her hot-rollers, her drawer full of make-up, and cancel next week's appointment for a facial and waxing. She is sick of spending so much of her time trying to make herself look beautiful. But soon she starts to regret her decision,[9] not because she questions that it is the right decision, but because of the rewards that she is giving up, which for her include greater respect and attention at work by those who have some control over the advancement of her career. There, she is in a double bind situation, where the likely consequences of choosing either of her options (of conforming or not conforming) are harmful (Morgan 1991). Since oppressed people tend to find themselves in those kinds of situations disproportionately relative to the privileged (Frye 1983), it is more common for them to confront barriers to their ability to act on their choices.

Oppression can interfere with that ability not only through double binds, but also by ensuring that whatever option would maximize one's desires or interests does not even exist. The autonomy of marginalized groups in health care contexts may be limited, as Sherwin notes, because the option they might have preferred is "prematurely excluded" (1998, 26). Usually that is the case for lesbian women, for example, who might choose a high-tech means of assisted reproduction to have a genetically related child if they had that option.[10] It is more common for the oppressed than the privileged to find themselves in that kind of position because the former are underrepresented on institutional bodies that make policy decisions about which options should be available to patients (Sherwin 1998, 27).

Thirdly, oppression can shape the desires and goals of oppressed people in ways

that limit their autonomy (Mackenzie 1999; McLeod & Sherwin 1999). It does that by so influencing their self-concepts or identities that they adopt goals and values that further their own oppression. For example, a woman who is infertile may have learned to identify so strongly with pregnancy and motherhood that she is willing to do whatever it takes to get pregnant, even subjecting herself over a long period of time to infertility treatments which she finds emotionally and physically harmful. Often oppression, along with abuse, encourages non-autonomous goals and values by diminishing self-respect and self-worth (Dillon 1992, 1997; Benson 1994). A person who is abused or oppressed may feel that she is not worthy of respectful treatment, and the life goals, desires, and values with which she identifies will reflect that self-conception. But to say that she suffers from some pathology would be disrespectful, for it implies that the fault lies within her. In her case, a social pathology, rather than an individual pathology, is interfering with the formation of her desires, values, and goals.

Thus, oppression is a potential barrier to each of the conditions necessary for autonomy. However, as Sherwin emphasizes, the actual barrier it poses to each oppressed person will vary significantly (1998, 37, 38). Not everyone who is oppressed internalizes oppressive norms or is denied any opportunity to develop autonomy skills. Some oppressed people (e.g., some black or aboriginal people) live in proud and culturally vibrant communities that tend to foster autonomy skills in their members. Unfortunately, rarely do women have such communities of their own (Bartky 1990, 25), though often they come close to creating them by establishing various kinds of women's groups. Furthermore, some women are situated in overlapping spheres of oppression and

privilege, and consequently, they experience some of the ways in which privilege can enhance autonomy. For example, a woman with middle-class privilege may have the opportunity to strengthen her capacities for understanding and critical reflection by receiving an excellent education. But even privilege is not an unqualified good in the domain of autonomy. The formation of the values and beliefs of that middle-class woman may be influenced by the forces of classism or racism, which she might regard as alien to her.

To review this section, I have criticized standard theories of autonomy for pathologizing people who lack autonomy by ignoring how their choices and actions may be profoundly influenced by oppression or abuse. Nonetheless, I have endorsed the conditions for autonomy outlined in those theories. Near the end, I mentioned a further condition in stating that diminished self-worth and self-respect can interfere with autonomy. Paul Benson (1994) and Robin Dillon (1992, 1997) have argued, respectively, that those forms of self-appreciation are essential for autonomy. Now having introduced those conditions, it is important to distinguish between what are called "substantive" as opposed to "procedural" dimensions of autonomy.

Most of the conditions for autonomy I attributed above to the standard theories are procedural. That means they require that the agent subject his beliefs, desires, or values to some procedure or method of evaluation, and that he act on whatever desires or values satisfy that procedure. Examples are that the agent reflect on his desires and values at a second-order level and that he determine whether any alienating forces influenced that act of reflection. Theories of autonomy that are purely procedural do not

require for autonomy that the agent believe or value anything specific to be autonomous. They are, as Benson puts it, "content-neutral" (1994, 653).

Most standard theories of autonomy endorse neutrality specifically with respect to the normative content of our mental attitudes. Few put any restrictions either on what many would regard as factual content (Benson 1994, 653). Bioethical theories are an exception, for they emphasize the condition of understanding, which limits what patients can believe about the nature of their options if they are to choose autonomously. That condition is "substantive," for it restricts the content of the beliefs of an autonomous agent. It means that if her beliefs about her options, specifically, do not accurately represent the nature of her options, then she is not choosing autonomously. Dillon and Benson argue for substantive restrictions on what autonomous agents can believe and value about themselves. They contend, and I agree, that to be autonomous, one must respect oneself and have a positive conception of one's own worth.[11]

3. Oppression-Related and Paralytic Self-distrust: The Context of Infertility Treatment

The various ways in which oppression can impact negatively on women's autonomy are present in the context of modern infertility treatment. Although proponents of the new technologies in that area claim that they enhance the autonomy of some women (and some men) by offering them choices that have hitherto been unavailable (e.g., Robertson 1994), many feminists have shown the weaknesses in their arguments. For example, Laura Shanner (1996) and Kathryn Pauly Morgan (1989)

contest that position by highlighting social norms, such as the norms of pronatalism, that make it extremely difficult for women to refuse a technology such as in vitro fertilization (IVF) when they discover that they are infertile. Such norms and other mechanisms of oppression can prevent women, as well as men, who experience infertility from trusting themselves to make autonomous decisions about the use of those technologies. Drawing on examples from accounts of the experiences of women and men with assisted forms of reproduction (IVF, in particular), I shall now explain why self-distrust is an obstacle to autonomy that is often tied to oppression.

Self-distrust can occur at all three of the levels at which oppression can interfere with autonomy: agents can distrust that they will choose well or that they will act on the choices they make, and they can distrust their judgment about which values, beliefs, or desires should inform their choices. To trust that they will choose well, they must be able to rely on their skills in making choices, rely on the information they use to make choices, and also trust the sources of that information. It is difficult for people who are oppressed or abused to rely on their autonomy skills if oppression or abuse has interfered with their development. But even if they have acquired those skills in the face of oppression or abuse, they still might feel pessimistic about their ability to choose autonomously because of what society or an abuser has taught them to expect about their own abilities. Even though they might have been successful in the past in making good decisions, for instance, they might interpret most of those successes as flukes, and suspect that, at any moment, someone will expose them as a fake.

However, a person need not feel "like a fake," or distrust herself in every domain

as a result of oppression or abuse. Distrust in one's own ability to choose well can be domain-specific if that self-distrust is motivated by emotional abuse or oppressive stereotypes that target specific competencies. For example, uneducated people are often stereotyped as incompetent in making decisions that involve abstract reasoning about intellectual moral issues, but not in deciding how to treat others respectfully or how to care properly for those who are close to them. Alternatively, the stereotypes that engender domain-specific self-distrust may target not the (in)competency of a particular group, but the expertise of another. Physicians, for example, tend to be stereotyped (positively from their perspective) as wise and thoughtful decision-makers on all kinds of health care matters, including those that are not primarily medical. A patient who is given the choice of seeking IVF may distrust her own ability to choose well while in the company of a physician, whom she may feel is more qualified than her to make the decision.

Sometimes self-distrust is appropriate, but where it is not and it persists, it forms a barrier to autonomy. It is sometimes appropriate, for example, to distrust one's ability to choose well in domains where one has frequently made bad decisions in the past. However, people who cannot trust themselves to choose well in a variety of domains can be paralyzed from choosing on their own at all. They may avoid making choices as much as possible and/or simply defer to the judgment of others. As Govier writes, "[w]ith the self in default, something else would take over. Perhaps one would be governed by others--a parent, husband, or charismatic leader" (1993, 108). The other may govern benevolently or simply manipulate the self-distrustful person to fulfill the other's desires.

The manipulation would be easy since the one who is self-distrustful prefers not to choose on his own anyway.

Also, to trust that one will choose well, one has to be able to rely on the information one has received that is relevant to one's choice and also trust the source of that information. In the context of infertility treatment, it is difficult to rely on the relevant information since it is often vague or incomplete. Many forms of assisted reproduction are still experimental in nature and so the risks associated with them are largely unknown. As Laura Shanner observes, it is common for women who undergo IVF to feel that their physicians could not provide them with "good evidence or straight answers to [their] questions about [their] risks for cancer or other complications in the future" (1996, 130). Concerns about cancer, for example, arise in connection with the drugs used to suppress or stimulate ovulation, and they extend to the health of the potential child.[12]

Physicians in IVF clinics also sometimes refuse to give straight answers about success rates. There has been much controversy about that issue recently in Canada, where most clinics do not publicize their own live birth rates. Instead, they quote universal data to patients about the success of the procedure globally or within Canada specifically. Such information is misleading since the success rates in Canada are often much lower than in the United States, for example, and they can vary substantially among Canadian clinics.[13]

Lastly, in the context of IVF, patients are not always adequately informed about what an "emotional roller-coaster" IVF can be, especially for the woman who undergoes

frequent hormone injections, invasive physical exams, and who can be "cancelled"[14] from the program at any moment for "failing" to ovulate or because the embryos do not implant in her uterus.[15] One woman quoted recently by the media in Canada said that "it was like going to a used-car dealership. You had no idea what you were getting into" (Globe & Mail, May 22, 1999, A9). Some, but not all,[16] clinics have counsellors on hand who could describe the emotional aspects of the treatment and provide some emotional support while the treatment is ongoing. However, as employees of the clinics themselves, those counsellors have dual loyalties (to patients and to physicians); and that likely compromises their relationships with patients. Understandably, many patients may feel uncomfortable expressing concerns about what kind of treatment they will receive or are receiving to counsellors who have some allegiance to the program's physicians.

Some patients may find it difficult to rely on the information they receive about assisted reproductive services because they lack trust in the providers of those services. Their distrust may be related, moreover, to their own socio-political position. For example, a black woman, or black couple, in North America may find it difficult to trust health care providers to perform experimental procedures because of the terrible history of black people serving as research subjects without their consent in atrocious medical experiments. As Rayna Rapp explains, many black people are all too aware of that history, for experiments such as the infamous Tuskeegee syphilis experiment was and still is "widely reported in Black-focused media" (1998, 147). The media coverage makes it even more likely that black patients will be distrusting in the context of infertility treatment, given that much of that treatment is experimental.[17]

If, for whatever reason, patients cannot rely on information about assisted reproductive services, but they trust a decision to use those services nonetheless, their decision may not be fully autonomous. As I have mentioned, not all forms of self-distrust are detrimental to autonomy, and similarly, not all forms of self-trust promote autonomy. Autonomous choices are meant to further our own values and interests, but choices with many unexpected consequences can have the opposite effect, that of subverting our values and interests. Granted, there are times when we value making a choice merely for its own sake, in which case the consequences of it are irrelevant to whether the choice is autonomous. But usually we make choices for the sake of achieving a certain outcome, which is true in the case of infertility treatment, where the desired outcome is a (genetically related) child.

However, the consequences relevant to whether a choice in favour of IVF is autonomous may not only be the probable outcome of the procedure. There is a limit to what many patients are willing to go through to achieve the goal of having a child of "their own." In other words, many do not have the mindset of doing "whatever it takes." For example, it is not clear that Joanne was willing to go as far as IVF took her to have a child who is genetically related to her. She trusted her decision to undergo IVF knowing that doing so would be difficult emotionally, but she assumed that she could cope because she had been successful in coping with many difficult situations in the past (Williams 1989, 136). However, she never expected IVF to be as difficult as it was:

> It was so bad, so stressful. And I consider myself pretty good at coping with things usually. But at one point ... honest to God I almost packed up

> and left. I thought, 'I cannot stand this another second.' It was like a time capsule of all of your expectations and all of your stress just jam packed into five days or six days or whatever it was. And you never got any relief from it.[18]

It may be that Joanne simply underestimated her ability to cope *or* she was never informed properly about how emotionally draining an IVF cycle can be. Either way, her choice might not have been fully autonomous, since she suffered extreme and unexpected consequences, which undermined the value she probably placed in her own well-being.

When Joanne "almost packed up and left," she may have decided that quitting the program was the best decision for her; but she did not act on that decision because she could not trust herself to do so. Trusting oneself to act on one's choices is also crucial for autonomy, and in the context of IVF and other reproductive technologies, there are factors relating to women's oppression that can inhibit that trust.[19] As Morgan explains, we live in a culture of "obligatory fertility" for women (1989, 70),[20] where women who are infertile are "diseased" and those who choose to be childless are selfish or crazy.[21] Feminists who argue that technologies such as IVF limit women's choices point to the ease with which they allow others to judge women who are infertile but who choose not to have or not to continue with infertility treatment (Royal Commission 1992, 37). When women stop the treatment or choose not to start it, they are susceptible to the criticism that their infertility is their own fault, and thus, to the stigma of "voluntary childlessness" (Shanner 1996, 131). Worry over that stigma might partly explain Lois's behaviour after discovering that she had been cancelled from an IVF program because she had ovulated

before her ova could be retrieved:

> ... I remember getting in the car and crying all the way home. I'm never going back there. They've had enough! I'm not a guinea pig any more! (she laughs nervously) And I was just ... I'd had it. I thought--this is it. I'm not doing this again. But about two days afterwards it was, okay, let's go back in (she laughs) (Williams 1989, 130).

If one views her choice to "go back in" without reflecting on the social context of it, one might assume that she is masochistic and, perhaps, even schizophrenic. But a more charitable interpretation in light of that context is that Lois cannot trust herself to act on a decision to end her infertility treatment since not only might that make her childless, it would imply that she chose to be that way.

Patients who are undergoing infertility treatment might distrust themselves to act on or to voice decisions about how their treatment should proceed. They might fear that if they go against their physicians' recommendations or object to the way that their physicians are performing procedures, they will be labelled "noncompliant" and uncooperative, and, as a result, will lose the support of their care-providers. Recall the case of Lee from the Introduction. She strongly objected to what was happening to her during the hysteroscopy, but getting off of the operating table and leaving the room would have given her providers further reason for viewing her as a "problem" patient.

Women or men might distrust themselves to act on a choice to *enter* an infertility program if they are aware of some of the complexities surrounding that choice, such as the way in which it might reinforce the social perception of women as childbearers or the notion of infertility as a disease. They might be aware of the restricted access of

procedures, such as IVF, to couples who can afford it and sometimes to women who are heterosexual or married. Also, they may realize that many disadvantaged women in North America and elsewhere do not even have access to basic reproductive health care services (Royal Commission 1992, 38, 39). Overall, they may understand, in other words, that a choice in favour of infertility treatment is not purely personal (Sherwin 1992). It lends support to a certain stereotype of women as well as to an unfair distribution of health care resources.[22] However, despite what that choice implies, it is understandable why some people are drawn to it (i.e., without presuming they are just selfish). All of their lives, they may have pictured having a child "of their own," and now they face continual reminders in the media and elsewhere about how empty their lives must be without children. They may trust that a decision to have infertility treatment is the right decision for them because of the pain of childlessness they are enduring; yet still they may have lingering desires to avoid perpetuating social injustice.

The double binds of infertility in a pronatalist and high-tech culture can promote self-distrust at the level of one's judgment about the beliefs, values, and desires influencing one's choices. Some women who are infertile might question whether the strong need they feel to have a genetically-related child is autonomous because of its obvious connection to pronatalist norms and the gender socialization of women. They might question a desire to enter an infertility program because of how that decision might further their own oppression, especially given the severe emotional and physical stress it might entail. Lois's sudden reversal in her position about further IVF treatment could be explained by distrust in her own judgment about which of her desires or values should

inform that position.

During infertility treatment, distrust at the level of one's judgment can also arise as a result of feeling objectified. Frequently having your body exposed and prodded by people unknown to you can easily cause such feelings. Lee connected her own objectification with feelings of confusion and uncertainty about what she needed and deserved. The more objectified she felt, the more confused she became. Such a response is explicable on an understanding of objectification as a form of "psychic alienation," or "estrangement...of a person from some of the essential attributes of personhood" (Bartky 1990, 30). It causes such estrangement, as Sandra Lee Bartky explains, by reducing a person to the status of parts of her that are inessential to her personhood, such as her sexual or reproductive parts (Bartky 26). It makes sense that feeling separated from what makes one a person would result in confusion about whether one truly deserves to have one's opinions heard and to be treated respectfully.

Patients may be confused and distrust their judgment about whether feelings of objectification are even justified because of forces in our culture that normalize the kinds of medical interventions which they find objectifying. They may feel that the interventions treat women as mere "reproductive vessels," but at the same time, they know that it is "normal" for women to undergo such treatment. Consider Steven Mentor's response when his partner had her ova removed during an IVF cycle:

> ... all of a sudden I'm in the Twilight Zone. It's not a hospital, it's a...garage! And my wife is the car and these are the grease monkeys, down to the bad radio blaring and the power tools. I feel a surge of anger at this; how could they treat my wife's body as if it were a machine? Then

> I waver--no; it's just that they've done this so many times it is mechanical for them. It shows confidence, not disrespect. After all, I'm in their shop (1998, 68).

