"Now it's your choice": Nondirective genetic counseling, other minds, place and counselee empowerment

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Abstract: In this article we use a variety of philosophical literature to support and clarify the tenets and importance of a form of nondirective genetic counseling. We do this by referring to the problem of other minds and our philosophy of place which is informed by Jung, Lacan, Heidegger, Malpas and Zizek. Our major thesis is that nondirective counseling is the most ethical way to help a counselee. A genetic counselor cannot enter into the lived first person conscious experience of the counselee and so can never really know the best decisions for each individual person. Ultimately, we argue that in most cases, choices and decisions need to be made by the counselee so that they are able to discover their non-obstructed home or *place* in the world where their mental health awaits them. We argue that counselee decisions in genetic counseling cannot be prescribed as 'prepackaged' solutions because the best outcome is facilitated by the nature of the therapeutic alliance and the unique interaction between the *place* of each individual counselor and counselee.

Keywords: genetic counseling, other minds, place

INTRODUCTION

As a result of the unbridgeable gap presented by the problem of other minds, we encourage the development of therapeutic relationships and alliances that recognise and respect the beliefs and final decision of the counselee. Moreover, we acknowledge that it is the effectiveness of the therapeutic relationship itself that has significant impact on positive counseling outcomes. We argue that humility, open-mindedness, unassuming judgment and respect for alterity, otherness and difference are consistent with the nature of virtuous genetic counseling. We consider these as having distinct relevance to genetic counseling and as such are important extensions on the usual psychotherapy (counseling)

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virtues or regulative ideals identified elsewhere as compassionate empathy, respectful positive regard, congruence and trustworthiness (Crowden 2008). While counselors should not tell counselees what to do by respecting their decisions and how they arrive at them, in order to prevent counterintuitive consequences, the counselor should develop an ability (practical wisdom or Aristotelian *phronesis*) so that they know when it is ethical to stop any actions that are unethical, harmful or that they have a legal obligation to stop. We justify this by noting the problem of other minds also applies to the mind of the counselor, so they also have authority over their responses to the counselee. Ultimately all outcomes of the counseling session are determined through a unique *place* of dialectic or dialogue between the counselor and counselee. Our ideas concerning this outcome take some inspiration from our earlier publications on virtue ethics and *place* (Crowden, Gildersleeve 2019). As a result, we claim that decisions in genetic counseling cannot be prescribed as 'prepackaged' solutions because the best outcome is determined by the unique interaction between the *place* of each individual counselor and counselee.

Finally, our reference to counselee choice in the title is important not only for the general mindset of the counselee in genetic counseling (who are encouraged to take or leave using the suggestions provided by the counselor) but also for applying to the arguments we outline in this article. Since we also encounter the problem of other minds of our readers, we have no proof that our arguments should apply or be valid for those who read this and therefore we leave it to each individual to determine if our ideas are valuable to them or not. To do otherwise would hubristically ignore the problem of other minds.

GENETIC COUNSELING AND THE PSYCHOTHERAPY RELATIONSHIP

The foundations of counseling and psychotherapy assume that it is possible for one person to resolve a problem through the process of listening to, and talking with, another (Symington 2006, 2). The psychotherapist's goal is to increase choices by assisting the recipient of psychotherapy (the counselee) to experience a sense of psychological well-being, an increased awareness of their self, and an appreciation of how their self connects with other's experiences, so that they are better able to develop the skills necessary for dealing with the challenges of life. Such goals can only be realised if a counselor or psychotherapist is able to create a strong therapeutic relationship and

alliance with a counselee. Thus, a core condition that informs the character of counseling and psychotherapy is the psychotherapeutic relationship and alliance itself.

Psychotherapeutic relationships are not all the same. Psychotherapy is not practiced by all therapists at a consistently intimate or deep level of relationship. It is usual to identify at least three different levels of psychotherapeutic relationship. We can call these respectively *Psychotherapy relationship level 1, level 2, and level 3*. For convenience we modify Cawley's levels and identify the different levels as *Pr1*, *Pr2*, and *Pr3* (Cawley 1977). Accordingly, *Pr1* is akin to what any good General Practitioner (GP), Registered Nurse (RN), school counselor or other health professional would do to provide appropriate supportive psychotherapy and counseling. Psychotherapy at this level often involves the straightforward unburdening of problems to a sympathetic listener and ventilation of thoughts, feeling and actions within a supportive relationship. The next level, *Pr2*, is what the good Psychiatrist, Psychiatric/Mental Health Nurse, Social Worker, Psychologist or other mental health professional does. Psychotherapy may be eclectic, is inclusive of the attributes of *Pr1* but further extends psychotherapeutic processes to a deeper discussion of patient problems. At *Pr2* a non-judgemental professional would be expected to be familiar with the nature of mental health to the extent that therapy includes attention being paid to the clarification of problems; identifying their nature and origin within a deepening therapeutic relationship which includes the therapist acknowledging and confronting patient defences. The final level of therapy, *Pr3*, is akin to the depth of practice represented in the quote by Symington that was used to open this section. Psychotherapy at this level is normally undertaken by specially trained and qualified psychotherapists from a range of different mental health disciplines, (psychiatry, psychology psychiatric/mental health nursing, medical, and other health care professionals), and is inclusive of those characteristics outlined for the previous two levels. Also, the psychotherapist usually uses more complex psychotherapeutic processes such as interpretation of unconscious motives and transference phenomena, repetition remembering and reconstruction of past experiences, regression techniques and resolution of conflicts by re-experience strategies and analysis within deeper therapeutic relationships (Bateman et al. 2010).

Each of the three levels are quite different. For instance, while there may be some similarities between *Pr1* and *Pr3* in relation to therapeutic unburdening of problems, ventilation of feelings, discussion of problems, support within a 'working alliance', and the like, there are very real differences too. At *Pr1* defences are supported and reinforced while at *Pr3* defences are confronted and modified. Patient anxiety is kept to a minimum with *Pr1* while an optimal level of anxiety is sought and explored in *Pr3* practice. Transference is minimised in *Pr1* and fostered, revealed and analysed in *Pr3*. Also, at the *Pr1* level practice regression is discouraged, reporting of dreams is not encouraged and advice is offered as necessary. At *Pr3* regression is allowed within sessions, reporting of dreams is welcomed, and advice is withheld (Bateman 2000, 95).

At *Pr1* the psychotherapeutic relationship is not deep. Accordingly, it may be suggested that *Pr1* should not really even qualify as psychotherapy. However, this criticism would be misplaced. It is important to recognise that psychotherapy takes place on a continuum. All three levels are integral to the process of psychotherapy. The goals of psychotherapy at each different level are the same. What is different is the way the goals at each level inform the regulative ideals of practice. For instance, psychotherapists at all levels attempt to encourage recipients to have increased choice through the development of a trusting relationship. A GP at *Pr1* may be more willing to disclose information to a third party than a psychotherapist conducting a long-term analysis at *Pr3*. At each level a therapist has the goal to increase the recipient's choices. However, there are very different shared understandings about the nature of the therapeutic relationship at each level. Moreover, as the depth of the psychotherapeutic relationship increases, recipient expectations about the psychotherapist's character inevitably differ too.

Core psychotherapy characteristics are relevant too and encompass all levels of therapy. There are core psychotherapist virtues such as respectful positive regard, compassionate empathy, congruence and trustworthiness. However, as the character of psychotherapy varies at each level, psychotherapists apply psychotherapy virtues in different ways at each respective level of practice. For example, we can assume that all psychotherapists act from the virtue of trustworthiness as they attempt to create strong therapeutic alliances with patients. However what trust means in any particular therapeutic relationship situation can vary. Acting from trustworthiness will mean that all psychotherapists

will maintain confidentiality to some extent. However, a psychotherapist at a school counseling service (*Pr1*) may not maintain as stringent a level of confidentiality as a psychoanalyst in a *Pr3* relationship. In counseling practice in schools, it is often disclosed to the recipients of counseling that there are many exemptions to the requirement for confidentiality. On the other hand, like criminal lawyers, some journalists and catholic priests who refuse to disclose to a third-party information shared in confession, many psychoanalysts at *Pr3* often choose to maintain absolute or near-absolute confidentiality in many situations (Crowden 2008).

Such distinct nuances of the psychotherapy process can only really be appreciated when the differing depth or level of psychotherapeutic exploration that is undertaken within various types of psychotherapeutic relationship is appreciated. It is important to recognise that the levels are on a continuum, meaning that there will be a natural overlap between each level of psychotherapy. However, differentiating each respective level of psychotherapeutic relationship depth as we have done allows one to better appreciate how the ethical demands requirements for ethical psychotherapy practice may differ and be distinctive in relation to each different level of relationship. Parallel examples can also arguably be seen in other health professions. For instance, the depth of a therapeutic relationship that a patient has with a nurse who is measuring baseline physical observations such as temperature, pulse and blood pressure before the patient's ingrown toe nail operation will be very different from the sort of relationship that a pregnant woman has with the midwife who is managing her homebirth. Any therapeutic relationship can be differentiated from another by the level of depth of the relationship itself. Moreover, while health professionals' goals, motivations and dispositions in different relationships may be similar, how the corresponding virtues and regulative ideals are likely to be played out can be very different. This certainly applies in psychotherapy. Psychotherapy goals may be consistent but the way the goals at each level inform the regulative ideals of practice differs. Understanding the different levels of psychotherapist relationship depth goes some way toward explaining why different ethical decision-making and actions by individual psychotherapists occur in what may often appear to be similar situations.

