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Taking Responsibility: Toward an Understanding of Morality in Practice

A Critical Review of the Empirical and Selected Philosophical Literature on the Social Organization of Responsibility

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Although the nursing literature overflows with references to the myriad things for which nurses and patients are de facto responsible, nurses have never explicitly examined the social construction of responsibility in any clinical context. This article reviews and integrates the empirical and philosophical literature on moral responsibility in the context of mental health nursing. It selectively reviews both traditional and feminist philosophical accounts to more deeply understand the socially constructed nature of responsibility and the implications for understanding morality in practice. It seeks to illuminate the concept of "taking responsibility" qua moral responsibility and asks what makes this notion of responsibility particularly "moral." **Key words:** *morality*, *moral practices*, *moral responsibility*, *social construction of responsibility*, *taking responsibility*

Philosophers are chronic cognizers running in packs of chronic cognizers. Among philosophers, choosing to cognize deeply appears to be a capacity equally open to all. But it is no more plausible for philosophers to propose this as grounds for moral responsibility than it would be for an assembly of marathoners to suggest that everyone can simply choose whether to run 26 miles at a sustained rapid pace.[1(p228)]

According to traditional notions of analytic philosophy, responsibility becomes *moral* responsibility when simple causal responsibility for actions, events, phenomena, or consequences attaches to individual moral agency in particular ways. Moral agency, of course, assumes the absence of ignorance, coercion, or constraint in an agent with free will, control, choice, and considerable rational capacity to "cognize deeply." It also assumes a certain amount of (good) moral luck, for example, the kind of "constitutive luck" that affords one the opportunity to develop a good character (or not to, say, develop a mental illness) and/or the kind of "incident luck" that allows one to avoid unfortunate events like traumatic brain injury.[2] Of course, those criteria exclude many of us from the domain of the (morally) responsible. I am thinking particularly of the severely and persistently

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mentally ill clients with whom I have worked for most of my nursing career. These are the same clients I consistently urged to "take responsibility" for behaviors, acts, events, and consequences despite the supposed lack of agency that would exempt them from (moral) responsibility.[3] Yet the expectation that even the severely and persistently mentally ill will attempt to take responsibility for their behavior despite the fact of their mental illness is a pervasive feature of psychiatric approaches to the care and treatment of the mentally ill, and rightly so.[4] What notion of moral responsibility makes sense of this practice? Surely not those that find responsibility attribution—generally for purposes of praising or blaming—sufficient on the basis of the intact, reasons-responsiveness of the individual will. Here, all that is needed for responsibility is the individual choice to "cognize deeply," that is, to exercise one's capacity for practical reasoning.[5,6] For my variously impaired clients, most of whom receive assistance within a complex matrix of interpersonal relationships, this notion seems insufficient to account for the profoundly moral, collaborative process of incrementally "taking responsibility" to patch up their broken lives. Here, responsibility is a social not an individual achievement. Why is this issue so important to nursing?

Moral responsibility, as Waller notes, "is running out of room."[1(p223)] From where does it issue now that rationalism and scientific naturalism have eclipsed religion and divine law?[7] Where are we to locate it now that biology, psychiatry, psychology, and sociology have discovered causes of behavior that undermine our sense of choice and control—and therefore our claims of agency and responsibility?[1] In the absence of free will and alternative possibilities, the scope of moral responsibility seems to narrow to a small corner of the individual, self-reflective, reasons-responsive, rational mind where "it is fair to hold people morally responsible [only] if they possess the rational power to grasp and apply moral reasons, and to control their behavior by the light of those reasons."[8(p1)] However, exempting the mentally ill from moral responsibility by such criteria falls far afield from our *actual* practices of responsibility. These practices commonly include, for example, evicting the mentally ill from their apartments for behavior that makes other residents uncomfortable; jailing them for trespassing, behaving bizarrely, or urinating in public, which is not so bizarre when you are homeless; and expecting their participation in treatment plans. Clearly, landlords, shopkeepers, neighbors, relatives, psychiatric nurses, and a host of others hold the mentally ill (morally) responsible in ways not so dissimilar from the ways they hold responsible those of us lucky enough to possess the rational power to effectively grasp moral reasons so as to consistently control [our] behavior by light of them.[8] Moreover, exempting the mentally ill from moral responsibility runs counter to the moral intuitions of psychiatric nurses, who have always seen their clients as *worthy* to answer for their conduct to others—as fellow participants, in other words, in moral communities. Perhaps it is not so much that moral responsibility is "running out of room,"[1] but rather that our failure to grasp its interpersonal and socially constructed nature causes us to look in the wrong places for it.

PURPOSE AND METHODOLOGY

The purpose of this article is to examine the evidence for an interpersonal, or socially constructed, notion of responsibility and to ask what makes such a notion of responsibility particularly *moral*. It does so with the findings of a comprehensive search of the empirical, theoretical, and philosophical literature on "moral responsibility," "taking responsibility," and the "social construction of responsibility" from nursing, medicine, psychology, sociology, and philosophy over the past 25 years. This search is part of a larger ethnographic inquiry, as-yet incomplete, into the social construction of responsibility in the residential dialectical behavior therapy of women

diagnosed with borderline personality disorder. That inquiry aims to examine practices of responsibility in a particular outpatient psychiatric treatment facility with an eye to look critically at how responsibility is socially constructed, that is, how it is signified, defined, actualized, made meaningful, and/or given its content and form by social processes rooted in time and space. For present purposes, the terms *socially constructed*, *socially organized*, and *socially negotiated* are roughly synonymous. An important assumption of this ongoing project is that morality is embedded in social practices, particularly practices of responsibility that allot, assign, divide, or deflect particular responsibilities to (or away from) the occupants of social roles. Here, morality *just is* our shared (moral) understandings of our socially negotiated practices of responsibility.[9–14] Within this framework, the empirical study of the social construction of responsibility addresses "questions about how responsibilities come to be assigned to one group of people rather than another and why there is more choice about the acceptance of some kinds of responsibilities than others."[15(p15)] It pays attention, in other words, to social context, especially to social position, social role, political power, and difference; for moral responsibility is a constructed reality not an objective fact. It does not exist ideally in transcendent space, awaiting discovery by the correct empirical or philosophical method.

