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Therapeutic Responses to Harmful Conduct by Service Users in Mental Healthcare

Daphne Brandenburg &
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Abstract: In this article, we discuss what are ethical forms of holding service users responsible in mental health care contexts. Hanna Pickard has provided an account of how service users should be held responsible for morally wrong or seriously harmful conduct within contexts of mental health care, called the clinical stance. From a clinical stance one holds a person responsible for harm, but refrains from emotionally blaming the person and only considers the person responsible for this conduct in a detached sense. Her account is based on what are considered best practices in the treatment of people with borderline personality disorder and addiction. We ask if this account generalizes across different diagnostic criteria and different clinical contexts. To begin to answer this question, we compare the clinical stance to an account of what are considered best practices in the treatment of service users at a specialized clinic for people with autism spectrum disorder in the Netherlands. We refer to this alternative account as the nurturing stance and highlight relevant similarities and differences between the clinical stance and the nurturing stance. We conclude with suggestions for further research and theorizing.

Keywords: Philosophy of psychiatry, clinical ethics, responsibility, autism spectrum disorder, responsibility without blame, congruence

How, if at all, should we hold a person responsible for morally harmful conduct when this person has a particular mental illness? In philosophical theory there has recently been a surge in engagement with this question. The answer will, of course, depend on a number of factors. How, if at all, is the person's moral agency compromised due to the mental illness? What is the nature of the moral norm in question? Would the person benefit from being held responsible? What is the relationship between the person who is holding responsible and the norm-transgressor? And so on. In this article, we focus on responsibility practices within contexts of mental health care. The question at stake is whether, and if so how,

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clinicians should hold service users responsible for transgressing a moral norm when mental illness compromises the service user's agency.

Hanna Pickard (2011, 2013b) developed an ethical account of how service users with personality disorders (PD) or substance use disorders should be held responsible for harmful conduct in mental health care settings. Her account is based on what are considered best practices in a variety of effective psychological treatments of PD.[1] She argues clinicians should ideally take, what she calls, a clinical stance toward service users who have transgressed a moral norm and harmed others. From a clinical stance, one holds a person responsible for transgressing a norm but does not feel and express blame related emotions toward the person. One would, from this stance, only in a detached sense judge that a person is blameworthy for what she did, without experiencing accompanying feelings of indignation or resentment.

The question of what would be ethical forms of holding responsible in mental health care contexts is important and merits further philosophical engagement. We aim to contribute to such further engagement by asking if Pickard's clinical stance generalizes across different diagnostic groups and clinical contexts. We compare Pickard's clinical stance to an account that is based on what are considered best practices at a specialized clinic for people with autism spectrum disorders (ASD) in the Netherlands.

We conducted a small qualitative study asking what are considered desirable responses to moral norm-transgressions by clinicians at this clinic and why. We then used these responses to develop an alternative normative account called *the nurturing stance*. Both the nurturing stance and the clinical stance recommend a response that does not reduce to either condoning or blaming, but they do so in a different manner and for different reasons. Pickard's account is supposed to explain how one can hold someone responsible for harmful behavior without affectively blaming the person for this behavior. In contrast, the nurturing stance embodies controlled expression of negative affect on the part of the clinician that appeals to a set of future-directed responsibilities of the service user, but without attributing responsibility or blame to the person for the harmful conduct to which the correction was a response.

We discuss what lessons can be drawn from this comparison and provide suggestions for further research and theorizing. We could not include the perspective of the service users in our current study. Their take on both their own challenging behavior as well as the stance adopted by clinicians in response, is vital for furthering our understanding of ethical responsibility practices in mental health care contexts.

The Clinical Stance

As a novice clinician, Pickard observed that the ways in which patients were held responsible in a therapeutic community for people with PD were very different from what she was used to outside of this context. In this clinic, "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" (Pickard, 2013b, p. 1135).

According to Pickard such a stance is generally desirable in clinical contexts where service users suffer from a so-called "disorder of agency." Pickard writes that the "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" (2013b, p. 1135). She mentions PD, substance use disorders, and eating disorders as examples of disorders of agency. The behaviors that are constitutive of these disorders (e.g., deliberate self-harm, reckless and impulsive behavior, attempted suicide in borderline PD, drug consumption in substance use disorders, eating too much or too little in eating disorders) are not merely bodily movements. Rather, Pickard argues, these behaviors often constitute voluntary actions, by which she means "that the agent can exercise choice and at least a degree of control over the behavior" (2011, p. 212). As evidence for this claim, she observes that on most occasions, service users who display these kinds of behavior routinely choose to behave otherwise when they have an incentive and are genuinely motivated to do so.

When a person's agency is in this way disordered, she believes it to be important that service users are held responsible for problematic patterns of behavior. More specific: "so long as they know what they are doing, PD service users are responsible for their behavior to the degree that they can exercise choice and control over it" (2011, p. 213).[2] These behaviors are among the main reasons for the person seeking or needing treatment and those behaviors have to be addressed for the person to recover. According to Pickard these behaviors are best addressed by holding the person accountable for harmful actions and omissions, thereby augmenting the service users" existing capacity for agency—an essential part of effective treatments. But at the same time one should not blame a person, because blaming would be highly detrimental to therapy as it may trigger feelings of rejection, anger, and self-blame, which undermine recovery.

Holding service users responsible in this sense 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" (2013b, p. 1141). These forms of holding responsible avoid the so-called "rescue trap," a response where the person is solely seen as a victim of her disease who cannot help doing what she does (Pickard, 2013b, p. 1138). We would like to add here that these types of interactions are also distinct from condoning norm-transgressive conduct. If one condones problematic behavior, one does not hold a person to account for what she did either. Contrary to rescuing, condoning does not amount to any type of intervention in the person's behavior. Both rescuing and condoning arguably enable rather than address disorders of agency.