Genetic Counseling sits in a distinct place within the frame and milieu of counseling and psychotherapy. The Human Genetics Society

of Australasia (HGSA) rightly identifies genetic counseling as a communication process which aims to help individuals, couples and families understand and adapt to the medical, psychological, familial and reproductive implications of the genetic contribution to specific health conditions. The process integrates

> Interpretation of family and medical histories to assess the chance of disease occurrence or recurrence. Education about the natural history of the condition, inheritance pattern, testing, management, prevention, support resources and research. Counseling to promote informed choices in view of risk assessment, family goals, ethical and religious values. Support to encourage the best possible adjustment to the disorder in an affected family member and/or to the risk of recurrence of that disorder" (Resta et al 2006, 80).

Thus, we see that genetic counseling is a practice that primarily operates as a level 1 and level 2 psychotherapy. However, it is important to note that, primarily because of the sorts of life changing decisions and choices that counselees may be required to make, genetic counseling at times can enter into a deeper level 3 psychotherapy practice relationships. This has implications for the training and preparation of genetic counselors.

NONDIRECTIVE GENETIC COUNSELING

Weil (2003, 200) explains the "Sarah Lawrence College in 1969, initiated a period of more organized theory and education in genetic counseling". He states "the Sarah Lawrence Program adopted Carl Roger's theory of nondirective counseling" as a way of developing genetic counseling. Roger's ideas can be understood as leading genetic counselors to be concerned with "supporting the beliefs, values, and decision making process of the counselee". Weil suggests that non-directive genetic counseling developed from changing social and political attitudes "with the abortion rights, patient rights, disability rights, and feminist movements all providing support for reproductive decision making based on the beliefs and values of the individuals involved" (Ibid, 201).

Nondirective genetic counseling is supported by the American Society of Human Genetics which states genetic counseling involves "help[ing] the individual or family...choose the course of action which seems appropriate to them" and "The Code of Ethics of the National Society of Genetic Counselors (NSGC) also states in part that genetic counselors "Respect their clients' beliefs, cultural traditions, inclinations, circumstances, and feelings," to "Enable their clients to

make informed independent decisions, free of coercion" (Weil 2003, 201). Furthermore, the "Code of Ethical Principles for Genetics Professionals" states that genetic professionals should "provide counseling that is nondirective...and [that] respect[s]the choices of patients and families" (Ibid).

A broad definition of nondirectiveness is "to promote active, knowledgeable counseling that supports counselee autonomy, facilitates informed decision making" or "[Nondirectiveness] describes procedures aimed at promoting the autonomy and self-directedness of the client" (Weil 2003, 203). Congruent with other publications on this topic we understand "genetic counseling as a highly circumscribed form of psychotherapy in which effective communication of genetic information is a central therapeutic goal" (Austin, Semaka, Hadjipavlou 2014, 903). We show how we believe genetic counseling relates to psychoanalytic psychotherapy in our section 'Place, Psychoanalysis and Genetic Counseling'.

Our ideas in this later section align genetic counseling with psychotherapy which is the application of "established psychological principles for the purpose of assisting people to modify their behaviors, cognitions, emotions, and/or other personal characteristics in directions that the participants deem desirable" (Ibid, 904). We highlight how our philosophy of *place* and psychoanalysis combined with nondirective genetic counseling can "provide symptom relief and personality change, reduce future symptomatic episodes, enhance quality of life, promote adaptive functioning in work/school and relationships" and "increase the likelihood of making healthy life choices" (Ibid).

Our article provides further insight to show how nondirective genetic counseling is "a helping relationship in which one person has the knowledge and skills relevant to helping another person address a problem through conversation" (Ibid) where the genetic counselor helps the counselee "understand and adapt to the medical, psychological, and familial implications of genetic contributions to disease" (Ibid). We also outline a philosophical and psychoanalytic basis to explain why genetic counseling can "evoke feelings of shame and guilt, especially when psychological concerns are not addressed" (Ibid). We agree that genetic counseling should be "a psychoeducational process focused on the communication of genetic information that is embedded within a therapeutic relationship" (Ibid, 908).

The major argument we present is built from the philosophical *problem of other minds*. We discuss this in greater detail in the next section but as an introduction we wish to highlight that Kessler has implicitly recognized this problem and its relationship to nondirective counseling stating "'the counselor does not share the same life space, life history, and life dilemmas' as the counselee, that the counselor may be confused and uncertain herself, and that the counselor 'does not share in the economic, social, and psychological consequences of a counselee's decision' and so cannot honestly share in the 'agony of decision'" (Kessler cited in Kopinsky 1992, 345). Our use of the problem of other minds provides stronger support for nondirective counseling and for those who recognize "the fact that the counselor and counselee may hold different values in life" (Kopinsky 1992, 345).

Fortunately, "the principle of nondirectiveness has come to be seen as a 'universal norm' in relation to genetic counseling" (Williams, Alderson, Farsides 2002, 339). In the next section we will outline why this is important and why nondirectiveness should continue to be practiced in genetic counseling. Williams et.al (2002, 339) explain "client autonomy can best be encouraged within this approach, with only the client's values being discussed within the counseling process". Clarke notes nondirectiveness aims "not to lead clients to make particular decisions or choices (those preferred or recommended by the clinician, the health service or by society) but to help them to make the best decisions for themselves and their families as judged from their own perspectives" (Clarke cited in Williams, Alderson, Farsides 2002, 339).

The goal of "nondirectiveness means that 'genetic counselors should not impose their personal views on patients' (Fine, 107). 'To maximize client autonomy, the counselor is to provide information, clarify options, and their consequences, and assist clients in reaching decisions consistent with their personal values'" (Anderson 1999, 128). The problem of other minds provides philosophical support for these goals. We believe being a virtuous genetic counselor means "presenting fact without influencing decision (non-directiveness). The couple is provided all the available information about the disease and reproductive options open to them, but the decision has to be taken by the couple" (Phadke 2004, 154). We argue that this is the best approach to counseling because the counselor cannot enter into the consciousness or first person lived experience of the counselee and therefore cannot really know the best decision to be made.

This shows the problem with directive counseling which can negatively affect the client's psychological well-being. Our work here on the problem of other minds highlights that the counselor should trust "clients to make good decisions for themselves that are consistent with their own values and needs not assume that the decisions will be consistent with those of the providers of counseling" (Ibid). The decisions by counselors and counselees need not be consistent because they are two unique and individual people. It is a fallacy to assume that the counselor knows what is best for the counselee when they can never be or enter into the lived conscious experience of that person. This is important to show because it has been suggested that "Medical doctors find nondirectiveness of counseling as against traditional doctor patient relationship, which assumes medical advice as doctor's responsibility" (Ibid).

Phadke (2004, 154) argues the counselee "may ask for help in decision making by asking as to what the counselor or other people would do in a similar situation, but it is unwise to be drawn into expressing personal opinion" (Ibid). We argue the counselor should make it clear to the counselee that they are two unique and different people and therefore a choice the counselor could make should not automatically apply to the counselee. We believe the job of the counselor is not to tell the counselee what to do but to help them "consider consequences of each decision so that decision is taken after careful deliberation and not in haste. Ultimately, it is the consultant, and not the counselors, who have to live with the consequences of the decision" (Ibid). There are infinite factors that can lead the counselor and counselee to have different preferences for decisions such as "desire to have children, severity and burden of the disease, personal experience with the disease, social and religious views" (Ibid). As a result, we argue that genetic counseling must be nondirective "noncoercive and nonjudgmental. The couple's decision (even if it is different from counselor's personal views) should be respected and supported" (Ibid).

Oduncu highlights other aspects of good genetic counseling. For example, "counselors support their counselees in the decision-making process by providing impartial and non-directive counseling. To achieve this goal, counselors use several techniques to enable individuals to weigh the consequences of potential results of the genetic tests, and support possibilities to enhance the person's autonomy with respect to the decision" (2002, 53). This is consistent

with the dictionary definition of counseling "where 'to counsel' is defined as 'to advise')" (Ibid).