Researchers have empirically examined the socially constructed nature of phenomena as diverse as infertility[16] and information privacy.[17] However, there is only one empirical study from sociology of the social construction of responsibility (in neonatal intensive care),[15] as well as one narrative exploration from feminist philosophy of the social negotiation of responsibilities in genetics research.[18] The discipline of nursing has not itself investigated this complex, undertheorized, and underresearched[15] topic. I discuss both works and, because of their relevance to the larger project underway, also examine findings on the social organization of ethics[19] and the social construction of borderline personality disorder in women.[20] In addition, I integrate a small body of diverse, multidisciplinary empirical literature that in various ways researches, employs, or locates as a finding the concepts of moral responsibility, moral attribution, and "taking responsibility." Ultimately, the empirical findings are integrated with the philosophical inquiries in the identification of 5 tightly intertwined concepts that shed light on the nature of being morally responsible when you are mentally ill. Difficult to separate, they are as follows: (*a*) forward- versus backward-looking moral responsibility; (*b*) moral agency as integrity; (*c*) self-worth and recognition as conditions of responsibility; (*d*) the interconnection of responsibilities, relationships, roles, and identities; and (*e*) the salience of social context, social structure, and social role.

FORWARD- VS BACKWARD-LOOKING RESPONSIBILITY

Attributing responsibility: Moral responsibility looking backwards

Most philosophical inquiries into the nature of responsibility in contemporary Anglo-American moral philosophy look backward from privileged standpoints toward the past to assess credit or blame for one's (or, more typically, for another's) having been the morally relevant cause of something's happening or not happening.[21] What makes this view privileged is its location in educated, politically powerful, economically advantaged spaces, for example, the halls of academe or centers of law and government. The discourses of the poor, uneducated, and powerless, especially the mentally ill, are generally not heard—or heard so well. Nor is "cognizing deeply" a capacity equally open to all.[1] Although one can learn to take this perspective on oneself, this backward-looking orientation typically embodies a third-person, observational perspective—what the philosopher Bernard Williams calls the "view from there"

as opposed to the "view from here."[2,21] It is a view of moral responsibility that tends to ignore or discount its own temporal and spatial qualities, or that it is a situated perspective on life (actions, events, phenomena) *back then*, not *from now*, and takes place in a corner of the individual self-reflective mind. Looking down and back, the "view from there" is often that of the impartial judge who looks to the past to determine who among us can be held morally responsible—and by what metaphysics or practical processes of deliberation—so that credit and blame are fairly apportioned.

When we hold someone morally responsible on this view, we appraise them as praiseworthy or blameworthy whether or not we choose to act on our appraisals. Because moral responsibility on this account is predicated on powers of rational deliberation, which depend on certain intact connections between reasons and actions or judgments and actions, and because issues of fairness and justice *are* important, the backward-looking dimension of responsibility is preoccupied with matters of excuse, exemption, and mitigation. We must not blame those whom it is unfair to blame, like the mentally ill, because they fail to meet conditions for moral agency and responsibility. Blame, of course, is an attitude that necessitates looking backwards. We blame ourselves or others for that which has occurred, not for that which might exist in the future or exists at present only in our moral imaginations. The status of the mentally ill has always presented a thorny philosophical problem for backward-looking accounts of moral responsibility. Analytic philosophy turns to reasoned judgment as the essential condition for moral responsibility. However, the capacities of the mentally ill for rational deliberation are often seriously impaired. The "problem" of the mentally ill is most often solved, therefore, by showing how they do not meet the conditions of moral agency and/or moral responsibility. In various ways, they are shown to be either exempt or excused from responsibility.

Of the vast philosophical literature on moral responsibility, the accounts offered by Wallace[8] and Scanlon[3] are 2 of the best, most elegant accounts of this line of philosophical thought. Their arguments are presented below in some detail to provide a standpoint from which to contrast accounts of moral responsibility in the forward-looking sense. I maintain that the forward-looking accounts of moral responsibility lend credence and coherence to the moral intuitions and experiences of psychiatric nurses, who have borne witness from their relational perspective to the legions of mentally ill who, whatever the degree of impairment in their powers of practical deliberation, have "taken responsibility" for various things to various degrees. These legions reside in moral communities alongside the rest of us, and all are seen as worthy to answer for their conduct. We are all moral agents, weaving together this complex fabric of social responsibility called morality. To better understand the significance of looking forward, however, we must understand what it is to look backward.

Responsibility and the moral sentiments

Wallace[8] presents an account of moral responsibility that builds on the influential work of the philosopher P. F. Strawson,[22] who urged that we understand responsibility in the context of a certain range of sentiments, or reactive attitudes, to which we are subject in the context of our interpersonal relations. These include, for example, gratitude, love, forgiveness, hurt feelings, resentment, disapprobation, indignation, or blame. According to Strawson, moral responsibility, which requires freedom to act within a range of morally informed possibilities, and determinism, which, if true, eliminates alternate possibilities, are quite compatible. For to treat someone as morally responsible is simply to be disposed to respond to the person with the reactive emotions, which are *natural* sentiments and an inevitable function of our participation in interpersonal relationships. Where Wallace parts company with Strawson is in

narrowing the morally relevant reactive attitudes to those connected with breached expectations, for example, resentment, indignation, or disapprobation.

Intuitively, it seems problematic that only the "negative" reactive attitudes are relevant (or are *more* relevant) to holding people morally responsible. However, Wallace does this as a logical maneuver to hold the reactive attitudes together as a class—namely, a class of emotions to which blame and moral sanction are susceptible as a response to breached expectations around the moral obligations that "we" accept. Not much is said about who "we" are or which obligations are the obligations to have; but it is clear these are *shared* assumptions, expectations, and obligations among members of a social group, or community. Hence, the attribution of moral responsibility appears to depend on social processes that take place within the boundaries of moral communities, although accounts of this sort would have us believe it largely happens within the boundaries of the individual, self-reflective mind. Wallace sets the boundaries of that community, or society, as follows: "The community of morally accountable agents is . . . the set of people who are capable of successfully exchanging moral criticism and justification: grasping the reasons behind moral criticism, and responding constructively on the basis of such reasons."[8(p165)] As we will see below, by these criteria this community necessarily excludes most of those with severe mental illness.

