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ORIGINAL PAPER

The Ethics of Trauma Memory

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Abstract
In well-documented cases, it is plausibly unethical to ask trauma sufferers for details relating to their trauma. We propose that the reasons are twofold: First, the details requested are not required by those asking for them; second, the request comes with potential for significant harm for the victim arising from the exchange. Requests meeting these conditions are widespread, including in predominant forms of psychotherapy, so accepting these conditions has surprising and challenging consequences for a wide range of interactions with the victims of trauma, including well-meaning ones. Given these surprising and challenging consequences, we explore what, if anything, could offset the two conditions, focusing primarily on therapeutic interactions, which are sometimes thought to have a distinctive or sui generis character. We conclude that none of the options we consider wholly off-set the two conditions, and that they are only partly off-set by insufficient research into alternatives. We outline implications for the status of treatments which require the recollection of trauma as the default kind of intervention, and for interactions with victims of trauma more broadly.

Keywords Clinical decision-making · Ethics of mental health care · Memory · PTSD · Recollection · Trauma

"Canst thou not … pluck from the memory a rooted sorrow" (*Macbeth*).

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1 Introduction

Sometimes, requests for information can seem awkward, discourteous, or indelicate due to more-or-less moderate forms of cultural impropriety. Sometimes, ethical rather than proprietorial considerations inform whether a request for information is above board. And sometimes, there are challenging combinations of cultural and ethical considerations. But intuitively, these are importantly different: the latter isn't merely about discomfort, awkwardness, or offence. Deep cultural impropriety can be ethically unproblematic: asking a stranger's weight—in non-professional contexts—looks like one example.[1] Culturally acceptable practices can be ethically dubious: gratuitous requests for personal information in exchange for goods and services are ethically concerning, but consenting is embedded in daily life.[2]

Some concerns about personal information relate to the ethics of data retention. But there are ethical dimensions to *requests* for information themselves, and these are brought into sharp relief when the implications of a request are not immediately clear; where declining a request is difficult or impossible; or where the services or goods promised are essential for health and well-being. In such cases, the line between information-*requesting* (with a live option to decline)[3] and information-*requiring* (where declining isn't a live option) narrows. Some cases might be surprisingly commonplace, but frequency isn't deleterious of ethical status. And ethical considerations around information-requests are highly relevant to professional conduct.[4] For these reasons, we take the range of ethical questions generated by human interactions of these kinds to be worthy of analysis.

In this paper we draw attention to a class of information requests which are plausibly ethically problematic: a class of requests directed at victims of trauma (hereafter, victims). In such cases, victims are typically required to *dredge up* and recount traumatic and potentially distressing memories. Despite the potentially distressing nature of recollecting, such requests are commonplace. Surprisingly, many obvious examples of such interactions occur in contexts designed to help victims.

We focus on diagnosable forms of trauma, such as post-traumatic stress disorder (PTSD) and complex post-traumatic stress disorder (C-PTSD) for which symptoms

[1] Asking personal questions, e.g., in the UK can lead to awkwardness. Ethical considerations might encroach upon interactions when the impropriety relates to cultural or religious freedoms, or might count against equitable treatment, e.g., in the case of weight.

[2] This seems true at least for technologically developed countries.

[3] James (1896) took a "living option" to be an option between two hypotheses that one might take (as a solution to a problem, or an answer to a question) given the kind of person one is (i.e., one's training and/or prior beliefs). Unlike an option between the *merely* possible (e.g., be an astronaut or a coal miner; or more dramatically, live the life of a mediaeval Samurai or Bronze Age chief (Williams 1975, p. 224), a live option is one such that there is something the chooser can do, and knows how to do, which will make the outcomes achievable, or more likely. A live option to decline, then, is one where the chooser knows that they can decline a request and knows, at least to some extent, that the consequences of declining are also a live option for them. Such a constraint might be violated if the decision to accept rather than decline was coerced with major life-changing threat.

[4] Requesting information about "protected" characteristics during a job interview, e.g., is ethically dubious, and negative discrimination based on those characteristics is widely considered unethical. It is, of course, illegal in some countries (see, e.g., UK's Equality Act (2010).

include "re-experiencing" of the traumatic event. Much of what we say may apply to cases in which symptoms are similar but fall short of the diagnostic threshold. (We do not consider other forms of trauma here.)[5] We explore the ethics of these interactions in light of potentially harmful results of requiring trauma-memory content. Given the potentially harmful results, we think there is a good case for assessing the plausibility of a principle that guides interactions with victims. We call this the *Principle of Necessity for Trauma* (PNT):

> (PNT): Other things being equal, do not require trauma victims to verbalise, or otherwise recollect, traumatic experiences unless the information is necessary for a process they have consented to, and it cannot be acquired in another way.

Broadly speaking, (PNT) says this: when it comes to dealing with victims of trauma, don't ask for details unless you need them. It is stated in terms of "requiring" which, for our purposes, is requesting without a live option to decline. Other requests—those with a live option to decline—are in principle permissible. However, we think the lines are easily blurred, and that a counterpart principle for "mere" requests would benefit from its own analysis. Our focus, then, is *requiring*: requesting without a live option to decline. The *ceteris paribus* clause acknowledges the defeasibility of the principle in conditions which would make acting in accord with it impossible or intractable.[6] The notion of consent that we deploy is one that requires the decision-maker to understand the best reasons there would be for them to decline consent. (Thus, seeking treatment voluntarily, per se, would not suffice for consent.) The "necessity" condition may seem unusual when compared to general clinical norms which focus on the best interests of the patient, but which may allow for treatments which are not necessary, and involve risk, but which may, on balance, be in a patient's interests. Note, however, that (PNT) does not prohibit treatments which rely on such requests where that request is necessary (e.g., to improve a patient's condition), nor does it prohibit treatments that come with the risk of harm, per se (it allows, for instance, that there may always be some risk associated with medical intervention). The scope of the "necessity" condition is thus carefully restricted.[7] (We explore these issues further in Sect. 5.)

We think (PNT) has an intuitive appeal as an ethical principle; not just a principle relating to cultural propriety. But if (PNT) is a principle we should stand by, ethically

[5] Adjustment disorder, e.g., is characterised by "preoccupation with the stressor or its consequences, including excessive worry, recurrent and distressing thoughts about the stressor, or constant rumination about its implications" (WHO, 2018), but these do not appear to meet a "re-experiencing requirement" (*Ibid*.). The extent to which the relevant symptoms are present in other mental health disorders is worthy of exploration elsewhere.

[6] It is reasonable to inquire about the kinds of conditions that might activate the *ceteris paribus* clause, since such clauses can be controversial (see, e.g., Reutlinger et al. 2021). We have in mind "disturbing factors" (*Ibid*.) such as those which are systematic or structural in nature (e.g., competing legal obligations), as opposed to, for instance, marginal benefit to individual patients. This puts us into potential conflict with views of clinical decision-making that suggest even marginal patient benefit should win out. .