Mentor here seems influenced as well by sexist norms that physicians who are over-confident--that is, who display masculine characteristics of strength and certainty regarding their behaviour--are more reliable than physicians who are more hesitant or cautious (see Chapter 4, and Jones 1996, 21). Those norms, along with societal expectations about what is "normal" for the treatment of women in modern reproductive medicine, can influence patients' values and beliefs to the point that they seem alien to the self.

Lastly, patients may distrust their judgment in the context of infertility treatment because of the inherent complexity of some of the decisions they may have to make. For example, they might be faced with the decision to continue taking so-called "fertility" drugs (i.e., ovulation-induction agents), to try ovarian hyper-stimulation,[23] or to go with something "more high-tech," such as IVF. They also might have the option of IVF coupled with ICSI (intra-cytoplasmic spermatozoa injection), where sperm are injected right into the ova with the goal of improving the chances of fertilization. With each of those options, the likelihood of conception increases, but so does the financial cost, along with the harms and potential health risks. Given the difficulty of weighing those risks, the costs, and the success rates of the different procedures, patients may distrust their own judgment about which decision is best for them. They may trust their decision-making skills and the information they have received, but find that the decision

itself is so complex that it leaves them utterly confused. Consequently, they may pick up on any suggestion made by their physician about what they should do, and go with that suggestion. Their inclination to defer to the judgment of their physician because they distrust their own judgment may prevent them from making an autonomous choice--that is, a choice based on their own life goals and values, rather than the values of their physician.

Thus, in the context of infertility treatment, barriers such as oppression-related double binds and inadequate information can cause patients to distrust that they will choose and act autonomously. Although some of those barriers, such as inadequate information, can exist in other medical contexts as well, the context of reproductive medicine is unique overall in posing barriers to women's self-trust that are related to their oppressed reproductive roles. Women contemplating infertility treatment have to weigh their options not only in light of inadequate information but also in light of complex pronatalist norms and expectations that tend to reinforce sexist oppression. Those barriers can engender self-distrust that is so severe it paralyzes the patient or forces her to defer to others. Self-distrust of that sort is a serious threat to autonomy.

Not all of the ways in which patients might distrust themselves in infertility contexts threaten their autonomy, however. They might distrust that a choice to undergo IVF is consistent with their moral values, and worry legitimately that acting on that choice might subvert their values. They may hold values in favour of social justice but also value the rights of individuals to pursue, within limits, what is most dear to them, which, in their case, is the opportunity to have a child genetically related to them. They

may be uncertain about what all of their values together dictate about infertility treatment, and, therefore, distrust that whatever choice they make would further their moral commitments.

Thus, self-distrust poses a potential threat to autonomy, but not necessarily an actual threat to it. That point does not establish, however, that self-*trust* is important for autonomy, for someone could lack self-distrust and yet not be self-trusting. As I have argued, following Karen Jones, trust and distrust are contraries, not contradictories (Chapter 2, Section 4), which means that someone could be merely indifferent toward his own trustworthiness. But an autonomous agent must be more than just indifferent toward his own competence and commitment to make decisions reflecting his own values and interests; he must be optimistic in that regard. If he did not care about whether he was capable and motivated to choose and act in accordance with his own values, he would lack the will to be autonomous. It would not matter to him if his choices were informed by the values of others instead. Thus, to be autonomous, an agent must have some self-trust, of some sort.

But why should "self-trust" be the self-regarding attitude that describes our will to be autonomous? And, furthermore, if it is the relevant attitude there, and if I am right that it is a moral attitude towards the self, then does that not imply that all autonomous decisions should have a moral dimension? But can we not choose and act autonomously in spheres that are non-moral?

4. The Moral Dimension of Autonomy

In this section, I claim, in opposition to Meyers specifically (1989), that there is a moral aspect to all autonomous decisions, which means that self-trust can be the self-regarding attitude motivating us to be autonomous. In choosing and acting autonomously, we strive to meet moral responsibilities to the self, to others, or to both the self and others. We are optimistic that we will fulfill those responsibilities when we trust ourselves to choose well, to act on our choices, and when we trust our judgment about the values, beliefs, and desires informing those choices.

Meyers acknowledges the importance of having the will to act autonomously in her autonomy theory. She argues that two "volitional modes" are necessary for autonomy: resistance to "unwarranted pressure" from others, and resolve, which "is a person's determination to act on his or her own judgments" (1989, 83). The resolve criterion overlaps with my criterion of trusting oneself to act on one's choices. Resolve and self-trust are not identical attitudes, however. One can resolve to do something that has no moral significance (e.g., becoming good at playing at nintendo) whereas one does not trust oneself to do something unless it has a moral dimension.

But does acting autonomously always involve acting on a moral commitment? Meyers says no. She urges that the category of "personal autonomy" encompasses a wider range of behaviour than "moral autonomy" (1989, 13-19), where the latter refers, roughly, to self-regulating behaviour consistent with the agent's own "moral sense" of her responsibilities or obligations (Meyers 1987). According to Meyers, some autonomous

decisions are purely personal; she claims that is true ordinarily of the choice of someone as one's spouse, for example (1989, 15). However, on Meyers' account, no one type of decision is always purely personal. She writes that whether one chooses a particular person as one's spouse becomes a moral matter if "one has actively [and voluntarily] encouraged a suitor to think that his or her love is returned and that a proposal of marriage would be accepted" (1989, 15). It becomes a moral matter, then, when refusing might violate one's duties to the other person. As Meyers' argues, the kinds of personal decisions we can make without violating our moral autonomy are limited by the class of actions we deem to be morally permissible. In other words, our moral autonomy determines the "outer bounds" of our personal autonomy (Meyers 1989, 14).

It is conceivable, generally, that the boundaries to personal autonomy dictated by one's moral sense are not substantive boundaries. They would have to be substantive if being morally autonomous required that we conceive of our moral responsibilities in specific ways. It is possible, however, that moral autonomy is purely procedural. In other words, there might be only procedural restrictions on what our moral sense can dictate, such as the Kantian restriction that the rules governing our behaviour be universalizable--that is, applicable to any agent in relevantly similar circumstances (Meyers 1989, 13). There, as long as we successfully follow the procedure of universalizing what we conceive to be our moral duties, those duties are, in fact, moral; and we are morally autonomous in living up to them.

A purely procedural theory of moral autonomy, although conceivable, is unconvincing. As Meyers comments, horrendous types of behaviour could satisfy most

procedural restrictions. For example, someone could, as Meyers puts it, "sincerely universalize the most despicable practices" (1987, 150).[24] Thus, in her view, a theory of moral autonomy must place some substantive limits on what counts as *moral* behaviour, or as a *moral* attitude.[25] I have endorsed such a limit in arguing that autonomous agents must appreciate their own moral worth.

Meyers herself formally accepts the substantive restriction that moral responsibilities to the self should guide our behaviour (1989, 17; 1987, 152); however, many of the examples she gives of choices that are meant to be "purely personal" concern whether we are fulfilling those responsibilities. Once we acknowledge duties to the self, it is hard to imagine, for instance, why a choice of someone as one's spouse would not ordinarily have a moral dimension. There are instances where that choice is purely personal, but surely those instances are atypical. The moral dimensions of choosing a spouse are only mooted in situations where one has to choose between two people as one's spouse and either choice would fulfill one's responsibilities to oneself and to them. Normally it is not a moot issue, however, whether in choosing someone as one's spouse, one is being "true to [oneself]--[to one's] own needs and desires" (1987, 152). That is how Meyers interprets the way in which we are morally responsible to ourselves.[26] On that description, it is difficult to see why many of her examples fall outside of the realm of moral autonomy. Take the struggle of "Ibsen's Nora .... to break out of her husband's stifling emotional grip and also out of her society's hold on her apprehension of her proper role" (Meyers 1989, 19). Surely, Nora is *morally* obligated to be more attentive to her own needs and desires, rather than focused predominantly on the needs and

expectations of others. Standing up for what one values and desires is what it means to be appreciative of one's own moral worth.

There are decisions that fall into the realm of the purely personal, but, I suspect, that realm is not as vast as Meyers suggests. I disagree with her not only about the breadth of that realm, but also about whether it is relevant to ask of choices occupying it whether they are autonomous. True, there are some purely personal choices, meaning choices that do not entail any responsibility for doing the right or the wrong thing. That is the case, ordinarily, with the decision to wear a skirt to work, for example, or with the decision to have spaghetti for dinner. Meyers is right, though, that no one type of decision is always personal. Choosing a skirt could have moral implications if one worked in a sexist environment where women are expected to wear skirts, and where wearing pants would be an act of defiance against sexism. But where the choice to wear a skirt is purely personal, the question of whether I am autonomous in making that choice seems entirely out of place. Am I autonomous in trying on a pair of pants at the mall, in stopping at the corner store to buy a newspaper, or in spending this Saturday with my friend Ariella? It is odd to speak of autonomy in those contexts because of where the value of autonomy lies. It is valuable, as I have claimed, because of its emancipatory potential and because people who are autonomous live according to life plans that give their lives some purpose and direction. If that is why autonomy is meaningful, then the term "autonomy" should be reserved for non-trivial decisions, that is, for decisions that will probably have a significant impact on the direction our lives take. A good example would be the decision to undergo infertility treatment.

Meyers herself reserves discussion about autonomy for non-trivial matters, but she does not acknowledge that the non-trivial decisions we make have implications for whether we are fulfilling our responsibilities to ourselves. Thus, formally, she sets up a distinction between personal and moral autonomy, but I think the distinction becomes blurred in her examples of personally autonomous, or personally non-autonomous, choices, all of which seem to have a moral component. Those examples tend to focus on situations where a person is not "living in harmony" with his "true self" (1989, 18, 19). Personal autonomy, on Meyer's theory, is about achieving harmony between one's authentic self and one's life plan. To illustrate, she uses the example of a character from Frank Capra' s *Lost Horizons* named Robert Conway, who "in terms of the appurtenances of self-interest as it is normally understood, ... lacks nothing," but who feels that his life might be meaningless, nonetheless (1989, 19). As Meyers explains, "[h]is propensity for contemplation and his longing for a sense of unity with other people can find no outlet in his diplomatic career" (1989, 19). Because Conway's "self and his overall life plan are in tension," he is not fully autonomous, according to Meyers.

I agree that Conway is not fully autonomous, but I believe the reason why is that he is not taking full moral responsibility for himself. Meyers might assume that he is being responsible to himself because he seems to have chosen a life path in which he is not degrading himself. But whether that is true, exactly, depends on why Conway has remained in his diplomatic career. The explanation is that the career conforms with societal expectations of him as a member of a certain social class. As Conway himself says, he "[hasn't] the nerve to be anything else" (Meyers 1989, 4). Surely that reveals

about Conway that he is not honouring his moral responsibilities to himself (at least not entirely). Rather than leading a life that conforms to what *he* values and desires, he has allowed himself to be a pawn to upper-class society. If being responsible to ourselves involves acting in accordance with our own values and goals, then it must be a moral matter whether any serious tension exists between our selves and our life plans. People who experience intense and perpetual disharmony within themselves are not taking responsibility for themselves, or else, they are prevented from doing so.

I agree with Meyers that autonomy involves "living in harmony with one's true self" if that means following a life plan that is consistent with what one truly desires as opposed to what society dictates that one should desire. Furthermore, what one "truly desires" must reflect one's own moral worth, since life plans that endorse one's own subjection are incompatible with autonomy. Autonomy, then, requires that our life plans be our own, that they embody our worth, and that we act in accordance with them. But meeting our responsibilities to ourselves, or being "true to ourselves," as Meyers writes, requires the same thing. Thus, I would argue that autonomy inevitably has a moral dimension, and it is appropriate that the self-regarding attitude motivating us to be autonomous is a moral attitude. In choosing and acting autonomously, we aim to fulfill certain moral responsibilities, and to be motivated to do so, we need some self-trust.[27]

Note that there is an important implication for bioethics from my view that purely personal decisions are irrelevant to our autonomy. If autonomy and mere personal preference are distinct, then the duty physicians have to respect our personal preferences is separate from their duty to respect our autonomy. They or anyone else could coerce us

in the realm of the purely personal: for example, a physician could intimidate us into deciding to wait another half an hour for our appointment, rather than head home instead, which is what we prefer to do. If the decision to stay is purely personal, then the physician has not violated our autonomy. Still, she may have violated her duty to respect our personal preferences.[28]

5. The Value of Justified and Autonomous Self-Trust

The cases about infertility treatment in section 3 illustrated the importance of having some self-trust for autonomy. However, not every kind of self-trust is conducive to choosing and acting autonomously, precisely because there are some substantive restrictions on autonomy. For example, when we trust ourselves to choose well but do not have adequate information about our options, our self-trust does not promote our autonomy. In this section, I introduce a new substantive condition for autonomy, namely that agents have adequate self-knowledge. That condition requires that the trust they place in their ability to choose well and to act on their choices is justified. Furthermore, I argue that the self-trust needed for autonomy must be developed autonomously; and in defending that position, I clarify my own view of the nature of autonomy and of the conditions that promote it.

There are at least two reasons why autonomous agents require some self-knowledge. One is that they would not be self-directed otherwise. As I have argued, following Young and Meyers, self-direction requires that we decide and act in

accordance with a life plan. Now it makes sense to say that a person could be guided by a plan, but profoundly mistaken about whether most of her decisions or actions conform to it--that is, about whether they are likely to advance the plan. But if she were so wrong about the likely consequences of her decisions or actions, would we still say that she is self-directed? Consider the following analogy. Would it be accurate to say that I am directing my canoe through a maze of rocks if my canoe were swerving all over and bashing into the rocks? I would have to be maneouvring it around the rocks to be directing it through the maze, would I not? If the canoe were swerving all over, one would say that I was unsuccessful in directing it, or that the canoe lacked direction. The term "direction" implies some actual movement towards a goal, as opposed to utter chaos. The person who is never able to actualize her plans is not directed toward anything; she is best described as "lost," or lacking in direction.

One is not *self*-directed unless one causes one's life to move in the direction of certain goals. A person of privilege might succeed in achieving his life goals with a lot of help from others, but he lacks self-direction if most of his success is due to his privilege. If my canoe moves smoothly through a maze of rocks only because there are strong currents that take it through, then *I* am not directing the canoe. If a privileged person uses very few of his own abilities to achieve his goals, then he is only minimally self-directed. Alternatively, if he receives help from others only in developing his abilities and in having some opportunity to exercise them, then he could be optimally self-directed. Most abilities or competencies are not innate, and the fact that they are learned and fostered in certain kinds of social environments does not make them any less

authentic.

Self-direction, as I have defined it, demands some self-knowledge at the level at which choices are made, at the level at which we act on our choices, and at the level of judging whether the goals and values influencing our choices are truly our own. Because "direction" implies actual movement towards a goal, it is important to be realistic in choosing how to meet our goals. For our choices to be realistic, they must reflect some knowledge of where our competencies lie. Furthermore, our expectations about whether we will act on those choices must be realistic. Those expectations must be grounded in some knowledge of how committed we are to our goals and whether we are competent to act on the decisions we make. Lastly, to be self-directed, our judgments about whether our goals have been set by us rather than by others must be informed by some knowledge of the accuracy of our judgments about where our goals originate.

Our assumptions about ourselves and whether we are competent to meet our goals do not have to be completely accurate all of the time for us to be self-directed, or to be autonomous agents. Most of us have bad days when we make bad decisions that put us behind in meeting our goals; but usually, then, we do not all of a sudden become non-autonomous. Assessments of our autonomy should refer to our behaviour over a significant length of time, rather than to a single point in time at which we might have committed a non-autonomous act. Granted, it is possible that a single act with enormous consequences will have a negative impact on our autonomy. For example, Lee's decision to enter the kind of infertility program she did was not fully autonomous because she lacked sufficient information about what she would experience during the program. The

decision compromised her autonomy because of the severe consequences she suffered (which included a diagnosis of Post-traumatic Stress Syndrome). Most of the time, however, people can maintain autonomy and act non-autonomously every once in a while.

Moreover, people can be autonomous to varying degrees. Meyers distinguishes between minimally, medially, and fully autonomous agents based on the degree to which they possess the full "repertory" of autonomy skills (1989, 170). Roughly, a minimally autonomous agent is someone who "possesses at least some disposition to consult his or her self and at least some ability to act on his or her own beliefs, desires, and so forth," but whose autonomy skills, in general, are poorly developed (Meyers 1989, 170). I shall say that minimally autonomous agents must have the self-knowledge they need to trust themselves in a justified way to manifest their minimal ability to act on their own beliefs and desires. Fully autonomous agents, on the other hand, that is, those who are fully skilled in choosing and acting autonomously, must have the self-knowledge needed to manifest those skills; otherwise, the fact that they are more skilled generally than others would make no difference to their level of autonomy in comparison to others. Medially autonomous agents, as Meyers writes, "range along a spectrum between these two poles" (1989, 170); the degree to which they know themselves falls somewhere in between the minimally and the fully autonomous agent.