In essence, Wallace's[8] significant work on moral responsibility offers 2 accounts: (*a*) an account of what it is to hold people morally responsible in terms of the moral sentiments, or reactive attitudes; and (*b*) an account of the conditions of moral agency by virtue of which people can *be* morally responsible for the things they do. On the latter account, being a responsible moral agent is not really a matter of having free will, that is, freedom from ignorance, compulsion, constraint, or coercion. Rather, it is a matter of having a certain kind of normative competence, that is, having the rational power to grasp and apply moral reasons and to voluntarily control one's behavior by the light of those reasons. Within Wallace's framework, and all such backward-looking frameworks, one can clearly see the central place among the conditions for responsibility of rationality, for example, reasons-responsiveness, or the capacity for reasons-related deliberation. What about those, then, whose powers of reflective self-control are impaired—people like my bipolar client whose manic psychosis prevented him from seeing or responding to the reasons he had to put away his credit cards, vacate the shopping mall, and avoid financial ruin? He does not meet these conditions for moral agency and responsibility. For such cases, Wallace meticulously outlines and elegantly argues the conditions of excuse and exemption.

Excuses operate locally. Excuses make it inappropriate or unfair to hold an agent responsible *for a particular action.* They do not prevent our viewing the agent as morally responsible in general. Excusing conditions show that the person who appeared to breach our expectations did not in fact breach them after all. He did what he did inadvertently or by mistake; as the result of unintentional bodily movement; or under conditions of physical constraint, coercion, necessity, or duress. Perhaps an otherwise well-qualified moral agent did not rescue her drowning child because she had a gun held to her head, was locked in a closet, or accidentally fell and knocked herself unconscious. What she did, in failing to rescue her child, does not express a choice at odds with the moral obligations to which we hold her. Therefore, she did nothing morally wrong and should not be blamed. Exemptions, on the other hand, operate globally. While excusing conditions make it unfair to hold an agent morally responsible for a particular action, exempting conditions "such as insanity, childhood, or perhaps addiction"[8(p118)] make it unfair to hold a person morally responsible, period. What makes it unfair to hold them morally responsible are the "defects of reason" that deprive such persons of "the powers of reflective self-control"[8(pp168–169)] by which they recognize

what they have moral reasons to do and then govern themselves accordingly. By definition, those to whom an exemption applies are not only poorly qualified moral agents, they are not moral agents. By failing to meet conditions for agency, they fail to meet conditions for moral responsibility. However, Wallace recognizes that possession of the powers of reflective self-control admit degrees. Hence, his exemption of the mentally ill from moral responsibility is not hard and fast. Clearly, some kind of contextual evaluation needs to be made to determine the extent of their agency and moral responsibility, which holds the door open for at least some of the mentally ill to join "the community of morally accountable agents"[8(p165)] some of the time. In addition, he notes that "the standard list of exempting conditions" is not definitive: "[F]urther empirical and theoretical research about particular conditions, such as mental illness [and] addiction. . .might affect the classification of those conditions as exemptions."[8(p181)] What is curious in Wallace's account is the apparent paradox in implying that a determination of degrees of agency and moral responsibility requires some kind of social negotiation while also insisting that the determination of moral responsibility is a function of deliberative operations within the individual, self-reflective mind.

What we owe to each other

Scanlon's[3] account of moral responsibility has much in common with Wallace's, including its compatibility with determinism and the conditions it sets for moral agency, most important of which is the ability to understand and assess reasons and to bring those reasons to bear on actions. Scanlon locates reasons of all types—for belief, for action, and for attitudes like fear, resentment, and admiration—as a central element in rational deliberation. However, there are some important differences between Wallace's[8] and Scanlon's[3] accounts of moral responsibility. In particular, Scanlon does not rely on the *reactive* attitudes. In fact, his account moves explicitly away from reliance on the moral sentiments, or emotions, to make sense of moral responsibility. Scanlon relies instead on the *judgment-sensitive* attitudes—"the class of things for which reasons . . . can sensibly be asked for or offered"[3(p21)]—to form the basis of moral appraisal, that is, the process of judging praise- or blameworthiness. Rationality, including reasons-responsiveness, is important to Scanlon's account of responsibility. Rational creatures are reasoning creatures who can recognize, assess, and be moved to action by reasons, which is to say they can have judgment-sensitive attitudes—which are those attitudes that an "ideally rational person [of course, none exists] would come to have whenever that person judged there to be sufficient reasons for [those attitudes]."[3(p20)] What makes these attitudes judgment-sensitive is that they depend on our rational judgment as to whether we have reasons for them. The connection between actions, intentions, judgment-sensitive attitudes, and responsibility is important. Normative reasons for action can be given or demanded only when action is intentional, that is, when action is the expression of a judgment-sensitive attitude. Of course, on this account the mentally ill often act *un*intentionally and thus cannot offer reasons (at least not *good* reasons, on Scanlon's account) for their actions. Hence, they are not responsible; their actions are not the expression of their judgment-sensitive attitudes.

Scanlon[3] describes 2 kinds of responsibility: (*a*) responsibility as attributability, in which case to say a person is responsible for a given action means only that he can be morally appraised for it, and (*b*) responsibility as substantive responsibility, in which case a judgment of responsibility makes a claim that people owe something to each other. Responsibility as attributability is the kind of responsibility that justifies moral appraisal. Here, responsibility is a precondition of moral appraisal. A person cannot be praiseworthy or blameworthy if he cannot be held responsible for the action(s) for which he is being praised or blamed. In addition, the conditions of responsibility require a link between intentions

and actions, or as Scanlon more precisely conceptualizes it, between an action or judgment-sensitive attitude and the agent's judgments and/or character. Although he does not distinguish them from exemptions, Scanlon outlines the conditions that excuse moral responsibility. First are the conditions that show an action is not attributable to an agent, that is, the link between an action or attitude and the agent's judgments or character is severed. Second are the conditions that alter the *character* of the action as opposed to its attributability, that is, the action occurred as a function of coercion, duress, ignorance, or inadvertence. The third is the condition in which a person lacks the capacities for moral agency, that is, a person lacks the capacity to understand and assess moral reasons or to express his judgments in his actions. My severely regressed borderline client, who in a moment of disorganized panic takes a hammer to her ankle and breaks it in 7 pieces, would be excused from moral responsibility by virtue of all conditions. So would my manic-psychotic client who brings financial ruin to himself and his family; for he "lacks the general capacities presupposed by moral agency. . .[,] is unable to understand and assess reasons [and] his judgments have no effect on his actions."[3(p280)] According to Scanlon, he "cannot be a participant in a system of codeliberation [within a moral community] and must be seen, rather as simply a force to be dealt with."[3(p280)]