[7] We thank an anonymous referee for pressing us on this issue.

speaking, there would be far-reaching consequences for interactions with victims—even for those cases in which the interaction is intended to help.

Interactions with victims are multifarious. Besides individual, informal, and possibly spontaneous interactions, there are interactions between victims and law enforcement agencies, compensation bodies, healthcare organisations, and so forth. Many of these require victims, directly or otherwise, to verbalise—or otherwise recollect—details of their traumatic experiences, and such details are sometimes requested without need. Since requesting unnecessary information from a victim of trauma violates (PNT), accepting (PNT) as an ethical principle potentially affects the ethical status of services, organisations, and entire professions aimed at helping victims. Thus, although the adoption of (PNT) is intuitively forceful, it has counter-intuitive implications. It also potentially runs counter to some clinical intuitions, according to which more-or-less weak pro-tanto considerations–as opposed to "black and white" principles–are the appropriate basis for clinical decision-making.[8] One objective of this paper is to explore these implications and to see whether accompanying intuitions are well-founded.

Real-world decision-making around interventions can involve a complex weighing of competing considerations under time-sensitive and resource-sensitive conditions. An additional complexity, peculiar to the case of trauma, is that post-traumatic stress disorder (PTSD) is unique among psychiatric disorders in that its symptoms are directly associated with an etiological event (or events): the traumatic experience (Vasterling and Brewin 2005, p. 5).[9] This may contribute to the impression that, unlike other disorders, the etiological event is where the solution is to be found.[10] We do not imply that (PNT) is an obvious solution in light of all these complexities. We do, however, think that it is worthy of serious exploration, and that such an exploration may help to bring about innovation for clinical and non-clinical interactions with those in recovery.

In Sect. 2, we present an initial case in support of (PNT) by reviewing instances in which ostensibly well-meaning interactions with trauma victims are plausibly ethically problematic. In Sect. 3, we examine what makes these cases ethically problematic. In Sect. 4 we discuss (PNT)'s application to clinical decision-making. In Sect. 5 we address several objections, and we conclude in Sect. 6.

2 The Recollection of Traumatic Experiences

The idea that requiring trauma-related information from victims might be subject to special conditions has a solid foundation. Trauma memory has long been considered special or distinctive. In the mid-1800s, Jean-Martin Charcot took "paralysis, jerky movements, sudden collapse, frenzied laughter, and dramatic weeping" in "hysterical patients" to be the physical imprints of trauma (Charcot 1991; van der Kolk 2015; xi). Pierre Janet suggested that, "trauma is held… in automatic actions and reactions,

[8] Thanks to an anonymous referee for emphasising this tension.

[9] Note that both DSM and ICD have published revisions since the Vasterling and Brewin's (2005) claim.

[10] Thanks to Daniele Chiffi for a helpful discussion on this point..

sensations and attitudes, and… is replayed and reenacted as visceral sensations (anxiety and panic), body movements, or visual images (nightmares and flashbacks)" (van der Kolk 2015; xi).

Such observations have led clinical theorists to believe that traumatic memory "differs *fundamentally* from other types of memory" (Levine 2015; xx; our emphasis),[11] and that the difference has the potential to create "great confusion and the misapplication of therapeutic techniques" (*Ibid.*). The extent to which trauma memory differs from other forms of memory, and in what sense, has received attention in several literatures (see, e.g., book-length treatments from Caruth (1995), Levine (2015), and Sinason and Conway (2021) in psychotherapy and psychoanalysis; Hamburger (2018) in psychology). In anglophone philosophy, despite a few illuminating discussions (see, e.g., Brison 2002; Rowlands 2015; Ratcliffe 2017), there has been relatively little thoroughgoing analysis of the topic and there is sometimes a tendency to accept the conclusions of other disciplines.[12] Our inquiry need not await the outcome of an in-depth philosophical analysis: if views about the distinctiveness of trauma memory are even partly correct, there may be practical consequences for clinical and public services who come into contact with victims.

On the basis of the specialist literature and diagnostic manuals, there is *prima facie* reason to suppose that trauma memory is clinically relevant. The former recognizes that retrieval of, reliving of, or focus on traumatic memory content can not only be difficult, but also "distressing" and potentially "debilitating" (see, e.g., Mailloux 2013, p. 51). In the latter, *intrusive* re-experiencing of the content, and other memory phenomena, are diagnostic of post-traumatic stress disorder (PTSD). The *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5), for instance, lists the following criteria:

> B. Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:
> 1. Recurrent, Involuntary, and Intrusive Distressing Memories of the Traumatic Event(s)
> Note: In children older than 6 years, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.
> 2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s).
> Note: In children, there may be frightening dreams without recognizable content. (APA 2013, p. 271)

[11] Laboratory-based researchers are sometimes less impressed than clinicians by the claim that memory for trauma is different than for other events (Vasterling and Brewin 2005, p. 5). However, the former tend to focus on specific hypotheses proffered by clinicians rather than distinctiveness more broadly (see Shobe and Kihlstrom 1997; for an example of this strategy.)

[12] Its distinctiveness is sometimes acknowledged without being subjected to analysis, e.g., Fernandez (2015) and Frise (2024) take the controversial thesis that trauma memory characteristically occurs in observer perspective as a datum.

DSM-5 goes on to state that, "The traumatic event can be re-experienced in various ways. Commonly, the individual has recurrent, involuntary, and intrusive recollections of the event (Criterion B1)" (APA, 2013, 275).

Since both the distinctiveness of trauma memory, and the view that its distinctiveness is clinically relevant are prima facie warranted by the specialist trauma literature and diagnostic criteria, we proceed with the investigation of ethical implications on this basis.

Our interim conclusion is this. Interactions with victims, requiring divulgence of traumatic memory content, plausibly require special consideration, because there are specific harms in the shape of distress, discomfort, debilitation, and so forth. Decisions about information-requiring activities around victims will thereby have a normative ethical dimension: there is a right and a wrong way to go about them. Notably, the ethical considerations generated by these cases are not marginal or of purely academic interest. They are far-reaching in two respects: the number of people affected, and the variety of circumstances affected. We turn to these issues in Sect. 2.1 and 2.2.

2.1 The Prevalence of Trauma

Trauma is commonplace, and interactions with trauma victims are correspondingly commonplace. 70% of people worldwide can expect to experience at least one event that fits the "A1" criterion for a traumatic life event in DSM-5 (Frewen et al. 2019), and this does not capture the full range of experiences leading to trauma-related conditions. Some "non-traumatic stressors"—for example, issues related to housing, employment, and finances—can contribute both to the risk of developing PTSD (e.g., Rosen and Lilienfeld 2008), and the severity of its symptoms (Larson and Pacella 2016).