I mentioned that there was another reason why self-knowledge is crucial for autonomy. That reason concerns the substantive conditions for autonomy of self-worth and self-respect. To know whether we are deserving of respect or whether we possess

moral worth requires that we have some self-knowledge. The person who does not know whether she is responsible for many of her accomplishments does not know whether to respect herself. The person who does not know whether she inherently possesses moral worth lacks a sense of self-worth. She therefore could not be autonomous, since self-worth and self-respect are essential for autonomy.

If what we presume to know about ourselves reflects how competent and deserving we are only according to oppressive norms and stereotypes, then it is unlikely that we will develop self-respect or possess self-worth. Accurate attitudes toward the self are harder to come by when one's social identity is defined in terms of stereotypical norms. To be able to acquire such attitudes in those circumstances, one must be fairly successful in screening out distorting oppressive influences. However, achieving that success is extremely difficult without at least some informational resources at hand that expose the falsity of cultural assumptions perpetuating one's oppression. As I argued in chapter 4, self-knowledge is social, for it flourishes in conditions where there are some reliable external resources confirming or disconfirming the accuracy of our judgments about ourselves. Resources deemed "reliable," or "unreliable" must be assessed in terms of how often they target people's *actual* competencies, rather than in terms of the (in)competencies they supposedly possess according to oppressive social stereotypes.

Thus, self-knowledge, defined against the background of a social world in which our true competencies can manifest themselves, is essential for autonomy. It is a substantive condition for autonomy because it demands some accuracy in the beliefs and values about ourselves that inform our decisions. That condition explains why the

self-trust motivating us to be autonomous must be justified most of the time. It need not be well-grounded, for autonomy does not require perfect self-knowledge. Neither does it have to be justified all of the time, for autonomous agents can have lazy days when they make ill-considered decisions. What is required for autonomy is that our self-trust is usually reliable, meaning that it tends to be grounded in knowledge not only of the options available to us, but also of our competence and commitment to fulfill certain moral responsibilities, such as our responsibility to ourselves to stand up for our own needs and values.

Hence, it is crucial for autonomy that we have what I referred to in chapter 4 as "the skill of trusting oneself well" (i.e., the skill to develop justified self-trusting attitudes), and that we are able to exercise that skill most of the time. That does not mean, however, that the skill of distrusting oneself well is trivial. To preserve our autonomy and self-direction, it is important in some situations that we distrust ourselves, at least to some degree, if we lack the competence to choose well, to act on our choices, or where we simply lack reliable information about our options. But if we distrust ourselves most of the time, even in a justified way, we cannot be autonomous. As I suggested in chapter 4, oppressed people often find themselves in situations where it is justified to be self-distrustful. The double binds of infertility make infertility treatment one of those situations for women. Even though, there, self-distrust may be justified, it interferes with their autonomy. It paralyzes women from choosing and acting in ways that promote their own interests.

Thus, on my theory of autonomy and self-trust, people lack autonomy if they

cannot trust themselves in justified ways to further their own values and interests, either because their situation prohibits that trust or because they lack self-knowledge. Here, I have emphasized that we cannot be autonomous if we are frequently mistaken or uncertain about our own worth or about our ability to achieve our ends. That view of autonomy differs substantially from the standard view in contemporary autonomy theory, and below, I clarify how it differs exactly. I explain that unlike the standard theories, 1) my theory suggests that autonomy is about "being in a certain way," rather than merely about control (Wolf 1989); 2) it presupposes an autonomous self that is not presocial; and, 3) it demands that the processes forming our autonomous decisions be partly social in nature.

Standard accounts of autonomy recommend certain procedures for the evaluation of our values and beliefs, where the aim of those procedures is to determine what the self truly values and believes in the absence of "alienating" influences.[29] That "deep self," as Susan Wolf calls it (1989), is a self that is not determined by anything outside of itself.[30] As Meyers writes, It is "cleanse[d] of the stain of socialization" (1989, 42). Furthermore, it is not a self that is necessarily correct in what it believes and values about itself. On the standard theories, autonomy is primarily about control (Wolf 1989); as long as we control which values and beliefs inform our choices and act on those choices, then we are autonomous, no matter what the content is of our beliefs and values.

But autonomy is not only about control. What Wolf writes about responsibility and freedom is also true of autonomy: "not all things necessary for freedom and responsibility must be types of power and control. We may need simply to be a certain

way, even though it is not within our power to determine whether we are that way or not" (Wolf 1989, 144). The way we need to be, according to Wolf, is "sane," which means that we have the ability to "cognitively and normatively recognize and appreciate the world for what it is" (1989, 145). In other words, we must be able to distinguish between right and wrong and to perceive other aspects of the world clearly. For autonomy, I have argued, specifically, that we need to be able "to cognitively and normatively recognize and appreciate" ourselves for what we are, at least to a minimal extent. I have also claimed that we need to be able to manifest that skill most of the time. By contrast, Wolf argues that being responsible and free do not require that we exercise the ability she associates with sanity (1989, 150).

On my theory of autonomy, the self cannot be profoundly mistaken about its own competencies and worth, and neither can it be "deep." If we have self-knowledge and justified attitudes of self-trust and distrust, then some positive social feedback must be influencing our perception of ourselves. As I argued in chapter 4, the reason why the processes sustaining those attitudes must be partly social is that introspection alone is seriously limited as a means of gaining self-knowledge (Kornblith 1998). Since self-trust, grounded in our self-knowledge, is crucial for autonomy, the processes responsible for our autonomous decisions must also be partly social. Yet, on most standard theories of autonomy, those processes are purely individual. They involve merely the introspection of our beliefs and values, or the introspection of their formation. An example is the procedure of determining whether we identify with our beliefs and values.

Autonomy is not only about "being in a certain way" on my theory, namely, being someone whose mental attitudes accurately represent his own competencies and worth. It is also about following certain procedures for the evaluation of one's beliefs and desires, procedures that have a social component to them. Autonomy must be partly procedural, since, presumably, someone could be forced to adopt the attitudes necessary for autonomy, in which case she would not be truly autonomous. To be autonomous, she must engage in the various processes I outlined in section 2 for evaluating her values and beliefs, and she must respond to social feedback while engaging in those processes. However, she cannot allow that feedback to dictate what she believes and values. She must be skilled enough to be able to perform on her own the procedures of evaluation necessary for autonomy. As Meyers urges, autonomy is a competency because of the skills it demands (1989). It is about being skilled in a certain way, not only about being in a certain way.

Similarly, if someone has even well-grounded self-trust in her ability to make certain decisions and to act on those decisions, but the source of her self-trust is her deference to an admired and benevolent friend who tells her what to think about herself, then she lacks autonomy. Thus, not only must the self-trust required for autonomy be justified, it must also be formed and sustained autonomously. The relation between autonomy and self-trust, then, is symbiotic; autonomy is important for self-trust just as self-trust is important for autonomy. They feed off of one another, like some organisms who share ecosystems. Since relations can be symbiotic in nature, there is no reason to assume that symbiosis could not occur among different attitudes or states of persons.

Let me conclude by distinguishing briefly my view from Lehrer's of why autonomy is important for self-trust, and of what autonomy demands. In his book, *Self-Trust* (1997), Lehrer claims that we must be autonomous if we are to be worthy of our trust in ourselves. There, he is referring to "trust," specifically, in the reasonableness of what we "accept and prefer," that is, of what we believe to be true and prefer to have, given what we desire. Attitudes that are only about the reasonableness of our beliefs and preferences are not self-trusting attitudes, on my theory. Thus, a significant difference between Lehrer and I is how we interpret self-trust. Another important difference is that I do not argue that to be "worthy of our trust," we need to be autonomous, necessarily. Lehrer writes that,

> I cannot be worthy of my trust [by which he means that I cannot trust what is worth trusting (1997, 5)] if I am not autonomous because, if the evaluations I make are imposed or fortuitous, I have no way of telling whether what I evaluate as worth accepting or preferring is worth accepting or preferring" (1997, 95).

So unless I am autonomous and can evaluate whether my trust is justified, my trust cannot be justified. That presumes that the justification of self-trust is internal to the subject, however. The view I defended of its justification in chapter 4 is externalist. As long as the processes that generate our self-trust are reliable, our trust is justified. It is a further matter to ask whether we perform those processes autonomously.[31]

Furthermore, the kind of autonomy needed for self-trust in my theory is substantially different than in Lehrer's. His view of autonomy conforms to the standard model where autonomy is purely procedural, where the relevant procedure for choosing

autonomously is purely individual, and where that procedure is aimed at unmasking our "deep selves." Lehrer uses the language of preferences to describe our higher-order evaluations of our desires, and argues that to be autonomous, we must be the "author" of our own preferences (1997, 100, 101). That itself is guaranteed, supposedly, if we have what Lehrer calls a "power preference," namely a preference to have the preference structure that we have. He suggests that gaining the power preference is a purely procedural and introspective matter.

I have argued that the autonomy important for self-trust is both relational and substantive. It is relational partly because it demands that while engaging in the various processes of reflection on our values and beliefs, we pay particular attention to social feedback about the values and beliefs we have concerning ourselves. However, it places some substantive limits on the kinds of beliefs and values that we can have as a result of those processes if we are to be autonomous. If we do not end up with values and beliefs that accurately reflect our own worth and competencies, we will lack autonomy. If the social world with which we engage in forming those values and beliefs gives us a distorted picture of ourselves, then our autonomy will suffer.

6. Conclusion

The discussion in this chapter of some of the problems with modern infertility treatment, which I illustrated using the personal accounts of some patients, demonstrated how forces of oppression can interfere with self-trust at various levels of autonomous

decision-making. Sometimes, oppression interferes by confusing patients about whether they are truly competent and can rely on themselves to be committed to choosing and acting autonomously. That is, it can prevent them from knowing themselves, or at least from assuming that they know themselves, well enough to be able to trust themselves. For example, stereotypes about women's diminished autonomy can make some women uncertain of whether they are truly competent to make the kinds of difficult choices that often arise during treatment for infertility. Double binds rooted in their oppression, such as the bind of having to choose between infertility treatments that can cause serious harm and the stigma of "voluntary childlessness," can breed confusion in the level of their commitment to act on one choice or another, or about their competence to judge what is motivating them to choose one way or the other.

Thus, lacking self-knowledge, or simply experiencing self-doubt, can prevent us from developing the self-trust we need to be autonomous. But lacking self-knowledge can also interfere with autonomy if we trust ourselves to choose and act in the absence of that knowledge. It is important to get things right in trusting ourselves because of the importance of self-knowledge for autonomy and self-direction. Autonomy requires that we possess and exercise the skill of trusting ourselves well so that often our self-trusting attitudes accurately represent our own competencies and commitment to acting with moral integrity. Moreover, we require the skill of knowing when to distrust ourselves for the sake of preserving our autonomy in circumstances where our knowledge of ourselves and of our options is severely limited.

Notes

1. However, the degree to which people possess that skill may vary. I explain below that autonomy can admit of degrees and the degree to which one must trust oneself reliably in order to be autonomous depends on what level of autonomy we have in mind.

2. Susan Sherwin explains the appeal of that principle in health care contexts specifically in "A Relational Approach to Autonomy in Health Care" (1998, 20-23).

3. The term "untainted by socialization" comes from Diana Meyers (1989, 42). She herself does not object to the autonomy ideal, but she is sensitive to feminist concerns about the presocial self underlying most contemporary views of autonomy (i.e., the views in moral philosophy that I discuss in section 2). Those theories presuppose that kind of self, as Meyers explains, because they interpret autonomy as a kind of free will that demands transcendence above the level of socialization (see 1989, part II, section I).

4. Examples of those moral philosophers are Dworkin (1989, 61), and Young (1989, 81), where Young focuses specifically on ignorance that arises as a result of self-deception. Most moral philosophers do not specify, however, what agents must be able to understand to be autonomous. Unlike bioethicists, they do not emphasize that autonomous agents cannot be ignorant of the nature of their options.

5. I mention Meyers here, but do not include her among the "standard" theorists who ignore the relational aspects of autonomy. Meyers has made important contributions to relational autonomy theory by arguing that autonomy requires that the agent possess a set of skills which depend for their development on non-oppressive social relations.

6. A further reason Meyers gives for why a life plan is crucial for autonomy is that it allows us to explain how someone could engage in spontaneous autonomous behaviour. Meyers writes, "the alternative to having a life plan is to consult one's self at length with regard to each and every personal decision, that is, to have no preaffirmed dispositions and no preestablished policies" (1989, 51). I argue below that not "each and every personal decision" is relevant to our autonomy. Still, it is important that we be able to make some autonomous decisions spontaneously.

7. Young's version of the kind of life plan needed for autonomy is unpersuasive; surely people can be autonomous without having that much order in their lives (in fact, one wonders if they might lack autonomy if they did have such ordered lives). I support Meyers' theory of how planned out an autonomous life must be (see, especially, 1989, 49-53).

8. See, also Sandra Lee Bartky (1990, 24, 25). Bartky writes that women "cannot be autonomous, as men are thought to be autonomous, without in some sense ceasing to be

women" (24).

9. Regret is usually an indication that one has made a non-autonomous choice (Meyers 1989), but I suspect that is not always the case. For example, one could regret making a decision that caused one to give up something of value in favour of something else of equal or slightly greater value, even though the decision was made autonomously.

10. Julien Murphy explains that there are variety of reasons why that option is often unavailable for lesbian women, the most obvious of which is that some infertility clinics simply refuse them access (there, Murphy cites Robinson 1997; Murphy 1999, 105).

11. Benson's criterion of self-worth overlaps significantly with what Darwall calls "recognition self-respect" (see Chapter 3, Section 4).

12. Some of those drugs are estrogen-based, and, as Kate Fillion mentions, there is a well-known correlation between estrogen and breast cancer (Fillion 1994, 46). Furthermore, Mary Anne Rossing and J.R. Daling *et al* have found that women who have twelve or more cycles of drug-induced ovulation have an elevated risk of developing ovarian tumours (1994).

Fillion also notes the possible risk of childhood cancer. She writes that "[a] review of Japan Children's Cancer Register from 1985-89 identified significantly more cases of childhood malignant disease in children born to mothers who underwent ovulation induction" (55, ftn 2).

13. See *The Globe & Mail* (May 24, 1999, A1, A6, A7; May 22, 1999, A1, A8, A9). In response to the outrage, the federal government in Canada has proposed new legislation requiring IVF clinics to release their own live birth rates.

14. Being cancelled means that you miss a cycle, not that you are kicked out of the program altogether. Missing a cycle can be devastating enough because you may have placed all of your hopes in getting pregnant in one particular cycle and/or you might not have the financial means to try again (patients have to pay separately for each cycle).

15. A number of writers have described in some detail how stressful IVF can be. For example, se Shanner (1996), Fillion (1994), and Williams (1989). For a detailed account of what the procedure involves medically, see Farquhar (1996, chapter 5).

16. For example, the clinic I attended as part of my clinical practicum provides no counselling service. The Canadian Royal Commission on New Reproductive Technologies recommended that counselling be available at all clinics as a means to avoiding "unexpected consequences" of the new technologies (1993, 4).

17. It is experimental in nature partly because it involves the frequent use of ovulation-induction agents, which carry unknown risks.

18. Joanne's story is dated, but it is consistent with more recent reports about what many women, and men, experience emotionally during IVF treatment (see, e.g., Fillion 1994, Mentor 1998, Shanner 1996, and also *The Globe & Mail* reports I cited above). Fillion quotes one man as saying that "Every month for three days it's like a funeral. We've had twenty-four funerals. If she does get pregnant, I'm not going to feel that something is beginning. I'm going to feel 'Thank God it's over'" (1994, 33).

19. There are other factors indirectly related to their oppression that may undermine that trust. For example, a number of feminists refer to the "technological imperative" in the context of assisted reproduction and prenatal care (e.g., Davis-Floyd and Dumit 1998, Morgan 1989, Shanner 1996). The imperative is to seek out new technologies of any sort because, supposedly, they enhance our freedom.

20. Morgan acknowledges that not all women experience that dimension of sexism in every domain, and some women (e.g., lesbian women and poor women) are often pressured in the opposite direction, that is, not to reproduce. Yet as Morgan notes, within their own communities, lesbian and poor women may experience "fertility" as obligatory (1989, 78).

21. Shanner explains that the couples she interviewed at IVF clinics in Australia felt that their society made negative and unwarranted assumptions about adults without children (i.e., they are selfish, immature; 1996, 129). She cites a study, which unfortunately is outdated (1979), but which confirms that attitude (see footnote 28, 141).

22. That choice becomes even more complex once we factor in the implications it has for the value of the lives of children already living who are homeless or who are in foster care, and perhaps also for the value of children "produced" through IVF, who may be commodified by that process.

23. With ovarian hyperstimulation, the woman takes hormone injections to stimulate her ovaries to produce multiple eggs in one cycle, rather than the usual 1. The rationale behind the procedure is that the more eggs and sperm that are interacting, the greater the chances are of conception (source: patient information leaflet).