Our article here is an important addition to the literature on nondirectiveness because "studies are lacking in the field of human genetics and in other disciplines which address either the theory or practice of this type of communication in the context of genetic counseling" (Wolff 1999, 23). We highlight why we believe directive genetic counseling is problematic. Wolff describes directive genetic counseling by saying it occurs when "the counselor defines the problem of the patient/client and its cause. The counselor makes proposals for further clarification and to overcome difficulties. The counselor, therefore, works on the basis of problems and results, aims at social agreement and claims the right of the capable to guide the non-capable" (Ibid, 28). In directive genetic counseling "the counselor assumes great responsibility for the decisions of the client. The nondirective approach, on the other hand, is one in which the client defines the problem and selects life objectives with the counselor helping the client to find ways to achieve the stated goal(s)" (Ibid). We use the problem of other minds to support this nondirective approach. Our work also aligns with the philosophy of Carl Rogers who "took nondirectiveness to be an expression of humility on the part of the counselor who does not claim to have the wisdom to solve other peoples' problems but is able to assist them" (Ibid). Our ideas on the problem of other minds in the next section elucidates why it is important "he advised counselors to act with discretion concerning decisions and evaluations" (Ibid).

We disagree that "the health care provider-patient relationship" should be paternalistic in genetic counseling where "the health care provider holding most of the control and making many of the decisions" (Marvin 2000, 21). We believe this is erroneous because the provider is not the patient. They are distinct individuals with distinct lives and worldviews. The provider will never know what it is to be their patient and that is why we believe it is wrong for the provider to "define the patient's problem and prescribe an appropriate solution" (Ibid). Marvin says the "directive approach is based on the assumption that the provider has more skills and knowledge than the patient about health problems and interventions" (Ibid) and our work refutes this by showing the relevance of the problem of other minds.

Our work supports nondirectiveness as a "mainstay for the field of genetic counseling" (Ibid). This is important because nondirective

counseling can "empower patients to make autonomous, well-informed choices" (Ibid). Nondirectiveness is a suitable response to the problem of other minds because it promotes counselee decisions "based on their own values and beliefs, without the imposition of the genetic counselor's personal beliefs" (Ibid). As a result, it is good to see the commitment to a nondirective approach by the National Society of Genetic Counselors' Code of Ethics. The Code states that "the counselor-client relationship is based on values of care and respect for the client's autonomy, individuality, welfare and freedom...genetic counselors strive to enable their clients to make informed independent decisions, free of coercion, by providing or illuminating the necessary facts and clarifying alternatives and anticipated consequences" (Ibid).

So, what is left for the counselor to do if the counselee should have the freedom to direct the counseling session and their decisions during the counseling process? In light of our ideas on the problem of other minds we argue "the role of the counselor is to ensure that patients have accurate information, including knowledge of genetic risks and an appreciation of potential consequences of decisions" (Ibid). This also means the counselor should help the counselee understand the importance of nondirective counseling so as "to develop patients' confidence in their ability to make difficult choices" (Ibid). We believe the counselor should help the counselee by providing "a framework of issues to consider, and guide them through the decision-making process" (Ibid) while maintaining that the counselor does not know the best decision for the counselee. We recognize "Genetic professionals have expertise about chromosomes; Mendelian inheritance; testing methodologies; legal, emotional, and social implications of genetic issues" however "this expertise does not necessarily translate into the wisdom to make decisions for patients" (Ibid). We recognize that the counselor is forever separated from living the life of the counselee and therefore we argue nondirective counseling that still makes use of the genetic counselor skills is the best approach.

An example of when the problem of other minds is highlighted is when Marvin says, "While knowing a baby has a problem before birth may be useful for some families, other families feel more comfortable with a 'wait and see' approach" (Ibid, 22). In other words, we believe the counselor is wrong to direct the counselee into any decision they consider is best since every individual is unique and different. Due to the problem of other minds "Counselors can provide accurate information about genetic risks, procedural risks, specific genetic

conditions, and options for dealing with results; but in the end, what is right for one family may not be right for another" (Ibid). Because the counselor is forever isolated from the first person lived conscious experience of their counselee they should never pre-empt their decisions for them. This diversity is highlighted by Marvin who says:

> some patients may elect prenatal diagnosis so that they can emotionally and otherwise prepare for the birth of a child with a disability. Others may elect prenatal diagnosis with intentions of terminating an abnormal pregnancy. Furthermore, some may decline invasive testing because of concerns about the risks of the procedures and a commitment to continue the pregnancy regardless of test results. Others may decline to avoid being put in a situation where they have to decide about termination or continuation of an abnormal pregnancy (Ibid).

Therefore, we argue that there has been an error in nondirectiveness if counselees say things such as "We were told not to have children based on our carrier status," or "We were told that I should have amniocentesis, given my age," because this "falsely assumes that health care professionals know what's right for a family" (Ibid) in genetic counseling. We want to make it clear that our "nondirective approach does not suggest leaving patients on their own to sort through these trying choices. Rather, it suggests providing a framework by which they might think through the problem and arrive at their own decision" (Ibid). We advocate that the role of the counselor in "Nondirective counseling is an active process designed to challenge patients and to evoke the patients' competence and ability for self-direction" (Ibid) so they are able to make their own authentic life choices. In other words, counselors should "help their clients arrive at the best decisions from personal perspectives and are not guiding them towards any particular decision (for example, to test or not to test, to terminate a pregnancy or to continue it)" (Elwyn, Gray, Clarke 2000, 135).

Elwyn et al (2000) provide a nice framework for shared decision making (SDM) and nondirectiveness in genetic counseling which we take inspiration from. SDM involves "counselor and the client share information on the basis of which a decision is to be made. They then discuss their views and come to an agreed decision" (Ibid, 136). SDM allows the counselor "to contribute his professional opinion (a valid biomedical perspective) into the decision making process, without denying the critical importance of the patient's wider value systems" (Ibid). SDM respects counselee autonomy "making SDM a natural

approach to the negotiation of management decisions in clinical genetics" (Ibid, 137). SDM allows the counselor to have an important role in genetic counseling by removing directiveness. The counselor should make sure there is "a two way exchange, not only of information but also of preferences about plans for management or intervention" (Ibid). To overcome the slippery slope problem of no counselor involvement in counseling "It is especially important that clients/patients do not feel abandoned to make important decisions without sufficient support" (Ibid). This is highlighted in one study where most women "wanted to hear providers' recommendations about testing. Women still wanted to make their own decision, either choosing to follow the provider's recommendation or choosing to veto it" (Ibid). This shows that SDM can provide "an additional and useful framework for the complex interactions that inevitably occur in genetic consultations" (Ibid, 138).

We argue counselors should be able "to communicate complex risk information accurately while refraining from advice-giving. In this sense, nondirectiveness seeks to align informed consent with client autonomy" (Arribas-Ayllon, Sarangi 2014, 171). This is consistent with Carl Rogers who wanted "clients to 'set the agenda' and explore their own solutions" (Ibid, 173). By using the problem of other minds in the next section, we highlight the significance of Rogers ideas and why "the shift from 'content-oriented' to 'person-oriented' counseling marks an important break from a medical focus on advice-giving, to a psychosocial focus on client autonomy and personal reflection" (Ibid).

Wolff (2001, 1), gives some more insight into nondirectiveness noting that it "has its roots in humanistic psychology". Our article is concerned with showing the problem with directive counseling where "the patient is seen as an 'object' to be treated" (Ibid, 2). This can happen if the problem of other minds is unconscious to the counselor. This is when the counselor believes they know the counselee (which we call the counselor complex) and what is best for them because the "counselor defines the problem and its cause, and makes proposals for further clarification and to overcome difficulties. The counselor therefore works on the basis of problems and results, aims at social agreement, and claims the right of the capable to guide the noncapable" (Ibid). Unfortunately, this counselor complex gains momentum when some believe "nondirectiveness only serves to transfer sole moral responsibility to the parents and helps the counselors wash their hands of any responsibility ('it is their

responsibility and we wash our hands of any responsibility')" (Wolff 1999, 34). From our point of view this could not be further from the truth and only serves to objectify counselees.

Our philosophical analysis leads us to prefer nondirectiveness where "the patient defines the problem, selects life objectives, and chooses the way of adaptation, with the counselor helping the patient to find ways to achieve the stated goals" (Wolff 2001, 2). Here the counselor is still important by providing genetic information to influence the "thinking process; therefore, he/she takes great responsibility for the counseling process, but not for the behavior and the decisions of the patient" (Ibid).

Our title for this article is similar to a paper by Wessels, Koole, Penn (2015) "'And then you can decide' – antenatal foetal diagnosis decision making in South Africa". Our 'now it's your choice' motif is similar in that both titles suggest the counselor gives information or advice to the counselee, but it is up to the counselee if they believe it is useful for their own situation or not. Our reference to 'take it or leave it' in the title is important not only for the general mindset of the counselee in genetic counseling (who are encouraged to take or leave using the suggestions from the counselor) but also apply to the arguments we outline in this article. Since we also encounter the problem of other minds of our readers, we have no proof that our arguments should apply or be valid for those who read this and therefore we leave it to each individual to determine if our ideas are valuable to them or not. To do otherwise would hubristically ignore the problem of other minds.

Thus, we argue "the genetic counselor's role is to provide information about the relevant genetic conditions, risks and testing options so that women or couples can make informed decisions" (Ibid, 3314). Because the counselor cannot enter into and experience the life or *place* of the counselee a "non- directive approach is advocated with the premise that the information given should be unbiased and neutral and that the counselor should not influence or advise on a specific course of action. This approach is believed to enhance patient autonomy and result in informed decision making" (Ibid). This nondirective approach recognizes the alterity or otherness of the counselee and so "aligns with patient- centred communication as both emphasize care that is attuned to patients' needs, values and preferences" (Ibid).