Adverse childhood experiences (ACEs) are also related to long-term physical and mental health (see Oral et al. 2016; Boullier and Blair 2018; Frewen et al. 2019). ACEs occurred in 59% of 26,229 individuals participating in a 2010 study; and 65–83% of 42,272 participants in a (2015) report covering Balkan states (Oral et al. 2016, p. 228). ACEs have a tendency to "co-occur", with 15% of the 2010 study reporting at least four ACEs (*Ibid.*).[13]

Many of us, then, will have endured ACEs and/or experienced traumatic life events. ACEs, and "combined traumatic experiences and non-traumatic stressors across a lifespan", uniquely impact the development of trauma symptoms and stress-related disorders (Frewen et al. 2019). In the UK, it's estimated that one-in-three people who experience a traumatic event will be affected by PTSD[14] (not the only trauma-related condition). In the US, around eight million adults have PTSD in a given year (3.5% of the population).[15] PTSD can develop as a result of rape (49% of victims develop it), severe physical assault (32%), serious accidents (16.8%),

[13] For the view that the psychiatric community over-estimates the prevalence of PTSD, see Bonnanno (2021).

[14] NHS Choices. (2015) *Post Traumatic Stress Disorder*. Retrieved from: http://www.nhs.uk/conditions/Post-.traumatic-stress-disorder/Pages/Introduction.aspx.

[15] See, e.g. https://www.ptsd.va.gov/understand/common/common_adults.asp.

shootings and stabbings (15.4%), the unexpected death of a loved one (14.3%), and so forth. [16] A significant proportion will have the quality of their lives negatively affected by traumatic experiences. So, the interactions we are considering are far from marginal phenomena. They will be of considerable relevance to large numbers of persons. There is also recent evidence that the characteristic symptom of trauma—intrusive memory experiences—may be present, and even prevalent, in other conditions such as grief, depression, anxiety, and psychosis.[17] This prevalence—including the presence of characteristic trauma-like symptoms in a range of other mental health conditions—would count against any attempts to "screen off" cases of PTSD leaving other cases of inquiry into trauma permitted by the principle. [18]

2.2 Requiring Narratives

Given the risks, the extent to which trauma victims are required to verbalise—or otherwise recollect—traumatic memories can seem surprising. Even more surprising, divulging traumatic memories is required in several contexts designed to help the victims: for immigration and asylum purposes, in the aftermath of sexual assault, and following interpersonal violence. They are required or expected to do so in numerous healthcare contexts, truth and reconciliation committees (e.g., Brounéus 2008),[19] and criminal compensation procedures (e.g., Newlove 2019). These latter examples ostensibly aim at *directly* assisting victims as opposed to, for example, bringing assailants to justice. Criminal compensation provides an illuminating case for our proposal.

The 2019 UK Victims' Commissioner's review (Newlove 2019)—*Compensation without Re-traumatisation*—engaged over 200 victims, police and crime commissioners, victim support services, criminal justice agencies, and lawyers. It focused on various elements of the compensation process and led the Commissioner to declare that the "process of making a claim was often traumatic" (*Ibid*.).

The review found that elements of the process which "require victims to relate their experience of the crime can re-trigger trauma and distress" (2), and the process overall "often re-traumatises victims" (2). One reason for this conclusion is that victims are often required to recollect and verbalise the details of their traumatic experiences: a Police and Crime Commissioner stated that, "Having to relive the experiences over and over to furnish the required information … is an impossible hill

[16] See, e.g.,https://www.therecoveryvillage.com/mental-health/ptsd/related/ptsd-statistics/.

[17] See, e.g., Payne et al. (2019) on depression.

[18] An anonymous referee remarks that if (PNT) relates only to PTSD, and PTSD can be adequately screened off, the principle would allow other (potentially otherwise ill-advised inquiries). We do not say that the principle is restricted exclusively to PTSD, but even if it were, the suggestion doesn't appear to count against us. In that case, those interacting with victims would need to develop and/or implement (a) a PTSD screening process, and (b) an alternative means of processing for victims with PTSD. But if one has developed a new means of processing (with appropriate levels of caution), it would be legitimate to inquire what considerations would favour deploying both means, rather than simply a more cautious one that fulfils the same function and would dispense with the need for a screening process.

[19] Truth and reconciliation councils are not the best example for analysis as, arguably, they are intended to deal with a combination of cultural and individual trauma.

to climb" (40). A Victim Support representative described the process as "both retriggering and potentially unnecessary" (41), and stated:

> A lot of victims have been telling me they have to…describe in detail the crime and then have to have [sic.] reported it to the police. Victims are saying it is re-triggering by having to fill out the details of the crime…It's unnecessary because they are going to request the crime report…they are making people give these descriptions and actually for the claims assessors it's based on the police report which they will be requesting immediately in every single case. So other than the crime reference number, they probably don't need any more details than that. (Newlove 2019, p. 41)

Requiring victims to recount the details of the experience "goes against known current best practice in working with victims":

> So much now of the system around victims is trying to reduce the number of times they have to tell their story … we try to reduce the number of times victims have to go over it, and then it could be 18 months down the line and they are having to do it again. It's really impactful. (see Newlove 2019, p. 41)

These concerns were borne out in victims' statements. Victims complained of being "worn out", "stressed", "distressed", or left "too emotional" by the process. A typical account of the process stated:

> The whole experience was draining and emotional, putting it in writing, the whole thing…it was just distressing…Stressed, and depressed. Because it was just bringing back what happened to me but it puts it in your head again, and then when you see it in black and white, it makes it real because it's in your head all the time but seeing it as real…I thought it was totally unfair, and it was very distressing for me. (Newlove 2019, p. 42)

The distressing intrusiveness of traumatic memory can be experienced as a kind of "re-living", and, in itself, can make victims ill. Reports were explicit in this respect: One victim reported that, "to keep reliving it made me ill" (41); and legal representatives speak of clients needing to be medicated for the tribunal process or failing to turn up (93 f.). One victim service provider explicitly claimed that, "It is potentially unethical to question [victims] in detail about e.g. visits to hospitals, where the abuse took place etc." (41). We agree.

Although such reports don't amount to demonstrations that requests of the kind we're investigating can be unethical, we think they do—especially in combination with the specialist literature and diagnostic manuals—lend credence to the claim. They go beyond cultural impropriety and suggest medically relevant harm. On the basis that the ethical dimension to these interactions is plausible, in Sect. 3 we outline two ethically salient features of these requests.