24. In her more recent work, Meyers explains that it is compatible with the Kantian categorical imperative to will despicable practices because the imperative relies solely on the use of impartial reason and ignores the importance of empathy in moral reflection (1994, chapter 2). Moreover, in earlier work, she discusses other types of procedural restrictions on moral autonomy, such as Rawls's reflective equilibrium, and explains how they too could be consistent with "abominable solutions" (1987, 150).

25. Although in *Self, Society and Personal Choice*, she says only that "there *may* be substantive as well as formal and procedural goods that all morally autonomous lives exhibit" (my emphasis; 1989, 82).

26. She makes that point, specifically, in the context of defending a form of moral autonomy that is consistent with an ethic of care. She says that "mature adherents of the care perspective embrace a dual injunction to be true to themselves--their own needs and desires--while giving care to others" (1987, 152). That injunction must be moral since a care perspective is a moral perspective.

27. Those responsibilities can be other directed as well as self-directed. For example, in trusting herself to be autonomous in deciding whether to attempt to have a child through an assisted means of reproduction, a woman might be concerned about whether the decision reflects what she truly desires and values not only for herself but also for her potential, future child. She may perceive that there are norms commodifying children in her culture, and may trust that she is not influenced by those norms in making her decision.

28. That duty must be circumscribed by a duty to uphold fundamental moral values of our society (and, therefore, to refuse prenatal sex selection, for example).

29. Another possible interpretation of an "alienating" influence is whatever causes us to feel alienated from ourselves.

30. "Deep Self" theorists, as Wolf explains, are attempting to allay fears of determinism by distinguishing "cases in which desires are determined by forces foreign to oneself from desires which are determined *by* one's self--by one's 'real,' or second-order-desiring, or valuing, or deep self" (1989, 141). It should be noted that the "deep self" is not defined in that way throughout philosophical discussions of the self. In deep ecology, a deep self is "ecological," meaning that it is shaped by a web of relations, including relations with non-human entities (see Naess 1994; Devall & Sessions 1985).

31. For as I suggest above, the process of deferring to a wise and benevolent person about which self-trusting attitudes we should adopt could be a reliable process (although, granted, our self-trust would then be minimal given that we are deferring to someone else). However, we would not be autonomous if the self-trusting attitudes motivating us to act were generated in that way.

Chapter 6

Improving Respect for Patient Autonomy: Patient Self-Trust in a Woman-Centred Obstetrics

1. Introduction

Autonomous agents have some knowledge about themselves and about their options, and they have various skills allowing them to further their values and to act in accordance with a life plan. Self-trusting attitudes motivate them to be autonomous and self-distrusting attitudes guard them against non-autonomous behaviour. But those attitudes can play those roles only if they are manifestations of the skills of trusting and distrusting the self well. In the previous chapter, I discussed how oppression can suppress the development and use of those skills at the levels of choosing well, of acting on one's choices, and of judging the authenticity of the values and beliefs that inform one's choices. In domains where oppression is most likely to influence the expression of self-trust at each of those levels, one's autonomy can suffer greatly. One of those domains for women is the domain of modern reproductive medicine.

In reproductive medicine, the gender socialization of women and the dynamics of gendered, and often class-based, epistemic power in many physician-patient relationships are potential obstacles to justified self-trust among female patients. We have witnessed in this thesis the impact of gender socialization on the ability of women to trust

themselves well in the contexts of both miscarriage and infertility treatment. Pronatalist norms can explain why women such as Sheila (chapter 3), who miscarried, and Lois (chapter 5), who had trouble deciding whether to continue with infertility treatment, were self-distrustful. The epistemic authority of physicians was ultimately a barrier to self-trust in the case of Janet from chapter 3. Her physician's authority was gender-based as well as based on his access to technological scientific evidence. Sometimes physicians maintain epistemic authority, moreover, because patients simply fear, as we saw in the case of Lee (Introduction), that if they disagree or are "non-compliant," they will lose the support of their care-providers.

But even in the face of pronatalist pressures and physician authority, some female patients maintain self-trust and autonomy in reproductive contexts. Moreover, not all physicians wield their epistemic authority in ways that can undermine the self-trust of patients. However, the obstacles to patient self-trust in obstetrics and infertility treatment do necessarily not stem from the behaviour of physicians, and even where those obstacles do arise primarily because of their behaviour, well-intentioned physicians can be unaware of them. Thus, it is important to consider what changes can be made to reproductive health care practice to promote the self-trust and reproductive autonomy of patients, and how individual health care providers can be respectful of patient self-trust.

In the bioethics literature on autonomy and informed consent, there is no detailed discussion of the importance of self-trust for autonomy, and, furthermore, in most of that literature, aside from the feminist contributions, the threat to autonomy of oppression is ignored. Physicians are told that they have a duty to respect the autonomy of patients,

where that is often reduced to the duty to obtain their informed consent, but rarely are physicians told to respect and promote the self-trust of patients to further their own goals and to determine what those goals should be.[1] In this chapter, I use cases involving prenatal diagnosis to illustrate how self-trust is frequently undermined in obstetrical situations, and what health care providers can do to bolster patient self-trust. I argue that we must reconceive the duty to respect patient autonomy so that we understand how oppression can interfere with the skills of trusting and distrusting oneself well, and so that we acknowledge the importance of certain forms of self-trust and self-distrust for autonomy.

But it is not enough to argue that health care practitioners should create an optimal environment for the development and expression of patient self-trust. In certain ways, the whole paradigm of medicine and the epistemology that underlies it are opposed to that kind of environment. Thus, we can only incorporate into the practice of medicine insights about the relation between patient self-trust and autonomy by first making substantial changes to that practice. For example, as I argue, physicians can no longer be the sole authorities on the nature and meaning of patients' own bodily experiences. To have self-trust, patients need to be able to define those experiences in ways with which they identify, meaning in ways that are integrated with their own belief and value systems.[2] For that change to occur in obstetrics, the practice of it would have to become more woman-centred. As I shall explain, in situations involving prenatal diagnosis in particular, a woman-centred obstetrics respects the embodied relation of a woman to her fetus, as well as her embodied knowledge of her pregnancy.

2. Informed Consent, or "Choice," in Theory and in Practice

In bioethics and in medical practice, informed consent is meant to be a mechanism for preserving patient autonomy. Because of how it is often obtained in practice, however, it is not a way for many patients to become autonomous agents in choosing the treatments they receive. Some bioethicists have recommended changes to the procedure of obtaining informed consent so that it is more conducive to the exercise of patient autonomy (e.g., Lidz, Appelbaum, Meisel 1988, Beauchamp & Childress 1994). But the recommendations of non-feminist theorists, in particular, fall short of identifying how power imbalances in physician-patient relationships and how cultural norms and stereotypes can interfere with patient autonomy. In this section, I discuss what is present and what is absent in most of the theory about and practice of informed consent.

Usually in medical practice, informed consent occurs as a discrete event in which physicians fulfill their legal obligation to patients to disclose whatever a reasonable person would want to know about the harms and benefits of a recommended procedure. That event is described in detail by Janet Farrell Smith in "Communicative Ethics in Medicine" (1996). She gives the following synopsis: after analysing information obtained through a patient interview, a physical exam, and possibly through laboratory tests, physicians will inform the patient of a diagnosis or a recommended course of action, highlighting the legally relevant harms and benefits (187-190). Physicians then ask whether the patient agrees with the recommended procedure, and sometimes have the

patient sign a consent form. In situations where physicians tend not to give specific recommendations, but simply describe the options available to the patient,[3] they will often inform the patient that she must choose based on her own values and beliefs. Smith explains that rarely does any significant communication occur about the patient's options beyond the transfer of medical information. Studies have shown that "patient-initiated questions are often 'dispreferred'" in medical interviews, but even when patients do ask questions, they rarely challenge the accuracy of the information provided or the recommended course of action, if a recommendation is given (Smith 1996, 190).

Most patients do not question what physicians recommend to them because of the authoritative knowledge of physicians in the area of human health. Many patients welcome that authority; what it means for them to trust their physicians is that they do not have to worry about what is the best approach to their care or the accuracy of their physicians' diagnoses. They can simply take their physicians' word for it. At the other extreme are patients for whom the knowledge of physicians is not authoritative. Those are patients who believe that their physicians are fallible and that their knowledge has no greater value than the patients' own knowledge of their bodies or than the knowledge of people who practice alternative forms of medicine. Still, those patients may not question the approach of their physicians when they disagree with their approach if they have no choice but to see a physician and they fear being abandoned. They may have no choice if alternative healing practices are unavailable or financially prohibitive. The reason why those people are in the position of having to rely on a physician in the first place, however, is because of the epistemic hegemony of physicians in our culture, a hegemony

which ensures that alternative healing methods are often unsubsidized. Thus, even for patients for whom medical knowledge is not authoritative, their resistance to challenging their physicians can usually be explained in terms of the epistemic authority of physicians.

Medical anthropologists, Carole Browner and Nancy Press (1997), have found that American women seeking prenatal care tend to fall somewhere in between the above extremes.[4] That is, some of the advice their physicians give to them is authoritative for them and some is not. Sometimes they reject their physicians' advice simply because it is too difficult to follow, given their own daily routines and responsibilities, but other times they reject it because they suspect it is unfounded. What often guides them in evaluating their physicians' recommendations is their own embodied knowledge of their pregnancies. Such knowledge is "derived from a woman's perceptions of her body and its natural processes as these change throughout a pregnancy's course" (Browner & Press 1997, 113). If medical advice conflicts with that knowledge, then women will often question the advice. Yet, as Browner and Press found, if the advice is supported by medical technology or it concerns the use of such technology (such as ultrasound or prenatal genetic testing), then women are *un*likely to reject it. Browner and Press conclude that what is authoritative for many women in prenatal care in the United States is medical technology, more so than the physicians themselves.

However, a further reason why some women might accept advice about reproductive technologies is that they feel they have little opportunity to refuse it. The difference between advice about how their lifestyles should change and advice about

having an ultrasound or prenatal genetic testing is that women can reject the former, unlike the latter, usually without their physicians knowing anything about it. The study that Browner and Press performed did not show that when women reject any recommendations about changes to their diet, for example, or about exercise, they do so *openly* with their physicians. Thus, their prenatal visits may still conform to the pattern Smith describes for patient-physician interviews. Patients can consent to advice about lifestyle changes, knowing full well that they will not follow it. On the other hand, if they consent to an ultrasound, they cannot easily avoid it afterwards. Although Browner and Press are probably right that many women prefer technological monitoring of their pregnancies and births, an alternative explanation for why some of them consent to it is that the dynamics of their relationship with their physicians make it difficult for them ever to flatly refuse what their physicians recommend.

Many bioethicists have objected to the traditional dynamic of patient-physician relationships and the way that informed consent is often obtained within them. They argue that if patients merely consent to procedures that their physicians recommend, there is no guarantee that the decision they have made is right for them, given their values, life goals, and social circumstances (see, e.g., Lidz, Appelbaum, Meisel 1988). For patients to choose autonomously, they must participate in a meaningful way in the decision-making process. Moreover, they must have the opportunity to refuse as well as consent--in other words, they must be able to make a choice. The problem with physicians maintaining epistemic authority through whatever means in their relationships with patients is that it leaves patients little opportunity to refuse. In defence of their right

to refuse, some bioethicists, such as Francoise Baylis (1993, ftn 1), argue in favour of a shift towards the language of "informed choice."[5] That shift is not merely semantic; it reflects an enlightened view of the nature of autonomous decision-making.

Some bioethicists specify that satisfying the conditions for autonomy requires that informed choice occur as an interactive process, rather than as a single event at which physicians disclose information to patients (e.g., Lidz, Appelbaum, Meisel 1988; Beauchamp & Childress 1994). As I discussed in chapter 5, the standard list of conditions for autonomy in contemporary bioethics is the following: 1) patients must be competent, or have "decisional capacity"; 2) they must possess relevant understanding; and, 3) they must choose and act voluntarily. To ensure the presence of those conditions, advocates of the "process model" of informed choice argue that it is important that physicians engage with patients in evaluating the available options, and that they assist patients in making decisions that are consistent with the latter's values. Through the active involvement of patients in negotiating the approach to their care, physicians can assess whether the patient likely possesses decisional capacity[6] and whether he is likely to be choosing freely, rather than under the influence of some coercive or manipulative force.

Furthermore, giving patients the opportunity to ask questions and to express concerns should improve their understanding of the relevant medical information. Only once they appreciate the significance of that information for their own lives is the condition for autonomy of understanding satisfied (Appelbaum & Roth 1982). Appreciating that significance means that patients are aware of the possible or probable

changes that could, or would, occur in their lives if they were to choose any of their options. To achieve that awareness, they must factor in non-medical information about the possible or probable impact of a particular decision on their work, for example, on their sense of self, or on their relationships with others.

Clearly, on the process model, it is essential that physicians develop a relationship with their patients. One of the ethical problems in the case of Lee from the Introduction is that she was denied a relationship with her health care providers. As a result, she felt that she was deprived of the ability to make informed choices. Only in relationships with patients can physicians give patients the assistance they need in understanding and evaluating their options.

The inventors of the process model, namely Charles Lidz, Paul Appelbaum, and Alan Meisel, argue, furthermore, that physicians should clarify what their own values and expectations are to patients, so that patients will understand exactly why their physicians are recommending a particular approach to treatment (1988, 1386). Physicians themselves must realize that their recommendations are not value-free: that they presuppose values, including, perhaps, the value of living in optimal health as opposed to enjoying a few physically harmful pleasures, or the value of living without any pain as opposed to living with all of one's cognitive faculties intact. Patients may disagree with physicians about which values should be guiding the approach to their health care.

The process model of informed choice does identify many of the problems with the standard "event model"; however, it does not go far enough in addressing the potential barriers to autonomy in interactions between patients and physicians. If

physicians were to be open and honest about their values and expectations, that might diffuse some of their epistemic power, thereby leaving more room for patient involvement in decision-making.[7] But as we have seen, physicians gain at least some of that power through the technology they use to support their diagnoses, and medical anthropologists have shown that for many of us, the authority of medical technology goes unquestioned (e.g., Davis-Floyd 1992, Browner & Press 1997). Although much of medical technology is extremely useful, not all of it warrants the exalted status it has in our society. Maternal serum screening, which is a form of prenatal genetic screening, is an example. It has a false-positive rate of approximately 5%, increasing to over 40% for women over the age of 35 (Mennuti 1996, 1442). The screening tests a woman's blood for serum markers that are predictive of Down's syndrome and open neural tube defects.[8] It can inform her only of her individual *risk* for having a fetus with either of those types of genetic anomalies. Thus, the meaning of a "positive" result tends to be ambiguous not only because of the high rate of false positives, but also because the result is still only an indication of risk. In spite of that ambiguity, as Browner and Press have found (1995), very few women refuse maternal serum screening when it is offered. Although a variety of factors may influence whether they consent to that test (as I illustrate in the first case below), one of those factors may simply be "the power of medical technology."

The crucial element missing in most process accounts of informed choice is the way in which oppression can undermine patient autonomy. Those accounts tend to leave out an important condition for autonomy (one I outlined in chapter 5) that the formation of the self-concepts, values, and goals of agents are not influenced by coercive forces,

including forces of oppression. Such coercion is not necessarily directed toward or away from one of the patient's options (Sherwin 1998, 26),[9] whereas advocates of the process model usually assume that coercion must have that focus (see, e.g., Beauchamp & Childress 1994, Faden & Beauchamp 1986). Oppressive stereotypes can influence the self-appreciation of some patients, and the threat posed by those stereotypes can be heightened in interactions with physicians, the majority of whom are members of dominant groups. Oppressive norms may have the overall effect of inhibiting some patients from participating at all in the decision-making process. It is not enough to recommend that all patients be encouraged to participate because the reasons why some do not are more complex than the mere absence of encouragement. For example, some patients lack self-trust, which means either that they will not be inclined to participate or will only participate in such a way that they are deferring, ultimately, to the judgment of others, such as the judgment of their physician.

There are many obstacles in health care settings to the formation of justified attitudes of self-trust for patients who are oppressed. I have identified many of those obstacles already, and I identify a few others in this chapter. However, my main purpose here is to explain how physicians can minimize those barriers, and how the practice of medicine can be conceived differently to make room for the preservation or promotion of patient self-trust. My discussion centres around the area of obstetrics, but many of the recommendations I make are relevant to other areas of medicine. I want to emphasize that by focusing on obstetrics, my intention is not to reinforce the hegemony of physicians in caring for pregnant women. In fact, I accept that midwives and doulas tend

to be better than physicians at promoting the self-trust of patients. Moreover, I recommend that the obstetrical care of pregnant women be more inter-disciplinary than it currently tends to be, so that social workers, for example, and other types of counsellors, play a more integral role in it.

3. Promoting Self-trust Around Prenatal Diagnosis:

3.1 Patient Trust in Choosing well

The theory of autonomy I defended in chapter 5 is more elaborate than the standard theory in contemporary bioethics. For example, I argued that at the level of choosing well, agents must have more than just decisional capacity and understanding. They must identify with the values and beliefs informing their choices, and they also must trust their ability to choose well. That self-trust is contingent on whether they can trust the source of the information they use to understand their situation. It also must be grounded in some knowledge of the accuracy of their decision-making skills, and of whether they are competent and committed to do what their decision requires of them (if anything). As I argued, self-knowledge is a substantive condition for autonomy, and therefore, the self-trust motivating us to choose autonomously must be justified.