"Forces to be dealt with" does not refer to people *worthy* to answer for their conduct. I find this conception of my clients morally problematic. Even if it somehow can be shown that my moral intuitions have no reasonable bearing on their status as responsible agents—that my judgment is perhaps clouded and my dubious experience of my clients' agency despite their psychosis is only a function of empathy, proximity, or other qualities of my caring relationships with them—I find other difficulties with these sorts of accounts of moral responsibility: *Which moment* in a client's trajectory through time and space, and from reasons-responsiveness to madness and back, was *the* moment of loss of agency? For my clients are not always so sick. There are long periods of time when they function well and qualify for moral agency and responsibility on *any* account. *Whose deliberation* determines when that moment of severance occurs—or *which range* of moments, if agency and responsibility admit degrees, are the relevant ones? *How* are these determinations made? In the practice situation those determinations are a matter of social negotiation among the members of the moral community constituted by an entire treatment network that includes the clients. If my clients' loss of agency does not occur in a single moment, which it surely does not, and if a determination of their degree of agency and responsibility is a matter of social negotiation among the members of a moral community, how does moral responsibility exist only as an individual attribute? There must be another view that accounts not only for my moral intuitions, but for agency that waxes and wanes, for responsibility that grows and develops, for the social negotiation of degrees and distributions of responsibility, and for the pervasive practice of treating such clients, as we do children, *as if* they are morally responsible. For we encourage—even require—them to "take responsibility" without much doubt that in some measure they can.

Taking responsibility: Moral responsibility looking forwards

> [F]orward-looking moral responsibility is relatively unfamiliar in the lexicon of analytic philosophy. . . . As a matter of everyday speech, however, the notion of forward-looking moral responsibility is perfectly familiar. Today, for instance, I said I would be responsible for watching my nieces while they swam. Neglecting this responsibility would have been a moral fault. . . . The notion of a responsibility that we accrue or take on, to look out for some range of concerns over some range of the future, is, then, perfectly familiar.[23(p218)]

Striking a note that resonates with Walker's[12] understanding of morality as embedded in socially negotiated practices

of responsibility, Richardson[23] discusses morality as "a society-wide cooperative enterprise marked by a highly differentiated division of labor,"[12(p238)] the examination of which (division of labor) reveals the substantive content of our moral practices, especially those related to responsibility. An understanding of moral responsibility as forward-looking, that is, as a "taking on" in the present of a certain range of concerns that we will carry into the future, informs Richardson's examination of the "institutionally divided" nature of moral responsibility. By this he means that an agent's responsibilities will depend on the regular features of her social situation and role, because it cannot depend upon a "supra-institutional 'we' that somehow speaks for human society as a whole."[12(p238)] Recognizing that our moral responsibilities are highly differentiated, he questions how forward-looking moral responsibility is distributed over individuals and argues that it systematically varies on the basis of how social institutions divide morally relevant labor.

Richardson's[23] account of forward-looking responsibility incorporates 2 elements that move the notion of "taking responsibility" beyond any simple notion of the duties we take on. First, we take responsibility prospectively for a specific range of concerns uncertain of all it will entail, for the future is unforeseeable. Thus, an essential part of taking responsibility is undertaking to cope with surprises: "Saying that the babysitter is responsible for the children for the evening is saying more than that a list of rules is incumbent upon him; it also implies that he will look out for the children in myriad unforeseeable circumstances."[23(p221)] Second, these unforeseeable circumstances may require the revision of preexisting rules, because the rules and our current concerns clash or harmonize in ever novel ways.[23] Discretion is thus required in taking responsibility. Forward-looking moral responsibility authorizes this pragmatic revision of rules so we can better serve our concerns.[24] However, individuals in different roles and situations have different ranges of authorization to revise moral rules. Richardson[23] thus argues that forward-looking moral responsibility and its requirements are differentially distributed, that is, institutionally divided, in 2 important respects. First, differently situated agents are concerned with different ranges of consequences. Second, they have differential authorization on the basis of their social location to revise or respecify the rules that impinge on them. We do not "take responsibility" equally. Social circumstances must be taken into account. Hence, my borderline client in private, fee-for-service therapy has more discretion (with different consequences) to choose to miss a therapy appointment than does my public assistance client on an involuntary commitment to a residential treatment center. One can see the close connection between the concepts of "forward-looking responsibility" and "the salience of social context."

MORAL AGENCY AS INTEGRITY

There is also a close connection between the concepts of "forward-looking responsibility" and "moral agency as integrity." When Card[21] considers what notion of responsibility emerges in looking "forward and up, toward the future and from the standpoints of those struggling to put their lives back together,"[21(p23)] she clearly sees that we are talking about taking responsibility not attributing it. She is especially concerned about what it means to take responsibility when burdened, as are some of my borderline clients, with bad moral luck, for example, histories of child abuse and heritages of oppression. Here, taking responsibility is less about having autonomy, one of the pillars of backward-looking moral responsibility, and more about having integrity—an integrity that does not develop spontaneously. It requires my participation. Card's forward-looking orientation embodies a perspective of agency focused on what is not yet completed or does not yet exist. Taking responsibility from this conception of agency involves judgments of one's worthiness and capacity to undertake it, and

whether it is worthwhile to do so, whereas attributing responsibility involves judgments of deserts, that is, praise or blame.[21] Different notions of agency suggest different notions of "taking responsibility":

1. [T]he . . . managerial sense of responsibility—undertaking to size up and organize possibilities . . . ;
2. the accountability sense of responsibility—agreeing to answer or account for something . . . ;
3. the care-taking sense of responsibility—committing oneself to stand behind something . . . (or make good on one's failure to do so);
4. the credit sense of responsibility—owning up to having been the (morally) relevant cause of something's happening or not happening, [and] taking the credit (or blame) for it.[21(p28)]

