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THE NURTURING STANCE: MAKING SENSE OF RESPONSIBILITY WITHOUT BLAME

BY

DAPHNE BRANDENBURG

Abstract: Mental health-care clinicians report that they hold patients responsible for morally objectionable behaviour but at the same time consider blaming attitudes to be inappropriate. These practices present a conundrum for all Strawsonian theories of responsibility. In response to this conundrum, Pickard has proposed severing the Strawsonian connection between being responsible and being an appropriate target of blaming attitudes. In this article I will argue that her solution fails to explain the practices at stake and provide an alternative solution that uncovers an under-theorized stance we take towards those whose abilities are underdeveloped or compromised.

The central aim of this article is to make sense of a type of responsibility practice that is central to mental health-care contexts. This practice can be characterized as ‘allocating responsibility without blame’ (Pickard, 2013). When a patient behaves in a manner that does not meet moral standards – e.g. verbally abuses someone, throws things across the room or is aggressive and threatening towards other patients or staff – it is considered good practice to hold the patient responsible for this, but blaming the patient is typically considered inappropriate. It may at first seem difficult for both clinicians and philosophers to make sense of this practice. This difficulty is due to the intuitive link between someone’s responsibility for harm and the appropriateness of blaming attitudes towards this person. This link is one that has been stressed most prominently by Strawsonian theories of responsibility. In the first section I will expand on the apparent tension between Strawsonian theories and these practices of allocating responsibility without blame.

There is one rather straightforward explanation for refraining from expressing blaming attitudes to a patient in psychiatric practice that does not pose a problem for Strawsonians. The expression of blame can be detrimental to the therapeutic relationship and to the patient's wellbeing. This provides reasons not to blame the patient, especially for a clinician whose main concern is the patient's recovery. However, these reasons do not undermine the appropriateness of blaming attitudes; they only render the expression of these attitudes inappropriate in a clinical context. I will briefly discuss this non-threatening explanation in Section 2. But, although this may be an accurate explanation for some practices of holding patients responsible without blaming them, it certainly does not adequately explain all of these practices.

Sometimes clinicians refrain from blaming a patient for causing harm or abuse because the patient is not considered blameworthy. Even in these cases, however, the patient is, in a sense, held responsible. The challenge this presents us with is a more serious one. It has to be explained how and why a patient is held responsible after behaving in a morally problematic way when he is, at the same time, not considered to blame for this behaviour and blaming attitudes are *therefore* inappropriate. The rest of the article is concerned with solving this challenge.

Hannah Pickard proposes solving this challenge by severing the link between someone's responsibility on the one hand and the appropriateness of moral blame on the other hand. According to her, one's responsibility should be based on the normative capacities that one has, but responsibility can be *detached* from blaming attitudes (Pickard, 2013). In Section 3 I will argue that Pickard's solution fails to explain the practices at stake. I argue that she in fact fails to detach the appropriateness of blame from the normative capacities that one has to have to meet moral expectations.

As an alternative solution, I propose that responsibility without blame does *not* track full-blown normative capacities and responsibility for harm, but instead has underdeveloped or compromised capacities as its target. Underdeveloped or compromised capacity grounds the type of responsibility that is central to responsibility without blame: a responsibility to work towards developing or repairing one's own moral abilities. I dub this form of holding responsible 'the nurturing stance'. This responsibility to engage with one's own impairments differs from but closely relates to traditional responsibility for harm.

In conclusion I argue that the nurturing stance does not undermine the Strawsonian theories at stake but does provide an important addition to them. In practices of allocating responsibility without blame, patients are held to the responsibilities they have to become able to meet moral expectations. This stance is a common but under-discussed aspect of our moral practices. The Strawsonian typically overlooks it by suggesting that we may appropriately respond to a moral transgression by *either* blaming *or*

exempting the person; this stance shows that such a binary approach is misleading. People who transgress a norm are sometimes not blamed for this because they couldn't help transgressing, but when they can become able to meet our norms, our attitude towards them in response to this transgression is not properly described as exempting.