In this section, I use cases to illustrate the potential barriers to patient self-trust at the level of choosing well. Some of those barriers emanate from oppressive forces that inhibit women's reproductive autonomy. Others appear in health care contexts more generally--that is, in contexts where women's reproductive health is not necessarily at

issue. The first case I use, and my discussion surrounding it, are based on clinical observations I made of patients and practitioners in prenatal clinics and genetic counselling sessions while doing a clinical practicum in ethics and obstetrics as a Ph.D. student.[10] The case is also consistent with sociological and anthropological literature on the pressures many women tend to feel in Western culture when deciding whether to undergo genetic testing in pregnancy.

Case 1

Lara is a 37 year-old woman, pregnant for the first time. At her first prenatal visit, she asks her obstetrician about prenatal diagnosis. She is told that the generic risk for a person of her age for having a child with Down's Syndrome is 1 in 227 (~0.4%) and the total risk for chromosomal abnormalities is 1 in 130 (~0.8%). Her options are the following: 1) chorionic villus sampling (CVS), which is a diagnostic test taken at 10 to 11 weeks, and which carries with it a 1 to 1.5% risk of pregnancy loss; 2) an amniocentesis at 16 to 17 weeks, which is also diagnostic and has a 0.5% loss rate; 3) or, maternal serum screening at 16 to 17 weeks, which will not diagnose a fetal abnormality, but will tell Lara her individual risk for having a child with Down's syndrome or an open neural tube defect. If the screening test is positive, she can elect to have a detailed ultrasound and/or an amniocentesis. Depending on the timing of her screening test,

she would receive the results of her amnio at about 19 to 20 weeks.[11]

Lara tries to determine what her risk for having a child with a disability means to her and what the risks of the different procedures mean as well. Her financial situation requires that she work, and she is worried that her work schedule would not allow her to care properly for a child with a disability, a child for whom she would be the sole care-giver. Intellectually, she is not opposed to abortion, but emotionally, it is difficult for her to imagine terminating this pregnancy, for she has longed to have a child for years and, until now, has had no success in conceiving. Hence, the loss rates of the diagnostic procedures worry her considerably. She is also concerned that any choice she makes would elicit negative responses from people she respects.[12] For example, if she decides to forego the diagnostic tests, some would regard her as irresponsible. If the results of an amnio, undergone after serum screening, convince her that she should terminate her pregnancy after 20 weeks, then some would wonder if she had any maternal instincts at all.

The complexity of her options and the conflicts among her concerns and desires leave Lara profoundly confused. She desperately wants to make the right decision, but is not sure that she is capable of determining what that is.

Lara is in a classic double bind situation, originating partly in the mixed messages she

receives from her society about prenatal genetic testing. If she refuses testing, she is irresponsible, for a strong voice in her community assumes it is irresponsible to bring a child with a disability into the world. It might be irresponsible for Lara to refuse, moreover, if she could not care properly for a child with a disability, given her financial situation. Consenting to testing, on the other hand, could place Lara on a path toward a second-trimester abortion, which is a heartless act for any mother, according to the dictates of at least one segment of Lara's community. It would also be an extremely difficult act for Lara because of her past history of infertility.

Lara distrusts that she will choose well about prenatal testing because of the double bind she is in and also because of the complexity of her options. Her options are complex because of the small risks they entail for Lara and for her potential, future child. Weighing small risks is difficult for anyone and it is especially difficult when one's values or goals conflict in the relevant domain. Interpreting risks involves making value judgments, for what a risk means, however small, depends on how much we devalue whatever we are putting ourselves at risk for. Lara is probably confused about what a 0.4% risk for Down's should mean for her, not only because it is such a small risk, but because she does not know how much she should devalue having a child with a disability (compared to maybe having no genetically related child at all). Even if that risk were to increase significantly, say to 4.4%, she would not necessarily be in a better position to choose well. Hence, the option of discovering what her individual risk is through maternal serum screening may not be very appealing.

While individual obstetricians cannot be expected to free women from the double

binds of prenatal genetic testing, nor eliminate the difficulty for them of deciding in the face of small risks, they can give them the support, time, and information they need to sort through their decision. For example, Lara's obstetrician could give her equal support for authorizing testing or for refusing it, as well for the termination or the continuation of her pregnancy if she learns that her fetus has a genetic abnormality. Contrary to what some advocates of the process model recommend, it is not always appropriate for physicians to reveal their values to patients. In the context of prenatal diagnosis, they should refrain from adding to the pressure that many women feel to "be responsible" and have some testing done. One study found that 75% of women believe that they would not be able to refuse an offer of prenatal diagnosis once that offer was made to them during a pregnancy (Sjogren 1988, cited in Gates 1994, 188).[13] There is already a strong connection, in North America especially, between maternal responsibility and prenatal diagnosis (Mitchell & Georges 1998, 118; Charo & Rothenberg 1994). However, as the case of Lara reveals, that connection is riddled with inconsistencies. "Good mothers" do not risk bringing a child into the world with a disability (Charo & Rothenberg 1994), but how "good" can they be as mothers if they can terminate a pregnancy in the second-trimester?

It is questionable whether some pregnant women autonomously accept the responsibility of undergoing prenatal diagnosis. Some have values conflicting with that view of their maternal obligations, and furthermore, with that kind of medical intervention in pregnancy. Not all women, or men, are adverse to having a child with a disability, for example, and that is especially true of parents who already have such a

child (Wertz, Rosenfield, Janes *et al* 1991, cited in Charo & Rothenberg 1994, 106). Others simply do not want to be placed in the position of having to choose "the kind of baby [they]'d get" (Rapp 1997, 138). Rayna Rapp has shown (contrary to the findings of Browner and Press, 1997) that many white middle-class women, in particular, are ambivalent towards prenatal diagnosis (1997). Many seem to feel that with that kind of medical intervention in their reproductive lives, they have less control over their pregnancies than they otherwise would (Rapp 1997, 139). Thus, it is not the case that for every woman, it is an autonomous choice to accept prenatal testing as her maternal responsibility. However, for many women, including Lara, rejecting testing altogether would not be an autonomous choice either. Some women may feel that they have little alternative but to seek testing because for them, raising a child with a disability is simply not an option, given their social and financial circumstances. Still, those women may not believe that it is any woman's maternal responsibility, necessarily, to have prenatal screening or diagnosis.

Some would argue that although the social pressure to have prenatal testing may limit the reproductive freedom of some women, that limit is justified because of the suffering and financial burden on society that accompanies the birth of a child with a disability. If women are morally obligated to have testing, then obstetricians and other clinicians should encourage them to have it, rather than support the options of authorization and refusal equally. However, that view is highly contentious for a number of reasons. One is that the diagnostic tests for fetal abnormalities rarely reveal the degree of suffering that a child with a disability will experience. A positive test result for many

conditions, including Down's syndrome, neural tube defects, and sickle-cell anemia, indicates only the presence of the abnormality but not the severity of it.[14] Furthermore, only a small percentage of disabilities are genetic, and thus, if it is in society's interest to prevent disability,[15] then before infringing on women's reproductive freedom, society is obligated to strive to prevent forms of disability that are not genetic (e.g., by improving road safety or the safety of workplace environments; see Charo & Rothenberg 1994).

In medical contexts where patients *do* have a moral responsibility to choose one option over another, it would be inappropriate for health care providers to support each option equally. Consider the example of a pregnant woman who is HIV positive and has the option of taking a drug during pregnancy that would significantly reduce the risk of viral transmission to the fetus. Her physician would probably be remiss in giving as much support to the option of refusal as she does to consent (which should not be confused with the act of revoking the former option). But prenatal diagnosis is not a situation of that sort--that is, one where it is clear where the woman's moral responsibilities lie--and, certainly, neither is infertility treatment, for example. In those situations, physicians should avoid disclosing their values to patients as much as possible, especially given the epistemic authority they wield with many patients.

Physicians could also help to loosen the double binds of prenatal diagnosis for a patient such as Lara with the aim of enhancing her trust in her decision-making capacity, by offering her some counselling to sort through her decision. Lara must develop that trust in a way that is justified if she is to choose autonomously. Thus, her self-trust must reflect some self-knowledge in her ability to make a choice that is consistent with her

goals and values, and that is realistic given her own competencies and commitments. For Lara to have that knowledge, she needs to be informed of the possible and probable changes that would occur in her life if she were to choose each of her options. Lara seems to assume that her life would be altered in mostly negative ways if she were to give birth to a child with a disability. But before she can know that with any certainty, she needs to find out what the known disabling conditions are of different genetic disorders and which social services would, in fact, be available to her if she had a child with one of those disorders who might live for a significant length of time. She should be able to seek counselling from social workers who could describe the available social services, and from genetic counsellors who could discuss with her the nature of different disabilities with genetic origins, and perhaps even get her in touch with parents who have raised children with those disabilities themselves.

Some would argue that proliferating discussion about a woman's decision of whether to terminate her pregnancy by adding or improving the kind of counselling I have recommended would simply increase the "tentativeness" of modern pregnancies. Barbara Katz Rothman urges that as a result of prenatal diagnosis, women are forced into "tentative pregnancies," where they are hesitant about developing an emotional connection with their fetus because they cannot know until the test results are back whether their pregnancy is truly wanted or unwanted (1986). Rothman's view suggests that if we want to allow women to have positive pregnancy experiences, it might be better, overall, not to even have prenatal testing as an option. But it is not clear that eliminating testing altogether is the solution, especially in an ableist society where social

assistance for the care-givers of people with disabilities and for those people themselves tends to be poor. Moreover, it is not the best solution for women who have fetuses with horrendous abnormalities (e.g., anencephaly) who would want to be spared the shock and emotional pain of giving birth to their child. Still, if women are to have the option of prenatal screening and diagnosis, it is important that they be adequately informed of it, and of the alternative of possibly having a child with a disability. Only then can they develop justified trusting attitudes towards their decision.

To advocate counselling in an obstetrical setting about raising children with disabilities is to object to the way "health care" is often understood in that setting. As Abby Wilkerson describes (1998), "providing health care" in medicine usually means fixing whatever physical problems patients have, but not attending to aspects of their social circumstances that might shape their health status. There is an implicit message conveyed in many physician-patient encounters that it is not the job of medicine to provide patients with information beyond biological facts and facts about medical treatments. But if patients are to trust their ability to choose well in a justified way, often they need information that goes beyond mere biology or pharmacology. They need health care that attends to the constraints of their social environments. As Wilkerson recommends, they need for medicine to interpret human health not in a purely biological way, but in a "biosocial" way, where the health status of patients is determined partly by their social context (1998, 133).[16] A patient, such as Lara, cannot trust herself to make a decision that would promote her health status or the status of her potential, future child, unless she knew what her future social context would probably be like for each of her

options. Physicians do not have the expertise to give out such information, but they can take the need for it seriously by advocating for the type of counselling I have recommended for patients in their clinics.

For patients to have justified self-trust at the level of choosing well, it is also crucial that they receive some information, and some guarantee, about the follow-up care they could expect upon choosing each of their options. Women, such as Lara, who are faced with the choice of whether to have prenatal diagnosis need to know whether, where, and for how long abortion services would be available to them if they were to receive a positive test result and decide in favour of terminating their pregnancy. If they were to choose prenatal testing without that knowledge, and had the goal of not having a child with a disability, then their choice would not necessarily enhance their self-direction. They might not have the option of a second-trimester abortion, given that in Canada at least, they have no legal right to have those services available. Normally, whether that option is available to them in Canada depends on how far along they are in their second trimester. Restrictions on when second-trimester abortions can be performed are dictated in Canada by hospital policy, which tends to vary from one province to the next.[17]

From the point of view of promoting patient self-trust, it is important that women and their partners have the time they might need to sort through the complex array of factors potentially influencing their choice of whether to have prenatal diagnosis or of whether to terminate a pregnancy when faced with a positive diagnosis. Providing that time by loosening restrictions on second-trimester terminations is not the best solution,

given how emotionally wrenching those abortions can be. Still, the current time pressures on couples to decide about prenatal diagnosis or pregnancy termination are inappropriate. For example, if the woman has a positive serum screen, she and her partner are usually forced to decide about further testing *during* an appointment for genetic counselling, where the results of the test are explained along with information about genetics and genetic disorders. Usually, a tentative appointment has been made already for prenatal diagnosis immediately following the counselling session, since the window of opportunity for further testing and for a possible termination is so small, given the restrictions on terminations (Charo & Rothenberg 1994, 109). Clearly, that gives women, or couples, very little time to absorb the relevant information and weigh all of the relevant factors. The counselling sessions need to come earlier in the pregnancies of women who opt for testing, at which point they and their partners should be encouraged to reflect on the information they receive, rather than be forced to reflect on it all of a sudden after they receive their test results.

But giving patients more time and more information with which to decide about prenatal diagnosis cannot ensure that they will be able to trust themselves in a justified way to choose well. Even if Lara were given ample time and information, she may persist in distrusting her ability to make the "right decision." Such self-distrust would be understandable because her decision is inherently difficult, given the small risks she must weigh and the various social factors she must take into account. Because of its inherent difficulty, Lara's obstetrician is in no better position than Lara to make the decision. In fact, the obstetrician is probably in a worse position given her limited understanding of

Lara's values and social circumstances. Hence, the obstetrician should not intervene paternalistically on the assumption that she knows better than Lara what is best for her with respect to prenatal diagnosis. Such a response would be unwarranted even if Lara were 47 instead of 37 (and so had a higher risk for Down's syndrome) and also had a family history of a congenital abnormality. In that case, even if her obstetrician felt strongly that Lara should consent to prenatal diagnosis, she should not take the decision away from her, especially since there is, in fact, no moral obligation on Lara's part to accept (or to refuse) testing.

The objection against paternalism in the above scenario is not that it is disrespectful of Lara's autonomy; the objection is that the obstetrician is not in any better position than Lara to know what to decide. It is not clear that there is any space for autonomy in that scenario because of Lara's persistent and profound self-distrust. Thus, if Lara were to *request* that her obstetrician decide on her behalf, it would probably not violate Lara's autonomy for her obstetrician to do so. Whether Lara defers to her obstetrician's judgment or struggles to choose from a position of profound self-distrust, she does not exercise her autonomy. By deferring, she only fulfills a desire to have someone else decide for her, and I would not count that even as a minimally autonomous act. Since there is no room for Lara to act autonomously, there would be no objection from the point of view of respecting her autonomy to a kind of paternalism that is consensual on her part. Still, there is good reason for her obstetrician to be uncomfortable in consenting herself to that solution, for to decide on Lara's behalf, she would have to assume at some level to know what is in Lara's best interests, which, as I

have suggested, would probably be an unwarranted assumption.

Overall, self-trust as a condition for autonomy should not be viewed as a potential avenue for paternalistic intervention. Like the condition of understanding, physicians have an obligation to promote or preserve self-trust in patients, but not to remove patients' decision-making authority if they do not trust themselves. Such a paternalistic response is inappropriate even where the physician *does* understand the values, goals, and social circumstances of the patient well enough to make a decision on her behalf that would truly promote her interests. If that is the case, then he also knows how the patient should be trusting herself, and he can encourage her to develop that trust in ways that preserve her autonomy. Part of providing such encouragement is for the provider himself to trust the patient to decide well. It is hard to expect a patient to trust her autonomy competency if her physician distrusts it, and hence, it is reasonable to suppose that physicians have an obligation to trust, or at least to cultivate trust, in the autonomy skills of their patients.

The distrust of some patients in their ability to choose well may persist because they cannot rely on the information they receive that is relevant to their choice. As I argued in chapter 5, to have self-trust at the level of choosing well requires that one can rely on the relevant medical information, which, in turn, requires that one can trust the purveyor of it. As Rapp has shown, some women are skeptical of the accuracy of the information provided by prenatal testing (1998, 155). Other women distrust medical professionals because of how members of their minority group have been treated by them historically, or even recently.[18] Rapp describes a case of a black couple who refused

amniocentesis once they discovered that the left-over amniotic fluid could be used in medical experiments (1998, 146, 147). They were informed that they could say "no" to its experimental use, but they refused nonetheless, which suggests that they distrusted the technicians not to experiment with it against their wishes. Their distrust probably stemmed from fears that the results of the experiments could be harmful to black people, just as the methods of performing some experiments in the past (e.g., the Tuskegee syphilis experiment) were harmful to them.

To bolster patient self-trust at the level of choosing well, it is therefore important for health care providers to gain the trust of their patients, and to strive to overcome barriers to trust in relationships with patients who may have good reason to distrust them. To do that, they must display moral integrity and competence in addressing their patients' health care needs. Acting with integrity means that they honour their commitments to patients, and if they fail to meet a specific commitment, that they at least try to make amends for the harm or disappointment they caused. Along with optimism about the competence and moral integrity of others, interpersonal trust also involves two different expectations, as I argued in chapter 2: 1) the expectation that the values of trusted others are similar to our own values in the relevant domain; and, 2) the expectation that they perceive their relationship with us similarly to the way in which we perceive it. To try to encourage the first expectation in patients, health care providers could state what they value generally about patient care. For example, they could assure patients that they are committed to promoting their well-being and to respecting their autonomy. Declaring such values to patients would be beneficial, unlike declaring values around issues such as

prenatal diagnosis and infertility treatment.