As Card[21] notes, only the "credit" sense of responsibility is essentially backward-looking. The first 3 look forward, beginning with an undertaking that requires follow-through and thus some measure of integrity. Without follow-through, the assessment that someone took responsibility can be withdrawn. Card's analysis of moral responsibility as largely forward-looking helps make sense of these *actual*, and therefore easily recognizable, practices of responsibility, including that we take responsibility more or less freely. Often we are *given* responsibilities as assignments or inheritances that we would not otherwise choose, and we are only more or less free to accept or reject some assigned responsibilities. Even so, when we accept them, they become *our* responsibilities. As our integrity grows, we may embrace, even identify with what we did not bring about, for example, our ethnic heritage, our history of child abuse, or our "borderline" status.[21] In taking responsibility for something in the forward-looking sense, then, there is no assumption that we produced or caused it; although there *is* the assumption that if we praise or blame a person depending on whether she has the integrity to follow through on accepted responsibilities, we are presupposing at least her minimal capacity to "take responsibility" in the forward-looking sense.[21] Card thus argues that backward-looking attributions of responsibility are in fact derived from the assumption that one is a responsible moral agent in the forward-looking sense.[25]

An interesting series of studies lends empirical support to the complexity Card[21] ascribes to notions of agency and responsibility. First, Bell[26] investigated how participants differentially attributed causality, moral responsibility, and blame when asked to rate perpetrators engaged in negligent acts. Findings indicated that judgments of moral responsibility are indeed much more complex than backward-looking attributions of causality or blame, casting doubt on the notion that people generally evaluate the moral responsibility of perpetrators in the process of judging their blameworthiness. The results suggest we consider factors in the evaluation of moral responsibility that are not considered when evaluating blameworthiness. For example, although we might judge a mentally ill person as blameworthy for some negligent act because he refused to take the medications he knew might prevent it, we might also exempt him from moral responsibility because he was in the throes of a manic psychosis and could not control his behavior. However, there are contradictions in this process of moral attribution. The same mentally ill person who, in a state of manic psychosis, caused his own or his family's financial ruin by running up credit card bills is held responsible for this financial chaos when he is better. Sooner or later, he is required to take responsibility for his debts and pay his creditors—or declare bankruptcy. Despite his mental illness, he will not be exempted from these social consequences. Our attributions of causality, blame, and moral responsibility seem to vary, then, depending on whether we are looking forward toward the integrity required of an agent in putting his life back together, or backward at whether or not he possessed the autonomy necessary to even qualify for agency, responsibility, and hence blame.

Pizarro et al[27] also looked at attributions of moral responsibility. They showed that even when all factors generally assumed to be sufficient for the attribution of moral responsibility are present, blame and praise are not fully assigned when the factors are not linked in the expected manner. For example, there is an intention to perform an action, the agent causes the outcome, but it does not happen in the intended way. The causal chain is deviant. Thus, a self-destructive but competent psychiatric client stands at a street corner intending to kill himself by walking into traffic. Just as he takes a step forward, he is accidentally pushed from behind by a careless pedestrian, falls off the curb, and is hit by a car. Across all 4 experiments, participants discounted moral responsibility for acts that were causally deviant. This client would not be held responsible for his injuries. Furthermore, the investigators demonstrated that judgments of diminished responsibility for causally deviant acts stem from participants' moral intuitions not logical analysis, although logic can undo the effects of moral intuitions about causally deviant acts. They rightly conclude that current (backward-looking) theories of moral responsibility may be missing the complexity of our moral knowledge and how it bears on actual moral practices, including the common psychiatric practice of encouraging this client to take responsibility in the first place for the consequences of poising himself dangerously on a busy street corner.

Control is a necessary condition in almost all backward-looking theories of responsibility attribution. Lack of control diminishes responsibility and mitigates blame. Focusing on how individuals take information about intention and control into account when arriving at judgments of praise and blame, Pizarro et al[28] showed that praise was distributed in equal amounts regardless of whether actions were perceived as deliberate and voluntary or impulsive and involuntary. Blame, however, was discounted where lack of control was perceived. In addition, asymmetrical judgments of moral blame and praise for acts committed under diminished control are mediated by the assumed presence of a positive second-order desire. For example, a mentally ill client has a desire or impulse to behave self-destructively but has a second-order desire to maintain an important treatment relationship. What is significant here for the notion of "taking responsibility" is that individuals can actively construct second-order contingencies in their environment when they are aware that, looking forward, they may be unable to control themselves through willpower alone. When you are mentally or emotionally impaired, constructing such contingencies may be an important dimension of "taking responsibility." Hence, our self-destructive client with diminished autonomy might show his responsible agency (integrity) by constructing a plan to telephone his therapist prior to walking to the busy street corner that tempts him.

Finally, Wilks[29] also began with the (backward-looking) assumption that moral responsibility is conceived and experienced in terms of praise and blame. The investigator found that people accept blame, and moral responsibility as a corollary, for perceived moral failures but do not accept special credit and moral responsibility for perceived moral successes. In fact, the 2 categories were seen as mutually exclusive. One might infer from these findings that the mentally ill may need encouragement and support to credit themselves for their incremental moral successes—for behavior as "simple" as learning to make a telephone call prior to taking a walk—and that "taking responsibility" for behavior entails constructing a notion of moral responsibility that focuses at least as much on the development of integrity as on that for which one might deserve blame. Ultimately, I think theoretical notions of moral responsibility that pose blameworthiness and praiseworthiness as mutually exclusive, binary opposites limit our research endeavors. Knowledge of the complex social circumstances within which mentally ill patients struggle for agency shows them situated in contexts where they sometimes can be both blameworthy and praiseworthy at the same time, or for the

same thing. Consider once again the manic patient whose spending sprees bring financial ruin to himself and his family. Whether he is blameworthy or praiseworthy might depend, for example, on whether we are construing his decision to stop his medications as an ill-considered, obviously poor decision that ignores our warnings about consequences or as a considered, risky, and probably inevitable developmental move to exercise a healthy, growing desire for greater autonomy. A moral community can construe it as both. But that is hard to see because, through centuries of weight in analytic philosophy, the notion of blameworthiness and praiseworthiness as binary, mutually exclusive individual attributes has settled in our collective consciousness as more or less self-evident.