1. *Strawsonians and the clinical conundrum*

P.F. Strawson observes that there is a connection between our reactive attitudes and being a responsible agent. Strawson notices that when we respond with resentment, indignation or similar blame-related attitudes to another person's actions, we typically consider this appropriate if the agent disregarded our shared moral expectations and demands. But if someone's abilities to meet these interpersonal demands are severely underdeveloped or impaired, we generally feel differently: we modify, suspend or do not even experience these attitudes, or, at the very least, think we *should* not respond with indignation or resentment (Strawson, 1962). Blaming attitudes are considered to be an inappropriate response to someone whose underdeveloped or impaired normative capacities render them unable to meet the demand at stake. This does not mean that we never resent someone whose transgression was due to impaired normative capacities, but it is generally accepted that we *should* not do so. Blaming the incompetent for transgressing a norm that they cannot meet is generally considered inappropriate.

Many philosophers after Strawson have agreed that being responsible implies being an appropriate target for praising or blaming attitudes. Some have argued that these attitudes generally indicate or track the criteria that make for a responsible agent (Wallace, 1996). Others prefer to say that our disposition to praise and blame is what constitutes the responsibility of the subject of such praise or blame (Shoemaker, 2015; Watson, 2004; for discussion see Todd, 2016). Which criteria exactly are singled out by these attitudes and hence are the responsibility-making features of an agent is also a matter of debate. But although the details of this relation are fleshed out differently, many maintain that an agent is responsible if, and only if, she is an appropriate target of blaming or praising attitudes (i.e. Fischer and Ravizza, 1998; Shoemaker, 2015; Wallace, 1996; Watson, 1993).

But this connection between blaming responses and responsibility gives rise to a clinical conundrum. The clinical conundrum arises if one takes a close look at nursing practices in psychiatry. Clinicians hold patients to be *responsible* for their actions when they misbehave, but often consider blaming them to be inappropriate (Pickard, 2013). My understanding is that this practice should be imagined as follows: imagine that a patient is throwing a chair across a living room, thereby breaking things and endangering

and upsetting other patients. In response to this transgression, good practice prescribes that a clinician speaks to the patient later and says something like ‘I understand that you were upset, but this behaviour cannot be accepted here. What are you going to do about it? And how can we help you?’ Clinicians report that they consider the patient to be responsible for his own behaviour and hold him responsible for it in such a case (Brandenburg, 2010unpublished). That the patient is held responsible in this practice is *prima facie* a plausible description of what is going on here. I take it that the patient is being held responsible when it is pointed out to this person that his or her behaviour was problematic and it is made explicit that changing this is expected of her and (at least partly) considered up to him or her. This is the form of holding responsible that will be central to this article.

Note that the patient is not blamed in such a situation. The clinician would not address the patient with anger, resentment or indignation, nor would she say something like ‘You had no concern for us or others’ or ‘You have been negligent. You should know better than this’ or ‘This is your fault!’ and so on. Such responses would be considered grossly inappropriate.

Pickard describes how this practice at first struck her as a philosophical and clinical conundrum. She could make sense of the idea that, despite appearance, patients are not responsible or culpable because of their disorder and hence are not to be met with anger or resentment. She could also make sense of the idea that despite their disorder they are responsible and culpable and hence liable to anger or resentment. But she found it difficult to make sense of this stance of allocating responsibility without blame (Pickard, 2013, p. 1135). Family, friends and clinicians of patients who transgress in these ways and often encounter the same difficulty in making sense of this practice of allocating responsibility without blame. The two questions that will be central to this article are as follows: how can this conundrum be solved, and how is the Strawsonian relation between reactive attitudes and responsibility affected by this solution?

2. *Responsibility without expressed blame*

Surely some of the practices described above may concern patients who *are* blameworthy for what they have done.¹ Whatever the exact criteria for blameworthiness are, a patient may – just like anyone else – meet these criteria on some occasions (McKenna and Kozuch, 2015; Sripada, 2015). Maybe the patient throwing the chair across the room knew very well that he had got himself into a situation that would make him uncontrollably upset, and maybe it would also have been quite easy for him to avoid getting into this situation. Even then, responding in a blaming fashion is typically considered inappropriate within a clinical context.

A blaming response can undermine the patient's trust in the clinician and make him feel rejected, which in turn compromises the therapeutic relationship and the patient's recovery. A clinician may also find it inappropriate to blame the patient because such a response doesn't fit well with her professional and caring role. Pickard seems to suggest that it is *always* crucial that clinicians refrain from expressing blaming attitudes, even when a patient is blameworthy, so as not to risk damaging therapeutic efficacy (Lacey and Pickard, 2013; Pickard, 2013). I believe that this is taking it too far. There are reports of cases in clinical settings in which a temporary and moderate expression of anger or indignation has been conducive to a better therapeutic relationship and has actually worked towards certain therapeutic aims (Brandenburg, 2010unpublished). But blaming attitudes are better held at bay if they would stand in the way of a good therapeutic relationship and meeting therapeutic aims even when a patient culpably misbehaves.