3 Ethically Salient Features of Requests

In accepting the cases above are plausible cases in which it is unethical to require of victims of trauma details relating to their trauma, we can capture two ethically salient features of the requests:

1. The details requested are not necessary for those asking at the time of the inquiry, or they do not need to be acquired from the victim. (In the compensation case, for instance, they have already been supplied and are available via other means.)
2. The request comes with the potential for non-negligible[20] harm for the person being asked (harm that arises from the exchange itself, predominantly through revisiting traumatic content).

If these two factors are enough to deem a request for information unethical in the compensation context, then—other things being equal—it's plausible they are enough to deem requests unethical in other contexts (at least we would need good reason to dismiss the possibility). That is to say, in the absence of mitigating circumstances, factors that make the two sets of circumstances substantively different, or ethical considerations that offset or override (1) and (2), these factors are jointly sufficient to determine that a request for information about trauma content is an unethical one. There is potentially a case for them to be severally—that is, individually or separately—sufficient for a request to be unethical. However, we do not argue for that conclusion here.[21] Neither is a necessary condition for the requiring of information to be unethical.

We take the case for joint sufficiency both to be intuitively strong, ethically speaking, and to be reasonably well-established in healthcare. We use an instrumental notion of necessity on the understanding that the aim of healthcare is health. Necessity, in this sense, is a widely recognised mitigation across a range of contexts. In two otherwise like cases of *harm by doing*, for instance, if one act is necessary (e.g., essential; required; indispensable) and the other unnecessary (e.g., inflicted by choice; gratuitous), the former will be mitigated at least to some extent in a way that the latter will not. We do not offer an extensive defence of the thesis here[22] but note that something like it is well-established in healthcare contexts. The World Health Organisation acknowledges the importance of reducing the risk of unnecessary harm

[20] We accept *ex hypothesi* that trauma-related conditions such as PTSD are non-negligible harms, so it is reasonable to infer that reactivation or exacerbation of associated symptoms (or "re-traumatisation") are also non-negligible harms.

[21] Complications for that claim would include complexities around cases of (informed) consent, including "undue inducement" (e.g., much-needed cash or high value commodities), and "no choice" situations where there is "a lack of decent alternatives to accepting a bad offer" (Eyal 2019). These fall short of coercion, but are plausibly ethically relevant (see, e.g., Eyal 2019 for discussion). Unfortunately, a detailed discussion of the ethics of consent is not possible in this paper.

[22] An extensive discussion of ways to measure and compare outcomes in terms of health may be interesting and valuable but is not the topic here.

associated with healthcare in their definition of patient safety (WHO, 2023).[23] In cases such as major surgery, inflicting risk and severe pain may be essential to restore a person's well-being. Causing this exposure to risk and pain when surgery is unnecessary would be abhorrent. (We do not claim that harm in the required case is always ethically permissible, though in many cases it will be.)

So far so good. But a difficulty arises because requests for information about victims' traumatic experiences are a regular occurrence in psychotherapy and counselling for trauma-recovery clients. Such requests are the mainstay of predominant forms of therapy—for example, trauma-focused cognitive behavioural therapy (TFCBT). So, accepting these conditions not only says something about the ethics of interactions around compensation, and so forth, but has potentially surprising implications for standard treatments of trauma and may present challenging conclusions for relatively typical activities in psychotherapy and counselling which focus on trauma narrative. In Sect. 4, we consider an initial attempt to avoid this conclusion.

4 Psychotherapy and Trauma Memory

Traumatic experiences are "anchored in the memory" and the "memory plays a central role in the development and maintenance" of trauma-related conditions such as PTSD (Schock et al. 2010). This assumption is both well-founded and in accord with diagnostic material, such as DSM-5. This leaves us with a a predicament. On the one hand, evidence suggests a sensitivity to exploring memories of traumatic experiences because doing so can be disturbing, distressing, or debilitating for victims. On the other, prominent forms of therapy require that victims divulge the details of traumatic experiences, and are thereby potentially unethical.

4.1 First-Pass Response

A likely response to this challenge is to claim that therapeutic interactions don't meet one or both conditions for unethical interaction, because:

A. The details of the traumatic experience *are* necessary (e.g., in order for the client's condition to improve), and/or.
B. They *do not* carry a risk of non-negligible harm (e.g., due to the clinicians' training, experience, etc.) However, it is neither obviously true that the psychotherapist requires the information for treatment treatment purposes, nor that there is no potential for non-negligible harm. Indeed, there are reasons to suppose the contrary: for (A), non-narrative interventions exist and appear to be effective in the treatment of trauma-related conditions (see Imel et al. 2013; Frost et al. 2014); and for (B) re-traumatisation and drop-out are significant risks in therapies that require victims to divulge the details of their traumatic experiences (see, e.g.,

[23] "the absence of preventable harm to a patient and *reduction of risk of unnecessary harm* associated with health care to an acceptable minimum" (WHO, 2023; our emphasis). See: https://www.who.int/news-room/fact-sheets/detail/patient-safety.

Imel et al. 2013; Frost et al. 2014).[24] So, the first-pass response is not promising. We return to these issues, below, but proceed for now on the assumption that (A) and (B) alone are not enough to avoid the surprising conclusion. This leaves predominant forms of therapy with a dilemma.

4.2 A Dilemma for Narrative-Focused Therapy

The foregoing suggests that at least those forms of therapy relying heavily on narrative-focused interventions, and perhaps others, face a dilemma when it comes to interactions with trauma victims. It arises in part from the fact that victims are not able to verbalise or otherwise recollect details of their traumatic experience at all stages of their recovery without risk of harm arising from interaction. This harm—hitherto glossed as distress, discomfort, debilitation—can manifest in clinical outcomes such as the premature termination of treatment, or adverse responses such as re-traumatisation. It is plausibly an important case of iatrogenic harm. The horns of the dilemma are as follows:

(I) The therapist can pursue a potentially unnecessary[25] course of treatment that carries with it a significant risk of non-negligible harm.
(II) The therapist can withhold treatment, and risk ongoing (and sometimes unknown) difficulties faced during trauma-recovery.

Neither option is appealing—both appear to risk harm, and the kinds of certainty that might disarm the problem are rare—so we now consider several other ways to resolve the dilemma.

One option is to deny that the harms listed above are harms genuinely *arising from* the interaction. One might, for instance, emphasise that there's always a risk of dropout or other adverse outcomes. Or one might object that re-traumatisation should not be classed as an "adverse outcome", or perhaps even an *outcome* at all. In the former case, there would be no special problem of adverse outcomes for information requests: the risk of harm lies in the nature of the therapeutic enterprise *tout court*. (After all, our best medications carry the risk of side effects.) This is an insufficient response to the quandary because comparative risk—rather than risk per se—is the pertinent factor for this kind of clinical decision-making.[26] For it to be a sufficient response, the risk *differential* would need to be shown negligible, but this has not been shown and is a matter for ongoing empirical investigation.