Since the first-person conscious experience of the counselees *place* in the world is shut off from the genetic counselor, they should aim "not to guide the patient (or client) to an outcome predetermined by the counselor or the genetics service but instead to support the patient in reaching their own decisions" (Clarke 2017, 543). We believe the genetic counselor is ethical and practices the virtue of nondirectiveness by having "no particular outcome in mind" and "is not attempting to sway the patient to make one decision rather than another" (Ibid, 553). It must be made clear that the counselor has an important job even though we advocate they be nondirective. We believe the genetic counselor needs to show "concern for the patient and their welfare—they are not indifferent—and they are interested in how the patient makes their decision. In fact, they are more interested in that than in the decision that is made" (Ibid). This highlights the key role of the genetic counselor in light of the problem of other minds, the counselor is there to assist the counselee to arrive at their *own* decision best suited to their unique *place* in the world. This is how we understand the best way the genetic counselor can act by providing "information and explanation, to help the patient understand their situation and weigh the information they have been given. This allows them to make the best decision they can, a decision with which they, and not the counselor, will then have to live" (Ibid).

The genetic counselor is suited in this role due to their experience of seeing "how other families make decisions and the aftermath, can lead them to challenge the initial judgements of a patient without wanting to supplant their right to make the eventual decision" (Ibid). The counselor in our nondirective philosophy of genetic counseling is important to clarify when "the patient has misunderstood some fact, or has not recognised the relevance of some aspect" (Ibid). This can occur when the counselor "recommend that the patient considers some potential consequences of their decision without this meaning that the professional is wanting to make or impose the decision" (Ibid). This is necessary for the counselee to make authentic decisions in their life where the goal of the counselor should be to promote "the autonomy and self-directedness of the client" (Ibid, 560).

Statistics from Wolff and Jung (1995, 4) highlight that many counselors appear to support nondirective counseling. They quote a study that found "more than 75% of all medical geneticists in more than 75% of the countries surveyed consider themselves committed to the principle of nondirectiveness in genetic counseling". This is

supported by Bartels, LeRoy, McCarthy and Caplan (1997, 176) who found "that nondirectiveness is a valued goal of genetic counselors. Almost 96% of the sample rated nondirectiveness as very important to their clinical practice". Our article shows in a new light why we believe nondirectiveness should continue to have high number of adherents and why it is the most "ethically responsible approach to the difficulties and consequences of genetic diagnosis" (Wolff, Jung 1995, 4).

It is clear to see our ideas lay in the tradition of humanistic psychology with its "concerns of supporting the values and decision-making process of the patient" (Chieng, Chan, Lee 2011, 37). The problem of other minds shows why the counselee should define "the problem and selects life objectives with the counselor helping the client to find ways to achieve the stated goal" (Ibid). We believe it is the counselor's responsibility to understand the problem of other minds and act nondirectively, otherwise counseling can be considered directive which will "undermine the individual's autonomy and compromise his or her ability to make an autonomous decision" (Kessler 1997, 466).

We agree with Suter (1998, 161) who recognizes that it is ethical for "genetic counselors to preserve the 'autonomous nature of decision making'" for counselees. The problem of other minds shows why genetic counselors need "to respect the profoundly personal nature of reproductive decision making, and to facilitate and support clients' decision making" (Ibid, 162). Broadly stated we agree that "the ethical principles of autonomy and beneficence" (Ibid) should underpin nondirective genetic counseling. This can occur when the counselor facilitates and helps the counselee understand their options. To overstep their mark as a counselor is to not understand that "the counselor, in most circumstances, does not know what outcome would be best for the client; the decisions are 'deeply personal,' rather than medical" (Ibid). This is overstepping the mark of the counselor because their consciousness is forever separated from an experience of the mind of the counselee. As a result, we disagree that the counselor can "correctly determine the best decision for a particular client" (Ibid, 163). Instead we believe the role of the genetic counselor is to "lead the client to examine her decision more fully and in ways she had not contemplated earlier. This could facilitate the decision-making process, enhance self-determination, promote autonomy, and therefore advance beneficence" (Ibid).

The problem of other minds brings into focus why genetic counselors should "value and respect the personal nature of decision making; the importance of personal freedom, self-determination, and reproductive choice" (Biesecker 1998, 146). Later in this paper we will highlight how our philosophy of *place* combined with the problems of other minds supports nondirective genetic counseling. One way to briefly highlight this is to note that "childbearing is a personal matter and because genetic conditions have unique meaning to each family, genetic counseling has largely been offered in a nondirective manner" (Ibid, 148). In this last part of this section on nondirective genetic counseling, we further outline what we believe the role of the counselor should be. In particular we highlight the importance of dialogue between the counselor and counselee and use the work of Mary White (1997; 1998) to elucidate this.

The problem of other minds highlights the importance of nondirective counseling which promotes "informed and independent decision-making. To the extent that it minimizes risks of coercion, this counseling approach effectively respects client autonomy" (White 1998, 6) as well as the independence of the mind and consciousness of the counselee. With this view of reality, we believe the expertise of the counselor comes from an emphasis on the role of deliberation to produce "thoroughly reasoned decisions. In such an approach, characterized by dialogue, counselors are responsible for ensuring that decisions are fully informed and carefully deliberated" (Ibid, 12). Because the counselor cannot ethically tell the counselee what to do, "counseling remains nonprescriptive, but in the course of discussion counselors may introduce unsolicited information and/or challenge what they believe are questionable choices. By this means clients can be better assured that the decisions they make are fully considered, while counselors demonstrate a limited degree of professional accountability" (Ibid, 5).

The problem of other minds shows why counseling needs to "enable clients to make informed and independent decisions with minimal risk of manipulation or coercion. Nondirective counseling is grounded in the belief that clients are capable of solving their own problems" (Ibid). Our work supports White who argues "the counselor's role is to provide clients with accurate genetic information and respond to their questions and concerns. Counselors minimize the risks of coercion or manipulation by communicating in value-neutral terms as much as possible" (Ibid). This method requires an important balance by

providing "support to clients while respecting their freedom to make their own decisions" (Ibid).

In order to respect the problem of other minds, the counselor needs "a stance of moral neutrality" (Ibid, p.6). This means the nondirective genetic counseling that we support is "implicitly pro-choice, a position that is ideologically in agreement with mainstream feminist values and is consistent with the emphasis on patient autonomy" (Ibid). In light of our understanding of the problem of other minds we believe the best form of genetic counseling emphasizes "dialogue, in which decisions arise from a process of deliberation between counselor and client" (Ibid, 7). As a result, we agree with White that the "primary goal of nondirective counseling is client-education, while the ethical priority is to minimize the risk of coercion" (Ibid, 8). This follows Carl Rogers client centred counseling where "discussions are led by the questions and concerns of clients" (Ibid).

Instead of imposing their desires, values, needs and decisions on the counselee, "the counselor's role is to view the problem from the client's perspective" (Ibid). Since the counselor and counselee are unique individuals it is important that "counselors are trained to be alert to their own values and preferences and to speak in value-neutral language as much as possible" (Ibid). This can be achieved by expressing "information in a number of ways and trying to use objective terminology" (Ibid). It is positive to see the Code of Ethics of the National Society of Genetic Counselors is consistent with our views from the problem of other minds. This is shown in a number of places for example

> The counselor-client relationship is based on values of care and respect for the client's autonomy, individuality, welfare, and freedom. The primary concern of genetic counselors is the interests of their clients. Therefore, genetic counselors strive to:
> Respect their client's beliefs, cultural traditions, inclinations, circumstances, and feelings.
> Enable their clients to make informed independent decisions, free of coercion, by providing or illuminating the necessary facts and clarifying the alternatives and anticipated consequences" (Ibid).

These passages are significant because they show the importance of valuing self-determination and respect for individual differences. It is important for the genetic counsellor to acknowledge they will forever be different and separate from their counselee because they cannot enter into their lived experience which is "shaped and

limited by numerous factors, including the person's socioeconomic status, education, cultural and religious beliefs, health, significant relationships, and the environment within which he or she lives and works" (Ibid, 11). As a result of recognizing individual differences and the problem of other minds we along with White argue "that counseling take the form of a dialogue in which counselor and client are mutually involved in the deliberative process" (Ibid, 12). Here

> both counselor and client have important roles. Counselors would bring to the discussion their knowledge and experience and be free to offer additional information or question clients' choices. Clients would bring their values, goals, and beliefs, which, if a decision must be made, would provide the criteria by which alternatives are evaluated. Clients make their final decisions independently, but not until both counselor and client are satisfied that the deliberative process has been thoroughly and carefully conducted (Ibid, 13).