Of course, more generally speaking, giving expression to blaming attitudes is not always the appropriate thing to do, even in cases where the person is blameworthy for transgressing a certain norm. Angela Smith has before pointed out how these observations would pose a serious objection to those Strawsonian theories that suggest that the expression of blaming attitudes is *always* fair and appropriate when a competent agent expresses ill will or insufficient regard (i.e. is blameworthy) (Wallace, 1996, pp. 187–193; Smith, 2007).

But the existence of further conditions for the appropriate expression of blame ultimately does not challenge the Strawsonian relation between the appropriateness of blaming attitudes and someone's responsibility for harm. If the subject from our example is blameworthy, blame is still an appropriate response in a similar sense to the way in which fear would be an appropriate response to something being dangerous (Russell, 1992). This appropriateness relation still holds even if other considerations trump the appropriateness of *expressing* blame in a specific context. A comparable example is that although it may be very unwise and ineffective to give expression to fear when confronted with a roaring lion, the experience of fear is not thereby inappropriate. On the contrary, as an appraisal of the situation this is an accurate response.

In our imagined case, where the patient is blameworthy for throwing a chair through the room, the *experience* of blame-related attitudes in response to this action would also still be appropriate. Whilst expressing reproach may not be efficient or useful in this case, it is certainly apt to feel reproachful in the light of what the patient has done. In addition, this solution to the conundrum, strictly speaking, does not provide us with a case of responsibility without blame; it only provides us with a case of responsibility without *expressed* blame.

But this solution does not apply to all those cases in which a clinician holds a patient responsible without blaming the patient. In some cases

blaming attitudes *would* be inappropriate because it would be wrong to say that the patient *is* blameworthy for transgressing a certain norm. Imagine that the patient in our case could not foresee that getting into this situation would get him as upset as it did, and that the emotional overload was just beyond his control at that very moment. He felt unsafe, got very stressed and threw a chair across the room, which at that point seemed for him to be the only way to deal with his feelings. We also know that because of his mental illness he is much more likely to get stressed in such situations and never really learned how to cope with that stress. Even in such a case, and in many similar cases, a patient will typically be held responsible for this behaviour in the sense described in the first section. How are we to explain that the clinician holds the patient responsible when the patient is *not* blameworthy for her behaviour? In Section 3 I will discuss Hannah Pickard's solution to this challenge and argue that it fails to explain the practices at stake.

3. *Responsibility without blameworthiness*

Pickard also points out that psychiatric patients often cannot be considered blameworthy for what they do. In order to explain why patients are nonetheless held responsible, she proposes separating responsibility for harm from blameworthiness for harm. According to her, patients *are* responsible for norm-transgressions but are not blameworthy (Pickard, 2013, pp. 1141–1142). Hereby Pickard provides a solution to our challenge. The patient is held responsible for the transgression because he *is* responsible for the transgression. But blaming the person is deeply inappropriate, because the patient is not blameworthy for the transgression. This solution drives a wedge between being responsible on the one hand and being an appropriate target for blaming attitudes on the other. But her solution is conceptually puzzling and not satisfactory as it stands.

Pickard defends her conceptual solution of 'responsibility without blame' by probing the reader's intuitions. As readers we are asked to compare the following:

1. Service users may be responsible for verbal aggression towards clinicians but not blameworthy, because they are acting to relieve high levels of psychological distress, and lack alternative coping mechanisms (Pickard, 2013, p. 1140).
2. *Service users may be morally responsible for verbal aggression towards clinicians but not blameworthy, because they are acting to relieve high levels of psychological distress, and lack alternative coping mechanisms (Pickard, 2013, p. 1140).

The distinction between the two descriptions is demonstrated by the fact that 1 is intuitively plausible whilst 2 is not, and it explains, according to Pickard, how it is 'possible to be responsible and treated thus, for actions which are morally wrong but for which one is not blameworthy because one has an excuse' (Pickard, 2013, p. 1142). But it is not very clear why our intuitions should diverge here if the actions at stake are indeed morally problematic and the agent is responsible for those actions. As far as my own intuitions are concerned, if the patient *has* capacities for control then intuitively he is both responsible and blameworthy, and if he does not have the capacities for control, then he is neither responsible nor blameworthy. The distinction between responsibility and moral responsibility doesn't help avoid this conclusion.