The latter response rejects the classification of re-traumatisation (etc.) as a source or kind of harm. A proponent of this view has a few potential strategies. She might

[24] Re-traumatisation is difficult to measure directly due to differing clinical conceptions (Purnell et al. 2024) and uncertainty over what causes dropout. Purnell and colleagues (2024) found that it occurs but is uncommon. Data from Davies et al. (2019) suggests it is not uncommon.

[25] By "potentially unnecessary", we draw attention to the possibility of deploying interventions that do not require of a client that she divulge trauma-related content. We are not making the claim that *no* treatment is necessary.

[26] See Chiffi (2021) for an analysis of varieties of clinical reasoning.

insist that re-traumatisation is a natural part of the trauma-recovery process, that it is negative but unavoidable, or even that it is *impossible* in the therapeutic context (e.g., managed interactions between therapist prevent it from occurring, or require different classification). One—admittedly marginal—view classes re-traumatisation as *positive*, and a legitimate therapeutic tool.[27] This, too, is the wrong way out of the dilemma: call it "re-traumatisation" or something else, there is response to treatment, and other life events, that results in increased, intensified, or renewed symptoms of trauma. Since we generally conceive of these symptoms as worthy of treatment or prevention, we would need a special reason to think of repetitions or intensifications of them in a positive or neutral light.

Disagreement around re-traumatisation is nevertheless worthy of an aside. The sometimes contrasting range of views on "re-traumatisation" stem from widespread and multiple ambiguities in the use of the term in clinical circles and even in specialist literature. "Re-traumatisation" is both a neologism and a term of art; both factors which can drive misunderstanding. However, a good deal of specialist literature paints re-traumatisation as a negative and/or to be avoided where possible. Definitions of re-traumatisation, where they can be found, are indicative of increased or renewed pathology (e.g., "relapse", "symptom exacerbation") rather than recovery and health. And while competing views of re-traumatisation exist, they are perhaps better described by other terms, such as "serial trauma" or "re-victimisation" (see Layne et al. 2006).

Dropout—premature termination of treatment by the client—is also a common feature of trauma therapy. Some studies claim that, overall, around 18% of PTSD sufferers drop out on average (behind closed doors, clinicians speak of far greater numbers, especially in clients with histories of abuse). However, these factors do not suggest that dropout is an invariable or inevitable risk: there is a good deal of focus on what can be done to increase retention and minimise dropout.[28] Importantly, the fact that dropout varies for different kinds of intervention suggests that the risk can be mitigated (cf., Imel et al. 2013; Frost et al. 2014).

Our ethical quandary, then, is relatively robust: it resists a range of initial responses. In Sect. 5, we explore three further strategies for avoiding the surprising conclusion that we might have structured our interactions with victims of trauma not only incorrectly, but incorrectly on a grand scale and with wide-ranging ethical implications.

5 Three Objections

Since the initial attempts to avoid the conclusion are unpromising, a plausible strategy for a response would explore factors that override, counteract, or neutralise the conditions that underpin the plausibility of (PNT). Potentially overriding factors include the proposals that:

[27] Proponents are not always eager to defend the view in print, but more confrontational styles of therapy are discussed, e.g., in Farber and Metzger (2009).

[28] "Retention" refers to the proportion of clients that remain in treatment for its intended duration; "dropout" is that proportion which leaves prior to the intended duration (cf., Najavits 2015).

i. The harms, societally speaking, of not asking are worse than those of asking.
ii. The special—perhaps *sui generis*—nature of the client–therapist relationship permits such requests.
iii. The retrieval of the information requested is so important for treatment that its absence might impede client recovery.

5.1 The Negative Consequences of not Asking

Our conclusion can be understood as generating a duty not to request the details of trauma unless it is necessary to do so (PNT). The duty is generated by the potential harms arising from inquiries into traumatic memories. One attempt to off-set the harms of inquiry is to suggest the consequences of *not asking* outweigh the consequences of *asking*. And one way to develop this strategy is to argue as follows. There is a substantive class of cases, C, in which the potential for negative consequences arising from inquiry are outweighed by the potential negative consequences of not inquiring. For such a class, it would plausibly be morally permissible—if not morally required—to inquire about traumatic experiences. The existence of such a class would suggest that there are duties which override the potential harms of inquiry, and it is a reasonable assumption that some C-like cases involve victims of trauma. Therefore, there are likely to be cases of ethically permissible inquiry into the details of trauma which are not explained by (PNT). Therefore (PNT) is not a good guide to the ethics of information requests to trauma victims.

Let us fill in some details. We take a plausible version of this objection to invoke consequences at a collective—rather than individual—level (see Sect. 5.3 for a discussion of individual off-setting factors). In this case, the objection might focus on real-life problems such as the under-reporting of offenses like sexual assault, and the likely consequences of allowing sexual (or other) predators to escape prosecution. Such considerations have already led to the introduction of policy and legislation, such as "compelled disclosure" policies in some US universities (see, e.g., Holland et al. 2018, p. 256). These practices provide support for the objection: there are instances in which the wishes of the individual must be balanced against the good of a community.

Of course, these are examples in which societal harm is judged, by society, to outweigh potential harm to an individual. And the harm–benefit calculus may be different for some cases of individual traumatic experience. Nevertheless, one might think that C-like cases can generate a "duty to remember", including in contexts such as talking therapy. And if, on balance, remembering reduces the likelihood of further harms, that duty may override the ethical concerns highlighted above.

5.1.1 Duties to Remember

Duties to remember are recognised in several spheres of human activity. Two of the main arguments for them are: commitments to take moral responsibility for the past and promises of a "better future" (Meral 2012). Plausible examples include duties relating to humanitarian disasters, or atrocities. In these cases, the duty usually aims

at preventing recurrence or repetition; and the remembrance of events or "important" individuals (war dead, civil rights activists, local philanthropists, etc.). Let's allow (a) these duties exist and are ethically salient; (b) the right kind of move might deliver ethically salient duties for individual atrocities such as sexual or violent assault;[29] and that (c) such duties would be relevant to the kinds of case we are considering. We now consider in what way C-like cases might neutralise (PNT) by off-setting or overriding the conditions we have sketched above. In doing so, we highlight some plausible constraints on such duties.

