

## CHAPTER 66

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### RESPONSIBILITY WITHOUT BLAME: PHILOSOPHICAL REFLECTIONS ON CLINICAL PRACTICE

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My first experience as a clinician was in a Therapeutic Community for service users with personality disorder.<sup>1</sup> As well as having personality disorder, many of the Community members also suffered from related conditions, such as addiction and eating disorders. Broadly speaking, these conditions are what we might call “disorders of agency.” Core diagnostic symptoms or maintaining factors of disorders of agency are actions and omissions: patterns of behavior central to the nature or maintenance of the condition. For instance, borderline personality disorder is diagnosed in part via deliberate self-harm and attempted suicide, reckless and impulsive behavior, substance use, violence, and outbursts of anger; addiction is diagnosed via maladaptive patterns of drug consumption; eating disorders involve eating too much or too little. If a service user is to improve let alone recover from these disorders, they must change the diagnostic or maintaining pattern of behavior.<sup>2</sup> For instance, service users with borderline personality disorder must stop self-harming; addicts need to quit using drugs or alcohol; anorexics must eat. There are, no doubt, equally central cognitive and affective components to these disorders. Borderline personality disorder involves instability of self-image and emotional volatility; addicts may use drugs and alcohol to deal with psychological distress; anorexics may have over-valued ideas about low body weight and express anger and achieve a sense of control by refusing to eat. Nonetheless, actions and omissions are diagnostically central to disorders of agency: effective treatment must address these patterns of behavior, even if outcome is improved by an integrative approach that treats behavior alongside cognition and affect.

Service users with personality disorder are notoriously difficult to treat. Within psychiatry they are stigmatized as the service users “no one likes.” In his landmark study of staff

<sup>1</sup> For further information on the nature and treatment of personality disorder see Box 66.1.

<sup>2</sup> Cf. Pearce and Pickard (2010).



attitudes to service users with personality disorder in three High Security Hospitals in the UK, Len Bowers suggests the following explanation:

The generally hopeless, pessimistic attitudes of carers can be seen to originate in the difficult behaviours of PD [personality disorder] patients. They bully, con, capitalize, divide, condition, and corrupt those around them. They make complaints over inconsequential or non-existent issues in order to manipulate staff. They can be seriously violent over unpredictable and objectively trivial events, or may harm and disfigure themselves in ways that have an intense emotional impact on staff. If this were not enough, they also behave in the same way towards each other, provoking serious problems that the staff have to manage and contain. (Bowers 2002, p. 65)

This description is in many ways accurate. Within the Therapeutic Community where I worked, Community members regularly behaved in ways that were harmful to staff and other members, even if physical violence was very unusual. They could be emotionally cruel, or extremely angry and threatening without just cause; they might self-harm or disengage from the Community without explanation, provoking high levels of anxiety in others concerned for their well-being; they might shirk their Community tasks and responsibilities, leaving others to pick up the work. But the staff attitude towards this behavior was not as Bower describes. Rather, the staff were very clear about what their attitude as clinicians should be, and usually, although not invariably, succeeded in achieving it. Service users were responsible for their actions and omissions and accountable to the Community for them, but an attitude of compassion and empathy prevailed, and they were not blamed. As a novice clinician, this stance of responsibility without blame struck me forcefully. It is very different from our ordinary, non-clinical reactive attitudes, where behavior of the sort described typically evokes blame, no doubt alongside related attitudes such as dislike and rejection. And, if I am honest, I initially had no idea how this stance was possible to achieve: when a service user, who was not psychotic and knew what they were doing, was angry and threatening toward me for no reason, and made me feel angry and scared, how was I to hold them responsible for this behavior without blaming them for it? I could make sense of the idea that, despite appearances, they might not be responsible because their disorder excused them, and hence not to be blamed. And I could make sense of the idea that, despite their disorder, they were responsible, and hence to be blamed. But the combination of responsibility without blame for wrongdoing struck me as a philosophical and clinical conundrum.

This chapter offers a solution to this conundrum. Appropriate clinical engagement with the actions and omissions that are the core symptoms or maintaining factors of disorders of agency is central to effective treatment. Clinicians must hold service users responsible and accountable for behavior if they are to improve and recover.<sup>3</sup> But blame, in contrast, is highly detrimental.<sup>4</sup> Blaming service users may trigger feelings of rejection, anger, and self-blame, which bring heightened risk of disengagement from treatment, distrust and breach of the therapeutic alliance, relapse, and, with service users with personality disorder, potentially even self-harm or attempts at suicide: it is essential that compassion and empathy be maintained. So how is this combination possible: How is it possible for clinicians to

<sup>3</sup> Cf. Pearce and Pickard (2010) and Pickard (2011).

<sup>4</sup> Cf. Gilbert (2010). For an ex-service user perspective on the role of blame in impeding recovery see Lisa Ward's commentary on this chapter.



hold service users responsible for actions and omissions that are central to their disorder and cause harm and suffering, without blaming them for them? This chapter has five parts. First, I describe the conundrum in more detail. I suggest that clinicians can often find themselves trapped between a desire to rescue and a desire to blame, despite neither response being clinically effective. The key to avoiding this trap is to link responsibility fundamentally to the idea of agency, and to distinguish it clearly from ideas of blameworthiness and blame. So, second, I offer a conceptual framework that clearly distinguishes ideas of responsibility, blameworthiness, and blame. I suggest that these distinctions have not always been sufficiently marked within philosophy, and I argue that clinical practice illustrates the need to do so. Third, within this framework, I distinguish two sorts of blame, which I respectively call “detached” and “affective.” Affective, not detached, blame is detrimental to effective treatment. I sketch an account of what affective blame is. This overall framework is central to understanding how the stance of holding a person responsible for harm but not blaming them is conceptually possible. Fourth, I turn to the question of how clinicians can effectively keep affective blame at bay. It is one thing for the appropriate clinical stance to be conceptually possible, but quite another for it to be achieved in practice. I suggest that the key to striking this balance, and avoiding the rescue/blame trap, is an understanding of each individual service user’s past history, and that history’s power to directly evoke compassion and empathy. Finally, I conclude with some brief reflections on whether or not the clinical stance of responsibility without blame is an appropriate ideal to which we should aspire in ordinary, non-clinical interpersonal contexts.