The clinical stance avoids forms of rescuing or condoning by holding the person responsible for her conduct. It does so without blaming the person for what she did or does. Blaming a person, according to Pickard, is not compatible with the therapeutic relationship. Pickard has a particular account of what a blaming response exactly consists in. She discusses "reactive attitudes" as the sort of reaction that amounts to blame. Philosophers have different definitions of reactive attitudes, but these attitudes at least minimally refer to those emotional responses we have toward perceived morally harmful conduct (e.g., Deigh, 2011; McGeer, 2011; Shoemaker, 2015; Wallace, 1996). Typical examples are resentment and indignation. Pickard has her own specific definition of these attitudes. She argues that the type of hostile anger that amounts always to blame comes with a sense of entitlement: if someone is blaming "they feel that the other is blameworthy and so deserves their anger." According to her these feelings can come apart from our considered judgments (Pickard, 2013a). We would like to flag here that the question of what blame-related emotions exist in is contested, and whether blame need be emotional in kind is contested too. The importance of this disagreement is brought into sharp relief when we look at the concrete examples of blaming that Pickard discusses in here online learning module (Pickard 2018). Here blaming reactions are typically described as the person being cold and dismissive combined with an insinuation that the person withdraws from the relationship. One could explain this difference by assuming that Pickard conceives of these reactions as one important way in which people tend to give expression to blame related emotions. We will return to some alternative definitions of blame later in the article, and stick with Pickard's definition for now.

An example of what a clinical stance amounts to is provided in Pickard's online module for people who work in mental health care (Pickard, 2018). Two police officers are called to check on Amy, a person with PD who is at that point in time threatening to people in her hallway and appears to be under the influence. Amy has to be taken to hospital for a check up but once at the hospital Amy becomes violent whilst waiting for a doctor. She assaults a police officer and is consequently arrested. Later at the police station, Sarra, one of the police officers, walks into Amy's cell with a cup of tea.

At this point Pickard discusses three responses to Amy. From a rescuing response, Sarra brings Amy a cup of tea and is trying to comfort Amy and tells her she will be the one who is going to

interview her. Amy then throws the cup of tea through the room screaming that she will file a complaint. A blaming response is illustrated by a cold reply "go ahead and do that', and by slamming the door when leaving. Furthermore, in the blame scenario, the police officer describes her to others as "a pain" and difficult to deal with. From a clinical stance, Amy is told that she is free to file a complaint, that this is her choice, but that she will also be interviewed now for her earlier assault of a police officer. This is told to her without anger and in a "matter-of-fact like manner."

According to Pickard, the first rescuing response sees Amy too much as a victim of her disorder who cannot help acting as she does, whereas the blaming response is counterproductive to Amy's recovery. From a clinical stance one would consider Amy responsible for her earlier assault and current aggressive conduct without also blaming her for engaging in such harmful behavior. Because Amy is considered responsible, she has to bear the consequences of being aggressive and verbally abusive toward others. Amy is also charged with assaulting a police officer; she will be interviewed about this and possibly fined. In response to her abusive conduct the officer may stress some of those responsibilities and choices that Amy has, but should refrain from affective blame. This last response of responsibility without blame is seen as the therapeutically effective response.

Therapeutically effective as the clinical stance may be, it is also conceptually confusing. For, how can one hold a person responsible for harmful conduct, without also blaming the person for that harmful conduct? If Amy is to be held responsible for throwing a cup of hot tea through the room, why should one also not blame her for such a rash action that may end up getting someone seriously hurt? In accordance with most philosophical theories, and arguably common sense too, being responsible for harmful conduct implies being blameworthy for this harmful conduct and the resulting harms too.[3]

To make sense of responsibility without blame Pickard distinguishes between two types of blame: detached blame and affective blame. Service users can be appropriately held responsible for their conduct because they are blameworthy. Detached blame amounts to the non-emotional judgment that the service user is blameworthy for what she did. As we saw, Pickard thinks that service users who are held responsible are not fully excused from blameworthiness for the norm-transgressions they engaged in because they can exercise choice and a sufficient degree of control over their behavior. Surely for people with mental illness this degree of control is often lower than average, and their circumstances mitigate their blameworthiness. According to Pickard these circumstances need not suffice for being excused (2013b, p. 1142). The mere judgment that a person is blameworthy, for example, detached blame, is compatible with a clinical stance. Affective blame is what is detrimental to therapy and is what one, from a clinical stance, will not engage in (2013b, pp. 1142–1146). As discussed, affective blame refers to the feelings of resentment, indignation or anger combined with a sense of entitlement to these feelings. On Pickard's account responsibility without blame specifically refers to responsibility without *affective* blame.

We are now in a position to list a few defining elements of the clinical stance. The clinical stance recommends a response of detached blame, that:

1) Is appropriate given the person's sufficient ability for choice and control and (mitigated) responsibility for what she did.
2) Is not accompanied by felt and expressed affective blame toward the person
3) Avoids a condoning or rescuing response to the person

This clinical stance, according to Pickard, fosters therapeutic recovery and as such provides an ethical guideline for responsibility practices in contexts of psychiatric care where it concerns service users for whom disorders of agency are (partly) constitutive of the disorder.

The Nurturing Stance

In these sections, we assess Pickard's clinical stance by comparing it to what are considered best practices in response to harmful conduct in another mental health care setting. We interviewed clinicians at a clinical center in the Netherlands specializing in the inpatient treatment of adults

with (comorbid) ASD with an average or above-average IQ. The center provides so-called tertiary care for service users whose treatment in regular psychiatric inpatient or outpatient settings has proved ineffective. Most of the service users admitted, met the criteria for one or more comorbid diagnosis such as PTSD, depression, anxiety disorders, eating disorders, addiction, attention deficit/hyperactivity disorder, or PD. At the time of the study (late 2016), they were 18 to 45 years old, with an average age of about 25 to 30. The male/female ratio was approximately 30/70. A significant subgroup of the service users admitted had been diagnosed with ASD at a relatively late stage of their development, often in early adulthood. Typically, these people had received treatment directed at comorbid (sometimes incorrect) diagnoses in the past, such as depression, eating disorder, addiction or PD, and had had a long, unfortunate and sometimes adverse history in mental health care characterized by a chronic misunderstanding of and by others, aloneness, growing despair, distrustfulness and alienation.