SELF-WORTH AND RECOGNITION AS CONDITIONS OF RESPONSIBILITY

Benson[30] elaborates on Card's notion of moral agency as integrity in considering how traditional conceptions of moral responsibility, blameworthiness, and excuse mask and sustain social arrangements that oppress women—and by implication, others who do not meet the received view's criteria for agency. They do this in part by construing the responsible person as a "self-governing, self-constituting, and self-sufficient agent whose natural freedom and moral identity do not essentially depend on socially elaborated powers, roles, and relationships."[30(p73)] Benson's alternate conception of moral responsibility includes a condition for agency and responsibility that clarifies the extent to which responsibility is a social, or relational, matter—namely, the condition that integrity and a sense of self-worth are what allow for the experience of *worthiness to answer for conduct*. Thus, it is a condition of responsibility that a person recognizes her worthiness to answer for herself, which develops in an interpersonal context as a result of others' recognition of her worth, *and* that she have standing in a moral community that invites her answer. This condition of responsibility is particularly relevant to the "borderline" client with deeply rooted self-hatred mistrust, and an acute sense of aloneness. She and others among the oppressed and mentally ill do not meet society's notion of proper self-sufficiency or self-governance and therefore lack standing as moral agents in the moral community that would allow them to answer for their conduct:

> Persons who have internalized the prevailing norms of [a] society and who are unfortunate enough to be assigned to the lowest social stratum will feel, and will be given much reason to feel, that it is not their place to answer for their conduct. This attitude will be one element of the broader lack of moral self-respect, the failure to recognize their fundamentally equal moral worth as persons . . . [with] the kinds of moral sensitivity, reasoning, and self-control that would warrant their recognition as fully accountable agents.[30(p80)]

In arguing for a self-worth condition of responsibility, Benson[30] also illuminates the social, relational, and political dimensions of moral responsibility in 3 ways: First, the self-worth required for responsibility entails a sense of worthiness to give an account of oneself *to others*. Responsibility thus depends on the presence of others. It exists—if it exists at all—in a social context. Second, publicly shareable norms regulate both the moral appraisal of an agent's actions and the account of her conduct she might give in response. Such norms are shared understandings negotiated by members of a moral community, some of whom by virtue of their social positions and roles have more clout than others. Third, being responsible is itself a matter of occupying a social position and having the status of an eligible participant in a moral community.[30] Responsibility thus rests not only on self-worth, but also on recognition, inclusion, and opportunities for self-disclosure.[30,31] In other words, one who is unable to answer for her conduct to others for lack of self-worth, recognition, and inclusion is also unable to express through her actions who she is and what really matters to her, that is, her values and commitments.

It is a kind of painful invisibility that fosters irresponsibility—as the mentally ill know all too well.

INTERCONNECTION OF RESPONSIBILITIES, RELATIONSHIPS, ROLES, AND IDENTITIES

Several studies point to the close connections between responsibilities, relationships, roles, and identities. In a novel study of the discursive construction of moral identity, Barker[32] analyzed the moral discourse of adolescent girls who tape-recorded their discussions about television soap opera. Arguing that identities are discursive constructions instantiated in the flow of language, Barker aimed to explore the use of moral language as a resource that, in the guise of beliefs and attitudes, forms a guide to responsible action for young people. The investigator's analysis showed the contradictory nature of the girls' moral discourse as they apportioned responsibility and blame between individuals, on the one hand, and social circumstances on the other. At times, individual agents were held to be the source of morality, and individual choice depended on a unified and coherent self that was able to make independent moral judgments. However, the girls also contextualized moral choices within an explanatory and mitigating set of social relationships: "Morality talk thus embodies the paradox that morality is a *social* resource that constructs the self as *individually* responsible. Morality is about what I should do. . .but originates in, and refers to, social relationships."[32(p75)] Barker concluded that "the morality of relationships,"[32(p79)] which I take refers not just to the importance of social relations to moral thinking and decision making but also to the nature of morality as embedded in social structure, is crucial to the identity formation of young people and is located at the very center of their lives and identities. His research points to the close connections between identities, relationships, values, and what we take our responsibilities to be—a point also made by Walker[11] in her discussion of the intertwining narratives of identity, relationship, and value that are central to living a responsible life. What a borderline client, for example, takes her responsibilities to be depends on these intertwining narratives—that is, on her role in the social structure, her standing within social relationships, and the identity and values that devolve from that social matrix.

Similarly, Nicholas[18] used the feminist moral philosophy of Walker[11] to frame a qualitative investigation of the social negotiation of moral responsibilities among senior molecular geneticists who were asked to identify the critical social and ethical issues raised by genetic technology. In so doing, she offers one example of how Walker's notions of "practices and geographies of responsibility" and "narratives of relationships, values, and identity" help us understand how people in morally contested territory renegotiate their identities in the process of determining which responsibilities might be theirs to take. Analysis of narrative data revealed 2 key features of this social negotiation: First, it was spatially located in boundary areas where meanings are contested—places where genetics knowledge is challenging both social practices (eg, medical or reproductive practices) and the boundaries of concepts and categories we thought we understood (eg, "disease" or "species"). Second, this social negotiation of moral responsibilities was effected through strategies by which the geneticists established their relationships with other communities, groups, institutions, or discourses and in so doing redefined their identities (and values) as scientists.

Wirth-Cauchon[20] also investigated the discursive construction of moral identity in her examination of the social construction of borderline personality disorder, with which most afflicted are women. She saw the symptoms grouped together under the borderline label—fragmented or unstable identity, feelings of emptiness or numbness, depersonalization, self-mutilation—as "exaggerated. . .forms of some of the cultural

contradictions of gender in late modern society . . . visible in the moment of breakdown of the feminine subject."[20(p30)] She drew on feminist analyses of gender and subjectivity as a perspective from which to view borderline symptoms in a sociocultural context as a response to women's position at cultural borders. Women positioned here live in "borderland territory. . .a place of struggle over meanings."[20(p168)] In essence, Wirth-Cauchon argued that *the borderline*—as metaphor, diagnosis, and/or descriptor for certain kinds of selves or identities—is a site of contention, controversy, and struggle over boundaries.[20] It demarcates the boundaries of the self; the boundaries of madness (where "the borderline" is the boundary between "the psychotic" and "the normal"); the boundaries between categories of disorder; and the boundaries around psychiatry's limits. It also demarcates the boundaries around a certain gender-specific mode of being sick, as well as around the socially accepted, gender-specific modes of "taking responsibility" for what manifests as that sickness. This is not to say she does not view the suffering and instability of the borderline subject as real. She acknowledged the symptoms and suffering as real but considered the borderline diagnosis fictive albeit a fact of psychiatric classification.