## THE CLINICAL TRAP

Bowers found that staff working with service users with personality disorders believe that, unless the service users are also psychotic or otherwise cognitively impaired, they are responsible for their behavior because they act deliberately and “know what they are doing” (2002, p. 85). When the behavior causes harm, they are therefore “to blame” for the harm caused. We can express this line of thought thus:

1. Service users with personality disorder have control and conscious knowledge<sup>5</sup> of their behavior.
2. Therefore they are responsible for their behavior.
3. The behavior causes harm.
4. Therefore they are to blame for the harm.

<sup>5</sup> Throughout this chapter, I use the term “conscious knowledge” of behavior to refer to the way we normally know what we are doing when we do it. It is not straightforward to say what this way is. Normally, we have some knowledge of why we are acting, some knowledge of how we are acting, some knowledge of what we intend in acting, and some knowledge of what effects our actions have on the world. All of this can be part of what we mean when we say we know what we are doing when we act. I do not develop a nuanced account of ‘conscious knowledge’ in this chapter, but rely on our intuitive understanding.



(1) and (2) embody our common sense conception of agency and responsibility. Our common sense conception of agency draws a basic distinction between actions and mere bodily movements, such as automatic reflexes. What makes a piece of behavior an action, as opposed to a mere bodily movement, is that it is voluntary, where this means that the agent can exercise choice and at least a degree of control over the behavior. This conception of agency and action is traditionally linked, within philosophy, to the idea of free will.<sup>6</sup> On this view, agency and action require two capacities. First, the capacity to choose from a range of possible actions, at least in the minimal sense that, on any particular occasion, one can choose either to act, or to refrain from so acting. Second, the capacity to execute this choice: to do as one chooses, given normal circumstances.<sup>7</sup> This common sense conception of agency naturally grounds judgments of responsibility: one is responsible for actions, as opposed to automatic reflexes, because it is up to one whether and how one acts. So long as one knows what one is doing, one is responsible for one's behavior to the degree that one can exercise choice and control over it.

Core symptoms and maintaining factors of disorders of agency are not mere bodily movements. They are kinds of actions and omissions: the kinds of behavior over which we have choice and control. On the whole, service users possess both relevant capacities with respect to these behaviors. On at least most if not all occasions, service users diagnosed with disorders of agency could, for example, choose not to self-harm or be violent, drink or take drugs, binge or refuse to eat. The evidence for this claim is relatively straightforward: service users routinely do choose to behave otherwise and alter entrenched patterns of behavior, when they have incentive, motivation, and genuinely want to do so.<sup>8</sup> Indeed, this is presupposed by most standard forms of effective psychological treatment for disorders of agency. Cognitive behavioral therapy, motivational interviewing, stop-and-think training, exposure therapy, emotional intelligence, mentalization-based therapy, group therapy for addiction, and Therapeutic Communities, are all united in presuming that service users have the capacity for choice and control over maladaptive behavior, and that the clinical aim is, at least in part, to engage this capacity and support the service user to do things differently and alter entrenched maladaptive patterns. These therapies differ only in the extent to which this presumption is explicitly part of how the clinician engages the service user. For instance, in motivational interviewing, the clinician adopts a non-challenging stance, simply expressing empathy and encouraging the service user to see the unwanted consequences of their behavior. In contrast, the language of agency and responsibility permeates the culture of Therapeutic Communities: the Community is explicit that members are expected to see themselves and others in this light. But in all cases, it is a presumption of treatment that service users have choice and control over their behavior and can therefore be asked to take responsibility for it, as we naturally say.

However, it is important to note two caveats. First, service users with disorders of agency may not always have full conscious knowledge of why they are behaving as they do, or what

<sup>6</sup> Steward (2009, 2012) offers a contemporary defence of the view and argues that it is found in philosophers as diverse as Aristotle (1984), Hobbes (1999), Hume (1975), Kant (1960), and Reid (1994). See too Alvarez (2009) for further defence and Bobzien (1998) for historical discussion.

<sup>7</sup> Cf. Holton (2010); for an important analysis of the nature of such capacities, see M. Smith (2003).

<sup>8</sup> Cf. Pickard (2012), Pickard (2013), and Pickard and Pearce (in press). For an ex-service user perspective on the role of choice in recovery see Lisa Ward's commentary on this chapter.



the full effects of their behavior on others may be. Of course, in this, they are not unique: this is a predicament we all face to some extent. But it is possible that some kinds of disorders, most obviously borderline personality disorder, will be associated with reduced capacity for such conscious knowledge: the possibility of mentalization deficits (Fonagy et al. 2004) and high levels of emotional arousal associated with borderline personality disorder may have this effect. Second, it is important to recognize that, on the common sense conception of agency presented earlier, control is a graded notion, and the degree of control possessed by service users with disorders of agency may sometimes be diminished compared to the norm. Patterns of behavior associated with these disorders may be habitual and strongly desired. In so far as these patterns are ways of coping with psychological distress, service users may lack alternative coping mechanisms. Without these alternatives, alongside the hope of a better life, they may also lack the will or motivation to change their behavior, to kick a habitual pattern, and find another way of behaving that is less harmful to self and others. For these reasons, control may be diminished relative to the norm, and with it, responsibility.<sup>9</sup> But reduction is not extinction. The core symptoms and maintaining factors of disorders of agency include actions and omissions: there is at least a degree, and often a significant one, of choice and control.

(1) and (2) thus not only reflect our common sense conception of agency and responsibility. With the earlier mentioned caveats, they are also correctly applicable to service users with disorders of agency. Nonetheless, clinicians working with such service users recognize, at least to some extent, the effect blame can have on care, and struggle not to blame service users for the harm they cause. To this end, so as not to blame service users, they may swing to the opposite pole, and deny (1) and (2). They instead try to rescue service users from blame by denying their agency and absolving them of responsibility. This alternative response may be bolstered by the obvious fact that service users with disorders of agency suffer extreme degrees of distress and dysfunction, which they may have no clear sense how to alleviate or manage, together with the fact that it is a clinician's duty to help and to care. In this mindset, staff may hold that service users "cannot help" behaving as they do. Indeed, this idea is in keeping with popular conceptions of pathological compulsion, whereby the disorder forces service users to engage in the maladaptive behavior, by-passing their capacity for choice and control.<sup>10</sup>

But this alternative response is not viable. First, and most simply, it flouts the evidence regularly and forcefully presented to clinicians who work with service users with disorders of agency. Core symptoms and maintaining factors are actions and omissions over which service users have choice and at least a degree of control, which they routinely exercise when they have incentive, motivation, and genuinely want to do so. Second, it precludes offering clinical treatment that directly addresses the problematic patterns of behavior, whether implicitly or explicitly. For, if clinicians give up the belief that service users have choice and control over their behavior, they cannot rationally decide to work with service users to engage this dual capacity. Indeed, if service users themselves come to believe that they

<sup>9</sup> For more detailed discussion of how to explain diminished control particularly in addiction, see Pickard (2012) and Pickard and Pearce (in press).