Many of the service users admitted manifested "disorder of agency," in Pickard's sense explained in the previous section. Destructive or otherwise debilitating patterns of behavior (e.g., verbal or physical aggression toward others, breaking furniture or cutlery, deliberate self-harm (cutting, head banging, strangulation, self-embedding), restrictive eating and drinking, running away, suicide attempts) and extreme (social) avoidance or inactivity were among the central maintaining factors in the chronic problems experienced by the service users (and their families), severely undermining the possibility of recovery. Moreover, the challenging behaviors displayed were not "mere movements," but on many occasions allowed for a minimal possibility for choice and control.[4]

The clinicians interviewed (see below) had serious doubts or simply did not know whether these service users had the capacity of choice and control as suggested in Pickard's writings on PD. In some cases, they were positive that the capacity for choice and control was significantly more compromised than described there. Nevertheless, the considerations Pickard discusses in relation to PD seem to at least partly apply to these service users with ASD. The core of treatment consisted in helping them to better understand the way ASD "works" in their lives, how to address their basic needs and impairments in light of this using the skills they have, and how to alter maladaptive coping patterns that stand in the way of recovery. The basic assumption behind such a treatment program is, as Pickard put it, that therapy can augment existing agential capacities, capacities that, though limited, are present in the problematic patterns of behavior displayed.

In an exploratory study, the first author conducted 11 semistructured interviews with clinicians. The participants were four psychiatrists, two senior clinical nurses, one social care worker, one clinical nurse, one family therapist, one psychologist/remedial educationalist and one clinical nurse specialist, and consisted of four men and seven women. The participants were invited by email for an interview. Of the invited participants, no one refused to be interviewed. The interviews were audio-recorded and took place in a quiet interview room at the clinicians" place of employment. They lasted between 60 and 90 minutes.

We interviewed clinicians about what they considered desirable responses to challenging behavior.[5] We focused on responses to behavior that the interviewed clinicians perceived as hurting, disrespecting or endangering other people (the clinicians themselves and their colleagues included).[6] The interviews were semistructured. Among other things, the clinicians were asked if they had emotional responses to this harmful conduct, considered the person blameworthy for this conduct, and held the person responsible. They were also asked what they considered to be the desirable response and why, and were asked if they would respond differently in non-psychiatric contexts.

On the basis of these interviews, the authors developed an account of ethical responsibility responses in this particular mental health care context. This account was presented to the interviewed clinicians in a focus group, to confirm and calibrate. The focus group was attended by eight of the participants: three psychiatrists, two senior nurses, one family therapist, a nurse and the psychologist/remedial educationalist. All participants

were informed of the data analysis and proposed account of best practices either during the focus group meeting or by email. All participants signed a statement of informed consent and their answers will remain anonymous.

There are three common elements to what were considered the right responses to harmful conduct in this particular mental health care context. First, when one perceives the service user to behave objectionably toward others and thereby cross the boundaries of what can be tolerated within the clinic (from now on we refer to such conduct as harmful conduct), the clinician will typically be *negatively affected* by such conduct and it is considered desirable to set clear boundaries and firmly correct the service user for such conduct. In doing so, the clinicians would often communicate how they were affected by this conduct and why. Negative emotions here include (mild) anger, but also shock or fear.

Second, one should *correct* the service user in a manner that does not threaten the therapeutic relationship and is consistent with an overarching concern for therapeutic recovery. This means that the affective attitudes of the clinician should not be communicated in an excessive and unfiltered manner, and that it should be clear this response does not amount to rejecting the person or breaking the therapeutic relationship, over and above a negative evaluation of this person's conduct. One clinician put this succinctly when she said, "The patient should know this does not mean I will not see you anymore'; "the possibility for contact is never foreclosed." Furthermore, concern for therapeutic recovery and maintenance of the therapeutic relationship, means the response should be attuned to the person's ability to understand and respond to it in a meaningful and constructive way. Within a clinical population of people with (co)morbid ASD, this required, for example, careful assessment of the service users" level of social-emotional development, their understanding of the norms transgressed, their particular and sometimes idiosyncratic ways of making sense of the (social) world and current levels of distress. The specific manner of communication that is desirable will therefore vary depending on the person, and the context.

Third, the clinicians typically *did not attribute blameworthiness or sufficient choice and control* to the patients. When we asked clinicians to explain and justify their responses, they did not mention blameworthiness as providing a consideration in favor of correcting the person. When explicitly asked if they considered any of the service users who behaved objectionably to be blameworthy for what they did, most interviewees replied in the negative and some said they did not know. We also specifically asked if they considered these service users to possess the level of agency that would suffice for blameworthiness. In answer to this question, the clinicians would often report that they did not know, or could not know given the range of difficulties that may compromise the person's understanding or control in different contexts and at different moments in time. Sometimes they reported to be quite certain that the service-user did not possess the required level of understanding and control. The clinicians did consider service-users responsible in some sense but they were not considered to be blameworthy for the harmful conduct and related harms. The clinicians attributed other responsibilities to service-users, like a responsibility to participate in shared therapeutic processes, or a responsibility to respond to nurturing reproach.

We refer to the response that is characterized by these three elements as "nurturing reproach." This response is an expression of a stance referred to in the literature as "the nurturing stance." From this stance one relates to the other person as someone who cannot yet sufficiently live up to certain interpersonal norms, but who is sensitive to moral appeal and capable of moral development (Brandenburg, 2017). We will say more about this in the last section of the article.