So, when we ask a person diagnosed with borderline personality disorder to take responsibility for her *self*, what are we asking that person to do? How is the person to construe her task(s), and how does her diagnosis impinge on this construal? In part, the answers to these questions depend on how a society constructs the meanings, consequences, and normative obligations that attach to the borderline diagnosis. In other words, our understanding of our responsibilities and how we are to "take" them depends to some degree on how others signal who we are (or are not) and what we are (or are not) supposed to do. These social interactions are conditioned by gender, which is a social category that operates as a significant cultural resource (or liability) in particular social and organizational contexts. In neonatal intensive care, for example, mothers participate, and are expected to participate, in the care of their sick newborns much more than do fathers. Mothers are seen as healthcare resources and are maximized as such by medical staff.[15] How mothers and fathers "take responsibility" for their newborns, and which responsibilities they take, is clearly a function of gender as both social space and discursive identity.

SALIENCE OF SOCIAL CONTEXT, SOCIAL STRUCTURE, AND SOCIAL ROLE

> The social organization of responsibility is stunningly complex. . . . On the one hand, to take responsibility means to exercise agency, to make decisions independently, to mobilize resources, to make commitments, and to make sacrifices. . . . To take responsibility in this sense is part and parcel of what it means to be human, to be *social* creatures. On the other hand, we would be naïve not to recognize the limitations on people's capacity to act independently, to resist others' definitions of themselves and their obligations, to work their way through bureaucratic routines, to overcome the limitations on resources and rights associated with particular social locations.[15(p368)]

But for Heimer's and Staffen's ethnography of the social organization of responsibility in the NICU,[15] there would be a complete dearth of empirical research on the actual processes by which responsibility arises in particular contexts. In choosing to examine how parents come to accept responsibility for the complex care of their critically ill newborns, the researchers strategically situated themselves within an organizational setting where meeting parental obligations is ambiguous, consequential, contested, observable, and subject to a variety of social control systems and their agents. The end result is the identification of 5 dimensions of "taking responsibility": (*a*) taking other people's interests and needs seriously; (*b*) thinking long-term, including about hoped-for outcomes, and planning for the future; (*c*) defining obligations broadly, even following

them across organizational boundaries; (*d*) using discretion to meet unforeseen contingencies; and (*e*) accepting the consequences of contingency and discretion, that is, accepting the costs and benefits entailed by choices and consequences.[15] Thus, parents who take responsibility for their sick, sometimes permanently disabled neonates will take their child's ongoing impairment very seriously and plan for the child's long-term management despite an uncertain future. They will define their obligations to their child broadly, evaluating medical interventions they were never formally prepared to assess and exercising their discretion to change care providers, medical supply companies, treatment programs, or schools despite the financial or interpersonal costs.

Ultimately, Heimer and Staffen[15] show that responsibility is not simply an individual attribute. Rather, responsibility requires intervention in organizational routines and is bolstered (or undermined) by certain kinds of social arrangements. Consider what happens, query the authors, "when our dependence on others' efforts is not matched with the resources and memberships that would allow us to induce them to help us meet our responsibilities?"[15(p372)] What happens when you are an outsider, "especially a lower-status outsider,"[15(p372)] and you must cross organizational boundaries to meet your obligations, you lack the right kinds of resources to induce others to act on your behalf, and you lack the right kind of information to monitor others' actions? The implications beyond the NICU are enormous, particularly for the resource-poor, low-status, poorly functioning, stigmatized mentally ill. Organizational contexts and social conditions are highly influential in creating the circumstances under which people can think of themselves as accountable and can act to take responsibility. Their empirically derived central argument, which lends support to the feminist moral philosophy of Walker,[11] is that morality in practice is uncovered when we study the taking of responsibility. In examining the processes by which people take responsibility, we are showing how moral commitments are created, strengthened, loosened, or obscured by social arrangements, including what Walker[11] calls practices of responsibility, that encourage (or discourage) us from holding ourselves accountable. For this considerable scholarly effort, we have a richer understanding of how morality is enacted in practice through processes of taking responsibility for that which requires our attention and care.

The sociologist Daniel Chambliss[21] also undertook an ethnographic inquiry in a nursing context that indirectly sheds light on the social processes involved in "taking responsibility." He set out to describe in detail how emergency department nurses in several mid- to large-size American medical centers conceptualize and respond to the ethical problems they encounter in their everyday work. He, too, found that responsibility is not simply an individual attribute enacted within the boundaries of the nurse-patient relationship. Rather, it is created and constrained by the social context. The nurses' understanding of what was responsible of them to do was fundamentally shaped by their position as subordinates in the medical hierarchy. Nurses were deeply concerned about the welfare of their patients but also felt constrained to follow doctors' orders. Their definition of moral problems was the result of a complex process of socially negotiating the demands of their "in-between" spatiality:

> In the complex hospital organization embedded in a complex society, nursing finds itself at the intersection of competing occupation groups and moral ideologies, and this competition is the source of its ethical problems. Each day nurses juggle the orders of physicians, the needs of patients, the demands of families, the rules of the law, the bureaucracy of the hospital and their own physical and emotional limits. The conflict of these are expressed as "ethical problems in nursing."[21(p93)]

Chambliss[21] argues, and I could not more strongly agree, that we have misconstrued the ethical problems of nurses by constructing them as individual ethical dilemmas existing

as individual decisional conflicts within the minds of individual nurses. This was not the form moral problems took for workers who needed to act more or less autonomously on behalf of their patients *and* follow superiors' orders. This highly significant work has implications for all practice contexts, including the mental health context. It discloses the nature of morality in practice as socially organized, that is, constructed around the form and content (requirements) of the social organization and social roles by which I, for example, am both constrained and actualized as a psychiatric nurse. It reveals that moral feelings and everyday actions (practices) are not separate entities. Moral issues are solidly embedded in the practice (organizational) context and often remain invisible and unformulated until a particular—in this case ethnographic—mode of looking and seeing sheds enough light on them to render formulation possible. What was seen in this case is that the nurse and his or her practice context are integrally joined and mutually defining.[21]

Finally, Fisscher et al[33] also point to the salience of social context in their study of the emergence and disappearance of notions of responsibility in the social processes that operate within organizational settings. They identified 4 key social processes involved in acting on a sense of moral responsibility: (*a*) taking distance, (*b*) weighting values, (*c*) analyzing the situation, and (*d*) addressing, that is, either attributing or taking responsibility. Distance—physical, emotional, and temporal—creates space for the processes of weighting values and norms and of analyzing the moral situations that require taking or attributing responsibility. Balancing proximity with distance is an important process in living up to responsibilities. Too much distance can "take away an essential starting point of moral behavior, namely a moral appeal based on the visibility and proximity of. . .other people."[33(p213)] This is a significant finding for those of us in the business of titrating our proximity to our highly impulsive, affectively dysregulated clients, as well as assisting them to titrate *their* proximity to others. For these clients, regulating proximity—holding off, taking time, acknowledging others, taking space, moving closer, moving away—might be an important part of "taking responsibility."