There are noteworthy features of duties to remember. First, cases such as cultural atrocities and notable individuals are primarily concerned with the dissemination of information[30] or commemoration,[31] rather than with individual "recollection". Note that one can recollect without disseminating or commemorating, and that one can do either of the latter without recollecting. Note also that "recollection" is one use of the verb "to remember". On another use—an allowable paraphrase of knowledge (cf., Ryle 1949)—a subject can remember without recollecting, without disseminating, and without commemorating. The generation of a specific duty to remember for an individual would require clarity over what that individual has a duty "to do" from the available options (disseminate, commemorate, remember1, remember2, …, etc.). In at least one case, the voluntariness (or otherwise) of memory may be a salient factor, since *ought implies can*[32] (the voluntariness of memory will not be a focus here.)[33]

Second, the burden of such duties does not usually fall upon individual victims. Note, for example, that for atrocities such as the Holocaust, "it is incumbent on humanity collectively … and its purpose, to a significant degree, is to put the world on guard against a repetition of crimes of this magnitude" (Blustein 2017, p. 351). But if we take such duties as a guiding example, we need an explanation of how the collective duty (e.g., of humanity, or a community), transmits onto an individual victim. The transmission of some collective duties onto individuals is intuitively plausible: if the last person to leave the office must turn on the alarm, and I am the last person in the office, then I must turn on the alarm. However, memorializing can be structural and its continuation passive (consider memorials to controversial figures such as Cecil Rhodes). And some collective duties to remember do not easily transmit to individuals: there may be collective duties to remember important individuals via the erection of sculptures or plaques, but no one member of the collective (nor

[29] It is worth noting that any duty for public memorialisation in such cases may be restricted to individual atrocities with a particular social or political significance.

[30] That is, the "passing on" of information to ensure that it is not forgotten is a variety of collective remembering that might presuppose the ability to recall individually, in some form. But it does not presuppose a specific kind of remembering, nor the remembering of any specific "content".

[31] The verb "to commemorate" is cognate with actions that "mark", "celebrate", or "honour". A "commemoration" is a "remembrance activity explicitly designed to mark the loss of life" (Baines 2019), for example, "Remembrance Day" in the UK which commemorates war dead.

[32] The principle is associated with Kant, though see Stern (2004) for a discussion of the principle, its relation to Kant, and various formulations.

[33] Both philosophical and psychological literature—and in particular the latter—tend to acknowledge an element of *involuntariness* (see, e.g., Berntsen 2009; Blustein 2017; Mace et al. 2010; Mace 2007, 2006; Mole 2016; Schlagman et al. 2009), and involuntariness is sometimes taken to be ethically salient.

an obvious set of members) carries the burden of erecting sculptures or plaques (see Blustein 2017, p. 353). So, while some collective duties can fall on individuals, nothing about collective duties immediately guarantees transmission onto an individual. Whether or not a specific duty to remember can be transmitted, and how, is a matter to be settled for each class of cases.

Third, for a duty to be transmitted, the function or aim of the duty must relate, in an appropriate way, to its execution. A duty whose purpose is the prevention of similar future events does not require multiple repetitions of the same information to a person or organization. In the compensation case, for instance, any reasonable duty to this end is fulfilled in a police report. Subsequent repetitions serve no such function (see Sect. 2).

Some cases, such as sexual assault, are no doubt more intractable than the compensation case. In such cases, there may be complex societal and individual reasons for disclosure. These may include, for example, not only limiting the activities of a dangerous individual, but exposing problematic patterns of behaviours in society, and helping to ensure that vulnerable individuals are not unjustly silenced. Here, the ethical considerations we have highlighted may be in competition with, and ultimately give way to, considerations relating to epistemic injustice.[34]

However, as these issues connect to the therapeutic context: (i) therapists are not the right people to dispense justice (legal, moral, or epistemic), nor to ensure the prevention of a similar events;[35] and (ii) therapeutic requests for information are not directed at the prevention of events similar in nature to the traumatic experience, nor at exposing problematic patterns of behaviour in society, but at recovery, and usually proceed under the assumption that multiple exposures to difficult material has a therapeutic effect to that end (see Sect. 5.3).

Finally, it's a plausible constraint that the aims of such duties must be more-or-less achievable by those on whose shoulders the duty falls: we can make sense of a duty to commemorate, but no individual or collective has a duty to undo the past. For individual victims of trauma, duties to remember could be especially difficult to bear, and having no reasonable prospect of success would count against the transmission of such a duty.

We have not argued that commemoration and remembrance could not, in principle, prevent future instances of tragedies or atrocities. However, examples of them playing this role are relatively difficult to find. The world has contrived to avoid peace at least since the outbreak of World War I (cf., Hobsbawm 2002), and the century which followed that war saw genocides in each decade. The number of rapes in the UK rose sharply between 2015 and 2020, while the proportion of cases making it to court more than halved in the same period;[36] only 3% of "rape complaints resulted in a suspect being charged" in 2019 (Baird 2020, p. 17). Both examples count against

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[34] We thank an anonymous reviewer for pressing us on this important issue. We discuss the importance of epistemic injustice for victims of trauma elsewhere.

[35] One might argue that some duties to remember in cases of sexual assault, for example, are embodied in the sex offender's register, rather than in the individual victim. (The effectiveness of such registers in reducing crime rates and preventing reoffending is disputed.)

[36] Retrieved from BBC News: https://www.bbc.co.uk/news/uk-48095118.

the plausibility of the proposal that dissemination and commemoration—let alone remembering more broadly—are effective in preventing atrocities. For burdensome duties to be transmitted to individuals recovering from trauma, the aims of those duties would need to be of a different kind, or else transmission of the duties would need to be warranted via a different route.

5.2 The Client–Therapist Relationship

The value of the client–therapist relationship is emphasised across different approaches to psychotherapy (Callaghan, 1996; Farber and Lane 2001; Farber and Metzger 2009). It is sometimes seen as an important aspect of treatment, and even an essential component of treatment, or mechanism of affecting change (Callaghan, 1996, 382). There is also empirical support for the claim that a positive client–therapist relationship can improve therapeutic outcome (381).

Discourse around these relationships sometimes highlights the importance of common characteristics such as warmth and empathy (*Ibid*.; Farber and Metzger 2009) and can give the impression that the client–therapist relationship is *sui generi*s (unique, or of its own kind).[37] Formulating what is special or unique about it is challenging, in part due to different models of therapy. Conceptions of the "therapeutic alliance" include the therapist as "observer" (psychodynamic), "educator" (psychoeducational), "unconditionally accepting conveyer of feedback" (humanistic), or an "analyst" and "reinforcer" of clinically relevant behaviours (functional analytic psychotherapy) (Callaghan, 1996, 382 f.).

Some explore notions of "positive regard" (Farber and Lane 2001) characterised by "non-possessive warmth" (390), and there is widespread adoption of the metaphor of the "therapist as a secure base" in attachment theory (Farber and Metzger 2009). Characteristics which promote the establishment of the latter are "constancy, availability, sensitivity, and responsiveness" (48), which bestow upon the therapist a pseudo-parental role.[38] Such properties are, of course, not unique (cf., 49), however, they have been thought by some to be unique when *deployed by a therapist*, who must have the strength and security to challenge client (*Ibid.*). But "strength" and the "ability to challenge" are not peculiar to the therapeutic trade either, and "deployed by a therapist" will not do as an explanation of uniqueness: everything is what it is and not another thing.