We support the view that "If a client seems to be missing important points or basing a decision on a narrow view of the circumstances, a dialogical counselor can offer additional information and perspectives as a way of broadening the client's understanding or range of options" (Ibid). Because we don't believe the counsellor can ever say what the counselee should do, we see their role being limited to "deepening the client's grasp of his or her alternatives" (Ibid). The counsellor's aim in mind should be to help the counselee by minimizing "the likelihood of future regret due to some easily avoidable error of omission, ignorance, or unanticipated consequences" (Ibid, 14). As a result, in response to the problem of other minds, we believe the genetic counsellor is limited to helping the counselee achieve "an informed and well considered decision, the quality of which is directly related to the thoroughness of the deliberative process" (Ibid).

We suggest the genetic counsellor take note of a framework for authenticity which "calls for consideration of clients' prior beliefs, values, and experiences as well as their goals and preferences" (Ibid). In our framework the counsellor's job is to help the counselee come to a well-reasoned decision so the counselee can "be confident that they have made the best choice possible at that moment in their lives" (Ibid). White implicitly highlights the problem of other minds in the following key passage

> Genetic decisions are highly personal, and in a pluralist society there are no common values that could serve as ethical guidelines for the uses of genetic

> information. This is clear from the kinds of decisions made. While one person might perceive raising a child with Down syndrome as imposing intolerable suffering on the child or a burden on society, another might view the same child as an opportunity for parenting and compassion. While some may want to know if they carry a gene for a late onset disorder in order that they may feel empowered and responsible, others would rather ignore the burden such knowledge might impose. The Asian couple that needs a male child in order to maintain a family lineage may be viewed by Americans as discriminating against women. Clearly, the differing values and needs of clients must be acknowledged and respected (Ibid).

This coupled with our philosophical analysis shows "the only prerogative counselors have is to ensure that clients carefully consider the full range of personal, practical, and ethical issues that are potentially relevant to their decisions" (Ibid, 15). White argues "the counselor's skill will entail determining how much clients want and need to know; when to offer additional information or further explore clients' reasoning; and when the decision-making process is approaching resolution" (Ibid). She also adds important tips to prevent misuse of this method when she says, "Counselors should make it clear to clients that the decision is to be made by the client and that the counselor's aim is only to ensure that the decision is informed and carefully considered" (Ibid, 16). Her advice is very useful, for example "Counselors should ask for permission to introduce unsolicited information and question decisions, and ask clients to tell them if they feel they are being pressured into a choice that is not their own. Such a process could do much to minimize the risk of coercion" (Ibid) and prevent the counselee from making decisions which are not their own. To respect the problem of other minds the counsellor needs to make "use of empathy as a means of understanding clients' perspectives; sensitivity to the particular experiences and concerns of individual clients; conscious efforts to avoid manipulating client choices" (Ibid). In summary, we believe an ethical nondirective counsellor will be "responsible for ensuring that decisions are based on careful consideration of all the factors the client identifies as significant" (Ibid).

These principles are aligned to nondirective counselling which we define "as clients' right to noninterference in decision- making" (White 1997, 297). It must be made clear that this "counseling remains nonprescriptive but holds counselors responsible for ensuring that decisions are thoroughly and carefully considered" (Ibid). The counsellor and counselee aim at a "good decision, defined as one in

which clients' values and goals, identified through the deliberative approaches of authenticity, effective deliberation, and moral reflection, are in equilibrium" (Ibid). This is important because genetic counselling should aim at "helping people make some of the most important decisions of their lives" by helping "clients to make informed and independent decisions" (Ibid, 298).

Our work advocates nondirectiveness "understood as nonprescriptiveness, meaning simply that counselors do not tell clients what to do" (Ibid). Instead of the counsellor telling the counselee what is right or wrong "the relationship between counselor and client becomes one of mutual engagement in problem solving. Counseling would consist of a dialogue in which counselor and client are each recognized as bringing unique knowledge and experience to the decision to be made" (Ibid, 305). The role of the genetic counsellor should be to provide "a broad range of medical, psychosocial, and moral information, introduce different perspectives as appropriate, and thoroughly explore clients' values and choices with them" (Ibid). The counsellor should be trained in "introducing information into the discussion that clients had neglected or overlooked" (Ibid). Importantly "Clients would contribute their respective values, circumstances, goals, and beliefs which would serve as the parameters or determining criteria of the decision" (Ibid). As a result, we argue "the counselor's aim is not to control the decision but to ensure that all relevant information has been considered and that the process by which the decision is determined is sound. Clients make their final decisions independently, but only when both the client and counselor are confident that the client fully understands the implications of the decision and its alternatives" (Ibid). The genetic counsellor should make sure the counselee considers "'authenticity,' 'effective deliberation,' and 'moral reflection'" (Ibid, 306) in their choices. White explains "Authentic choices are those that are in keeping with a person's most cherished values, goals, and beliefs, both rational and non-rational, provided they are 'in character'. Effective deliberation most closely resembles the standard definition of competence, and implies a conscious, rational evaluation of alternatives and consequences based on factual information. Moral reflection requires that choices correspond to the moral values of the decision-maker, such as belief in the sanctity of life, feelings of responsibility to other family members, or concern for how decisions will be interpreted by others" (Ibid). Nondirective genetic counsellors also need to

> make it clear that clients should make their own decisions and that the aim of counseling is only to ensure that decisions are fully informed and carefully considered. They should mention that everyone has particular values and communication styles that may inadvertently communicate messages, and encourage clients to inform them if they feel they are being pressured into a decision that is not their own. Counselors should ask for permission to question or challenge choices and explain their reluctance to provide specific advice unless it is requested (Ibid, 307).

These recommendations are ethically justified and strengthened when combined with the problem of other minds. We believe our recommendations do not overstep the mark of counsellor involvement in the counselling process. In consideration of the problem of other minds and "the variety of values, goals, and circumstances held by different individuals, client choices cannot be required to conform to any particular ethical standard" (Ibid, 308).

OTHER MINDS

In this section we outline the problem of other minds which is vital to our arguments concerning nondirective genetic counselling. The problem of other minds is a problem of scepticism where the "sceptic raises a doubt about the possibility of knowledge in connection with the mind of another" (Avramides 2019). Avramides explains "Some see the problem as arising from reflection on an apparent asymmetry in the way I know about my own and another's mind: in my own case, at least most of the time, I know what I think and feel directly and without inference from any evidence" (Ibid). In the case of others, "all access to what they think or feel is thought to be indirect, mediated by the other's behavior". The sceptic raises a legitimate philosophical problem "How do we know that, for example, another individual is angry?" "Do we (ever) know…?" (Ibid). Some believe this is an easy problem to depose of. However, it is important to consider the seriousness of the problem of other minds. Avramides notes "while some draw a parallel between the problem of gaining knowledge of the past and of another mind, there is an important asymmetry to be noted here: in the case of the past it is at least logically possible that there should be direct knowledge, while in the case of another mind such knowledge seems to be logically ruled out. As A.J. Ayer writes: It can be argued that one's position to observe a past event is due to the accident of one's position in time…But it is not an accident that one is not someone else" (Ibid).

Philosophers who have tried to resolve this problem have accepted "that, while our knowledge of our own mental states is direct, our knowledge of the mental states of others must proceed by reasoning from what we observe—the other's—to what we cannot observe—the other's mental states" (Ibid). This distinction between direct and indirect knowledge is important for our arguments supporting nondirective genetic counselling. Succinctly put, the counsellor does not have direct knowledge of the mental states of their counselee, therefore they should not be permitted to be directive in their counselling. Many philosophers support the view that the mind of another is not directly observable. For example, "as early as the fifth century AD, St. Augustine writes: 'For even when a living body is moved, there is no way opened to our eyes to see the mind, a thing which cannot be seen by the eyes'" (Ibid). Furthermore "The idea that we should have direct knowledge of another's mental states has also come under fire more recently by Colin McGinn, who writes that direct perceptual reports specifying the mental states of another 'seem definitely wrong'" (Ibid). The intractability of this problem is highlighted when Avramides says "One can twist and turn - make this philosophical move or that - but the possibility of one's aloneness in the universe remains" (2001, 3).

The problem of other minds arises because "we know about the minds of others in a very different way from the way we know our own minds. We know about our own minds partly by introspecting. If I am trying to figure out what I think about a certain question, I can concentrate on the contents of my conscious mind until I work it out. But I can't concentrate in the same way on the contents of your mind in figuring out what you think" (Crane 2015, 47). In other words, "the way we know about the states of mind of others is not, so to speak, symmetrical to the way we know our own states of mind" (Ibid). Crane uses an example of "the different ways we use to know about the position of our own bodies and the bodies of others. In order to know whether your legs are crossed, I have to look, or use some other form of observation or inspection (I could ask you). But I don't need any sort of observation to tell me whether my legs are crossed" (Ibid).