Our clinician's responses were typically charged with some degree of negative affect, while also being consistent with therapeutic aims and considered "attuned to" the service user's cognitive and social-emotional profile. These affective responses were informed by or moderated by therapeutic aims of recovery, enabling the service user to "grow" in applying self-governing capacities conducive to recovery. Words like "reproof," "reproach," "reprimand" or simply "firm correc-

tion," or "disapproval" could be considered apt to describe these attitudes, depending on specific context and persons involved. We will use the term "nurturing reproach" as a general concept that may refer to any of these responses. Although nurturing reproach is characterized by negative affect, we do not mean for this affect to refer to specifically blame related emotions like indignation or resentment.[7] As we will discuss elsewhere in the article, these clinicians reported not to attribute blame and blameworthiness to the person. Rather, nurturing reproach here indicates that the person may be negatively affected by the perceived harmful conduct and that there can be a place for mild forms of negative affect within a clinical setting which ensue in a form of holding the service user to account in a manner consistent with therapeutic aims. Nurturing reproach does not result from being angry with a person but rather results from being angered by harmful conduct.[8] According to the clinicians we interviewed, having some such negative affective response to harmful conduct toward others shows involvement with the service user as opposed to detachment. This affect need not necessarily be expressed in how one corrects the person but it would be wrong to actively hide or obfuscate that one is affected when one communicates disapproval of the service user's conduct.

The interviewed clinicians stressed that adopting a stance which is not at all negatively affected by harmful conduct toward others, or actively hides or obfuscates these felt responses, would undermine the therapeutic relationship and the service user's recovery. But why is nurturing reproach considered the desirable response when the clinician perceives a patient's conduct toward others to be harmful? The clinicians converged on a number of reasons that, according to them, speak in favor of this response to perceived harmful conduct.

Congruence

Part of a successful therapeutic relationship is that clinicians behave in a genuine way toward service users and that they remain themselves when the therapeutic relation comes under pressure in the face of the service user's challenging behavior. Communicating one's corrective attitudes in response to perceived morally problematic conduct makes for a personal and transparent way of relating to the addressee. This genuine and clear form of relating to a person under these circumstances is closely connected to the Rogerian principle of congruence (Rogers, 1957). A congruent therapist is a therapist who is genuine, involved and able to draw on first-person experience and self-disclosure in relating to a patient: "You should be congruent, do as you say and say as you do"; "a patient will notice if you hide how you feel." If one is not congruent, this will often be interpreted by the patient as (and often is) a withdrawal or detachment by the clinician, that is, a severing of the relationship. Congruence comes with involvement and a consequential openness to nurturing reproach in response to perceived off-limits challenging behavior, and at the same time provides a reason that speaks against withholding and suppressing negative affect. Our interviewees thought that even when they were on the verge of losing control over their emotions in response to extreme and persistent harmful conduct and should step out of the situation, it was still good practice to explicitly mark their anger and frustration, explain why they had to leave, leave to cool down, only then to come back and restore contact again.

Sense of Safety

The nurturing reproach also helps to provide the service user with a sense of safety, partly because being transparent renders a clinician more predictable and reliable in the eyes of the service user. Being congruent is instrumental to the service user's feeling of safety. Unsuccessful attempts to hide one's negative feelings will create more rather than less confusion and anxiety for the service user about social boundaries and renders the clinician less reliable and predictable (e.g., incongruence between one's verbal message and one's facial expression, bodily composure, and tone of voice). But a sense of safety is also provided because by labeling certain behaviors as unacceptable, the service user is presented with boundaries to what they can do. Our interviewees considered nurturing reproach to be crucial for such boundary setting. They made comments such as, "They

may notice that I am a bit angry when they really cross a line; if you say something too calmly they may think… is this actually a problem? Is this ok or not?!" Nurturing reproach illustrates that the clinician as a person has and respects clear sociomoral boundaries. This provides a holding environment that reduces anxiety; the patient is included in (rather than excluded from) a shared practice and shown what the rules of this practice are at the same time.

Fostering Agency

In the interviews clinicians refer to the different ways in which an expression of anger may encourage a service user's self-governing approach toward harmful patterns of behavior (Brandenburg, 2017). To illustrate, one clinician remarked, somewhat bluntly, "My experience tells me many patients are pampered [by their social environment], and that this makes them in fact more insecure and unsure of themselves … if you don't correct someone, you, without maybe meaning to do so, will give them the message that they cannot do this by themselves" and "You should place people in a position from which they can learn to improve." One thereby also helps to avoid victimization and disempowerment. Another clinician said in relation to this, "It is your therapeutic responsibility to recover the person's autonomy, make them feel human more than victim or underdog." Calling upon the person to have a self-governing approach does not imply, of course, that the service user will not be offered the help and support needed. What is relevant is that correcting a person may help to encourage the person's proactive attitude in this process of supported recovery.

A related manner, in which nurturing reproach may foster agential capacities, is by inspiring a process of reflection on one's conduct. One clinician put this succinctly by saying that after he expressed to be angered by harmful conduct, "I expect that responsibility is then placed on the stage, that this expression initiates internal dialogue."[9]

Recognition

A number of clinicians mentioned how, by showing that someone affects them—rather than concealing this—they "take a person seriously, by showing some things simply can't be done" or see "the person, in some sense, as an equal and valuable community member" or simply "express [that] you respect the person." This notion of recognition may be elusive if not intuitively grasped by the reader. There is an important sense, these clinicians explained, in which nurturing reproach conveys the message that the service user is recognized and treated as a member a shared norm-guided practice. One is an equal member of this practice in the sense that one can be called upon to recognize and work toward abiding by interpersonal norms, and is someone who can call upon other members to do the same (e.g., Brandenburg 2017.).

Exemplarity

Last, controlled expressions of nurturing reproach are also considered to provide instructive examples. First, they serve as a model of how people outside the clinic may react to challenging behavior. This is something that service users ought to know and be able to respond to when they leave the clinical setting. A concern voiced by our interviewees was that service users become more institutionalized when not directly confronted with a person's corrective response to their challenging behavior. One interviewee said, "At times you only realize how their behavior made you feel on your way home. I can understand a clinician's choice to defer a response… But still I worry; it makes me think, outside of the clinic you won't get deferred responses and to what extent is this then instructive?"