Also, to encourage patients to trust them as professionals, it is important for health care providers to assure patients that they perceive their relationship with them to be professional. Trust requires that the trusting person expect the trusted other to have a similar perception of their relationship, roughly, because the commitments that the former can expect the latter to fulfill differ depending on the type of relationship they have with one another. Hence, it would be easier for patients to trust health care providers to honour the sorts of commitments one would expect from different care providers if the latter ensured that their relationship with patients remained on a professional level.

However, health care providers should be cautious in trying to establish trust with patients whom they know or suspect to be in abusive relationships or who have histories of sexual, physical, or emotional abuse. Obstetrical patients are even more likely than other patients to be experiencing severe abuse because the abuse of women in heterosexual relationships tends to increase in pregnancy (Stewart & Cecutti 1993). People who suffer severe abuse often have problems with trusting, or distrusting, because they have trusted others whom they should have been able to trust, but who betrayed them severely (Herman 1992, 51, 52). Rather than perpetuate any damage to their trust skills, health care providers should not expect substantial trust from them until the patients have received sufficient evidence that the providers themselves are trustworthy (Lepine 1990, 275). What that would mean in practice, for example, is that in performing physical exams or procedures, physicians would continually ask those

patients if they are all right or feel comfortable, rather than simply expect them to assume everything will be all right and that they will not be violated (once again).

Abuse and oppression can also damage one's ability to trust oneself to make autonomous choices. A patient may, in fact, possess that ability but be convinced that she lacks it because she has internalized hateful messages from an abuser or from a racist, sexist, or classist society. Alternatively, her oppression or abuse may have starved her of the skills necessary for choosing well based on her own goals and values, and consequently, she may distrust her ability to choose well. Hence, the self-distrust of a patient in Lara's situation may persist not because of the complexity of her decision or because she cannot rely on the relevant medical information, but because she either cannot or does not know how to trust herself well. That patient would have a tendency to defer to the judgment of others whenever she is forced to make a decision. Rather than reinforce that tendency, physicians should take the time, if they can, to guide her through the decision-making process, or involve a counsellor in that process who could take the necessary time. If physicians were to allow that patient to defer to their judgment, they would only be perpetuating her self-distrust and the damage to her skill in self-trusting. Furthermore, they would be risking that the care she receives is inconsistent with whatever goals and values she may have that are relevant to her choice.

In this section, I have described a variety of ways in which health care providers can enhance justified self-trust in patients at the level of making choices about prenatal diagnosis, in particular. They can give equal encouragement for the decisions to opt for testing or to refuse it. They can ensure that patients have information that increases their

knowledge of the consequences of choosing each of their options and of whether they could cope with those consequences. Moreover, they can give patients as much time as possible to think carefully through the relevant factors and information that will ultimately inform their decision. Lastly, they can ensure that patients can rely on that information by allowing them to trust its source (i.e., the health care providers themselves).

3.2 Patient Trust in Acting on Choices: Combatting Stereotype Threats

Many of the barriers to self-trust at the level of acting on one's choices are similar to the barriers at the level of choosing well. For example, double binds can interfere at the former level by making a woman distrust her ability to act on a decision to forego prenatal testing because of a lingering desire to avoid the censure she would receive from some members of her community. Thus, many of the recommendations of how health care providers can reinforce or build a patient's trust in her ability to choose autonomously also apply for trust in the patient's ability to *act* autonomously. For example, providing equal support for each of the patient's options (where appropriate) can promote either form of trust. Promoting either in a justified way can also be achieved by disclosing the kind of information that would enhance the patient's knowledge in her ability to cope with the consequences of her decision.

In this section, I want to focus on a barrier to self-trust unique to the level of acting autonomously that concerns the power imbalance which often exists in patient-

physician relationships. The obstacle is a stereotype threat to patients, where the patient has not internalized what the stereotype says about her, but is anxious, nonetheless, about confirming the truth of it to her physician. I have often mentioned the influence of stereotypes in this thesis, but as yet, I have not discussed a case where a patient feels that influence without actually believing the stereotype.

Case 2

Melissa is 25 years old and in her second pregnancy. She has very little formal education, having quit school after grade 9. At each prenatal visit, her obstetrician asks her if she has any concerns or questions about her prenatal care. Melissa usually shakes her head, despite often having concerns. She is not normally shy, nor does she believe that her concerns about her pregnancy are trivial. She does not have a passive personality, nor does she lack confidence in her own judgment. The problem lies in her awareness of a stereotype in her culture of uneducated people as intellectually inferior to the educated. Melissa expects that her obstetrician's view of her is influenced by that stereotype, and she does not trust herself to be able to express her concerns or opinions to him without reinforcing the truth of that stereotype in his mind. Just to be on the safe-side, Melissa decides to keep her opinions to herself.

Whenever her obstetrician recommends something to her, Melissa

agrees with his recommendation. When he offers her prenatal diagnosis and tells her it is up to her to choose whether she wants it or not, she chooses it, assuming that he must believe she should have it, since otherwise he would not offer it. Moreover, Melissa assumes that being a member of the medical profession, he must be in favour of the use of such technologies, since whenever Melissa has met physicians in the past, they have always been quick to defend any new form of medical technology. Melissa herself would prefer not to have prenatal diagnosis, but does not want to risk having her physician think that she is therefore naive or ignorant.

Melissa does not distrust her own ability to make autonomous choices--she seems to trust her ability to decide what counts as a non-trivial concern about her prenatal care, for example. Also, within her own community, she trusts herself to voice her concerns, or to act on her own decisions. She lacks that trust, however, in the environment of her prenatal visits. There, she assumes she is in a world that constructs her differently than the world she normally inhabits. As Maria Lugones emphasizes, some stereotypes infect some "worlds" but not others, and as a result, the behaviour of people who are stereotyped can shift dramatically as they move between different worlds (1987).

Even if stereotypes are not internalized, they can influence our behaviour in ways that prevent us from acting autonomously. Lugones explains that I might internalize the construction of me in hostile worlds, or, alternatively, "I may not accept [that

construction] as an account of myself" (10). But even if I reject it, "I may be *animating*" the stereotype in the eyes of another (Lugones 10; her emphasis). I may be giving life to it, either intentionally--perhaps as a way of revealing its absurdity--or unintentionally, simply because I do not have complete control over the uptake of others. Those with "arrogant eyes" may perceive me through the lens of a stereotype even though there is little evidence of the truth of it in my behaviour (Frye 1983). If Melissa is right that her obstetrician believes in the stereotype of uneducated people, then even if she were to speak articulately and to ask intelligent questions about her prenatal care, it is possible that he would judge her stereotypically nonetheless. Still, Melissa assumes that she might have the ability to control how he perceives her. She simply distrusts that ability, which, in turn, inhibits her from acting autonomously.

Psychologist Claude Steele has developed a theory of "stereotype threats" confirming that behaviour such as Melissa's is not uncommon among people subjected to oppressive stereotypes (1995, 1997).[19] Steele has found that the threat of being judged stereotypically by others can cause some members of a stereotyped group to feel exceedingly anxious in some situations about the possibility of confirming a stereotype about them. His studies focused primarily on black students in the United States, and showed that while writing exams, they can develop intense anxiety about whether their results will confirm the stereotype of blacks as less intelligent than whites, and that anxiety can prevent them from performing well. As Steele argues, to feel the threat of a stereotype, one need not accept the truth of it, either on a conscious or an unconscious level. One might be inclined to interpret Melissa's behaviour by assuming that,

unconsciously, she does accept the stereotype of uneducated people. However, it is unnecessary to question her own explanation for why she is behaving passively; as she herself claims, she is concerned about reinforcing a stereotype in someone else's mind, not about actually living up to that stereotype.

But there is a stereotype influencing Melissa's behaviour that she does believe: one stereotype of physicians is that they rarely call into question the value of new medical technologies. Patients often arrive at clinics with preconceptions about the commitments of their health care providers. The preconception Melissa holds is probably common among patients, and so is the assumption, for example, that obstetricians have a strong bias in favour of creating "perfect babies." Given those stereotypes, what would probably amount to "equal support" from obstetricians for a patient's options in the context of prenatal diagnosis is for obstetricians to emphasize that they *do*, in fact, support the option of refusal. To minimize the influence of Melissa's stereotype of physicians, her obstetrician could tell her that he does not expect her to choose prenatal testing, but that if she were to choose it, he does not assume that she will want further testing or to terminate her pregnancy necessarily if the results are positive. However, care is needed in taking that approach, since it could send the message to Melissa that her obstetrician believes she is too stupid to understand what kind of choice situation she is in. The obstetrician should also reflect on his own motives for adopting that approach and ensure that he does not actually believe that Melissa is too stupid because of her lack of formal education.

It is important for health care providers to be aware of common biases and

stereotypes in our culture and do whatever they can to minimize their negative effects.[20] For example, instead of being complacent with passive patients, they could wonder whether they are experiencing a stereotype threat. They could even work with the presumption that patients are feeling such a threat if they are passive and they are the target of an oppressive stereotype. The perceived threat of stereotypes could be common in health care contexts, not only among patients who have little education in comparison to physicians, but also, for example, among female patients who have male physicians. The behaviour of the patient in such relationships may be influenced by the stereotype that she is less rational than the man before her or less capable of making sound judgments about her own interests.

Steele recommends ways of diminishing the threats of stereotypes (1997, 624, 625). He suggests being optimistic about the person's ability to perform well or to make good decisions, and challenging her with difficult decisions, which shows respect for her abilities. I have already proposed that obstetricians should display trust in their patients' abilities to handle decisions around prenatal diagnosis. They could do that while, at the same time, acknowledging how complex those decisions can be. The alternative of taking away the decision-making authority of passive patients who feel a stereotype threat would not only diminish their autonomy, it would also convince them, most likely, that they have confirmed the truth of the stereotype, despite their active efforts to avoid doing so. Furthermore, physicians could involve other practitioners or counsellors in communication with patients whom they suspect are experiencing stereotype threats. A female patient with a male physician or a patient who is less educated than her physician

may feel more comfortable expressing her opinions to a female doula or a female nurse.

Another barrier to self-trust unique to the level of acting on one's choices is the fear of losing the support of one's care-providers. That fear stands in the way of the patient's opportunity to refuse the advice of her physician, and therefore, it is a substantial obstacle to autonomy. Patients need to know from their physicians that if they refuse their recommendations, they will not be abandoned. There may be instances where physicians feel that going along with patients' refusals would threaten their professional integrity. Physicians could explain that possibility to patients ahead of time, even highlighting where those conflicts might arise, and promise their patients that were there to be an actual conflict, they would work toward a compromise or refer the patient to another care provider, unless, of course, the patient's request violated fundamental moral norms of our society (e.g., if the request was to have an abortion for the purposes of sex selection).

Aside from assurances against abandonment by a physician who might not support her decision and against the threat of being judged stereotypically, a woman deciding whether to undergo prenatal diagnosis clearly cannot trust herself to act on her own decision if she lacks bodily integrity. If a third party is dictating which decisions she makes in her pregnancy, and hence, usurping control over what happens to her body, then she will lack self-trust at the level of acting autonomously. However, that is not the only level at which an absence of bodily integrity can interfere with self-trust. I argue in the next section that bodily integrity is also important at the level of judging whether one truly endorses the self-concept, goals, and values that are reflected in one's choices.

3.3 Patient Trust in Her Own Judgment: Respecting Bodily Integrity

Autonomous agents must trust their own judgment about which self-concept, goals, and values should influence their choices. Furthermore, it is important that their self-conceptions are consistent with their own moral worth, since self-worth and self-respect are substantive conditions for autonomy. How agents conceive of themselves determines which values and goals they do endorse. If their self-conceptions are fragmented or confused, then they will likely be confused about what they want, need, and desire. We have seen some evidence of that in the case of Lee. The objectification she suffered during her infertility treatment alienated her to some degree from the needs, desires, and values with which she would normally identify as a self-respecting person whose status or worth is not reduced to the level of her reproductive capacity (or lack of capacity). She could no longer identify with that person that she once was, and her loss of identity made her distrust her judgment about what she needed and valued.

However, patients can lose trust in their own judgment without experiencing an assault on their identity as persons. As we saw with the case of Anna in chapter 3, a woman can be confused after a miscarriage about how she should value her fetus and interpret its death if others around her do not give uptake to her feelings. Anna's interpretation of her miscarriage was mediated by presumed or, perhaps, actual comments from others about how her miscarriage was "a blessing in disguise," or was a relatively insignificant event compared to a stillbirth, for example, especially since the miscarriage occurred early in the first trimester. Such comments are disrespectful of

Anna's own experience of pregnancy and miscarriage, an experience that clearly held greater personal significance for her than the comments suggest. Yet Anna could not trust her own judgment about the significance of that experience because her feelings about it contradicted what her society implied that she should feel.

Lee's self-distrust, and possibly Anna's as well, arose partly because they were denied what Catriona MacKenzie calls "bodily integrity" (1992).[21] The concept of bodily integrity is normally understood in debates on women's reproductive freedom as the ability to control what happens to one's own body (Boetzkes 1999, 121).[22] Mackenzie argues that our use of that concept should be extended to a woman's control over her "perspective" on her body, or on her bodily experiences. Such a perspective is always mediated by cultural and social images of bodies; we cannot expect to free ourselves of those images. Where we lose our bodily integrity is when we are persuaded to adopt bodily perspectives with which we do not identify. Lee did not identify with the view that her body, and more specifically, her reproductive bodily parts, are constitutive of her self. That view was reflected in the behaviour of those who ignored her existence and denied her emotional needs in the operating room before the hysteroscopy. In Anna's case, her self-distrust centred around the emotional significance of her pregnancy and miscarriage, yet that significance was probably bound up with how she perceived her bodily relation to her fetus. Anna may have assumed that in the minds of others that relation barely existed since the fetus was only six weeks in gestation before it died. But, in her mind, the fetus may have become a part of her already, which could explain, in part, why its death had such profound significance for her.

In this section, I argue that there are significant barriers to the kind of bodily integrity Mackenzie describes for patients in modern obstetrics, particularly in contexts involving prenatal diagnosis. Those barriers can interfere with self-trust, and hence with autonomy, at the level of the patient's judgment. Overcoming them would require that obstetrics become more woman-centred. It needs to be more respectful of the embodied relation of women to their fetuses (as opposed to constructing fetuses as "separate patients" from pregnant women), and more respectful of women's embodied knowledge of pregnancy.

Women often feel that they do not have control over their own perception of their bodies,[23] but they can feel that they have even less control in pregnancy, where they are subjected to inner as well as outer assaults on their bodily perspectives. In pregnancy, women must contend with cultural images of their inner bodies--that is, of their bodily relation to their fetus--as well as with the myths about their outer appearance. As many feminist theorists have noted, prenatal ultrasound has introduced into Western culture the image of the fetus as a free-floating entity (e.g., Overall 1993, 40-41; Petchesky 1987). Furthermore, enhanced images of the baby-like qualities of free-floating fetuses are used by pro-life activists to further their political agendas. By contrast, in some pro-choice literature (particularly in philosophy), fetuses are portrayed as parasitic beings that threaten to starve women of their freedom (see, in particular, Thomson 1971). Any of those constructions of the maternal-fetal dyad can conflict with the way that a woman experiences her own pregnancy and views her relation to her fetus. If she is pressured to perceive her pregnancy in light of one particular construction, then her bodily integrity

might suffer. She will almost certainly lose some bodily integrity if she is pressured to adopt conflicting perspectives on her pregnancy, which is the predicament of the protagonist in the film, *Citizen Ruth* (1996). Pro-life and pro-choice activists war to gain control over how Ruth views her pregnancy. Each group wants to use her as a symbol for their cause, offering her the resources she needs to continue on with her pregnancy or to have an abortion, respectively. There are scenes in which Ruth is utterly lost, not only because she is drug addicted, but also because she is forced to contend with these warring factions.

According to how Mackenzie defines bodily integrity in pregnancy, it demands a bodily perspective that is compatible with the way in which the woman views her moral responsibilities to her fetus, and presumably, also to herself. Mackenzie writes that bodily integrity,

> in pregnancy and abortion ... is a question of being able to shape for oneself an integrated bodily perspective, a perspective by means of which a woman can respond to the bodily processes which she experiences in a way with which she identifies, and which is consistent with the decision she makes concerning her future moral relationship with the foetus (151).

For example, if her decision about that relationship is to end it, but she is bombarded with pro-life images of fetuses, then she may lose her bodily integrity. Similarly, outside of or within pregnancy, the contempt for many women's bodies that cultural images of female beauty promote can conflict with a woman's conception of her own moral worth. Thus, those images are a potential obstacle to her bodily integrity.