<sup>10</sup> Cf. accounts of addiction that treat it as compulsive such as Charland (2002), Hyman (2005), Leshner (1997); for dissenting accounts see Foddy and Savulescu (2006), Pickard (2012), Pickard and Pearce (in press).



genuinely have no choice or control over their behavior, they cannot rationally decide to try to change. For one cannot rationally resolve to change that which one believes one is powerless to change.<sup>11</sup> Effective treatment for disorders of agency depends on clinician and service user alike believing that the service user has choice and at least a degree of control over their behavior: they are to that degree responsible agents. The cost of avoiding blame by denying service users agency and thus absolving them from responsibility is high: it precludes both clinician and service user alike from rationally pursuing psychological treatment, leaving only medication as an option.

Clinicians are often trapped between a desire to rescue and a desire to blame. They may cleave to (1) and (2) given the evidence available to them and the demands of effective treatment. But then when harm is caused (3) they find themselves blaming service users (4). Or, recoiling from blame and hoping to rescue instead, they may respond to (3) by denying (1) and (2). But this is not viable: it flouts the evidence available and precludes many forms of effective treatment. The solution is to challenge the inference to (4). It is possible to hold someone responsible for actions and omissions that knowingly cause harm but not to blame them for the harm. To appreciate this possibility we need to better distinguish and understand responsibility, blameworthiness, and blame.

## A CONCEPTUAL FRAMEWORK FOR RESPONSIBILITY WITHOUT BLAME

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Within philosophy, there is a tendency to link the idea of responsibility to morality. This link can be weak or strong. Weakly, philosophers often use “moral responsibility” and “responsibility” as if they were interchangeable, suggesting, if sometimes unintentionally, that all responsibility is moral. More strongly, philosophers sometimes argue that the idea of responsibility should be understood by appeal to our practice of holding others responsible via what are called our “reactive attitudes” or “moral emotions” (Strawson 1962). These consist in various responses we can have to the good or ill will that others display towards us, such as forgiveness and gratitude, indignation and resentment, and praise and blame. At its most radical, this link between responsibility and the reactive attitudes is thought to be constitutive. As Watson puts this view: “to regard oneself or another as responsible just is the proneness to react to them in these kinds of ways” (2004, p. 220). Slightly more modestly, Wallace has argued that to hold another responsible is to believe that reactive attitudes are

<sup>11</sup> Note that this claim posits only a minimal connection between resolution or intention and belief, in contrast to alternative formulations in the literature. For discussion, see Holton (2009). Note too that the success of twelve-step programmes such as Alcoholics Anonymous (AA) may initially seem striking in relation to this claim, as addicts are asked to admit they are powerless and to turn to God, or a personally chosen higher power, for help in order to change. One natural thought is that resolutions formed in this way are not rational but faith-based: the claim is only that it is not rational to form an intention if one believes one is powerless to effect it, not that it is impossible. Another thought is that AA members are not really asked to admit they are powerless, but rather, asked to admit they are powerless without the help of God or their higher power. Having embraced God or it, it is then possible for them to believe they can change, and so to rationally resolve to do so.



appropriate or fitting responses to their behavior, even if one does not actually feel anything oneself (1994).

Both weak and strong versions of this link between responsibility and morality obscure the possibility of responsibility without blame. With respect to the weaker, linguistic link, it is extremely important that clinicians are able to speak plainly to service users of their responsibility for problematic behaviors without implying that the behaviors even might be morally wrong or the person bad. Compare:

1. If you decide to self-harm/abuse substances/clean obsessively, you are responsible for that.
2. If you decide to self-harm/abuse substances/clean obsessively, you are morally responsible for that.

Note that (2) carries an implication that (1) does not. It suggests moral fault. But behaviors like self-harm, substance abuse, and obsessive rituals, can be damaging to the person without necessarily damaging others.<sup>12</sup> They are not sins, or unequivocally and inherently morally wrong. Whatever responsibility service users have for such behavior, it is neither clinically helpful nor obviously correct to view it as moral. We are responsible for behavior that is morally neutral as well as morally good or bad, and, in clinical and other contexts that support change and reflection, there is point in emphasizing this.

Relatedly, the weaker, linguistic link obscures that fact that service users can be responsible for harm, but not blameworthy, because they have an excuse. Compare:

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.
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.

Note that (2) does not ring true to native ears. And for good reason. How can it make sense to be morally responsible for behavior but not blameworthy for it? For both moral responsibility and blameworthiness imply moral fault. This is what the explanation appealing to psychological distress and lack of coping mechanisms excuses, despite the fact that responsibility for the aggression yet remains.

Turn now to the stronger link. On this view, the idea of responsibility is constitutively connected, via our practices of holding others responsible, either to the reactive attitudes themselves, or to a belief about their aptness. This link makes the possibility of responsibility without blame not simply obscured, but nearly incoherent. If holding someone responsible for harm just is responding with a reactive attitude like blame, then it is not possible to hold service users responsible for harm without blaming them. Similarly, if holding someone responsible for harm just is believing that blame would be an appropriate or fitting response, then, although one may not oneself be blaming them, one is hardly adopting the blame-free non-judgmental stance which is necessary for effective clinical treatment. In practice, one

<sup>12</sup> If this is not obvious, imagine that the behavior is entirely private, all effects kept hidden from view.



might as well be blaming them: for without further qualifications, it seems one believes that one should. In essence, a view of responsibility that links it so closely to the reactive attitudes is not adequate to account for the clinical practice of holding service users responsible for behavior that causes harm, without blaming them for it. For, according to such a view, blaming is too much a part of what it means to hold another responsible for there to be sufficient room to maneuver between them. On this account of responsibility, clinical practice should be nearly incoherent, never mind practically impossible.