Second, nurturing reproach also serves as an illustration of how service users themselves may learn to experience and express nurturing reproach, directed at self or others in healthier and more adaptive ways than they are used to. Many service users associate the negative affects in corrective attitudes with being bad, deserving punishment and being excluded. Nurturing reproach can provide a corrective experience of being held accountable for misbehavior while still being accepted and worthy of consideration and empathy. One clinician remarked that deferred suppressed responses would "fail to exemplify how it may be perfectly acceptable for a patients

to address their feelings and talk and think about them." He added that in his experience many patients are surprised by the realization that it is possible and acceptable to address and talk about negative emotions, which further stresses the need for showing how one may experience and express nurturing reproach. By setting an example, clinicians show service users when and how negative emotions can be expressed in a safe, non-disruptive way in social relationships. Internalization of these attitudes may furthermore enable service users to treat themselves in a more compassionate and constructive way in response to their own failures to meet moral norms or standards.

Assessing the Generalizability of the Clinical Stance

In this section, we compare nurturing reproach to Pickard's notion of detached blame from a clinical stance. We firstly discuss some similarities between the two accounts. Secondly, we explore how elements of our account could possibly supplement the clinical stance. Thirdly, we address a crucial difference between the two accounts.

Both nurturing reproach and detached blame are a response to harmful conduct that differs from condoning or "rescuing." As we discussed, the clinicians interviewed believed that one important reason that speaks in favor of correcting a person is that it fosters agency. A more "rescuing" or condoning approach fails to facilitate such empowerment and moral uptake. Nurturing reproach is thus similar to detached blame in that it avoids rescuing and condoning to maintain and develop the patient's agency.

Does nurturing reproach also distinguish itself from affective blame? The clinicians we interviewed did report to experience and express certain negative affect in response to harmful conduct. They also believe that there is a place for mild forms of anger within a clinical setting. However, these negative attitudes in response to norm-transgressions do not amount to blaming, according to them. One clinician remarked that "Blame is not the right term … People often acquire these problematic habits because nobody ever corrects them." "What I do is indicate my limits; express that this is something I will not tolerate." She considered her affective responses to have a "corrective" character rather than a retributive or blaming character. "I believe that you should always correct someone, just as one would do for a child. If a 2-year-old starts to throw things through the room, you would also correct them. This is how I see my responses to challenging conduct, and in such cases you are not blaming someone, I would not call that blame." This denunciation of blaming was shared by all clinicians interviewed.

This seems consistent with Pickard's account. According to Pickard affective blame is a specific type of negative affect characterized by a sense of entitlement. These feelings are inconsistent with sympathy and compassion and, therefore, do not belong in a therapeutic relationship. The clinicians we interviewed also rejected those particular emotional responses because they believed affective responses should not undermine therapeutic recovery and should be consistent with their professional role.

Other types of negative affect can, however, be consistent with sympathy and compassion. There is an important difference between the nurturing and educative manners in which one would affectively correct people that are in one's care, and the resentment or indignation one may feel toward say a friend, colleague or partner who has wronged you or someone close to you. The second type is considered incompatible with a therapeutic relationship in a context of mental health care, but the first is not.

It is worth noting here that some philosophical accounts of blame seem to include any type of nurturing negative response that is triggered by (perceived) harmful conduct toward others (Fricker, 2016; McGeer, n.d.). This raises the question whether these definitions of blame are inconsistent with natural language definitions, or whether the definition of blame within this particular practice is different from some philosophical accounts of blame and maybe other practices. This is not something we can pursue in this article, but it does leave the suggestion that some definitions of blame may have to be reconsidered in the light of general and specific usage of this term in practice.

Our account suggests that mild negative responses to harmful conduct are acceptable and sometimes even desirable in contexts of mental health care. The clinicians we interviewed would, however, not describe these responses as blaming.

Pickard's notion of detached blame suggests no involvement of negative affect at all and alludes to a cool and collected response to harmful conduct. Our account suggests that there are dangers to such a response if it would involve repressing and obfuscating any negative affect. Such a response may then, at least for this service user group, be incongruent and lack the sense of safety that comes with a more transparent form of relating to the person. We do not mean to deny here that it is possible to have a genuine calm and collected response to a person. Characterizing a detached response as the guideline may have undesirable consequences in all those cases where a clinician is negatively affected by harmful conduct and the service user would be sensitive to affective appeal. And such cases, according to our interviewees, are common.

On a charitable reading of Pickard, however, mild negative affect is not necessarily inconsistent with her notion of responsibility without blame. Although Pickard does not explicitly address these milder negative affective responses they may be consistent with her overall account because these responses would not qualify as affective blame on Pickard's definition, and it is only affective blame that she explicitly considers incompatible with the therapeutic relationship. Like the clinical stance, nurturing reproach distinguishes itself from Pickard's definition of affective blame. There is no justification for a hostile form of anger that comes with the feeling of the other person being deserving of this anger and the clinician being entitled to this anger. Nurturing reproach then helps to demarcate this type of blame from other affective responses that could be acceptable and maybe even desirable in the context of a psychiatric clinic. It is a further question in which contexts and relationships a more detached or a more affective response would be therapeutic.

There are ways in which our account can supplement Pickard's clinical stance. The reasons discussed in the last section provide additional considerations that justify forms of responsibility without blame. First they provide some additional ways in which forms of responsibility without blame may be conducive of therapeutic recovery. Pickard explains why the clinical stance is conducive of therapeutic recovery by contrasting it to two other types of responses that undermine treatment: rescuing and affective blaming. A rescuing response obfuscates the possibility that the service user can take control and engage in her own recovery process. A blaming response, on the other hand, fails to empower the service user because it tends to make the person feel rejected and incurs a vicious cycle of guilt. Both undermine the service user's self-governing approach to recovery as well. The clinical stance is conducive to recovery because it fosters or facilitates agency in recovery.

Our account supplements this justification by providing more considerations that explain how responsibility without blame can be conducive to therapeutic aims. Fostering agency in recovery is among those considerations. But in addition congruence, a sense of safety, recognition and exemplarity may also explain how responsibility without blame can secure therapeutic success (see previous section).