A more promising way to justify the use of specific kinds of inquiry within a therapeutic context is the fact that therapists are experts. But this too is not without difficulty. One difficulty is to identify a category (or categories) of practice in which individuals might be experts. Even by the 1980s more than 100 varieties of psychotherapy had been identified (Karasu 1980), and different conceptions of the therapeutic relationship "bring about different responses by the therapist to the cli-

[37] Farber and Metzger (2009) list Bowlby, and Dozier and colleagues as proponents of the view that the relationship is unique (49).

[38] While they "recapitulate the conditions in childhood that facilitate secure attachment" (Farber and Metzger 2009, p. 48), parallels between the therapist as secure base, and the parent as secure base are "at best inexact" (46).

ent" (Callaghan, 1996, 384). Notably, some contemporary forms of therapy do not appear to be based on plausible underlying theory.[39] A second difficulty is to find a *measure* of expertise, but not all practitioners (in any trade) operate at the same level of expertise, and not all training programmes operate according to the same guidelines. The idea that an appropriate qualification could act as a proxy for expertise also faces complications: we are not always inclined to call newly qualified individuals experts,[40] and in some countries (e.g., UK, Canada) there is no statutory regulation of counsellors and psychotherapists.[41] It might be objected that this is true of car mechanics. But recall the structure of the dialectic: the expertise in the therapist case is intended as a plausible overriding factor for an ethical principle. An analogy with car mechanics breaks down here if not elsewhere.[42]

A final consideration on expertise. Formal training and qualifications are a starting point in the therapeutic trade. There are gaps in theory and training that are intended to be filled by continuing professional development. Due to the ongoing nature of developments in theory and diagnostic criteria, it could not easily be otherwise. For example, whatever training there is around certain key symptoms of PTSD, such as dreams and nightmares, relies on dated assumptions about dreaming (see *[]*). "Complex PTSD" appears only recently in one of the two main diagnostic manuals (ICD-11) and guidance around the condition didn't come into effect until 2022. There are generations of highly experienced therapists who know little about recent developments in trauma. In the psycho-therapeutic trade, expertise is an ongoing process rather than a state.

In sum, the idea that therapists have the expertise to judge—within an appropriate client–therapist relationship—that a recollection is either necessary or a non-substantive harm has a great deal of intuitive appeal. However, we have challenged the idea that therapists are likely to have a special kind of expertise which allows them to take ethical risks that others are not permitted to take. The client–therapist relationship, then, despite being of great importance, does not offset the ethical considerations underpinning (PNT).

5.3 Paucity of Clinical Alternatives

A third option to override the ethical considerations underpinning (PNT) is that the retrieval of information requested—while not strictly necessary—is highly relevant to the treatment of the client, and that the absence of this information could impede the client's recovery. This response also trades on the costs and benefits of requiring information about traumatic memories. In this case, the objector can concede that

[39] For example, the eye movements assumed to explain client improvement following EMDR appear to be inefficacious (see 5.3).

[40] In the UK, for instance, newly qualified teachers (NQTs) serve a mandatory one-year induction.

[41] See BACP website: https://www.bacp.co.uk/news/news-from-bacp/2020/6-march-government-update-on-statutory-regulation-of-counsellors-and-psychotherapists/.

[42] There may be professions for which this claim is less intuitive, for example, professions in which there is a culture of expertise overriding ethical principles. Even if there are such examples, the case would still have to be made that overriding ethical principles was legitimate, and that the case sufficiently resembled the case we are examining here.

there is a genuine risk of harm arising from the interaction, and claim that the risk is counteracted by the benefits because, for instance, there is a paucity of plausible treatment alternatives offering broadly equivalent results. We take this to be the most plausible way to override the ethical concerns that make the adoption of (PNT) intuitively appealing.

Narrative-based treatments for trauma are the norm and require the client to divulge the details of—sometimes to explore at depth multiple times—her most troubling or difficult memories. Some methods claim that locating and focusing on memories of trauma is the *sine qua non* of therapy. Weaker versions of this view may either suggest that effective non-narrative therapies are possible, but unavailable, or that such therapies are available but demonstrably inferior. Thus, the plausibility of these views rests either on a theoretical claim about therapeutic mechanism or an empirical claim about the availability or efficacy of competing treatment forms. We briefly address both possibilities.

Trauma therapy is often said to work by "reprocessing"[43] traumatic memories into memories that clients can live with. In that sense it relies on a degree of exposure to the traumatic memories in question. This exposure is commonly achieved by talking through—and sometimes *pausing on*—the traumatic memory.[44] However, one can accept the claim that a therapeutic mechanism requires exposure to traumatic memory content, while denying that this entails the verbalisation or narrative recollection of traumatic content. Even some proponents of therapies strongly associated with narrative (e.g., CBT) concede that narrative is only one method of exacting exposure, and that other methods (e.g., the modification of visual cognitions) are possible, and may even be "powerful, if not preferred" for processing traumatic material (Holmes et al. 2007, p. 298). So, the theoretical claim is not initially plausible. The most forceful empirical claim would be that non-narrative treatments are available but inefficacious, or markedly inferior. But it is not obviously empirically supported.

Evidence for the efficacy of narrative treatments appears to be relatively robust (e.g., Watkins et al. 2018), in part because narrative approaches are widely studied, and narrative methods are currently prevalent. It is a less straightforward matter, though not impossible, to find evidence for the efficacy of non-narrative treatments. Methodological issues confound in this case: measuring the efficacy of non-narrative treatments seems to require the deliberate exclusion of references to traumatic memories or experiences, something that many "organically" formed therapies haven't thought to do. (Note the important asymmetry: evidence for the efficacy of narrative therapies doesn't require the elimination of non-narrative elements.) There is, nonetheless, a burgeoning literature that bears upon the issues both of efficacy and acceptability to clients. For example, Imel et al. (2013) found that non-narrative interventions for PTSD, when compared to narrative interventions, resulted in lower levels of dropout (see also Frost et al. 2014). To show this, Imel et al. (2013) draw

[43] "Re-processing", as among a number of terms in the psychotherapeutic lexicon which appears to be widespread in the field, but is not well-defined. Compare "re-traumatisation" which is both a neologism and a term of art (jargon). "Re-processing" is an existing term with a new ("lexically innovative") technical meaning. Both neologism, and lexical innovation can give rise to ambiguity (Carston 2021).