UNPACKING AND INTEGRATING

In conclusion, like a growing number of philosophers, especially feminist philosophers, I have parted ways with analytic tradition and embraced alternative conceptions of moral responsibility that acknowledge its social, political, interpersonal, and forward-looking dimensions. Such conceptions lend credence and coherence to the moral intuitions of psychiatric nurses who have long experienced their mentally ill clients as morally responsible agents worthy to answer for their conduct. We have called them to moral account in myriad ways in our insistence that they can "take responsibility" to patch up their problem-ridden lives—with our collaboration and support as necessary. I have discussed a few of these accounts. There are more.[31,34–38] My necessary selectivity in choice of alternative accounts—necessary because one must begin and end somewhere, *and* be brief—has no profound rationale other than that these philosophical inquiries make imminent sense to me. They are well-conceived and solidly argued and written. Collectively, they make explicit a forward-looking notion of responsibility that takes into account what the larger body of literature finds salient to a notion of moral responsibility, that is, its connections to interpersonal relations, social context, organizational structure, and political power. They are all compatible with the moral philosophy of Walker, who offers an exceptionally wise and appealing account of the nature of morality in practice as revealed in topographies of responsibility, that is, maps of the distribution of socially negotiated practices of responsibility:

> Morality is neither a dimension of reality beyond or separate from shared life nor a distinct and detachable set of understandings within it. Our moral practices are not extricable from other

social ones. Moral practices in particular lifeways are entirely enmeshed with other social practices; and moral identities, with social roles and positions. Moral understandings are effected through social arrangements, while all important social arrangements include moral practices as working parts.[12(pp6–7)]

Hence, none of us can access by pure reflection pure moral concepts that are not in fact derived from our socially situated experiences of actual forms of social life, because there is no morality or pure core of moral knowledge that transcends history and culture.[11,12] So philosophers must always ask themselves on what socially constructed experience of morality they draw in making claims about the concept of responsibility they claim is "ours."[12]

In summary, what might we infer about the nature of "taking responsibility" or "being morally responsible" when mentally ill? How are we to understand "morality" in the practice context? An integration of the empirical and philosophical literature points to the importance of 5 key, closely connected concepts in understanding the processes by which (moral) responsibility arises, that is, is constructed, organized, or negotiated in the practice context. These are as follows: (*a*) forward- versus backward-looking moral responsibility; (*b*) moral agency as integrity; (*c*) self-worth and recognition as conditions of responsibility; (*d*) the interconnection of responsibilities, relationships, roles, and identities; and (*e*) the salience of social context, social structure, and social role. To begin with, conceptions of moral responsibility differ depending on whether they look backward or forward.[23] Attributions of causality, blame, and moral responsibility all vary depending on whether we are looking backwards to see if it is fair to blame a person for what she has done or forwards at what is required of her from this point on.[26] Forward-looking conceptions seem more useful when looking at those, including the mentally ill, who are struggling to put broken lives back together.[21] Blame is often discounted where the lack of control so common to mental illness is perceived,[27,28] but adjudicating moral responsibility is much more complex than evaluating blameworthiness.[26] Here, the psychiatric nurse must rely more on moral intuition than logical analysis[27] in assisting clients to take responsibility—by constructing contingencies, for example, when they are not able to control themselves through willpower alone.[28] Supporting the strengths of our clients is nothing new to psychiatric nurses. Still, it is good to find evidence for a forward-looking notion of responsibility that focuses at least as much on incremental moral successes as on that which deserves blame.[29]

Next, there is a close connection between, say, a "borderline" client's role in the social hierarchy, her social relationships, her sense of identity (which includes her values and a sense of integrity and self-worth), and her understanding of her responsibilities.[11,20,30,32] These connections may not be obvious to her without our assistance. More to the point, she will understand her responsibilities and how to "take" them depending on how others signal who she is and who she can be.[20] That is, her morally responsible identity grows inside significant social relationships made available by her role and location in the social hierarchy—relationships with supportive peers[39] and with those who provide opportunities for self-defined goals,[40] participant modeling,[40] self-disclosure,[30] recognition,[31] distance,[33] and dignified failure.[41] It is an identity that incorporates a sense of self-worth as a condition for responsibility,[30] a blossoming integrity as evidence of moral agency,[21] and values that are the active expression of who she is and what matters to her.[30] Throughout, she is a participant in an ongoing dialogue with others, for responsibilities are socially negotiated through strategies by which relationships are established between persons, groups, institutions, communities, and discourses.[18]

Finally, the importance of social context to understanding the mentally ill as morally responsible (or not) cannot be overstated. Such moral understandings are effected through social arrangements.[12] Our understanding of our responsibilities depends on our role and location in the social hierarchy—on whether

we are even visible, as the mentally ill so often are not, in the social hierarchy. For "taking responsibility" is a matter of occupying social space and being an eligible participant of a moral community.[19,30] Responsibility is created and constrained, and bolstered and undermined, by the social structure of our practice contexts.[15,19] Such contexts create the circumstances under which our patients can see themselves as accountable—as worthy to answer for their conduct.[15,19,30] Similarly, barriers to taking responsibility are often organizational.[41] So we must carefully examine our practice contexts to see how responsibility varies systematically on the basis of how the institution divides morally relevant labor.[23] Who is required to do what for whom in this setting? And who is exempt from this labor? We must ask these questions to determine whether this "way of life" is, in fact, "the way to live"—which is what we like to think morality is all about.[11]

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