The counselor needs to recognize the problem of other minds because they "can never have direct knowledge of what another is feeling or thinking" (Cockburn 2001, 49). All the counselors can "actually see is the other's behaviour, and the judgement that another is angry or in pain always involves an interpretation of that behavior"

(Ibid). Cockburn highlights the distinction between behavior and mental states that constitutes the problem of other minds when he says "when one reflects on the fact that a person can pretend to be angry or in pain: a person may behave as one who is angry or in pain, and yet not be in these states. That, it might be said, is sufficient to show that we must draw a sharp distinction between a person's behaviour and her mental states" (Ibid, 28).

Another way of highlighting the problem of other minds is to note "that the content of one's own mental life is *immediate* or *transparent* to one in the way the content of another's mental life is not. Connected with this it is sometimes said that I have a certain *privileged access* to my own mental life or that I have a certain *authority* with respect to what I am thinking or feeling, and that this privileged access or authority does not extend to the mental life of anyone else" (Avramides 2001, 3). We highlight this below with some statements throughout the history of philosophy. The problem of other minds shows that other persons do not "have the kind of cognitive access to my mental states which they impute to me; hence by being in this kind of position one enjoys a kind of special epistemic privilege" (Alston 1989, 254). Whereas the counselor can be mistaken about how it is to be the counselee, the counselee cannot be mistaken how it is to be them. By existing they know this and therefore knowing how it is to be the counselee for the counselee "'cannot be false' (Descartes), 'are not subject to any possible error' (Lewis), 'cannot...be...in any way mistaken' (Ayer), 'it does not make sense to suppose that he is mistaken' (Shoemaker)" (Ibid).

The problem of other minds is evident again where "for example, can I know how you feel when you are depressed, or can I know that you see the same colour that I do when you look at the sky on a sunny day?" (Avramides 2001, 1). The philosopher brings these types of problems to our attention. We have applied this to genetic counseling, but sometimes philosophical problems are "taken by the non-philosopher to amount to either an oddity or an absurdity. A certain impatience is often voiced when the philosopher tries to raise this question or questions like it" (Ibid). We hope our readers do not react in this way and appreciate the problem we present to genetic counseling (and counseling or psychotherapy in general). We hope "the non-philosopher can see the point of wondering if your depression is really like mine, or if you and I have the same colour experience when we look at the sky" (Ibid, 2).

We vehemently disagree that a way around the problem of other minds is to agree with Mill who uses a classic argument from analogy. Mill writes "I conclude that other human beings have feelings like me, because, first, they have bodies like me, which I know, in my own case, to be the antecedent condition of feelings; and because, secondly, they exhibit the acts, and other outward signs, which in my own case I know by experience to be caused by feelings" (Ibid, 5). The argument can be summarized as follows: "(a) an assurance that I have a mind; (b) the observation that there is a connection between my mind and the behaviour I exhibit; and (c) the observation of a similar sort of behaviour (the 'outward signs') in others" (Ibid). We believe this reasoning is unethical which ignores alterity and reduces the other to an object of observation. The argument from analogy from Mill also encourages ideas that we are all the same which is very problematic for genetic counseling. Instead we wish the genetic counselor appreciates the problem of other minds and that they can never experience being the counselee. Avramides summarises by saying "I know my own mind immediately and can have the highest degree (or most secure form) of knowledge only of my own mind" and "I cannot know any other mind in this immediate way and that my knowledge of another mind cannot be as secure as that of my own mind" (Ibid, 10). With this understanding we hope the genetic counselor understands why nondirectiveness is so important instead of a bossy 'know it all' directive counseling method.

In this article we play the role of the sceptic. We understand the problem of other minds implicitly comes from the sceptic "writings of Descartes, and in particular his *Meditations on First Philosophy*" (Ibid, 21). Descartes *cogito ergo sum* highlights "of our own mind there can be no doubt" (Ibid). But with this certainty a problem arises how do I come to not have this doubt for the mind of another. The problem is we cannot remove this doubt regarding the mind of another. Avramides reminds us that

> what the sceptics of ancient times despaired of finding is a criterion of truth. What Descartes claims to have discovered is that there is at least one truth that does not need a criterion. The *cogito* is such a truth. What Descartes noticed is that the *cogito* is a truth that is self-guaranteeing and as such does not need a criterion. It is only truths that go outside the subject that need to be guaranteed - these truths are not self-guaranteeing. Once we see this, we can see also that a gap opens up between those truths that are self-guaranteeing and those that need to be guaranteed (Ibid, 34).

Descartes *cogito* gives rise to the problem of other minds because it "leads to a radical scepticism about knowledge of other subjects" (Ibid, 35). Augustine anticipated that there is a problem of other minds when he says "'Know the will of that man', for it is not within our reach to perceive at all, either by sense or understanding, unless by corporeal signs set forth; and this in such a way that we rather believe than understand" (Ibid, 48). This highlights something important for genetic counseling "that we can know ourselves, but not another" (Ibid). Genetic counselors should be nondirective because any argument they make about what is best for the counselee "amounts to little more than a hypothesis or conjecture" (Avramides 2002, 64). The reason for this that should have been made clear by now is that "the mind of another is something that is understood to lie forever outside my direct apprehension. I only see your behaviour, but your mind - your thoughts and feelings - are things that lie behind what I can see. I can never actually see your mind" (Ibid). In sum "Given the kinds of creatures that we are, one person's mind is forever hidden from another. This is why we can only get at another's thoughts and feelings by analogy, or by positing hypotheses" (Ibid). As a result, genetic counseling needs to proceed nondirectively because only the counselee knows what is right or wrong for them. The counselor is there to help the counselee explore the best directions and decision by providing dialogue and information but can never know what is best for their counselee. This is evident when Avramides (2011, 434) states that given "each person is aware of his own affections, and given that he cannot 'submit' to the affections of another, we cannot know whether what appears to me is of the same kind as what appears to another" and therefore it is improper and philosophically weak to extrapolate how I believe the other feels based on my own experiences. This is supported when George Berkeley highlights "that we do not *perceive* another Mind" and therefore "knowledge of the mind of another is only probable" (Ibid, 436).

The problem of other minds shows that the experience of my own mind and that of another are very different. Avramides (2009, 4) says "I cannot know another immediately and intuitively; I cannot know another in this way. Nor can I perceive the mind of another". Sollberger (2017, 1476) explains this as "a fundamental asymmetry in the means of knowledge. In my own case, I can know directly what I think and feel. This sort of self-knowledge is epistemically direct in the sense of being non-inferential and non-observational. My knowledge of other minds, however, is thought to lack these epistemic features".

There is an asymmetry between the "first personal access I have to my own psychological attitudes and phenomenal states" (Ibid) and not having this access to another. This asymmetry highlights that the genetic counselor is restricted from "direct perceptual knowledge of another's mental states" (Ibid, 1477). The counselor's knowledge of the mind of their counselee is only a hypothesis for which they "can have only indirect, behavioural evidence, so knowledge of someone else's mentality *must* be inferential" (Ibid). This highlights that the counselor is limited in their knowledge because they cannot "access another living being's experiential world" and "cannot perceive another's mental states" (Vaaja 2015, 18). The counselor is constantly faced with the problem whether they can know what the counselee's "mental states are like, how they feel from the 'inside'; in particular, whether their mental states are like" (Ibid) their own states or experiences. This is why we advocate nondirective counseling because "whatever knowledge we take ourselves to have of the minds of others, it is inferior in comparison with our knowledge of our own minds" (Ibid). The counselee has direct experience of their own mind, so they are best placed to direct their decision and the genetic counseling process.

This also emphasizes "a conceptual problem: how can we manage to have any conception of mental states other than our own?" (Hyslop 1998). This problem highlights even if in the future by some feat of technology the counselor is able to 'observe' the mental states of the counselee, the problem of other minds would still remain. This shows the problem "turns on the question of direct knowledge, not observation. Being able to observe the mental states of others would not enable us to avoid the problem. What would be needed would be the ability to observe those mental states *as* the mental states of others. They would have to come labelled. The situation would only then be symmetrical" (Ibid). Yet this is impossible because the only way this could happen is to be the other (the counselee). Being able to observe mental states *as* the other without ourselves being present is impossible. To eliminate ourselves would just leave the other being present and we are back at square one, unable to bridge the problem of other minds. Carruthers (2004, 9) agrees with us here when he says, "this is impossible I cannot be aware of your experiences, because anything which I am immediately aware of is, almost by definition, my own experience" and "I should not be able to have the sort of immediate awareness of your act of thinking which you have

yourself". As a result, we must resign ourselves to accepting the problem of other minds and changing our practice of genetic counseling by taking it into consideration.

We must make it clear that it is important not to agree with the perspective of behaviourism in relation to the problem of other minds. Rowlands explains

> One can think of behaviorism as an *eliminativist* position or as a *reductionist* position. Understood as an eliminativist position, behaviorism is the view that there are no such things as mental states. There is just behavior. That is not so much a solution to the problem of other minds but a *dissolution*—a denial that there ever was such a problem. Understood as a reductionist position, on the other hand, behaviorism is the view that mental states exist and they are simply—one and the same thing as—behavior (2019, 35).