The moral of this discussion is that a conceptual framework that is adequate to account for clinical practice must clearly distinguish between ideas of responsibility, blameworthiness, and blame.<sup>13</sup> Let us begin with responsibility.

Effective clinical treatment presupposes that service users are responsible for their behavior in so far as they have conscious knowledge of what they are doing, and can exercise choice and at least a degree of control over the behavior. As we saw earlier, this is a traditional and common sense conception about what it means to be responsible, applicable not only to service users, but to us all.<sup>14</sup> This idea of responsibility is essentially linked, not to morality and the reactive attitudes, but to agency. Crucially, on this view, we are responsible for all our actions, whether or not they are right, wrong, or neutral from a moral point of view. We are responsible for our actions because we are their agents: insofar as we know what we are doing, and can exercise choice and control our behavior, what we do is up to us.

With this idea of responsibility in mind, it is then possible to understand what, minimally, is involved in holding a person responsible. Most stringently, holding a person responsible may consist simply in judging that they are responsible, that is, that they have conscious knowledge, choice, and a degree of control of their behavior. Usually, however, the idea of “holding responsible” means more than judging others to be responsible, but actually treating them thus: treating them as accountable or answerable for their behavior. What accountability or answerability consists in will vary widely, depending on the context. Within clinical practice, holding a service user responsible for their behavior may involve asking them to explain why they made the choices they did, and encouraging them to behave differently in the future. Alternatively, it may involve the agreed imposition of negative consequences, to increase motivation, and show that the behavior, and the harm it causes, is taken seriously.

But, as the discussion of reactive attitudes makes clear, the idea of holding another responsible can involve more. It can involve judging a person not only to be responsible and therefore accountable for the behavior, but to be blameworthy, and indeed blaming them. So, let us turn now to blameworthiness.

<sup>13</sup> A. Smith (2007a) draws these and other distinctions very clearly, and offers a helpful discussion of the ambiguity in the meaning of “holding responsible” together with an account of what she calls “active blame” which is similar to my “affective blame.” Her discussion differs from mine in three important respects. First, she is content to maintain the linguistic link that I believe to be misleading, and to view all responsibility as moral responsibility, since she holds that the point of responsibility is that it makes moral appraisal appropriate. Second, she offers a ‘rationalist’ account of the conditions of responsibility as opposed to the more ‘volitional’ one suggested here. See A. Smith (2007a, 2007b, 2008). Third, she does not offer an account of what unifies all instances of ‘active blame’ as blame, nor does she attend to irrational blame (see later).

<sup>14</sup> Readers who are concerned about the threat of determinism or who believe for other reasons that responsibility is not linked to the dual capacities of choice and control can potentially substitute an alternative account of responsibility, such as reasons-responsiveness (Fischer and Ravizza 1998), into the conceptual framework offered here without undermining its basic structure.



We judge a person to be blameworthy when they are responsible for harm, and have no excuse. Excuses come in various kinds, such as bad luck, justifiable ignorance, limited choices, and the intention or quality of will behind the action. As suggested earlier, service users who are responsible, at least to a degree, for harm to self or others may not be judged blameworthy, because they have an excuse, such as limited choices, or levels of psychological distress that we do not expect people to tolerate without taking action to alleviate it. However, sometimes they do not have an excuse.<sup>15</sup> Clinicians may turn a blind eye to this, but equally, they may not: they may recognize that a service user is not only responsible, but blameworthy. Yet, they may still manage to avoid blame and maintain an effective clinical stance.

Distinguishing responsibility and blameworthiness is important to solving the conundrum. For it allows us to see both how it is possible to be responsible, and treated thus, for actions that are not morally wrong; and how it is possible to be responsible, and treated thus, for actions that are morally wrong but for which one is not blameworthy, because one has an excuse. But we are yet left with the problem of how it is possible for clinicians to hold service users responsible for harm for which they are recognized to be blameworthy, and yet not to blame them. To resolve this, we need to understand what blame is.

## BLAME

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Philosophical accounts of blame are surprisingly few and surprisingly diverse, but they tend to agree on one thing. Blame carries a characteristic “sting.” Being the object of another’s blame hurts. Capturing the “sting” of blame is thus a constraint on any adequate account of what blame is. The “sting” is also the reason why blame is so clinically counterproductive. Effective treatment is not possible if the service user feels judged, shamed, berated, rejected, attacked, or hurt.

But talk of blame is often ambiguous. When we say that another is “to blame” we may mean one of three things:

1. They are blameworthy.
2. We should blame them.
3. We actually do blame them.

These three propositions are distinct. (1) is a judgment about another. Whatever the conditions of blameworthiness ultimately are, they meet them. It is possible to make such a judgment about another, without also judging that we should blame them, let alone judging that we actually do. For instance, we might judge a historical figure from the distant past

<sup>15</sup> Note that the mere fact that a service user has a disorder of agency is not in itself an excuse. There is no reason why any psychiatric disorder should offer a sweeping, across the board excuse, if the service user retains the capacity for conscious knowledge, choice, and control of their behavior. Rather, different disorders point to probable incapacities or deficits, which may offer excuses on examination case-by-case of behavioral problems.



blameworthy for harm perpetrated, but we neither blame them, nor judge that we should—the harm is too far removed.

(2) is about us and what we should do. In this kind of context, “should” can have three different meanings. First, we may be saying nothing more than that blame is *warranted* or *justified*: we should blame another, because they are blameworthy. If so, (2) collapses into (1). Second, we may be saying that blame is *appropriate*, relative to various norms governed by the nature of our relationship with the other and the circumstances. For instance, it may be appropriate for victims to blame perpetrators for harm, when it is not appropriate for legal advocates to do so. Third, we may be saying that blame is *desirable* relative to a given end: whether or not blame is warranted or appropriate to our relationship and the circumstances, perhaps it would do us psychological good to vent, or perhaps it would serve an instrumental purpose, such as deterrence. In all three senses, it may be true that we should blame another, and yet we find that we don’t. Perhaps we are simply too weary of battling or teaching this person, or fighting for social good: we are beyond caring at this stage to muster the energy to blame.