Pickard is explicit in sentence 1 about explaining patients' responsibility on the basis of their 'capacities for choice and control'. According to Pickard, it is because patients *have* such normative capacities to refrain from inflicting abuse or harm that they should be held to account for their actions. But if it were true that patients have these capacities, then it would be intuitive to say that they are accountable *and blameworthy* for the things they do. They are culpable because they have the capacities for choice and control and hence *can* control their behaviour and can choose to refrain from doing harm. If Pickard is right about this, we should simply say that patients are responsible and blameworthy for the harms and wrongs they do but that one should not respond by means of expressing blaming attitudes because this is detrimental to therapy (Pickard, 2013, p. 1142).

The second half of statement 1 raises even more questions. According to Pickard, patients are often not blameworthy because they are excused. The patients are excused because 'they are acting to relieve high levels of psychological distress, and *lack* alternative coping mechanisms' (Pickard, 2013, p. 1140). This does indeed seem to be a likely explanation for the absence of blameworthiness, or at least for a strong mitigation of blameworthiness. But now it is unclear why Pickard wants to maintain that patients *have* the capacities for choice and control *and* are therefore responsible for verbal aggression. If one has problems with regulating emotions and lacks alternative coping mechanisms, one is – all other things being equal – neither responsible nor culpable for the harm one does, *because* one's capacity for control is impeded. It seems strange to hold someone responsible for a transgression like throwing a chair across a room or verbal aggression when this transgression is due to a serious control impediment.

The one way in which it may make sense to say that the person is nonetheless responsible in such a case is when one means to say that the person is *causally* responsible for what happened. But note that this can't be right either, because if one is merely causally responsible it is mysterious why one would be *held* responsible for what happened. Imagine someone is pushed over and breaks a vase as they fall; they are therefore causally

responsible for breaking the vase. It would in such a case be totally ludicrous to go up to this person and tell her that this behaviour cannot be tolerated and that she should do something about it. Hence, we are still left with the fascinating question of why these patients in practice *are* more than just causally held responsible if they are not culpable because of their impaired ability for control.

An interesting answer to this question remains obscured because of ambiguity about what it means to have capacities for control. I think Pickard is wrong to say that the patients in our examples simply 'have the capacity for choice and control' that is required, because these patients cannot control themselves in certain stressful situations. But there is a sense in which it also wrong to say that these patients *do not* have the capacity to control themselves in such situations. I will explain why, and this will in turn provide us with a clue for answering the challenge at stake.

4. *Ambiguous capacities*

In this section I will argue that there is an important sense in which patients who are held responsible without blame *do not* have the capacities to meet certain expectations to refrain from causing harm or abuse but another sense in which they *do* have these capacities. The crux is that in natural language, when we claim that someone has the capacity to do something, we may also be referring to capacities that are underdeveloped or compromised.

Compare the following sentences:

1. You have the capacity to walk.
2. You have the capacity to be a great leader.

Or:

1. You have the capacity to resist the extra glass of beer.
2. You have the capacity to get your driving licence.

Note that the meaning of 'capacity' is often different in sentences of type 1 and type 2. When put next to each other this becomes quite clear. The word 'can' or 'capacity' in type 1 sentences refers to something someone is normally able to do. Human beings can usually walk and they can resist the extra glass of beer in most circumstances too. In these sentences the word capacity simply refers to abilities that we take the average human being to have. When I say that you have the capacity to walk, I mean that you can get up and do so *right now*.

But being a great leader requires experience and learning. Most people can be said to have the capacity to be a great leader because they *can* be a great leader with sufficient practice and experience. And, even when you have the skills to be a great leader, there may be periods when your leadership falters because, say, lack of sleep or stress compromise your ability to exercise good leadership. However, even when your capacity to be a great leader is underdeveloped or compromised, I would not be lying when I say to you that you have the capacity to be a great leader. Similarly, when someone tells me that I have the *capacity* to get my driving licence after I have just had a driving lesson that left me in utter despair, this does not mean that I can get into a car and pass the driving test *right now*. On the contrary, it may very well be fatal to me, or others, if I try to do so. But still, this person is not necessarily wrong by telling me that I *can* get my driving licence, because with sufficient practice and training even I will probably be able to pass the test and get my licence.