But women can also become confused about where their moral responsibilities lie

or about whether they are, in fact, capable of being morally responsible, when they are encouraged to view their bodies in ways with which they do not identify. For example, when women are objectified according to cultural images that are disdainful of their bodies, they can come to question their own moral worth, rather than merely lose bodily integrity. Similarly, women such as Anna who miscarry can become confused about whether they had any moral responsibility for a fetus whose death is deemed insignificant by others. Thus, the forces that compromise bodily integrity can also generate distrust at the level of evaluating one's own (past and present) moral values and commitments.

As many feminist theorists have argued, the dominant construction of pregnant bodies in modern obstetrics is that of a female body and a fetus, who is a "second patient" (Mattingly 1992, 17; also see Rothman 1989, 160; Overall 1993, 40-41).[24] That is the image against which many women learn to redescribe their bodily perspectives on pregnancy when they undergo prenatal care. North American women confront that image during ultrasounds, and the reason why is not only that the technology itself gives them an actual image of the fetus with them "nowhere in view" (Overall 1993, 41). Medical anthropologists, Lisa Mitchell and Eugenia Georges, explain how in North America especially, physicians and sonographers usually relate to the fetus of the ultrasound image as though it were an active, socialized, and independent agent (1998). For example, they tend to describe fetal movement as "'playing,' 'swimming,' 'dancing,' 'partying,' and 'waving'" (108). They make comments about its personality, such as its shyness or its cooperativeness (109).

The obstetrical construction of fetuses as separate patients can disrupt a woman's

own perspective on her pregnant embodiment as well as her perception of the moral relation between herself and her fetus. Mackenzie argues that women experience that embodiment as the gradual differentiation between themselves and the fetus. In her phenomenological account of pregnancy, she writes that "from the perspective of the woman, the foetus becomes more and more physically differentiated from her as her own body boundaries alter" (1992, 148-149). In the early stages of that process of differentiation, the fetus is more like a part of her than a distinct entity. That may not be true for all women, especially those in unwanted pregnancies, who may perceive the fetus early on in pregnancy as being more like an alien being than a part of them. But what is often alien for many women in the early stages of wanted pregnancies is the idea that the fetus is somehow separate from them. Consequently, many women may experience an early ultrasound, carried out in the way that Mitchell and Georges describe, as an assault on their bodily perspective.

If all of the attention of sonographers is focused on the fetus as an independent and active agent, then the woman also might feel objectified by that experience. The more that the fetus is constructed as separate from her while it is still growing inside of her body, the more she becomes the mere "maternal environment." That perception of herself in pregnancy is inconsistent with a decision to be morally responsible for her fetus, as well as for herself. A passive environment cannot be morally responsible for anything; it exists merely as a backdrop against which others can be responsible for one another (i.e., against which sonographers or physicians can care for her and for their second patient). The effect of such objectification on women can be a loss of bodily

integrity along with self-distrust about their own moral role in pregnancy.

Some women also face the image of themselves as *hostile* maternal environments in the context of prenatal diagnosis, an image which can radically alter or confuse their perspective on their physical and moral relation to their fetus. Consider the following case, documented by Rapp, about a woman's response to amniocentesis (1997, 131):

Case 3

> I cried for two days after I had the test. I guess I was identifiying with universal motherhood; I felt like my image of my womb had been shattered. It still feels like it's in pieces, not like such a safe place as before. I guess technology gives us a certain kind of control, but we have to sacrifice something in return. I've lost my brash confidence that my body just produces healthy babies all by itself, naturally, and that if it doesn't, I can handle whatever comes along as a mother. (Carola Mirsky, white school teacher, 39)

It sounds as though Carola's experience of amniocentesis was mediated heavily by the view that a woman's body is an *un*safe place for a fetus. Presumably, an amniocentesis can be carried out in a way that is less likely to cause such a harmful shift in a woman's bodily perspective. The test itself may be essentially destabilizing for women who perceive their bodies as places where healthy fetuses can grow, yet its destablizing

effects are greatly enhanced when the test is performed by someone who does not share that perception. Like women who are mere maternal environments, women whose bodies are essentially hostile toward fetuses cannot be morally responsible for them. They will inevitably cause them harm. That conclusion might explain why Carola lost her confidence in her ability to "handle whatever comes along as a mother." She might have reasoned that if she could not be responsible in pregnancy, how could she expect herself to be responsible in motherhood?

Thus, the images of pregnancy and fetuses that tend to pervade contexts involving prenatal diagnosis can form a barrier to bodily integrity as well as to a woman's capacity for moral integrity. In their most extreme form, those images can promote distrust in a woman's judgment about whether she could even be morally responsible in the ways that she assumes she should be. At the same time, they threaten her self-worth and self-respect, which are essential self-regarding attitudes for autonomy, independently of self-trust. In their less extreme form, those images may simply generate distrust in a woman's own judgment about her physical relation to her fetus.

The images of pregnancy conveyed in obstetrical encounters are so powerful for many women because of the culturally sanctioned, epistemic authority of medicine. That authority itself can lead to disintegrated bodily perspectives for women whose embodied knowledge of pregnancy (i.e., knowledge gained through their own perception of what is happening in their bodies) conflicts with the supposedly disembodied knowledge of health care providers. If there is a "contest" over knowledge of the fetus between the woman and her health care provider, then the woman usually loses, especially if the

provider's knowledge is backed by the power of medical technology. Mitchell and Georges illustrate that point with various examples, including that of a woman who told her sonographer, "We could see [the fetus] moving and ... I felt it when I was taking the Metro. She said that wasn't it, that I couldn't feel it until a few more weeks. I thought for sure it was the baby moving, but I guess not" (1998, 110). There was a similar outcome to the contest over knowledge I described in chapter 3 between Janet, who claimed that she was pregnant, and her physician, who doubted her. When women are encouraged to simply ignore their own embodied or experiential knowledge of pregnancy, it is difficult for them to maintain a coherent bodily perspective. They have to continually explain away the significance of their own bodily experience. The result can be distrust in their own perceptions of their bodies and of what is happening in their pregnancies.

Thus, the bodily integrity of pregnant women in modern obstetrics is threatened both by the construction of the fetus as a separate patient and by disrespect for a woman's embodied knowledge of pregnancy. The former threat to bodily integrity can be a barrier as well to self-respect and to self-trust in a woman's perception of where she stands, morally, in relation to her fetus. Both obstacles to a woman's bodily integrity can encourage distrust in her own judgment about which beliefs about her pregnant embodiment should influence the choices that she makes about her pregnancy.

To remove the potential barriers in obstetrical contexts to women's bodily integrity and to self-trust at the level of their judgment, substantial changes would have to occur in obstetrics. Overall, there would have to be a shift toward what I have called "woman-centred obstetrics," where fetuses are constructed in relation to pregnant women

and respect is given for a woman's own knowledge of her pregnancy. Although there may be obstetrical contexts where viewing fetuses as separate patients is appropriate (e.g., in fetal surgery), in most contexts, they should not be constructed as separate or independent entities. Throughout ultrasound scanning of fetuses, for example, sonographers and physicians should try to avoid descriptions of fetuses suggesting that they are self-sustaining agents.

Constructing the fetus as a separate being is morally problematic because it can objectify pregnant women; however, it can be equally problematic to assume that all women in wanted pregnancies interpret their embodied relation to their fetus in the same way. For some women, the fetus may feel more like a part of them than it is for other women. It is important that health care providers respect the unique ways in which women might be experiencing their pregnancies, as opposed to dictating to them what their experience should be about. Part of the job of being an obstetrician is to offer women advice on how they should be perceiving their pregnancies, but obstetricians can do that without imposing alienating bodily perspectives on women. Obstetrics may inherently involve some negotiation between health care providers and patients about which bodily perspectives patients should adopt. However, the risk of avoiding negotiation altogether, and being authoritarian instead, is the undermining of patient self-trust and autonomy.

Similarly, in the contexts of miscarriage and abortion, it is important that health care providers be sensitive to the unique ways that women might interpret the pregnancies they lost or purposefully ended. However sympathetic health care providers

are to women in those contexts, they can cause harm by simply assuming that the women view their pregnancy experiences in specific ways. Such assumptions can promote distrust in women's own perceptions of their miscarriages or abortions, and that self-distrust can interfere with autonomous behaviour in overcoming those experiences or in truly understanding their personal significance.

To improve respect in obstetrics for women's embodied knowledge in pregnancy, there would have to be substantial changes to the existing medical epistemology. There is now little room in that epistemology for embodied subjectivity, as authors such as Foucault have argued (1975; cited in Wilkerson 1999). There is only room for "pure facts," known through objective scientific analysis and untainted by the subjective views of physicians and researchers. Not only is that kind of epistemology implausible, it can also lead in medical contexts to a loss of bodily integrity in patients. Health care providers need to be aware that if they are dismissive of the embodied knowledge of pregnant women, they may actually compromise the bodily integrity of their patients as well as their autonomy. Instead, they should try to incorporate that knowledge as much as possible into the bodily perspectives they encourage pregnant women to adopt.[25]

4. Where a Patient Trusts Herself too Much: The Role of Integrity-Preserving Persuasion

But what if a woman trusts her embodied knowledge of her pregnancy too much? Or, alternatively, what if she trusts herself to choose in ways that are divorced from an adequate conception of her own worth? In the former type of case, the patient might

assume that she is being responsible in trusting her own perceptions of what is happening in her body, when, in fact, her perceptions are unreliable. In this section, I introduce Martin Benjamin's notion of "integrity-preserving" persuasion, or compromise (1990), as a way for obstetricians to deal with too much self-trust in patients without destroying their self-trust at the same time. Preserving integrity helps to preserve self-trust because self-trust is an attitude about one's moral integrity. As I shall explain, however, there are clear limits to the usefulness of Benjamin's method of persuasion for solving the problem of unjustified self-trust in patients.

First, though, I want to emphasize that health care providers are often not in a position to assess whether a patient has too much self-trust because she has an unrealistic conception of her own competencies or of her ability to cope with the consequences of a decision. Health care providers are not in that position in many obstetrical situations, including many situations involving prenatal diagnosis and the termination or continuation of a pregnancy. For example, if a woman decides to continue a pregnancy knowing that her child will have a genetic disorder, and she has received ample information about raising a child with that disorder, then normally only she and people close to her can judge whether her trust in that decision is justified.

But there are some circumstances where health care providers can assess whether a patient is trusting herself too much because of inadequate self-knowledge. For example, if a woman decides to reduce her smoking dramatically during pregnancy without accepting any form of treatment, and she has often said in the past that she would quit but has never succeeded, then her physician could conclude that her trust in

her decision is probably unjustified. That does assume, however, that the woman has not been claiming to quit all along only to please or appease her physician.

When it is clear that a patient is trusting herself too much and in a way that could jeopardize her own health or the health of her fetus, health care providers could attempt persuasion that is integrity-preserving. That method involves encouraging the patient to consider *all* of her values and beliefs, and how her current position may not reflect all of them accurately (Benjamin 1990). As Benjamin writes, the aim "is to strengthen or encourage the recognition of [an] unacknowledged voice in the [patient]," rather than to coerce her to take a position that is somehow alien to her (1990, 34). For example, with the patient who trusts herself too much to quit smoking, the physician could assume that she knows she was unsuccessful in quitting on her own in the past, and ask her to reflect on that knowledge carefully. She, the physician, could also assume that the patient values her own health and the health of her fetus (at least to some degree), and that she knows that heavy smoking is hazardous to both of them. Thus, the physician could urge that from the patient's own perspective, it is important to choose a method of quitting that has the best chance of success. That form of persuasion is integrity-preserving, for the physician is only trying to persuade the patient to adopt a position that is already coherent, hopefully, with the patient's own beliefs and values. A physician who uses that method would only encourage a patient to change one of her beliefs or values if the majority of her beliefs and values demanded the revision.

Clearly, the usefulness of integrity-preserving persuasion is limited, however. A physician may be mistaken in assuming that a patient has latent desires or values that are

unacknowledged in the decision which she trusts so much. If the patient makes a choice that puts her own health at risk, for example, but she is suffering from depression or simply has low self-worth, then her physician might be wrong in assuming that she cares about her own health. Similarly, if a patient trusts her embodied perspective too much (e.g., she is adamant that she is not pregnant even though there *is* sufficient medical evidence to prove that she is), her physician might suspect, wrongly, that she values being a responsible knower or that she believes that medical information and technology has some epistemic worth. Especially where the values and beliefs of patients and providers diverge dramatically (e.g., on whether medical technology has any epistemic value), it is unlikely that integrity-preserving persuasion will work.

Still, it is worth at least attempting such persuasion, particularly before ever recommending that a patient lose her decisional authority. Even with patients who trust themselves in ways that are incompatible with respect for their own worth, integrity-preserving persuasion could work. Because the voices of physicians are so powerful for some patients, it could be persuasive for a patient to hear from a physician that she should attend more to her own needs, rather than focus merely on the needs of others. However, it is unlikely that a physician, alone, could make inroads with patients whose self-worth or self-respect has been damaged severely by oppression or abuse. In such cases, if the patient is trusting a decision that puts herself at grave risk of serious harm, then some counselling for the patient is appropriate with someone trained in helping people with histories of abuse or oppression.

5. Conclusion

For patients to be autonomous, they need to be able to trust themselves. Self-trust is not the only requirement for patient autonomy, but it is a requirement that is overlooked in almost all philosophical and bioethical accounts of autonomy and informed choice. The relation between self-trust and autonomy has theoretical implications for the way that we conceive of autonomy and of the value of trusting the self. Moreover, as I have argued in this chapter, it has profound practical implications for our understanding of the duty to respect patient autonomy, particularly in obstetrics. Attending to patient self-trust as a precondition for autonomy is crucial in obstetrics and in other areas of reproductive medicine because of the enormous weight that oppression can bear on the ability of women to trust themselves in those contexts.

Many of the recommendations I have made in this chapter about improving respect for patient autonomy in obstetrics cannot be found in existing models of informed choice, including the process model. It is implicit in that model that patients should have sufficient time and information to assess their options. Yet many of the barriers in obstetrics to self-trust are more serious than the mere lack of time or information. Many concern the power imbalances in obstetrician-patient relationships, imbalances that often exist because of the threat of sexist, classist, and/or racist stereotypes, or simply because of the authoritative epistemic position of obstetricians. There is also the barrier of the construction of pregnancy as a relation between separate entities, which permeates obstetrics and can interfere with self-trust at the level of the

patient's judgment about the values and beliefs informing her choices. Obstetricians need to try to eliminate or at least minimize those barriers for the sake of promoting patient autonomy. They could do that, in part, by avoiding complacency with passive patients who might be experiencing stereotype threats. They and other health care providers also need to be alive to the importance of appreciating a woman's own bodily perspective in pregnancy, and to be respectful, as opposed to dismissive, of her embodied sense of what is happening in her pregnancy.

On the theoretical side of the relation between autonomy and self-trust, I have argued in this thesis that the skill of trusting oneself well--that is, of developing justified attitudes of optimism about one's own moral integrity and competence--is one of the skills involved in what Meyers calls "autonomy competency" (1989). As I have proposed, that competency also demands the skill of distrusting the self well. Self-distrust can avert the damage that hasty choices can have on our autonomy. Lara's case is an example of where some self-distrust may be justified, at least temporarily, with respect to a particular decision. Like most people, Lara is probably not a reliable self-truster when she is forced to decide quickly about issues as complex as prenatal diagnosis is for her. However, if Lara's self-distrust were to persist, it could threaten her autonomy. Too much self-distrust, even if it is justified, is an obstacle to the expression of one's autonomy competency.

Melissa's case is an example of where self-distrust is probably justified, yet it interferes with autonomy nonetheless. Melissa does not trust herself to be able to convince her obstetrician of her ability to make wise decisions about her prenatal care

because of the threat of being stereotyped. Since members of stereotyped groups can animate stereotypes about them even while they strive to disconfirm their truth, it can be unreliable for them to trust themselves to succeed in that goal. Stereotypes are more likely to be threatening if they are demeaning to those whom they target, and the most common targets of negative social stereotypes are oppressed people. There may be many more situations, then, in which it is unreliable for the oppressed to be self-trusting, yet reliable for the privileged simply because of the influence of those stereotypes. As I have argued, one's socio-political status tends to determine, in part, when it is reliable to trust or distrust.

Oppression as well as abuse can interfere with either the manifestation or the acquisition of the skill of trusting the self well. Various mechanisms of oppression, such as stereotyping and objectifying, can encourage too much self-distrust in people who possess the skills of trusting and distrusting themselves well. Those mechanisms, along with abuse that is not oppression-related, can also damage or hinder the development of those skills. Some people living with the trauma of childhood abuse or in an environment of severe oppression may never have experienced what it is like to be self-trusting most of the time. Self-distrust may be a constant feature of their lives and a constant impediment to settled opinions about what they value and desire in many contexts.

Partly for the sake of those who live in perpetual self-distrust as a result of abuse or oppression, I have strived in this thesis to demonstrate that the concepts of self-trust and self-distrust are meaningful, and moreover, that we are obligated to foster and

preserve self-trust in one another since that attitude is necessary for autonomy. I have also made those arguments for the sake of patients such as Lee who are forced into positions in health care contexts where they cannot trust themselves. My concern has focused on how women's self-trust can be undermined in reproductive medicine in ways that threaten their reproductive autonomy.