Both of these positions are mistaken and can be very dangerous for genetic counseling. First to eliminate mental states is effectively to eliminate the counselee and their unique self, being or individuality from the world. Second to reduce the mind to behavior is again problematic because it assumes the counselor can understand and judge the counselee solely through their behavior. Again, this is very dangerous because it completely disregards the unique first person lived experience of the counselee, effectively foreclosing it from any consideration in the counseling process. Interestingly Schramme (2010, 33) has recently considered the problem of other minds in psychiatry noting "We don't have direct access to other persons' minds; so how can we ever know what is going on 'in their heads'". He adds "It poses a severe methodological challenge for psychiatry. Historically, it has been tackled by behaviourism, and more recently by biological psychiatry". However, Schramme, like us recognises "they don't provide the kind of knowledge needed when dealing with patients". Our work in this article can be seen to extend and expand these brief ideas from Schramme.

Before we move into the next section we will again highlight why the problem of other minds is important to consider in genetic counseling. The simplest way to show this is through an example from Carruthers (2004, 8). He highlights

> How do I know that what I see when I look at a red object is the same as what anyone else sees when they look at a red object?" That is: how do I know that our experiences are the same? Perhaps what I see when I look at a red object is what you see when you look at a green object, and vice versa. The point is: we naturally assume that we call objects by the same names (red, green, and so on)

> in virtue of having the same experiences when we look at those objects; but it could equally well be the case that we have different experiences, but the differences never emerge because we call those *experiences* by different names.

The detail we wish to derive from this is the counselor can never know what is right for their counselee because of the problem of other minds. Their understanding of the mind of the counselee will always be a hypothesis because they are forever separated from experiencing the existence or consciousness of their counselee. For example, "We know directly that there seems to be a sunflower in front of us and, in particular, how it appears to us, but we do not know directly how it appears to others nor, even, that it appears at all to others" (Hyslop 2013, 6). With this insight we believe nondirectiveness is the most ethical and philosophically strong method in genetic counseling. In the final section of this article we will integrate our previous research on the philosophy of *place* and psychoanalysis to further support this.

In conclusion, the "problem of other minds arises from a tension between our objective, third person knowledge of human behavior, and our apparently subjective, first person knowledge of our own conscious states" (Jaworski 2011, 17). The counselor faces a difficulty because "You do not have direct access to my mental states, nor do I have direct access to yours. You can hide your thoughts and feelings from me, and I can hide my thoughts and feelings from you" (Ibid). We advocate nondirective genetic counseling because "Thoughts and feelings seem to belong to a private, inner domain of subjective experiences" and "because I cannot access other people's mental states, I cannot really know what their mental states are" (Ibid). As a result, the counselor should be there to participate in dialogue to assist the counselee to make their decision, but the counselor can never claim to know what is best or what decision the counselee should make.

While, counselors should not simply tell counselees what to do by respecting counselee decisions and how they arrive at them, in order to stop counterintuitive consequences and harmful actions, the counselor should still have the power to stop any actions they disagree with (e.g. where there may be harm, unethical behaviours or in extreme cases, like being attacked by the counselee, they should be permitted to stop this). As we have stated earlier, the distinct nuances of the psychotherapy process can only really be appreciated when the influence of the differing depth or level of psychotherapeutic exploration that is undertaken within various types of

psychotherapeutic relationship is appreciated. The influence of 'place' is foundational. On our view, if a disposition to act from certain virtues and a keen nuanced awareness of 'place' is combined with technical skills (*techne*), distinct knowledge (*episteme*), intellect (*nous*), theoretical wisdom (*sophia*), and a well-developed sense of the governing virtue practical wisdom (*phronesis*), then a professional is likely to act with discretion and insight (sagacity) at the right time in the right way. If this all comes together, then arguably professional integrity is assured, the right decisions are made, and the right actions follow (Crowden, Gildersleeve 2019). In most genetic counseling situations, the counselor will thus be able to act in the right way at the right time. We believe nondirectiveness to be a virtue and the counselor should practice this principle as much as possible. Ultimately all outcomes of counseling sessions are determined through a unique *place* of dialectic or dialogue between the counselor and counselee (see Crowden, Gildersleeve 2019). Our ideas concerning this outcome take inspiration from our earlier publications on *place* which we discuss next in the final section of this article.

PLACE, PSYCHOANALYSIS AND GENETIC COUNSELING

In this final section we utilize our previous research on the philosophy of *place* and psychoanalysis to support nondirective genetic counseling. Our main thesis is that what is considered right or wrong for a counselee depends on their *place*. In other words, what decision is right or wrong in genetic counseling is relative to the *place* of the counselee. Although the decision may be wrong to the counselor from their unique *place*, it may be right for the counselee and this is why genetic counseling should be nondirective. Harman provides a useful example to get into the right frame of mind:

> Consider this example. Intelligent beings from outer space land on Earth, beings without the slightest concern for human life and happiness. That a certain course of action on their part might injure one of us means nothing to them; that fact by itself gives them no reason to avoid the action. In such a case it would be odd to say that nevertheless the beings ought to avoid injuring us or that it would be wrong for them to attack us. Of course we will want to resist them if they do such things and we will make negative judgments about them; but we will judge that they are dreadful enemies to be repelled and even destroyed, not that they should not act as they do (Harman 1975, 5).

This example can be related to genetic counseling. The outer space creatures and humans (or counselor and counselee) have different

views of what is right or wrong. The arguments we have presented in this article have led us to support ethical relativism in this situation where "there can be conflicting moral judgments about a particular case that are both fully correct" (Harman 1978, 146). Both the counselor and counselee have a different *place* in the world and therefore both views can be correct from their respective *places*. As a result, the counselor should respect the *place* of the counselee, so they are free to make the decisions that are right for them. If the counselor was to not do this they put the counselee at risk of being estranged from their unique *place* in the world (Gildersleeve, Crowden 2018, 79). Our earlier publications have provided much detail on the importance of being 'at home in the world' for mental health by discovering *place*. Our earlier work shows that the aims of psychoanalysis are to "return' to *place* — as a homecoming" (Ibid, 79) otherwise a counselee will experience the obstructiveness of a complex from 'not-being-at-home-in-the world'. As a result, the genetic counselor has a responsibility to ensure they do not estrange their counselee from their *place* in the world by giving directive counseling that does not respect *place* and the problem of other minds. Directive counseling can lead the counselee to lose their authentic *Self* or *place* when they do not direct their own decisions.

In our earlier research (Gildersleeve, Crowden 2018) we illustrate that complexes are formed when a person forecloses or leaves their *place* in the world hidden from conscious discovery or understanding. We described the phenomenology of the experience of a complex and how psychoanalysis helps an analysand achieve a 'homecoming' to their *place* in the world. *Place* or Self can remain unconscious or 'misrecognised (Gildersleeve 2016, 8) if the counselee does not follow the ethics of Lacanian psychoanalysis to act in "conformity with the desire that is in you" (Lacan 1992, 314). When *place* is not acknowledged individual mental health is challenged. Thus, directive genetic counseling will potentially contribute to mental illness through the formation of complexes (Gildersleeve 2017; 2018) if the counselee is not permitted the freedom to make their own choices in nondirective counseling. The counselee will develop an obstructive complex from directive counseling because he is not permitted to take "into account the actuality of his subjective needs and requirements" (Jung 1923, 420). Directive counseling restricts the counselee from acting in "conformity with the desire that is in you" (Lacan 1992, 314) and therefore misdirects their life away from their authentic *place* in the

world. Jung explains "functional (nervous) or actual physical disorders which result from this state have a compensatory significance" (Jung 1923, 420) as a consequence of neglecting the authentic Self. This occurs when directive counseling alienates the counselee from their Self (Jung), subject (Lacan), Dasein (Heidegger) or *place* (Malpas). If the counselee is not allowed self-expression through nondirective counseling to act in conformity with their desire, they remain at an imaginary or alienated relationship to their Self and *place* etc.

If the counselee is not given the freedom to make their own life choices and are directed into the 'right' decision by the counselor, the counselee will live a life estranged from the home of their authentic *place* in the world leading to experiences of angst and obstructive complexes (Gildersleeve 2018, 194). Their life will feel obstructive, unharmonious and 'not at home' because they have left their *place* (authentic Self) undiscovered. Their world will become obstructive and friction riddled rather than in congruence with the world. This supports the tenets of Lacan's ethics of psychoanalysis where "the paradoxical reversal by means of which desire itself (i.e., acting upon one's desire, not conceding it) can no longer be grounded in any 'pathological' interests or motivations and thus meets the criteria of the Kantian ethical act, so that 'following one's desire' overlaps with 'doing one's duty'" (Zizek 2014, 382). If the counselee does not listen to themselves and is directed by the counselor, they neglect 'acting in conformity with their desire' causing "compensatory reactions from the side of the unconscious" (Jung 1923, 422). The counselee will be obstructed by this complex and "Through this reaction of the unconscious, another category of symptoms arises which have a more introverted character." (Ibid).