The use of the word capacity in type 2 sentences refers to abilities that are available to us in the future after we have engaged in learning processes and/or have overcome the obstacles that are needed to develop or restore these abilities. These capacities differ from those that are developed and uncompromised. From now on I will refer to the latter as actual capacities, in contrast to underdeveloped or compromised capacities. Now that these different meanings of the word capacity are clear, I can return to Pickard's claim that patients have the requisite capacities for meeting the demands at stake. Pickard, for example, wants to say that

- Patients have the capacity to refrain from engaging in alcohol abuse; and
- Patients have the capacity to refrain from engaging in verbal aggression.

My contention is that in psychiatry, these two sentences are typically meant to refer to capacities that are either underdeveloped or compromised. One possible explanation for the patient's failure to meet an expectation or standard at this moment or in specific types of circumstances is that her ability to meet such expectations is underdeveloped or compromised. I do not want to claim that this *is* what Pickard means. I'm not sure it is, but I do think it is one good way to make sense of what she may mean. Though the average adult has the capacity to refrain from, say, using verbal aggression or abusing alcohol, many patients in the clinic have this capacity in an underdeveloped or compromised sense. Their abilities to, for example, refrain from being verbally aggressive or engaging in other types of abusive behaviour are yet to be developed or restored by, for instance, acquiring certain habits, lowering their levels of stress or anxiety and/or learning how to cope with their emotions. The transgressions from our examples

are often due to excessive anxiety, stress or other forms of emotional flooding. One further remark is therefore required here. It has been argued that being overcome by stress or anxiety may *fleetingly* mask an actual capacity (McKenna and Kozuch, 2015, p. 94). It should be noted that in clinical settings transgressions are more often due to robust forms of emotional flooding and hence to inhibitions of actual capacity rather than to 'incidental masking' of capacity to which everybody may be subject at times.

Norm transgressions in psychiatry are often, though not always, due to the patient's underdeveloped or compromised ability to refrain from causing harm or abuse. Pickard would be wrong to say that these patients have the capacity for controlling and voluntarily choosing to live up to these expectations if she means to say that they have the actual ability to do so to the same extent that the average adult in the street. But they do have the capacity in an underdeveloped or compromised sense. Capacity is an ambiguous term that can, among other things, refer to abilities that are underdeveloped or compromised (Morriss, 2002, pp. 52–60). Making this explicit will help us to explain why patients are at times held responsible for their actions even though they are not, or are hardly, blameworthy for what they have done.

5. *The nurturing stance*

Recall that the challenge is to explain how it is possible that patients are held responsible after a norm-transgression but are at the same time not blameworthy for this norm-transgression. My solution to the challenge is the following explanation: although actual capacities are typically coupled to both responsibility and culpability for a moral transgression, underdeveloped or compromised capacities are coupled to another type of responsibility. The ability to develop or restore certain abilities gives rise to the responsibility to engage with one's own failure by means of developing or restoring these abilities. This responsibility becomes salient and is something one is held to when a reasonably grave norm transgression takes place. Strictly speaking, the patients are then not responsible for what they have done, but they are responsible for altering these 'types of doings'. To see how actual capacity, compromised capacity and the absence of capacity give rise to different responsibility practices, consider the following normative scenario.

On a forgotten archipelago there is a community that has few food resources except for the fish swimming at the bottom of the sea. An average member of this community has the skills to dive for the fish and feed herself and some of the young, elderly and sick. But catching fish is hard, and there are times when there are hardly enough fish to live from. It is of course therefore expected that all the able community members dive for fish, and

those who are able to do so but don't are considered responsible and culpable for this. Other members of this community may reasonably get angry with these people, and surely they don't deserve to get any fish.

But there are also members of this community who do not learn to dive and hold their breath long enough as quickly and easily as the others because of their fear of the deep, dark water. One of these members is Toddy. One often finds him standing hesitantly on the shore for a while and once he gets into the water he doesn't manage to dive all the way to the bottom of the sea. It seems inappropriate to respond with resentment or indignation to his failure to get himself some fish because it is not that Toddy *disregards* the norms of his community; his ability to live up to the norms is underdeveloped and compromised by fear.

But the other members of this community will probably not cater to his need for fish as they would for the sick, the elderly and infants. Though they may give Toddy some fish, this would probably be on the condition that he does something about overcoming his fear and further develops his diving skills. Toddy is not like the elderly, the sick and infants, who cannot be expected to dive for fish *at all*. Toddy can't do it *now* but there is reason to assume that he may become able to fend for himself and, given the scarcity of fish and the work involved in diving for it, Toddy will be expected to do so.