I have established that understanding the relation between autonomy and self-trust is important to bioethics, moral philosophy, and feminist theory. In bioethics, it improves our grasp of how health care providers can relate to patients in ways that are respectful of their autonomy. It expands our understanding in moral philosophy of the nature of autonomy and of the conditions that promote it. Furthermore, a feminist account of self-trust as a condition for autonomy brings to light yet another way in which oppression works to disempower some members of oppressed groups.

Notes

1. The closest approximation I have seen to that recommendation is in a paper by Abby Wilkinson on "The Medicalization of Violence against Women." Wilkinson writes that "[w]omen need to be able to trust our own perceptions of our bodies and our experiences, a goal that medical theory and practice should respect and support" (1998, 133).

2. There, I draw on an argument by Catriona Mackenzie (1992) that women need to be able to define for themselves their pregnancy experiences if they are to maintain their bodily integrity and reproductive autonomy.

3. That is usually what happens with most forms of genetic testing for fetal abnormalities. Patients are told that they have the *option* of having maternal serum screening, and perhaps even of having amniocentesis or chorionic villus sampling (see Case 1 for a description of these tests). However, I have encountered physicians who

will recommend testing rather than simply offer it, particularly for patients who are at higher risk than the average patient of having a fetus with genetic abnormalities.

4. Moreover, in the study they performed, they did not find any significant ethnic or class differences in women's attitudes toward the medical advice they receive about pregnancy (115). However, they do acknowledge that a number of other studies have documented such differences (they cite, for example, Kay 1980, Lazarus 1994, Rapp 1993).

5. The term "informed choice" is still not widely used in the philosophical, legal, and medical literature, but, following Baylis, I shall use it in this chapter.

6. Physicians do preliminary assessments of decisional capacity and seek psychiatric consultation if a patient seems to lack that capacity.

7. However, as I argue below, it is not always appropriate for physicians to reveal their values to patients.

8. Versions of the test vary depending on how many markers are analysed. The "triple screen" is meant to be the most effective; it tests the serum levels of three different substances. Still, its false positive rates are high (they are the rates I gave above; see Mennuti 1996, 1442-1443).

9. It may be directed, more generally, at the competence of the patient in making decisions that reflect her own values or interests, for example. For a discussion of why oppressive forces that target the self-appreciation of patients count as coercive forces, see chapter 5, section 2.

10. I did that practicum over a period of about six months. I attended, on average, one clinic per week (where that includes prenatal clinics, ultrasound and amniocentesis clinics, and infertility clinics), and I witnessed about three or four genetic counselling sessions. I did not interview patients, but simply sat in during their appointments, with their consent.

Francoise Baylis was the coordinator of my practicum, and she gave me invaluable advice in that capacity. I would like to thank her along with my on-site supervisors, Barbara Parish and Glenn Gill. I would also like to thank all of the health care practitioners on-site who included me in their clinics.

11. As Dr. Barbara Parish confirmed for me, these are the options and risks for a 37 year-old woman who is receiving prenatal care at the IWK Grace Health Centre in Halifax. These risks for the diagnostic procedures are also given in a paper by Michael Mennuti (1996).

12. That concern is common among women, according to nurse Diane O'Reilly, who works in grief counselling for women who have had pregnancy terminations because of

fetal abnormalities (personal communication 1998).

13. It is sometimes assumed that middle-class women accept testing more often than women who are "working-class or working-poor," which suggests that the former might feel more obligated than the latter to accept it (Rapp 1998, 148). However, as Rayna Rapp explains, if poor women have access to a clinic where they feel comfortable and trust their practitioners, they are just as likely as middle-class women to consent to prenatal diagnosis (1998, 149, 150). Thus, the disparity in the rates of their refusal compared to middle-class women often has more to do with inadequate prenatal care services for poor women than with their attitudes toward testing.

14. That is true for all "mosaic conditions," where the fetal cells are "both normal and atypical in varying proportions" (Rapp 1998, 163). It is also true that the disabling conditions of some genetic anomalies are completely unknown to geneticists (see Rapp, 161, 162).

15. And, it is important that society express that interest in a way that does not further stigmatize and oppress people currently living with disabilities. See Laurie Nsiah-Jefferson (1994, 234) on how the very availability of prenatal diagnosis can perpetuate ableism.

16. Wilkinson in her paper focuses on the issue of domestic violence and the woefully inadequate way in which medical institutions tend to deal with that problem (1998).

17. Some American authors, such as Alto Charo and Karen Rothenberg (1994, 111), have pointed out that while the pressure on women to have prenatal diagnosis is increasing, their access to adequate abortion services and counselling in the United States is decreasing.

18. For example, distrust in medical professionals in the context of prenatal care may have been heightened recently among some aboriginal women in Canada because of the actions of a Manitoba physician who had an aboriginal pregnant woman who was addicted to solvents committed against her will for addiction treatment (see Winnipeg Child and Family Services (Northwest Area) v. G. (D. F.), S. C. C.).

19. I learned of Steele's studies from reading Walker (1998, 196, 197).

20. Clearly, health care professionals alone should not have that responsibility, especially in deflating stereotypes about oppressed people. However, they can play a role in reducing the negative effects of those stereotypes.

21. She also calls it "bodily autonomy," but I shall avoid that terminology. As I explain, whether we have bodily integrity influences whether we are autonomous, but "bodily autonomy" suggests that our bodies can be autonomous--that is, that they can choose and act in accordance with a set of values and beliefs--which is incomprehensible.

22. As Catriona Mackenzie explains (1992), that is how many philosophers use the concept to defend women's right to refuse unwanted interventions in their pregnancies, or simply to refuse to continue unwanted pregnancies (see, e.g., Warren 1975, Overall 1987).

23. Women in Western culture have few options for how to view their bodies because the cultural images of women's bodies are so narrow and exact. It is possible for them to construct bodily perspectives that are imagined variations on the dominant images. But to view their bodies continually in light of imagined alternatives is extremely difficult because of how much their bodily perspectives tend to be patrolled by others, who pressure them to conform to dominant beauty standards for women.

24. Many textbooks on obstetrics reveal the patient status of fetuses right in their titles: examples are *The Unborn Patient: Prenatal Diagnosis and Treatment* (Harrison *et al* 1990) and *The Fetus as a Patient* (Kurjak 1985).

25. As a model of how to be respectful of women's embodied knowledge in pregnancy, obstetricians could turn to midwifery. Midwives, in general, learn to value that knowledge.

Appendix

The Cases

INTRODUCTION

Lee:

Lee, a nurse and a counsellor, entered an infertility program feeling confident about where her boundaries lay in terms of how much she was willing to go through emotionally, spiritually, and physically in trying to get pregnant. She left the program feeling powerless, objectified, and as if her identity had been threatened. Those feelings arose, in part, because of how little control she had over who had access to her body. The program she was in utilizes a "team approach" to medicine where patients have no guarantees as to who will be examining them at any point in time and who will be conducting scheduled procedures. Because of the intrusive nature of the physical exams and procedures associated with infertility treatment, the team approach puts the dignity of women at risk. As one woman who went through the same program as Lee commented, you "park your dignity and integrity at the door and pay this price to get pregnant."

With no real relationship with most of the people treating her infertility, Lee had the impression that she "was only another procedure to be done" or a mere "number ... in a blood work report." At no point did she receive adequate attention to her emotional needs, even from the counsellor involved with the program. Moreover, when she tried to advocate for her needs, she was labelled "a problem": another non-compliant patient.

The labelling induced shame about what she described as her "sensitivity" and it also made her worry that she might be abandoned by her care providers. Those feelings, along with being treated as a mere object of medical scrutiny, caused her to lose her sense of who she was and of what she needed. Before entering the program, she had never thought of herself as uncooperative or as someone who tends to create problems where they do not exist, nor had she ever thought of her body as a mere reproductive vessel to which anyone could have access. In the end, Lee was left in an extremely vulnerable position.

After she left the program, Lee wrote letters to two of the physicians with whom she came in contact. Below, I give an excerpt from a letter she sent to the physician who gave her a hysterosalpingogram (HSG)--a procedure determining whether the fallopian tubes are blocked--and who then conducted a hysteroscopy to repair damage to the lining of her uterus which could have been caused by the HSG itself. The excerpt focuses on the events that led up to her hysteroscopy, an experience which Lee herself describes as objectifying. The events are not isolated; rather, they are representative of a larger pattern of unethical patient care.

> When you did the informed consent over the phone, I specifically asked you how many people would be in the O.R. [operating room] suite. You told me there would be three people--the anesthetist, the circulating nurse, and yourself. This was a very important issue for me because of my past history of trauma. I don't know if [John] told you that I originally was

asking for spinal anesthesia because I did not want to be unconscious in this type of situation. After talking with the anesthetist and with you over the phone, I felt reassured that I was heard. I couldn't believe when I was wheeled into the room I counted eight people (men and women) there cleaning instruments, laughing and showing no signs of finishing up before you got started (with my entire lower body fully exposed and my legs in stirrups). I looked at you to help me in this and to try to honor my need for control and personal dignity--and you responded in defense of the staff that were cleaning instruments rather than on my behalf. I still remember crying and begging the anesthetist to knock me out because what I was feeling at that moment was unbearable. I now wish that I had gotten up off the table and left the room. In addition, I was not informed that I would be catheterized as part of the procedure. When I awoke, I had searing urethral pain and knew I had been catheterized, which you confirmed when I asked you later. If I had known this ahead of time, I would have begun a preventive course of Pyridium because I have chronic inflammatory urethritis. I also find myself wondering which of the five extra people in that room actually catheterized me. I guess it wasn't supposed to be an issue because I was unconscious. It was another episode where I felt objectified.

CHAPTER 3

Janet:

Janet miscarried her first child at seven and a half weeks gestation. In order to conceive the child, she had "charted and monitored [her] cycle with great care until the exact moment" that she knew she could get pregnant. Because she had used a natural method of contraception in the past, she was already very familiar with her cycle. When she got pregnant, her charts showed it, and her GP accepted her charts as evidence (Hey *et al* 1996, 42).

Here is an excerpt from what Janet writes about the miscarriage: "Every morning the bleeding stopped and every afternoon it started and on the Wednesday we went back to our doctor. He felt, palpated, and prodded and questioned that I had ever been pregnant at all: 'You told me you were pregnant and I believed you.' And I, knowing that I had been pregnant, started to doubt myself and my knowledge of my body. I felt concerned for the doctor, that he felt he had made a mistake, and it was my fault. You are very willing to believe that everything is your fault.... I was afraid that the whole episode had just been hysteria, and he (the GP) was thinking 'neurotic woman' ... [she then explains that she had an ultrasound which confirmed that she had been pregnant] ... I had known that I was pregnant, and I had doubted it, doubted me, doubted this little baby's existence because some forms of knowledge are seen as more valid than others" (Hey *et al* 1996, 44, 45).

Sheila:

In her second pregnancy, Sheila had a miscarriage at eleven weeks gestation. She writes that at the first sign of trouble, "I knew immediately that I would lose the baby. It was the first moment after the full-term pregnancy and 11 weeks of the present pregnancy that I felt scared that something could go, and in fact now was going, wrong. The possibility of problems had never before occurred to me. I knew things could go wrong in pregnancy but I felt I was the <sic> one of the lucky ones who would sail through it with very little alteration from the norm .... I was totally shattered. I was someone whose life revolved around bodily activity. I had worked hard to gain control in body action, to be aware of how my body moved and reacted to stimuli. I was fit and healthy. Now I felt I had lost all control of my body. I kept bleeding and there was nothing I could do about it. It was the first feelings of guilt (feelings that were to remain with me for a long time)--that I of all people should be experiencing something other than a normal pregnancy. 'Pregnancy is not an illness'; you should be able to continue as before with slight limitations. I, who enjoyed fitness and activity, was now faced with terrible guilt. Had I brought on this miscarriage myself? Oh, why had I been so selfish to go away the weekened <sic> before? I had felt the need for a break so had naturally gone to the mountains. I must have overstrained myself--it was my fault. If only ..." (Hey *et al* 1996, 21).

Anna:

Anna had a positive pregnancy test at six weeks gestation, but the day after the test, she started bleeding severely and had a miscarriage. As a result of the miscarriage, she suffered a lot of emotional confusion. She had a loving partner who was deeply concerned about what she was going through, but who did not seem to be able to help her to get through it.

"I found it really difficult to express just how difficult I was finding it emotionally after the miscarriage, and ... I guess partly because I didn't know anyone else who'd miscarried and I felt sort of like, well, it was only six weeks. It wasn't like I'd lost, ... lost a baby or that I'd had a stillbirth or something like that, .. and you know that maybe I shouldn't be as upset as I was" (Leaney & Silver 1995).

CHAPTER 5

Joanne:

"It was so bad, so stressful. And I consider myself pretty good at coping with things usually. But at one point ... honest to God I almost packed up and left. I thought, 'I cannot stand this another second.' It was like a time capsule of all of your expectations and all of your stress just jam packed into five days or six days or whatever it was. And you never got any relief from it" (Williams 1989, 136).

Lois:

"... I remember getting in the car and crying all the way home. I'm never going back there. They've had enough! I'm not a guinea pig any more! (she laughs nervously) And I was just ... I'd had it. I thought--this is it. I'm not doing this again. But about two days afterwards it was, okay, let's go back in (she laughs)" (Williams 1989, 130).

Steven:

"... all of a sudden I'm in the Twilight Zone. It's not a hospital, it's a...garage! And my wife is the car and these are the grease monkeys, down to the bad radio blaring and the power tools. I feel a surge of anger at this; how could they treat my wife's body as if it were a machine? Then I waver--no; it's just that they've done this so many times it is mechanical for them. It shows confidence, not disrespect. After all, I'm in their shop" (Mentor 1998, 68).

CHAPTER 6

Lara:

Lara is a 37 year-old woman, pregnant for the first time. At her first prenatal visit, she asks her obstetrician about prenatal diagnosis. She is told that the generic risk for a person of her age for having a child with Down's Syndrome is 1 in 227 (~0.4%) and the total risk for chromosomal abnormalities is 1 in 130 (~0.8%). Her options are the following: 1) chorionic villus sampling (CVS),

which is a diagnostic test taken at 10 to 11 weeks, and which carries with it a 1 to 1.5% risk of pregnancy loss; 2) an amniocentesis at 16 to 17 weeks, which is also diagnostic and has a 0.5% loss rate; 3) or, maternal serum screening at 16 to 17 weeks, which will not diagnose a fetal abnormality (as I have mentioned), but will tell Lara her individual risk for having a child with Down's syndrome or an open neural tube defect. If the screening test is positive, she can elect to have a detailed ultrasound and/or an amniocentesis. Depending on the timing of her screening test, she would receive the results of her amnio at about 19 to 20 weeks.

Lara tries to determine what her risk for having a child with a disability means to her and what the risks of the different procedures mean as well. Her financial situation requires that she work, and she is worried that her work schedule would not allow her to care properly for a child with a disability, a child for whom she would be the sole care-giver. Intellectually, she is not opposed to abortion, but emotionally, it is difficult for her to imagine terminating this pregnancy, for she has longed to have a child for years and, until now, has had no success in conceiving. Hence, the loss rates of the diagnostic procedures worry her considerably. She is also concerned that any choice she makes would elicit negative responses from people she respects. For example, if she decides to forego the diagnostic tests, some would regard her as irresponsible. If the results of an amnio, undergone after serum screening, convince her that she should terminate her pregnancy after 20 weeks, then some would wonder if she had any maternal instincts at all.

Melissa:

Melissa is 25 years old and in her second pregnancy. She has very little formal education, having quit school after grade 9. At each prenatal visit, her obstetrician asks her if she has any concerns or questions about her prenatal care. Melissa usually shakes her head, despite often having concerns. She is not normally shy, nor does she believe that her concerns about her pregnancy are trivial. She does not have a passive personality, nor does she lack confidence in her own judgment. The problem lies in her awareness of a stereotype in her culture of uneducated people as intellectually inferior to the educated. Melissa expects that her obstetrician's view of her is influenced by that stereotype, and she does not trust herself to be able to express her concerns or opinions to him without reinforcing the truth of that stereotype in his mind. Just to be on the safe-side, Melissa decides to keep her opinions to herself.

Whenever her obstetrician recommends something to Melissa, she agrees with his recommendation. When he offers her prenatal diagnosis and tells her that it is up to her to choose whether she wants it or not, she chooses it, assuming that he must believe she should have it, since otherwise he would not offer it. Moreover, being a member of the medical profession, he must be in favour of the use of such technologies, since whenever Melissa has met physicians in the past, they have always been quick to defend any new form of medical technology. Melissa herself would prefer not to have prenatal diagnosis, but does not want to risk having her physician think that she is therefore naive or uninformed.

Carola:

"I cried for two days after I had the test. I guess I was identifiying with universal motherhood; I felt like my image of my womb had been shattered. It still feels like it's in pieces, not like such a safe place as before. I guess technology gives us a certain kind of control, but we have to sacrifice something in return. I've lost my brash confidence that my body just produces healthy babies all by itself, naturally, and that if it doesn't, I can handle whatever comes along as a mother" (Rapp 1997, 131).

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