Furthermore our justificatory framework may supplement the clinical stance because over and above facilitating recovery there are intrinsic reasons that speak in favor of a response that mediates between rescue and blame (see "recognition" in the previous section). The interviewed clinicians do not only engage in nurturing reproach to achieve certain therapeutic purposes. Nurturing reproach is also considered a sincere response to a service user's behavior that embodies respect for the person. It is a respectful form of relating because it is congruent toward the service user and recognizes him/her as a member of a shared norm-guided community. Forms of holding responsible without blame are then appropriate responses, not only because they contribute to therapeutic recovery but also because they amount to a respectful form of relating to the person.

There are similarities between nurturing reproach and Pickard's notion of detached blame, and our account can supplement the clinical stance, but there is also a crucial difference between the two accounts. On our account, detached

blame (an attribution of blameworthiness) neither explains nor justifies practices of holding responsible that are embodied in attitudes of nurturing reproach. Recall that on Pickard's account the notion of detached blame serves to explain how we can hold a person responsible without also "blaming" the person: we may judge the person to be blameworthy without getting emotionally exercised about this fact (2013b, pp. 1142–1146). On Pickard's account the clinical stance is also justified to the extent that the person is responsible for this conduct and in a detached sense blameworthy for it too.

As we explained in the previous section, the clinicians we asked to explain and justify their responses of nurturing reproach to harmful conduct by a service user, generally did not believe this person to be blameworthy or to have the level of understanding and control that may be considered sufficient for blameworthiness. To provide one example, a senior nurse reported that a week earlier a female service user on her ward had turned down the opportunity to speak to two of her colleagues to arrange a meeting with her. The woman refused to listen or talk to these two colleagues, and her behavior toward them became more and more verbally abusive. The senior nurse was at that point taking a break in a common room. She overheard her interacting with her colleagues in the hallway and considered her treatment of her colleagues out of line. The interviewee said, "I was totally done with this behavior. It crosses a line. You cannot treat other people this way and you cannot get things done by me that way either. I think it is appropriate to show this and let someone know." She took the woman aside and told her, "You are here because you want to receive treatment, but you refuse to speak to two of my colleagues. Do you want to cooperate and work on your treatment? It is up to you. But that requires you treat them with more respect." She then left the situation and let her colleagues take over.

This clinician clearly affectively corrected this service user for verbally abusing other staff members, but when asked whether she thought this person could be expected to have behaved better under the circumstances, she replied in the negative. Elaborating on her answer, she pointed out that this person's social-emotional intelligence was disproportionately low in relation to her above-average IQ (not uncommon in cases of ASD). Seen through the lens of poor social-emotional development, this kind of regressive behavior is understandable and even to be expected in stressful situations. She added that this service user had repeatedly been hospitalized elsewhere where such behavior was reinforced. According to the interviewee, this service user could not be considered blameworthy for her conduct given those agency-compromising factors. Yet nurturing reproach was considered desirable for the reasons discussed above.

On our account (detached) blame (worthiness) neither justifies nor explains the responses of the interviewed clinicians toward service users" harmful conduct. Rather, the reasons that were listed in the previous section (congruence, sense of safety, fostering agency, recognition and exemplification) together seem to provide sufficient justification for why a service user should be subject to nurturing reproach when she transgresses an important moral norm. But if nurturing reproach is a form of holding the person responsible, how can it be appropriate to do so if the person is not blameworthy for her harmful conduct?

Recall that Pickard introduces to the concept of detached blame also to explain how responsibility without blame is possible. The interviewed clinicians in our study considered the notion of (detached) blame to mischaracterize their corrective responses to harmful conduct in this clinical setting. They either did not know whether the degree of capacities for choice and control implied by Pickard's discussion of detached blame was applicable, or they were positive that it did not apply in the particular situation of the service user. In light of these considerations, the clinicians interviewed often did not attribute to the service users in question blameworthiness for their harmful conduct. The question then is how we can explain "responsibility without blame" embodied in nurturing reproach, without making use of some attenuated notion of blame in relation to the harmful conduct under consideration.

We take it that nurturing reproach does not imply that one considers the person to be responsible (and blameworthy) for her harmful behavior. When one engages in nurturing reproach, one allocates other types of agential abilities and responsibilities to the person that are relevant because of the harmful behavior. For example, the agency and responsibility to continue to work on one's own recovery, and the communicative skills and responsibilities to receive and respond to another person's attitude of nurturing reproach. These abilities and responsibilities do not amount to the person being responsible for her harmful conduct. They instead refer to a responsibility that service users have to work together with their clinician toward recovery and to the responsibilities they have to motivate and enable themselves and others to display due regard for one another within a given community. The clinician appeals to the service user and the latter is thereby, in a sense, "held responsible" by the clinician. However, this form of holding responsible does not amount to detached blame toward the harmful conduct; the patient is held responsible for other more future directed concerns.

The clinicians we interviewed did not always adopt the nurturing stance, nor did they think that this was always appropriate. They agreed that patients in the clinic are sometimes blameworthy for what they do. But they preferred not to attribute blameworthiness unless they could be quite certain about a person's level of understanding and control over her own harmful conduct. The service users' inability to control for certain forms of harmful behavior was often part of the reason why they sought treatment in this clinical setting. Contrary to the outside world, the clinic is then a place where the person is not yet considered to have the responsibility to control such behavior but is helped to become able to do so. For example, mental rigidity, emotional overload, or an underdeveloped social understanding can be reasons for not (yet) considering a person responsible for controlling their behavior in certain circumstances within a clinical context. But those are also obstacles that a person be helped to learn to overcome or manage.