In terms of the interpersonal practices of the community, this expectation is made explicit when Toddy fails to get fish again. Maybe not every time, but most of the times when Toddy comes out of the water empty-handed are occasions for the others to remind him how pressing the community demand to fend for your own fish is. They will perhaps encouragingly tell him, 'You have the capacity to do this, Toddy, we know you do!' or say more serious things to him, such as, 'You know things can't go on like this. We have many mouths to feed.' This is surely a form of holding Toddy responsible for this type of behaviour. But it is not a form of holding him responsible and culpable for his specific past failure to meet a norm. That would only be appropriate if Toddy already had the abilities to live up to this norm. Toddy, however, does not get exempted like the infants, the elderly and the sick, because he does have the abilities to meet this norm in an underdeveloped or compromised sense. These abilities ground a form of holding responsible that targets and bootstraps his potential to develop or repair them.

Similarly, if in our own lifeworlds climbing a mountain were to somehow become a strong moral requirement, we may ask everyone to learn to climb a mountain because they 'can'. Our underdeveloped or compromised abilities imbue us with certain responsibilities when these abilities are or become related to strong normative demands. In the process of acquiring these capacities, we typically *keep* holding one another accountable by reminding each other of this important expectation and by making explicit

that we need to live up to it on those occasions that we fail to do so. But note also that we thereby do not *blame* one another for failing to climb a mountain *now*. Instead, when someone fails to climb a mountain we remind this person that she should *become* able to do so and that it is required of her to keep trying and learning. We are more likely to show sympathy and understanding in response to failure. This goes hand in hand with reminding someone of and holding someone to their responsibilities. In such scenarios we typically hold one another responsible without considering the other to be culpable and without responding (experiencing or expressing) with feelings of resentment, contempt or agent-directed anger.

The scenarios just discussed involve similar elements to what happens in those situations within a psychiatric setting where a patient is *not* considered to be blameworthy for moral harm but is held to account in response to this transgression. Just like Toddy's failure to meet an expectation, the transgressions in clinical settings may be due to underdeveloped or compromised capacities. In a clinical setting, one may similarly be held responsible by being urged to work towards acquiring the sort of control that enables one to refrain from important norm-transgressions. And, of course, where possible the clinicians will help and assist in this learning process.

Such a response is illustrative of good practice surrounding norm-transgressions that come about as a result of stress, troubles with coping or other things that stand in the way of the ability to meet certain expectations. This response appropriately recognizes and targets the underdeveloped or compromised capacities the patient has, is conducive of therapeutic effectiveness and is in line with duties of care. I believe that in such a scenario, the patient is then indeed held responsible because he *can* do otherwise. But he is not blamed because he *can't* do otherwise. Both are true because *can* here refers to different *types* of capacities.

Please note that this does not mean that the patient in question *was* already able to learn not to transgress norms and *should* have already done so. That would reduce my account to a form of indirect responsibility, which would permit blame. This is atypical for patients in psychiatry. It is more plausible to assume that they are already engaging in this learning process, do not know how to engage in a learning process, do not believe or trust themselves to be able to do so and/or can only do so with a sufficient level of support that they did not have before. In these cases, blame would be an inapt response, but there is some value in holding patients to an expectation by urging them to engage in developing and repairing their abilities. Such a nurturing stance bootstraps patients' agency to develop or repair capacity and recognizes them as people who are able to do so.

Before discussing the implications of my solution for Strawsonian theories, I want to end with some reservations. Firstly, in practice it is of course very difficult to determine whether normative capacities are

compromised or underdeveloped. By providing such a schematic overview, I do not want to deny the difficulties involved in assessing whether norm-transgressions are due to compromised or underdeveloped capacities or to insufficient regard or ill will. Secondly, it should also be noted that the capacities or incapacities at stake are context-dependent and norm-dependent. They are norm-dependent because the capacity to meet one norm can be independent of the capacity to meet another norm. One may, for example, have difficulties in refraining from abusing alcohol whilst being perfectly able to refrain from using verbal aggression, or the other way around. These capacities are also context-dependent because one may be more or less able to do something in different contexts and at different moments in time (Vargas, 2013). This further complicates real-life assessment.