Finally, (3) is about us and what we actually do. Often enough, we feel blame towards others when we both judge them blameworthy and judge blame appropriate and desirable. But not always. Blame, like nearly all emotions, can be irrational. Although irrational emotions are often particularly prevalent in clinical contexts, a moment’s reflection on the vicissitudes of ordinary personal and family relationships should be sufficient to establish this. When things go wrong for us, especially within long-standing personal relationships, but elsewhere, too, we often look for someone to blame, whether as a way of avoiding responsibility ourselves, or simply as a way of venting our frustrations. We sometimes blame others even when we know that the person we are blaming is not at fault, and that we shouldn’t: “I know it’s unfair, they don’t deserve it, but I can’t help blaming them. I’m just so angry!”

In this respect, it may be helpful to compare blame and fear. It is one thing to judge a situation dangerous. It is another to judge that fear is warranted, appropriate, or desirable. And it is another again actually to feel it. The brave soldier judges a situation dangerous, so that they can respond rationally and effectively in battle. But they do not feel fear. Nor do they judge it appropriate or desirable that they should: given their role and aim, better they should not. In contrast, the well-informed British arachnophobe feels fear even when they judge there is no objective danger or reason that they should: it is neither warranted, appropriate, nor desirable to be pathologically afraid of UK spiders. Blame is like fear. It can fly in the face of considered judgments about what is true of the blamed object, and what should be true of the blaming subject.

Past philosophical accounts of blame have tended to draw on one of two ideas. Either blame is a form of punishment (Smart 1961). Or it is a sort of mental ledger or record of a person’s behavior, of use in assessing character or predicting behavior (Feinberg 1970; Glover 1970). Neither idea suffices to account for blame. As has often been remarked, blame is a mental state, and punishment is an action (Boyd 2007). It is perfectly possible to blame someone but not show it at all, let alone act so as to punish them. Similarly, it is unclear what a mental ledger or record of a person’s behavior is supposed to be, other than a memory that they did it. Moreover, we can blame people for actions we consider one-off, and would not use to assess their character or predict future behavior.

Partially in response to these deficiencies, more recent philosophical accounts of blame have focused instead on the idea that blame is essentially if not exclusively cognitive: a form



of consciously accessible, personal-level judgment or belief. For instance, Hieronymi (2004) suggests that blame is the judgment that a person has shown disregard or ill will towards another. Or again, Sher (2006) suggests that blame is the belief that a person has acted badly or has a bad character, in conjunction with a desire or wish that this were not the case. Finally, Scanlon (2008) suggests that blame is the judgment that a person is blameworthy, and so has shown impaired interpersonal attitudes, which renders appropriate the rational revision of one's own attitudes towards them, especially one's intentions.

Such cognitive accounts struggle to capture both the "sting" and the irrationality of blame. Consider first its irrationality. As we saw earlier, blame, like most reactive attitudes and emotions, can fly in the face of judgments or beliefs that a person is blameworthy.<sup>16</sup> If irrational blame is possible, these cannot be necessary, let alone sufficient, conditions of blame. This is not to deny that blame, like fear and other occasionally irrational emotions, can clearly involve subpersonal representations, potentially of threat, harm, slight, or ill will, at some level of information-processing. The cognitive psychology of emotional information-processing is not yet unified and advanced, but theories are developing that aim to explain the varieties of rationality and irrationality, consciousness and unconsciousness, that characterize emotions.<sup>17</sup> But, crucially, the representations posited to accommodate these aspects of emotions are not consciously accessible, personal-level judgments and beliefs.

Consider next blame's characteristic "sting." One complicating factor is that individual differences in temperament and values mean that there can be no universal claims about what does and does not "sting." Some people are more sensitive than others, and some people care more about interpersonal relationships, rights, and wrongs, than others. This point is especially important with respect to differences between service users. For instance, a service user with low self-esteem and a critical superego may be easily "stung" by blame, while a service user with narcissistic and psychopathic tendencies may be more immune. Assessing the extent to which an account of blame captures its "sting" is thus the task of assessing the extent to which an account of blame captures what commonly or prototypically "stings." Disagreements are clearly possible. Nonetheless, there is good reason to hold that personal-level cognitive accounts will not adequately capture this. For judgment and belief are commonly, indeed arguably prototypically, "detached."

Note first that, as discussed earlier, we can judge or believe that a person, such as a historical figure, is blameworthy, even if we neither do feel anything nor judge that we should. Furthermore, the addition of a desire or wish that this not be so need not make the attitude any less detached. But, even when the judgment or belief is about a person with whom one is presently in relation, they may not "sting." For, they may be formed and expressed in a way that does not hurt or harm. For instance, good parenting routinely involves pointing out when a child has shown disregard or ill will towards a sibling, and indeed imposing negative consequences for it. That is part of bringing up children to treat others, including rivals, with regard and respect. Sometimes, no doubt, parents do this in such a way that the child feels bad and blamed. But a loving parent can often help a child understand that their behavior

<sup>16</sup> For ease of exposition, I shall ignore the differences in precise content of the various judgments and beliefs suggested, and refer to them all as judgments of blameworthiness.

<sup>17</sup> For a review of the relevant science see Dalgleish and Power (1999), Lane and Nadel (2000); for discussion connecting the science to more standard philosophical concerns, see Prinz (2004).



towards a sibling is neither decent nor permitted, without the child feeling “stung.” Further, this “detached” mode of forming and expressing judgments of blameworthiness can be maintained even in face of revision of interpersonal attitudes and intentions. For instance, one can rationally and politely decide to stop socializing with an acquaintance who routinely offends, because one judges them blameworthy and no longer wishes to see them, without either party minding very much. This is importantly different from a situation where one party acts out of anger, writing the other off, whether justifiably or not, without due thought or consideration. There is no doubt that judgments and beliefs of blameworthiness, and the changes in relationship they license, can “sting.” The point is that they can also be “detached.” Presence or absence of “sting” often depends, not only on the temperament and values of the blamed, but also on the exact nature of the change in attitude and intention of the blamer, and, moreover, how this change is experienced and expressed.