How does this future directed form of holding responsible expressed by nurturing reproach relate to Pickard's notion of detached blame? It remains to be seen whether our account of nurturing reproach and Pickard's understanding of detached blame from the clinical stance are two competing approaches, or rather complimentary tailor made approaches that can be subsumed under an overarching therapeutic goal. One possibility is that the responses considered appropriate depend on the type of disorder and the particular context of intervention. Perhaps detached blame is generally more fitting for harmful behavior originating in the interpersonal dynamics of (borderline) PD, whereas nurturing reproach might be more appropriate for challenging behavior against the background of (certain forms of) ASD. For example, it could be theorized that, due to the nature of borderline PD and the specific interpersonal hypersensitivities this encompasses, detached blame is more appropriate and conducive to recovery than forms of nurturing reproach. We believe, however, that the appropriateness of each kind of response is not so much determined by (*Diagnostic and Statistical Manual of Mental Disorders*), diagnosis, but by individual characteristics such as the specific socio-emotional, cognitive and interpersonal attachment profile of the individual service user, as well as by the specific context of the objective conduct and the clinician's response.[10]

If we are right, there is a place for both detached blame and nurturing reproach in different therapeutic situations or settings. We hypothesize that detached blame is the more appropriate response in reaction to conduct that is explained by a person's attitude toward recovery and attitude toward the therapeutic relationship as part of recovery. Pearce and Pickard describe how a decision or choice on the part of the patient is needed for the patient to recover; they refer to this as "the will to recover" (Pearce & Pickard, 2010). When harmful conduct is primarily explained by the person's lack of commitment to recovery and lack of acceptance of the therapeutic relationship as part of recovery, the service user is less likely to be sensitive to the appeal embodied in nurturing reproach. Rather what is needed is for the patient to decide or choose to work toward recovery,

and, relatedly, to accept and trust the therapeutic relationship and the value of a collaborative effort in the therapeutic process toward recovery. This decision or choice on the part of the service-user may be absent for good reasons. As Pickard points out, service users may have had histories of trauma and abuse, which may explain why they are skeptical about the possibility of recovery, and unwilling to trust or accept someone who offers them help. Lack of the decision to recover may be explanatory of harmful conduct itself, and it may be explanatory of a refusal to respond to a clinician's nurturing reproach.

We take it a detached response that stresses responsibility is more appropriate in these cases because one thereby recognizes the person's choice and control in this matter and allows the person to take this position and reject the therapeutic relationship. One, furthermore, remains open to therapeutically relating to the person and accepting of the person, without forcing this relationship on the person. We agree with Pickard that the person should at least be seen as responsible for refusing to partake in recovery and to accept the therapeutic relationship as a part of this trajectory to recovery.[11] This is a choice the service-user makes and something that only she can decide to change and would have to change for therapy to become effective. The hypothesis is then that a detached response that attributes responsibility without thereby rejecting the person, or denying the possibility of a therapeutic relationship, would be a desirable response for service-users with this profile.

The nurturing reproach may be a less desirable and less effective response when the therapeutic relationship is under pressure in this way. First, if a person mistrusts or challenges the therapeutic relationship and is unwilling to engage in a therapeutic process, nurturing reproach is unlikely to be effective. A service user is only open to the clinician's evaluation and disapproval of her conduct if she considers herself to stand in a particular relationship to the clinician, for example, as together participating in a therapeutic process that is aimed at her recovery. Absent this underlying acceptance of the clinician as someone who can be trusted to be willing and able to help you, one will probably not take this clinician's appeal to be acceptable and helpful. Second, the nurturing reproach may be considered unduly paternalistic in these contexts, because it aims to engage and improve the person in a shared therapeutic process even though the person herself rejects this participation. The nurturing reproach aims to "develop" the person's abilities by engaging a person in a therapeutic process. But if the person is, at this point in time, unwilling to participate in this process, nurturing reproach would seem to go against the person's own will. As such, it would amount to a paternalistic response that fails to respect the person's autonomy and responsibility. The person would be better respected by an acknowledgment of the disagreement regarding therapy or the therapeutic relation.

In the contrary situation, however, we believe the opposite is true. Detached blame is less respectful and conducive to therapy when a service user is committed to recovery, involved in the therapeutic process, and accepts the role of the clinician in this process, the harmful conduct notwithstanding. In those cases nurturing reproach stresses that involvement and helps the person to take, or keep taking, the future directed responsibilities that enable the person to work on their recovery.

If this hypothesis is correct, the two different therapeutic responses are compatible and both have value in mental health care contexts. Further research is required to test this hypothesis and to evaluate these two types of "responsibility without blame." Other variables may have to be taken into account. Different sociocultural contexts may place different value on some of the considerations we discussed and/or may have different concepts of therapeutic recovery. The specific meaning of emotional expression may also subtly vary, depending on (sub)culture and possibly patient-group.

Our exploratory study has some limitations. We interviewed only 11 clinicians, who also worked at the same clinic. Our account of the nurturing stance is an attempt to make sense of their therapeutic responses to harmful conduct by service users in their care. Their views may not generalize to other clinicians and other clinical settings. It may also turn out that on further consideration and comparison, their (views on their) therapeutic

responses reveal inconsistencies or even may have negative side effects that demand modification of the ethical responsibility practices in this mental health care setting. Furthermore, our account needs to be tested from more than one perspective. Importantly, the perspective of the service user is missing in the present study. In further support of therapeutic responses to harmful behavior, the perspective of the service users involved—both on their own harmful behavior and the responses it invites by clinicians—is indispensable. In relation to this point some remarks about inequality and the examples from the interview are in order. Although all interviewed clinicians explicitly considered their patients to be equal participants in a shared practice, they also resort to comparisons with children (see pp. 387 of this article). It is a further question whether these comparisons disclose problematic implicit inequalities between the clinician and the patient, or whether they could be in line with the relatively harmless ways in which we may all sometimes describe ourselves, friends, or colleagues as being temporarily "immature" or childish. This question cannot be answered without the input of the experiences of patients themselves. More generally, maintaining a sense of equality within a caring relationship in the context of a therapeutic setting is a serious challenge that deserves further consideration in the light of the experiences of patients.

Despite this need for further research, we hope to have provided a critical comparison and the beginnings of a research project into therapeutic forms of holding responsible in mental health care contexts.