These assessment problems, of course, also apply to assessing whether someone has the abilities to develop or repair his or her underdeveloped or compromised agency. In reality one is often uncertain about these abilities when relating to someone who struggles to live up to moral expectations. But where uncertainty about abilities gives one reason to be careful and hesitant in allocating blame for harm, the uncertainty about one's abilities for learning does not, in the same way, give one reason to be careful in adopting a nurturing stance towards the person.

It is often more respectful and constructive to persist for quite a while in assuming and hoping that the addressee has abilities for learning and improving that can be engaged and bootstrapped by a nurturing stance, even when this is uncertain. Note how people sometimes engage abilities for learning that are quite probably themselves underdeveloped. Carers can be seen to respond to children as young as two or three in a nurturing manner: they tell them what they ought and ought not do in response to their objectionable behaviour.² It is at quite an early age already that a child may be minimally responsive to this stance and may be engaged in his or her own development in some minimal way. As they grow older, this ability for engagement further increases and develops. The same can be true for the abilities of psychiatric patients.

But in cases of uncertainty about the (level of) ability to engage in developing and repairing one's agency, a continuous failure and lack of improvement on the part of the addressee of the nurturing stance provides more reason to wonder whether one is expecting too much of the person than reason to allocate blame for these failures. Uncertainty about someone's (level of) abilities for learning does not undermine the appropriateness of employing a nurturing stance towards this person but does count against blaming him or her for subsequent failures to learn and improve. I take it that this is why we generally are – and should be – hesitant to blame children until they are in quite a late stage of their development and avoid blaming patients in relapse too.

6. *Strawsonians and the nurturing stance*

The nurturing stance does not undermine the Strawsonian story about the appropriateness of blaming attitudes, but it does provide an interesting addition to them. In order to meet Pickard's challenge, Strawsonians need to explain why the patient is not blameworthy for a transgression but is nonetheless responsible without thereby denying that 'being responsible' means 'being an appropriate target of praising and blaming attitudes'. I do not have the space to discuss all Strawsonian accounts of the required abilities for being responsible and an appropriate target of blaming attitudes here. My only aim in this section is to show how prominent Strawsonian accounts can perfectly explain the following:

1. Why the patient in our example is not an appropriate target of blaming attitudes *because* the patient lacks the abilities required for responsible agency, i.e. is not responsible, and
2. Why the patient *is* – in another sense – responsible *and* that this responsibility is still connected to being an appropriate target for praising and blaming attitudes.

Fischer and Ravizza argue that the abilities required for being an apt target of praising and blaming attitudes are at least the ability to grasp and apply moral reasons and the ability to act in the light of such reasons, and Wallace defends a similar position (Fischer and Ravizza, 1998; Wallace, 1996). The patient in our example may very well be able to grasp moral reasons. He knows, for example, that the risk of injury and damage provides a reason to refrain from throwing a chair across the room. But he *lacks* the ability to act in the light of such reasons in stressful situations. Because his ability is impeded in this sense, blaming him for transgressions within such contexts would be inapt because in *these contexts* some of the abilities required for responsible agency are impaired. Wallace and, Fischer and Ravizza can also explain why, as I have argued, the patient bears some responsibility for *becoming* able to handle stressful situations. The patient has this responsibility because he can grasp and understand why the norm 'you should become able to refrain from throwing things around when you get stressed' is a legitimate one, and he can – possibly with some help – come to act in the light of this norm, i.e. there is reason to assume that he *can* become able to refrain from throwing things around. But note that this also makes him liable to blame again. Those features that make him responsible are also the features that make him an apt target for blame if he does not comply with the demand to improve himself out of insufficient regard for this norm. The Strawsonian connection is still intact.

Other theorists, like Watson and McKenna, focus on the abilities required for being morally *addressed* (McKenna, 1998; Watson, 1993). According to such theories, the patient in our example may at first seem to be responsible and blameworthy to the extent that he can be *addressed* in terms of reactive attitudes. He can, in other words, understand what is being communicated by such attitudes. But the ability to understand praising and blaming attitudes is not enough on these accounts. Watson writes that the demand expressed by these attitudes should be inhibited in response to the person's incompetence 'in some or all respects for "ordinary adult interpersonal relationships"' (Watson, 1993, p. 123). According to Watson, if a person cannot express himself because of great strain or stress, the demand that he should express good will and regard should be inhibited. The person is not then appropriately addressed by reactive attitudes that communicate a demand the person could not meet because of such impairments (Watson, 1993, p. 131). McKenna similarly argues that apt targets of our responsibility practices should understand what others communicate to them within those practices *and* should not be impaired in such a way that they cannot themselves – through their deeds – communicate within those practices (McKenna, 2012). Because of this, both McKenna and Watson *are* able to explain why the patient in our example is *not* an appropriate target for blame but is still responsible in another sense.