Irrationality and “sting” are both secured by the same thing. The reason why blame can be irrational, and the reason why it hurts, is that it is a reactive attitude, a kind of emotion. Call blame which has these features “affective blame.”<sup>18</sup> We need not deny that we sometimes speak of blame in a more “detached” mode. As we saw earlier, judgments that another is “to blame” are ambiguous. Call this non-stinging sort of attitude “detached blame.” Detached blame can consist in a judgment or belief of blameworthiness. It can be accompanied by a revision of attitudes or intentions, or a further belief that such revision would be appropriate. It can also be accompanied by the imposition of negative consequences for the action, or a just demand for accountability or answerability. The point is that it need not have any of blame’s characteristic “sting.” “Sting” is commonly and prototypically secured by negative affect and the potential it has to be expressed and acted on. It is affective blame that really hurts.

But there is a challenge facing this suggestion. Grant that the “sting” of blame is affective. We now face the question: *What kind of affect?* For, it seems that affective blame can consist in a range of different emotions. Most obviously, these include hate, anger, and resentment. But the range can plausibly be extended to include certain other states that have an affective dimension without being uncontroversially identifiable as types of emotion, for instance, disapproval, dislike, disappointment, indignation and contempt. Moreover, as expected given this range, blame’s expression can be equally various: for instance, alongside punishing, blame can also be manifest in berating, attacking, humiliating, writing off, rejecting, shunning, abandoning, and criticizing, to name but a few behaviors. The challenge is thus to unite these various emotions and manifestations thereof into a single account of blame. For each kind of reaction can occur without counting as an instance of blame. So we must explain what makes these various reactions count, when they do, as instances of blame.

It is natural to be tempted by the idea that they are united in virtue of being caused by the judgment or belief that a person is blameworthy. But this cannot be right. For, as we saw earlier, blame can be irrational: one can blame someone in absence of such a judgment or belief. Instead, I want to suggest that the phenomenology of affective blame provides a cue. Part of what is distinctive about blame is that, when in its grip, one feels entitled to one’s blaming response, because of what the other has done: it feels as if they deserve it, even if one does not judge or believe that they do. This feeling of entitlement—of being in the right, in relation to another’s wrong—is the key to unifying affective blame. What makes

<sup>18</sup> Cf. A. Smith (2007a, 2007b) on “active blame” and Wolf (2011) on “angry blame.”



a negative emotion in reaction to another count as blame is the second-order response the blamer has to their first-order emotion: their feeling of entitlement. This feeling of entitlement places the responsibility for the blaming response on the blamed: the blamer feels entitled to their first-order emotion because of what the blamed has done. It thereby gives the blamer a (defeasible and resistible but nonetheless genuine) feeling of freedom to express blame, to vent, to act out of whatever negative emotion they are experiencing. The blamer acts as if, because of what the other has done, the first-order emotional reaction is *deserved*. In this way, although blame is not an action and so not a form of punishment, it is a *punishing* mental state: in reacting negatively, one feels oneself to be in the right, in relation to another's wrong.

It is important to recognize that this feeling of entitlement is not a judgment: we must eschew a consciously accessible, personal-level cognitive account of emotion at the second-order as well as the first. Rather, whatever the mature, agreed theory of the information-processing underlying first-order emotions turns out to be, we need to import this understanding to the account of blame offered here. This is important, if we are to account not only for the "sting" of blame but also for its potential irrationality. For, just as one can judge that spiders are not dangerous and yet feel fear, so too one can judge that another is not blameworthy and yet not only feel anger, but also feel entitled to this anger. One can feel this, even though one knows one shouldn't.

Of course, if the blamer views their blame as irrational and exercises their capacity for rational reflection, they may try to suppress the first-order emotion, and control their behavioral tendencies. Or, alternatively, in the grip of the feeling, they may not. But what makes an instance, say, of anger towards another into blame, is that the blamer cannot lose the feeling that they are entitled to be angry, even if they judge that this anger is not ultimately deserved.

With the distinction between detached and affective blame in hand, we can now complete the conceptual framework, and solve the conceptual part of the conundrum. Clinicians are able to hold service users with disorders of agency responsible, indeed blameworthy, for harm, without blaming them, because blame comes in two forms: detached and affective. Detached blame consists in judgments of blameworthiness, and may further involve correspondingly appropriate revisions of intentions, the imposition of negative consequences, and accountability and answerability. These can have a place within effective clinical treatment, and, in so far as they encourage responsible agency, may be essential to it. Affective blame consists in negative reactions and emotions, whether rational or not, which the blamer feels entitled to have. Effective treatment requires clinicians to avoid affective blame. Responsibility without blame is responsibility without affective blame: without a sense of entitlement to any negative reactive attitudes and emotions one might experience, no matter what the service user has done.

## IMPOVERISHMENT AND EMPATHY

Part of the solution to the clinical conundrum is conceptual: we need a framework that clearly distinguishes responsibility, blameworthiness, and blame, in order to understand how it is conceptually possible to hold service users with disorders of agency responsible for



harm without blaming them. But part of the solution is practical: it is not sufficient that it is possible to avoid affective blame, clinicians must actually manage to do so.

Clinical training and experience provide some skills that help with this task. Clinicians learn a way of speaking, which involves both a repertoire of phrases, and an attitude of calm respect, that helps them both think and talk with service users about their responsibility for harmful behavior, without blaming them. Clinicians also develop their own capacity to take responsibility for their own emotions: to reflect deeply on whether their response to a service user is warranted or necessary or even natural, and to “own” their part in interpersonal engagements. Bearing in mind the nature of their relationship with service users, and the inherent power imbalance between them, no doubt further aids this task: compare again, in this respect, the non-judgmental attitude loving parents show children. Finally, when all else fails, clinicians need a good poker face—a commitment and capacity to mask their emotions, and refrain from acting out of any blame they may feel.

But, alongside these various skills, clinicians must cultivate compassion and empathy for service users.<sup>19</sup> Quite generally, compassion and empathy are central to good therapeutic care (Gilbert 2010). They are essential when working with service users where the core symptoms and maintaining factors of the disorder typically cause harm. The reason is simple: a compassionate, empathetic stance is at odds with a blaming stance. Compassion and empathy push the negative emotions constitutive of affective blame aside. They simply cannot comfortably coexist.