[44] For a discussion of the mechanism as it relates to dreams and nightmares, see Davies et al. (2021).

a distinction between "trauma-focused" (or trauma-specific) and "trauma-avoidant" interventions (394). They also describe several levels of "trauma focus", including: "(a) treatments that primarily focus on retelling the traumatic event, (b) treatments that do not focus on retelling but allow discussion of the trauma, (c) treatments that refrain from any discussion of trauma' (396). Although (a) to (c) look ambiguous, it is clear that (a) would be classified as a "narrative" approach, and (c) as "non-narrative". Imel et al. found that narrative interventions had a higher rate of dropout when compared to non-narrative interventions. In some cases, the difference was as high as 14% (400 f.; also Frost et al. 2014).

Although the literature is nascent, more direct evidence can be found in comparisons of narrative and non-narrative interventions. Lely et al. (2019) found that both narrative exposure therapy (NET)—based on TFCBT—and present-centred therapy (PCT) were efficacious in the treatment of older adults (aged 55 or over). PCT is designed specifically as a non-narrative set of interventions, and was originally an experimental control. It was found to be a "credible therapeutic alternative", with "comparable effectiveness".

There is still reason to be cautious when drawing conclusions. The age-range of participants appears to have affected the results (e.g., dropout numbers were lower than expected). Not all evidence goes in favour of non-narrative therapy. Grech and Grech's (2020) review finds in favour of narrative therapies, for instance, but not often at a level of significance, and the selection of non-narrative approaches is highly contentious: "academic catch-up", "meditation-relaxation", "treatment for borderline personality disorder" are not obviously designed as therapies for trauma. Crucially, studies on PCT—which was designed as a therapy for trauma—were not reviewed in Grech and Grech (2020). The most forceful of the two empirical claims, then, is not obviously supported.

The second empirical claim is that non-narrative treatments may be efficacious in principle, but are not available. A version of this claim is empirically plausible, though it is less forceful against the ethical considerations underpinning (PNT).

Recall that one of the confounding factors for questions of comparative efficacy is what counts as *non-narrative*. Another is what counts as *trauma therapy*. Chess is non-narrative in the appropriate sense, but not plausibly a trauma therapy. Likewise, with meditation, relaxation, and so forth. Isolating distinctly non-narrative interventions for trauma is challenging. One form of trauma therapy which has gained recent traction is eye movement desensitisation and reprocessing (EMDR). EMDR is, on its face, either non-narrative or *narrative neutral*: eye movements are assumed to be efficacious in leading to clinical improvement, and attempts to explains the efficacy of EMDR rarely challenge this assumption (Stickgold 2002).

However, EMDR "smuggles" narrative into the process. A summary of the method includes a stage in which the client "describes the traumatic event and the associated feelings" (McFarlane and Yehuda 2000, p. 944). And the eye movements themselves are *inefficacious*: they have no effect compared to the same procedure used without eye movements (Davidson and Parker 2001, p. 305). What is efficacious about EMDR, then, is what is efficacious about its narrative components. Accordingly, some meta-analytic comparisons show no significant difference in efficacy between EMDR and TFCBT (e.g., Seidler and Wagner 2006).

Present-centred therapy (PCT)—probably the clearest example of non-narrative therapy—is non-narrative by design; has a “cogent rationale” (Imel et al. 2013); and is efficacious, safe, and “acceptable” (Lely et al. 2019). But its genesis, as an experimental control, might count against widespread adoption (Imel et al. 2013). Other candidates, for example, embodied reprocessing (ER), are non-narrative by design but has, so far, specified uses (for nightmares; flashbacks) and despite promising testimonial evidence it has not been subject to randomised control trial (RCTs).[45]

So, there is an element of truth to the empirical argument that non-narrative treatments may be efficacious, but are not—at least not widely—available. Is this enough to override (PNT)? It may be argued that, at least, it suggests that the *necessity* condition needs to be modified or eliminated in favour of a “standard” risk–benefit clause.

We think that these issues are sufficiently explained by the *ceteris paribus* clause, suggesting that no modification of the necessity condition is required. If such considerations are enough to override (PNT), they override it only insofar as we have neglected sufficiently to investigate promising alternatives, and only insofar as our ignorance with regards to these alternatives is not culpable, or the result of some blameworthy individual and/or collective bias or vice.[46] It is at least a possibility worth considering that the ignorance is indeed culpable or the result of individual and/or collective bias, since it is clear enough—from studies on therapies which are non-narrative by design—that non-narrative interventions can be both efficacious and acceptable to patients. But the potential of these therapies is not yet adequately reflected in research and practice to date. Note that culpability from the failure to explore alternatives is at the theoretical level, rather than clinical level. Only once alternative interventions are sufficiently researched and “on the market” would the culpability apply at the clinical level for clinicians.

Many of the current generation of therapists, then, may well be off the hook with regards to the ethical implications of (PNT). Note, however, that this is not because (PNT) has been found deficient as an ethical principle, but because the ethical relevance of research selection in this area is still an open question.

Even for current-generation therapists (PNT) might prove a useful action-guiding principle for the selection of interventions, especially during sensitive periods in a client’s trauma-recovery during which there may be an increased risk of re-traumatisation or dropout.

6 Conclusion

We presented a case in which it is plausibly unethical to ask trauma sufferers for details relating to their trauma, proposed two plausible conditions as the mark of unethical interaction with victims in that context, and concluded that these conditions appear to apply for interactions with victims of trauma more broadly. Since this

[45] See Davies et al. (2021) for discussion.

[46] Whether or not one is responsible for specific cognitive biases or intellectual vices, is outside of the scope of this paper, but a plausible suggestion focuses on whether the bias or vice is in principle revisable by the agent (see Cassam 2018).

would be a challenging conclusion for predominant approaches to psychotherapy, counselling, and services which involve interactions with trauma victims, we considered a range of possibilities for dispensing with the conclusion and several factors that might offset the two conditions which generate it. None of the ways we consideredwere entirely successful in dispensing with the conclusion or offsetting the two conditions.

Nevertheless, the conclusions we can draw are importantly different in clinical and non-clinical cases. In non-clinical cases, such as criminal compensation, (PNT) explains which interactions with victims of trauma are ethical and which are unethical. In the clinical case, a straightforward conclusion is hampered by a deficit of research into non-narrative interventions, which in turn plausibly impacts the clinical-decision-making around the potential deployment of such interventions. Whether or not current-generation clinicians are off the hook with regards to (PNT) turns on whether research-level ignorance around non-narrative interventions is culpable, and/or the result of blameworthy individual or collective bias or vice. But even while we await the outcome of this latter inquiry, we think there is a good case for challenging the assumption that the kinds of questions routinely asked in therapy sessions about trauma clients are always appropriate. There is also a good case for challenging broader assumptions about the necessity of narrative-focused treatments more generally, and their privileged status as the default kind of intervention.

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