Conclusion

In this article, we provided an account of therapeutic responses of clinicians to harmful conduct by service users in a clinical setting for adults with ASD. Based on an explorative qualitative study among clinicians who work in this setting, we developed an understanding of these responses in terms of nurturing reproach. We compared the results of this study to Pickard's notion of "detached blame" in her clinical stance account. Although there are similarities and ways in which our account may complement Pickard's clinical stance, there is also an important difference. Pickard's notion of detached blame is supposed to explain how one can hold someone responsible for harmful behavior without affectively blaming the person for this behavior. In contrast, our understanding of nurturing reproach embodies controlled expression of negative affect on the part of the clinician that appeals to a set of future-directed responsibilities of the service user, but without attributing any kind of responsibility or (detached) blame to the person regarding the harmful conduct to which the correction was a response.

As we pointed out in the previous section, it remains to be seen whether our account of the nurturing reproach and Pickard's understanding of detached blame from the clinical stance are incompatible, or rather highlight different aspects of an overarching therapeutic stance. We hypothesized an important contextual factor to take into account is to what extent the service user trusts and accepts the therapeutic relation in the process of recovery, as this suggests the person can constructively respond to the appeal on future responsibilities in therapy that is embodied in nurturing reproach. If the service user at that particular moment is not receptive to this appeal, it seems that nurturing reproach is the wrong kind of response. In situations where service users for example challenge or do not trust the therapeutic relationship, affectively charged corrections in response to harmful conduct may be counterproductive, and detached blame may be the more appropriate response.

Our proposed account critically compares with Pickard's clinical stance and provides the beginnings of a more extensive research project on therapeutic forms of holding responsible in mental health care. We should keep in mind that our own and Pickard's findings are based on what is perceived as best practice in particular clinical settings by clinicians working there. The findings should not be extrapolated to other health care settings without question. This explorative account needs further research from more than one perspective, in particular the perspective of the service user.

Notes

1. Pickard (2011) mentions varieties of cognitive behavioral therapy (dialectical behavior therapy, systems training for emotional predictability and problem solving), motivational interviewing techniques, mentalization-based therapy, and therapeutic communities.

2. Pickard mentions two important caveats. "First, service users with PD may not always have full conscious knowledge of why they are behaving as they do, or what the full effects of their behavior on others may be. . . . Second, it is important to recognize that, on the common sense conception of agency presented above, control is a graded notion, and the degree of control possessed by PD service users may sometimes be diminished compared with the norm" (ibid).

3. One could object here that maybe Amy is only causally responsible. Causal responsibility can come apart from blameworthiness. Although Amy caused the breaking of the cup, she was not in the right state of mind to act responsibly. However, in such a case one is left to wonder why one may appropriately hold the person responsible at all.

4. Here, the caveats Pickard mentions (see endnote ii) are especially important. Due to problems on the level of social interaction and communication (a core diagnostic feature of ASD) and underlying sociocognitive capacities relating to empathy and "theory of mind," many service users had serious difficulties realizing why they were behaving the way they did and what the consequences of their behavior may be, for themselves and others. Also, the degree of control over their behavior fluctuated and was significantly limited, against the background of immature coping mechanisms, rigidity and habit formation, problems with executive functioning and structural difficulties in signaling emotions and distress.

5. A definition of challenging behavior often used in the clinical literature is the following: "culturally abnormal behavior of such an intensity, frequency or duration that the physical safety of the person or others is likely to be placed in serious jeopardy, or behavior which is likely to seriously limit use of, or result in the person being denied access to, ordinary community facilities" (Emerson, 2001). The concept of challenging behavior is a socially constructed, descriptive concept. What behavior is and is not considered "challenging" is subject to various sociocultural (moral) norms, service delivery patterns and changes over time and across different (cultural) contexts (Emerson, 2001; Xeniditis, Russell, & Murphy, 2001). The concept carries no specific diagnostic significance and carries no etiological implications per se. It covers a diversity of behavioral phenomena across a heterogeneous group of people. Challenging behavior may, but need not, be related to intellectual disabilities or psychiatric conditions, either as a primary or as a secondary manifestation of the condition (ibid.).

6. We here limit ourselves to other directed behavior because reactive attitudes are understood to be a response to conduct that is harmful in its treatment of other people, and more generally philosophical theorizing about blame and responsibility typically focuses on sociomoral norms and sociomoral transgressions.

7. For more in depth discussion of this distinction see Brandenburg (2019).

8. It should be noted that we focus on responses to harmful behavior toward others. Within this moral domain, a transgression is especially likely to trigger negative affect. Not all of the examples of harmful behavior Pickard discusses fall clearly within this domain. When they do not, we are not sure nurturing reproach would be a desirable response. A person self-harming or not taking medicine, for example, need not similarly negatively affect caretakers, as these are not clearly forms of hurting, disrespecting or endangering others. Similarly in other care-relationships self-directed mistakes and other mistakes related to non-moral skills, call for some form of correction and explanation but also not for the negative affect that typically accompanies these forms of more moral correction.

9. This reason connects to an important insight central to feminist ethics: human autonomy is relational because good social relationships support one's ability to live one's life in the light of carefully considered and endorsed values, goals and plans.

10. In this context, it should be noted that research suggests that there is significant comorbidity of (borderline) PD and ASD (based on the *Diagnostic and Statistical Manual of Mental Disorders* IV/5 criteria) and also symptomatic overlap (e.g., Hofvander et al., 2009; Lugnegård, Hallerbäck, & Gillberg, 2012; Ryden, Ryden, & Hetta, 2008) Recent research shows relatively high scores on ASD traits in people diagnosed with BPD, also suggesting overlap of the two diagnostic constructs (Dudas et al., 2017).

11. One may, of course, still wonder if the person should be considered blameworthy for taking this attitude toward therapy and toward clinicians. If in this service-user's past, other people have proven to be untrustworthy and abusive, there arguably have good reason to be mistrustful of any other person. We suspect that sometimes this refusal is understandable and would not merit an attribution of blameworthiness for such conduct over and above responsibility for such conduct, but do not have the space to discuss this issue more in depth.

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