In other words, if the counselee is prevented from following the ethics of psychoanalysis by compromising their desire through directive genetic counseling, the "Superego is the revenge that capitalizes upon our guilt—that is to say, the price we pay for the guilt we contract by betraying our desire" (Zizek 2005, 69). Said differently, the counselee will experience guilt (from the Superego) for failing to discover their authentic *place* in the world.

Although the counselee may not be conscious of it, they are always guilty for not knowing their ultimate *place* in the world. However, the counselee can be more or less authentic depending on the depth of the understanding of their *place* in the world. Conscience (the Superego) summons/calls the counselee "to its ownmost potentiality-of-being-a-

self, by summoning it to its ownmost quality of being a lack" (Heidegger 1996, 249). We interpret this lack to refer to *place*. The counselee always lacks an understanding of their true (authentic) *place* in the world and therefore can never erase or get in front of this lack. Said otherwise, absolute "Self-Consciousness itself is radically unconscious" (Žižek 2009, 246). The counselee's conscience is important to uncover *place* because it leads to psychological growth and "this 'growth' is the objective activity of the psyche, which, independently of conscious volition, is trying to speak to the conscious mind through the inner voice and lead him towards wholeness" (Jung 1954, 183). Here Jung emphasizes the role of the psychotherapist or counselor is to help the counselee find their own authentic conscience (therefore implicitly *place*) by saying, "we physicians of the soul are compelled by professional necessity to concern ourselves with the problem of personality and the inner voice, however remote it may seem to be" (Ibid, 184).

The call of conscience calls the counselee to understand their thrownness (*place*) authentically. The call of conscience is always with a counselee, but they can inauthentically conceal this call by listening to the 'loudness' of the idle talk of 'the they' (Heidegger 1996, 107). The 'they' is the common average and similar ways humans understand each other. There is no unique, individual identity for the 'they'. Everyone is the same. By being-with-others in this way, directive genetic counseling can conceal the counselee's conscience or own authentic possibilities, choices and preferences. In this way, the counselee can fall into a 'levelled' or 'common' existence instead of making and living by their own authentic decisions. Being-with-others by following their 'common' mode of being-in-the-world in directive counseling neglects the authentic Self and meaning of the counselee's unique *place* in the world. In contrast, Jung advocates listening to an authentic conscience arising out of one's most intimate being when he says, "the inner voice is the voice of a fuller life, of a wider, more comprehensive consciousness" (Jung 1954, 184). In other words, conscience calls the counselee to expand consciousness to find their authentic *place* in the world which can be facilitated through nondirective genetic counseling.

We argue that directive genetic counseling is unhealthy for the counselee because it "does violence to a multitude of subjective emotions, intentions, needs, and desires, since it robs them of the energy which is their natural right" (Jung 1923, 423). If the counselee

is prevented self-expression by not being permitted to act in 'conformity with their desire', their conscience and guilt will forever return as an obstructive complex in their world. Ultimately, this inauthentic understanding constructed by directive counseling that tries to be "relieved of the unbearable pressure" (Gildersleeve 2017, 8) to act 'in conformity with the desire that is in you' culminates in complexes alienating the counselee from the truth and meaning of their *place* in the world, resulting in the world continuing to be "conspicuously and obstinately obstructive" (Ibid).

Said differently, directive genetic counseling that does not allow the counselee to act freely can lead to "the return of the living dead" which is when their desire "does not want to stay dead but returns again and again to pose a threat to the living" (Zizek 1992, 22). When the counselee does not 'act in conformity with their desire', the desire returns as an obstructive complex because it was "not properly buried, i.e., because something went wrong with their obsequies" (Ibid, 23). Jung (1923, 425) describes this return of an obstructive complex by saying it shows itself:

> in the form of a nervous collapse. Such a solution always comes about as a result of the unconscious counterinfluence, which can ultimately paralyse conscious action. In which case the claims of the unconscious force themselves categorically upon consciousness, thus creating a calamitous cleavage which generally reveals itself in two ways: either the subject no longer knows what he really wants and nothing any longer interests him, or he wants too much at once and has too keen an interest but in impossible things.

This nervous collapse "which can ultimately paralyse conscious action" is "The 'return of the living dead'" and is "the reverse of the proper funeral rite. While the latter implies a certain reconciliation, an acceptance of loss, the return of the dead signifies that they cannot find their proper place in the text of tradition" (Zizek 1992, 23). In other words, an obstructive complex will return as the living dead 'creating a calamitous cleavage' until the counselee 'acts in conformity with their desire'. Nondirective counseling allows the desires of the counselee to "find their proper place in the text of tradition" because they have not been foreclosed.

One reason acting in conformity with your desire is important to follow and is considered the ethics of psychoanalysis is because "The suppression of infantile and primitive claims, which is often necessary on 'civilized' grounds, easily leads to neurosis, or to the misuse of narcotics such as alcohol, morphine, cocaine, etc. In more extreme

cases the cleavage ends in suicide" (Jung 1923, 425). The obstructive complex and guilt will only be resolved if the counselee adheres to the ethics of psychoanalysis to take the journey to discover the possibilities and impossibilities of their desire (Gildersleeve, Crowden 2018, 90). Through nondirective genetic counseling the counselee can act in conformity with their desire to discover their authentic *Self* and meaning of their *place* in the world which highlights why "following one's desire' overlaps with 'doing one's duty" (Zizek 2011, 239). This demonstrates that psychoanalysis elucidates the importance of nondirective genetic counseling by outlining the mechanisms "of unconscious tendencies that, just in so far as they are deprived of their energy by a lack of conscious recognition, they assume a correspondingly destructive character" (Jung 1923, 426).

If the counselee neglects 'acting in conformity with their desire' "it disappears from consciousness and proceeds to unfold a subconscious activity, which runs counter to conscious aims, even producing effects whose causation is a complete enigma to the individual" (Ibid, 438). Directive genetic counseling can cause this where the desire of the counselee becomes experienced as the obstructiveness of a complex which "is that which objects, that which disturbs the smooth running of things" (Zizek 2009, 17). This experience of the chaos and obstructiveness of a complex indicates that the counselee has left part of their *place* in the world or authentic *Self* undiscovered. In other words, when the counselee experiences the obstructiveness of complex by being denied nondirective genetic counseling, this is "nothing but the inscription of the subject itself in the field of objects, in the guise of a blotch that takes shape only when part of this field is anamorphically distorted by the subject's desire" (Zizek 2006, 69). Directive counseling discourages and restricts the counselee from following their desires therefore leading their *place* (authentic Self) to be left undiscovered which will be experienced as an obstructive complex.

CONCLUSION

In conclusion, our work supports the idea that in order to facilitate "an individual or family's decision making by providing unbiased information and assisting them in exploring their own views regarding the available options" (Fine 2017, 107) genetic counselors should develop humility, open-mindedness, unassuming judgment and respect for alterity, otherness and difference in ways that are consistent with the nature of virtuous genetic counseling. We consider these as having

distinct relevance to genetic counseling and as such are important extensions on the usual psychotherapy (counseling) virtues or regulative ideals identified elsewhere as compassionate empathy, respectful positive regard, congruence and trustworthiness. Moreover, our work on the problem of other minds and principles from psychoanalysis and our philosophy of *place* bolsters the argument that a counselee should "make his/her own decision free of coercion and/or influence of the counselor as is humanly possible" (Ibid). As a result, we agree that the genetic counselor "must treat patients in such a way that facilitates their ability to make choices and take actions based on their personal beliefs and values" (Ibid, 108).

Our conception of nondirective counseling doesn't mean the counselor is completely passive and has no role to play. A disposition to act from certain virtues and a keen nuanced awareness of 'place' is combined with technical skills (*techne*), distinct knowledge (*episteme*), intellect (*nous*), theoretical wisdom (*sophia*), and a well-developed sense of the governing virtue practical wisdom (*phronesis*) guides genetic counseling practice. The role to provide "comprehensible information in a supportive milieu so that patient autonomy can be preserved as they make reproductive and treatment decisions" (Ibid) can thus be enacted ethically. The counselor should not tell the counselee what to do but they should be trained to provide accurate genetic information as well as presenting various options to facilitate "autonomous decision making for a patient or family" (Ibid). We outlined the psychological consequences if the counselee is prevented self-expression. We believe the counselor should promote "the expression and utilization of the counselee's own values in decision making" "in contrast to a more authoritarian medical model" (Weil 2000, 122) which can lead to adverse psychological outcomes for the counselee. In light of the arguments we have presented on nondirective genetic counseling, the problem of other minds, psychoanalysis and place, we conclude the genetic counselor's expertise involves enhancing "the decision-making process and ensuring that clients have the greatest opportunity to evaluate options to make the best decisions for themselves" (White 1997, 305). Finally, our reference to counselee choice in the title is important not only for the general mindset of the counselee in genetic counseling (who are encouraged to take or leave using the suggestions provided by the counselor) but also apply to the arguments we outline in this article. Since we also encounter the problem of other minds of our readers, we have no proof that our

arguments should apply or be valid for those who read this and therefore we leave it to each individual to determine if our ideas are valuable to them or not. To do otherwise would hubristically and hypocritically ignore the problem of other minds.

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