One central way that clinicians can achieve compassion and empathy towards service users is simple: proper attention to service users’ past history. As is well known, psychiatric disorders in general are associated with impoverished early childhood environments, and, of course, the ensuing psychosocial adversity, interpersonal and occupational problems, and stigma that is consequent upon poor mental health. In particular, personality and related disorders are associated with dysfunctional families, where there is breakdown, death, institutional care, and parental psychopathology; traumatic childhood experiences, with high levels of sexual, emotional, and physical abuse or neglect; and social stressors, such as war, poverty, and migration (Paris 2001). Service users often come from harrowing backgrounds, impoverished of all goods, to an extent that can be unimaginable to people who have not experienced these kinds of conditions. Effective treatment can involve helping service users to explore their past and recognize its effects on their personality and their present experiences and behaviors, both as a way of coming to terms with the past, and as a way of developing skills needed to better manage the present. But, in attending to service users’ past history, clinicians and service users together gain understanding of why the service users are as they are. A fuller life story or narrative comes into view, in which the service user is seen not only as one who harms, but as one who has been harmed.<sup>20</sup> As Watson has put this point in relation to the psychopath Robert Harris: “The sympathy towards the boy he was is at odds with outrage towards the man he is” (2004, p. 244). Attention to service users’ past history is not only part of effective treatment. It also has the power to help clinicians strike a balance between rescue and blame. It requires clinicians to keep in mind the whole of the person and the whole of their story, which undercuts a single, reactive stance, forcing

<sup>19</sup> Cf. Potter (2009).

<sup>20</sup> For information on a first-person narrative account that emphasises this Janus-faced aspect of personality disorder see Box 66.1.



**Box 66.1 Further Reading and Resources**

For further reading on the nature of personality disorder, see the Special Issue of *Philosophy, Psychiatry, Psychology* (2011, volume 18, number 2) on Personality Disorders, edited by Hanna Pickard. The Special Issue is a multidisciplinary effort to further understanding of personality disorder, drawing on scientific, clinical, philosophical, social, and legal perspectives. It also includes a first-person narrative of an ex-service user's experience of living with personality disorder: "The chasm within: my battle with personality disorder" by Jessica Gray. For a comprehensive collection that focuses more exclusively on scientific and clinical dimensions of personality disorder, see *The Handbook of Personality Disorders: Theory, Research, and Treatment*, edited by W. John Livesley (NY, The Guilford Press, 2001). In addition, two valuable internet resources are The UK National Personality Disorder Website available at <http://www.personalitydisorder.org.uk/> and the Emergence Website which is service user-led and available at <http://www.emergenceplus.org.uk/>.

affective blame to exist alongside compassion and empathy, and thereby at least reducing, if not outright extinguishing, its force.

It is important to recognize that this appeal to past history does not eliminate responsibility or blameworthiness.<sup>21</sup> It may reduce responsibility, insofar as certain kinds of background impede the development of skills that, for instance, facilitate emotional regulation and, correspondingly, behavioral control. Equally, extreme impoverishment can limit choices, which can sometimes excuse bad decisions and the harm they cause. But such reduction is not global, and would depend on the particular kind of background, skills, choices, and harm, in question. Rather, the compassion and empathy that consciousness of past harm arouses directly quells and tempers affective blame. It acts as an antidote.

**RESPONSIBILITY WITHOUT BLAME IN  
NON-CLINICAL CONTEXTS**

When I present the conceptual framework developed in this chapter to friends and family of service users with disorders of agency, they invariably ask whether they too should aim to adopt the clinical stance of holding service users responsible for harm caused by maladaptive behavior without blaming them for it. Friends and family of service users often bear the brunt of this behavior: unlike clinicians and indeed all but crisis services, they are available at all hours, and often a natural target for negative feelings and difficult behavior. But in principle, this is a question that applies not just to friends and family, but to society at large. What sort of attitude should we adopt to service users with disorders of agency who do harm?<sup>22</sup>

<sup>21</sup> Cf. Watson (2004).

<sup>22</sup> If the maladaptive behavior is also criminal, this question is also relevant to legal issues of liability and the purpose or intent in sentencing and imprisonment. For discussion of the theoretical value and practical possibility of taking the clinical model of responsibility without blame into a criminal justice context, see Lacey and Pickard (2012). For information on the development of a prison officer training based on this model see Box 66.2.

**Box 66.2 Responsibility without Blame Training**

The UK Department of Health and Ministry of Justice are currently engaged in a joint initiative to develop a *Knowledge and Understanding Framework for Personality Disorder*. The framework offers different levels of training to support people to work more effectively with personality disorder in a variety of roles and contexts. Hanna Pickard is developing a 'Responsibility without Blame' training as part of a strand of this framework dedicated to promoting psychologically informed and rehabilitative environments within prisons. Information on the *Knowledge and Understanding Framework* is available at <http://www.personalitydisorder.org.uk/training/kuf/>.

One lesson that clearly can be learned from clinical contexts is this: we do not help service users with disorders of agency by denying their agency and absolving them from responsibility. In so far as we aim to help service users improve or recover, their agency and responsibility should be upheld. Moreover, apart from this aim, agency and responsibility are goods. As Angela Smith elegantly points out: "being held responsible is as much a privilege as it is a burden. It signals that we are a full participant in the moral community" (2007b, p. 269). In other words, in holding service users with disorders of agency responsible, we treat them as *one of us*—as belonging with us, as equals.

Affective blame can, of course, undercut that belonging, by expressing hate, anger, resentment, disapproval, dislike, contempt, rejection, and any number of other negative reactive attitudes and expressions. So it might appear that, in so far as we aim to help, we should adopt the clinical stance: we should avoid affective blame so far as possible when holding service users responsible. I want to conclude by suggesting that such a blanket adoption of the clinical stance is not obviously correct.

First, and most obviously, although the clinical aim is to care and to help, that is not the only aim of friends, family, or others in society at large. Their aims will likely be different and various. For instance, at least one typical and significant aim of friends and family is to have real and genuine relationships. Blame for wrongdoing is ordinarily a natural part of such relationships in our society. Hence the possibility of real and genuine relationships, and of equal standing between service users and others, may be lost if the latter are too careful to act in the former's interest at the expense of how they naturally feel.<sup>23</sup> Outside of clinical contexts, equality, respect, and belongingness may best be expressed through ordinary as opposed to special treatment.

Second, even when we have a primary aim to help, withholding affective blame may not always further that aim. Affective blame is one way of holding people responsible for their behavior in so far as it itself counts as the imposition of negative consequences: it is an affective form of accountability. It may be that, in many non-clinical and clinical contexts alike, other forms of accountability are more effective as instrumental means to helping service users take responsibility. But the desire to avoid the affective blame of friends, family, and society at large, may be a powerful motivating force. There may be occasions where blame is not only natural, but also helpful, in the long-term, to the person blamed.