The patient is not an apt target because in the specific types of contexts in which the transgression takes place (stressful contexts), he is not able to communicate within a normative practice; he cannot – within such contexts – respond to the demand that would be expressed through reactive attitudes such as anger or indignation. Therefore the patient is not an apt target for blame when it comes to transgressions that occur under stressful circumstances. But when it comes to another demand that is central to our practices, the patient *can* understand, communicate and participate. The demand 'to develop the skills necessary for norm compliance in stressful contexts' is a norm that the patient can understand when it is being communicated to him *and* he can 'communicatively participate' within *this* aspect of our normative practice, i.e. he can respond to this demand. This is then the kind of responsibility he does have and this responsibility is *still* something that would make him liable to be a target of blaming attitudes if he were to disregard the demand for development. Hence, the conundrum, as I understand it, ultimately does not seriously undermine the Strawsonian connection on these prominent accounts.

But the nurturing stance does provide an important addition to a Strawsonian theory. Most Strawsonians tell an incomplete story when it comes to our repertoire of responses to norm transgressions. The suggestion often seems to be that we can *either* evaluate the person as responsible for the transgression, in which case blaming attitudes are an appropriate response, *or* we can consider the person to be exempted from responsibility for the

transgression, which means that our blaming attitudes are suspended and the person is seen as someone to be 'managed' 'handled' or 'controlled' rather than to be held responsible and reasoned with (Strawson, 1962; Wallace, 1996; Watson, 1993). Their relative silence about other forms of responding to transgressions suggests there are none, and this gives rise to the conundrum this article began with.

The nurturing stance is a response to a transgression that crucially differs from this description of interpersonal exempting. When a person is only exempted in response to harm that has been done and is in no way held responsible, we consider the person to be unable to develop or repair the inabilities that explain why a norm was transgressed. We, as it were, 'give up' on seeing the person as a current *or potential* participant in our norm-guided moral practices and instead see the person as someone to be 'managed' or 'handled'. But in the case of a nurturing stance, the harm done gives rise to a future responsibility that is expressed in the way that we relate to the person after he non-culpably fails to meet an interpersonal demand. We urge the person to *take* (or keep taking) responsibility for developing and repairing his own compromised or underdeveloped abilities. When one is subject to the nurturing stance, one is reasoned with and called upon. By adopting a nurturing stance, one recognizes and respects the other person as someone who can come to meet the shared expectations and norms at stake and bootstraps these capacities. By (only) exempting the person, these abilities for development or repair would not be duly respected, and by blaming the person we would misrecognize one's underdeveloped or compromised agency. The nurturing stance is an interpersonal response to norm-transgressions that does not reduce to interpersonal exempting or to interpersonal blaming.

I suspect that in all interactive processes surrounding the development or repair of an ability to live up to a norm, this form of relating to one another can be found. Because the nurturing stance is so common to our interpersonal practices and because it is different from both exempting and blaming a person, it provides an important addition to any Strawsonian theory of responsibility.

7. Conclusion

I have argued that the Strawsonian connection between 'being responsible' and 'being an appropriate target of praising and blaming attitudes' seems to give rise to a conundrum in mental health-care practice. The conundrum is that patients are often not blamed but are held responsible after norm-transgressions occur. The most interesting version of this challenge is the one in which the patient is not blamed because he is not blameworthy, but

nonetheless is held responsible. The challenge was to explain why patients are held responsible when they are not blameworthy and to spell out what this implies for the Strawsonian theories at stake. I have argued that these patients are held responsible because they have an underdeveloped or compromised capacity – rather than an actual capacity – to meet the norms that they transgressed. They are therefore held to their responsibility to engage in a process of developing or repairing these capacities. This solution to the conundrum ultimately does not undermine the Strawsonian theories at stake. But it brings to the fore a type of response to norm-transgressions that is a central but under-theorized aspect of our interpersonal practices.^{3,4}

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NOTES

¹ I do not want to exclude the possibility of blameworthiness – even in clinical contexts – here, but please note that I am not thereby committed to saying that moral scepticism is false either. It is still possible that the fittingness criteria for blame that are common to our practices are not sufficient justification for blame (Milam, 2016; Pereboom, 2001; Russell, 1992).

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