Hence there is no easy, blanket answer to the question of whether or when we should adopt the clinical stance of responsibility without blame. It is often complicated to

<sup>23</sup> Cf. Kennett (2007).

determine whether or not, in a particular context, affective blame is instrumentally effective relative to desired ends. It is equally complicated to determine whether, over and above its instrumental use, affective blame is appropriate, given the nature of the relationship between the parties, the kind of harm caused, and how and why it occurred. Cultural conventions to do with roles and relationships, alongside interpersonal histories and dynamics, affect what is and is not appropriate between people. For this reason, there is no ubiquitous, standardized, rational norm governing when affective blame is and is not appropriate. Working out when it is, and when it is not, is part of the meat of having real, genuine relationships.<sup>24</sup> In the face of this complexity, one thing remains clear: clinicians, family, friends, and others need to hold service users with disorders of agency responsible for their behavior, and ask that they change it, when it causes harm to self or others.

But given this complexity, a second lesson that can perhaps be learned from clinical contexts is this: We should all question, more often than we typically do, whether or not our inclination to affectively blame others is warranted, appropriate, and desirable, given the particular context. As mentioned earlier, clinicians must develop their own capacity to take responsibility for their own emotions: to reflect deeply on whether their response to a service user is warranted, appropriate, or even natural (let alone desirable given their aim to help) and to “own” their part in interpersonal engagements. That is something that, arguably, we all fail to do as much as we ideally should, in relationships with service users and non-service users alike. When we are harmed, deliberately or not, we often look for someone to blame, as a way of venting our anger, hurt, and frustration. Possibly, if we do have a part to play in what has happened to us, we look for someone to blame as a way of avoiding our own responsibility. If we hold others responsible for their behavior, it is incumbent on us to hold ourselves equally responsible, and that may include holding ourselves responsible for our inclination to affectively blame, by questioning our sense of entitlement to our negative reactions, even if we ultimately judge those reactions warranted, appropriate and desirable. If we do blame, we need to do so responsibly.

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<sup>24</sup> This is another reason why philosophical accounts of responsibility that constitutively link it to our actual reactive attitudes or our beliefs about their aptness are problematic. The norms that govern our reactive attitudes may be far more complicated, various, and indeed on occasion arational, than the conditions required for ascriptions of responsibility.

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## COMMENTARY: ENABLING CHOICE IN A THERAPEUTIC ENVIRONMENT

LISA WARD

The frustration that must come for clinicians working with people with personality disorder and disorders of agency when the client is still engaging in counterproductive coping mechanisms is understandable. How is it possible to continue to want to help someone who



repeatedly injures themselves or others, but seemingly without awareness of the impact of this on themselves and those around them? How is it possible not to blame, or judge, or recoil from a desire to work with the client? And yet at the same time, imagine the frustration at being filled with emotions so intense that they almost freeze you with their power. Particularly at the start of a therapeutic journey, this sense of being flooded by emotions can lead to a sense of impotence, an inability to express emotions in words. More often than not this ends up being expressed through very physical means, such as self-injury, self-starvation or binge-eating, reckless drinking, fighting with others, or even isolating oneself entirely to avoid all physical contact. In short, it can become frustrating, and perhaps even tedious, for clinician and client alike. The person diagnosed with personality disorder may not be able to fathom how the intensity of their emotions cannot be understood, and instead feel like their behavior is judged or criticized by the clinician, who may pressure them to change, or withdraw from the relationship. The clinician, in contrast, may be struggling to comprehend why the client persists in counterproductive coping mechanisms and does not seem to see or care about the impact that their behavior has, both on themselves and on others.

It is often said that those diagnosed with personality disorder typically lack empathy. But, in these kinds of situations, I would argue that both sides lack empathy, which often has negative consequences for quality of care and possibility of recovery. As someone who frequently self-injured, this type of frustration in clinicians often led to feeling blamed, both by them and by myself, that in turn fed into a cycle of guilt. Although to outsiders it may have looked as though I had no awareness of my behavior's impact on myself and others, this was generally not the case. When in the grip of such intense and powerful emotions, I felt forcefully driven to take action to manage these feelings and make them abate, often in a very physical, almost primitive way. The option of self-harming provided relief which I needed, despite the guilt I knew I would face later. Now, imagine coping in the best way you can (in my case self-injury) and being met with blame. Blame, when someone is already feeling guilty, compounds a cycle, and in my case, made me want to self-injure more to punish myself for the impact of my behavior on myself and others. Of course, with hindsight, self-injury was not my only choice to manage my emotions, but until I was supported in a blame-free environment to think about alternatives, it certainly felt like it was.

A clinical approach emphasizing responsibility but grounded in compassion and empathy not only ends the cycle of blame and guilt. It also begins to open up the sense of agency. It is in this state that alternative choices can be explored, and a sense of belief that there is a better way to cope can be instilled. Sitting with, thinking about, and finding new ways to cope with emotions, as well as finding ways to express them in words, were things I'd always longed for, yet never accomplished. Blame-free therapeutic environments work because they provide a place to learn—a place where it is safe to try out new behaviors, to make mistakes without feeling a complete failure, and even, sometimes, to find some spontaneity and a sense of play. Given that so many of the coping mechanisms utilized by people with personality disorder or disorders of agency are physical and so, in a sense, childlike (akin to a child who is not yet able to speak, and so communicates by very physical means) it seems likely that they have not had the opportunity to learn to cope with emotions in an environment which is caring, safe and free from blame.

For me, this approach removed the continued sense of blame and guilt for the ways in which I was coping, which had left me believing that all I was ever going to amount to was a continued disappointment. This in turn filled me with a sense of control: I felt that every





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1154 CURE AND CARE

action (or reaction) was a choice. This allowed me to see that I had the power to take responsibility and make more helpful choices, and to learn to communicate my emotions verbally and find ways to manage them without causing such harm or distress to myself and others. By being able to view every action as a choice, it felt less like I was being pressured by others to give up old coping mechanisms, and instead that I was willingly choosing to change how I behaved. In turn, this has enabled me to manage my emotional reactions in healthier ways, leading to a fulfilled life, with focus firmly placed on the positive choices I can and have made.

Lisa Ward



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