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Taking responsibility

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This paper examines the assumptions underpinning the concept of responsibility. We ask how psychology contributes to constructing the idea of taking responsibility as no more than a form of being seen to act in socially desirable ways.

A patient on an acute admissions ward secretes a knife in her room so that she can cut herself; when the knife is found all her personal possessions are confiscated to prevent her from self harming. When she becomes distressed, she is told she must learn to take responsibility. Another patient punches a psychiatric nurse in the face because he thinks she is trying to poison him with medication. He is put in seclusion and told that he must take responsibility for his behaviour. Discharged home, a young woman repeatedly contacts her key-worker in a state of distress; she has a crisis over money, her boyfriend, her housing, her mother. Her key-worker tells her that she must start taking responsibility.

We have often heard the phrase 'taking responsibility' used in such situations and have felt troubled by it. In this paper we hope to further explore what it means when we ask someone to take responsibility and what the alternatives might be.

The nature of responsibility

We want to address the construction of responsibility by first examining two assumptions within which the concept of responsibility nests: the idea that persons (and their various characteristics) are continuous and the related notion that people can be meaningfully described in terms of stable (and internal) attributes.

The second author has recently written about some of the consequences of a closed head injury and other injuries resulting from a car accident. The change in consciousness resulting from the accident raises questions about the confidence with which we assume that identity is continuous from day to day, whatever the interruptions. He had previously considered himself both reasonably concerned about the world around him and similar in this concern to others. Subsequent to the accident, things appeared to change:

The wider picture evaporates. Global warming? Neither here nor there. Weapons of mass destruction? Irrelevant. British politics? Love Actually *is more interesting. Sport? Who cares (especially about motor racing)? In this new world, environment is everything. People close at hand must be kind … trains as timetabled, traffic wholly safe and stimulation not too complex. Health professionals must be on time or fear and self-doubt mount. Noise must be controllable (hypersensitive hearing is quite something in conjunction with spinal injury: scraped chairs and certain pitches of voice send the body into spasm, legs*

and arms twitching like lightning conductors). ... And life, even getting out of bed, is exhausting …A lifetime's assumptions about similarities between you and other people are shattered. The whole idea of consciousness, let alone shared consciousness, is challenged. One wonders how the world functions at all.
(Newnes, 2004)

Assumed continuity (of the self, personhood, memory, day to day life, and so on) is a given within much philosophical discourse (Murdoch, 1992). To fundamentally change someone's circumstances through incarceration or psychiatric admission is not seen as affecting this essential continuity. Even when direct physical damage is sustained by an individual that damage is made sense of (by the individual and others) by reference to the ways in which the individual's continuous personal characteristics have been affected or interrupted. Damasio (2000, 2004) sees these as an aspect of extended consciousness (his term) that he calls the autobiographical self. We do not easily admit to major personality change (selves are seen as, more or less, intact across time and place). We almost never consider the possibility that the changed person is so different as to make the notion of taking responsibility for previous action the equivalent of being responsible for someone *else.* We wonder what psychology would look like in a world where the self was not assumed to be continuous. Therapy would be irrelevant as people would not need to be accountable for the self they were seen to be yesterday. Sadness or fear would be met with assertions that there is no need to face saddening or fearful events or relationships from one day to the next; parenthood, marriage and friendship would have to face the lack of commitment inherent in the notion of the discontinuous self. We suspect there would be anarchy. Certainly the prison system and psychiatric system would struggle to exist if the idea of contingent behaviour was made irrelevant by the loss of any individual accountability for that same behaviour across time. (For a further discussion of ways of re-conceptualising the practice of psychology, see Hansen *et al.,* 2003, final chapter).

At least one novelist, Carol Shields (1977), has no difficulty in challenging the assumption of continuous personhood. She opens *The Box Garden* thus,

... we change hourly or even from one minute to the next, our entire cycle of being altered, our whole selves shaken with the violence of change. (p.1)

Such a position is rare indeed in the numberless texts on counselling, self improvement and the more academically-inclined psychology end of the market.

Further, we would wish to criticise the view that responsibility is an individual attribute. Our position is essentially Strawsonian (Watson, 1987); that you cannot separate something called responsibility from the various attitudes and responses from which we infer that someone is responsible (Strawson's "reactive attitudes"). This position owes much to Ryle (1949): see, for example, his discussion of other mental predicates such as "understanding" as public displays. Responses such as guilt, shame, pride, indignation and so on are subject to change as contexts change. Even allowing that persons are continuous across time, these attitudes will surely change with circumstances; such as admission to a psychiatric ward. To expect people's sense of responsibility and display of what would typically be described

as responsible conduct remain undiminished or unaltered seems, to us, to expect too much. Prison guards and psychiatric staff are, implicitly, taking a position that emotions do not affect will, and thus, responsibility. For the psychiatric and prison systems, one can be responsible or otherwise, however one feels (arguments for and against this position can be found in Sabini and Silver, 1987; such arguments take up much of Oakley, 1992). Emotional reaction to, for example, being sectioned under the Mental Health Act, is not seen as relevant to responsibility and moral culpability. People who are upset after being sectioned under the Act are thus still urged to "take responsibility" even though their legal accountability for their actions has been suspended.

Analytically inclined thinkers might go further. Riker (1997), for example, suggests that people should be held accountable for all that they do on the basis that their actions might be unconsciously motivated – and as it is unquestionably their own unconscious, Jungian ideas on the universal unconscious notwithstanding, they can be held responsible.

If the mental health professionals involved in the (fictional) examples given above were to be asked what they had meant by taking responsibility they are likely to have talked about accepting the consequences of actions, feeling sorry and trying to find more constructive ways of solving problems. They tacitly assume that the person is still *capable* of these things despite their admission to hospital or other changed circumstances. Such capabilities are seen (conveniently) to be continuous.

Even within the definition typically used by mental health professionals, it is entirely possible that someone could engage in self harm and similar behaviours and yet still be described as acting responsibly. When someone self harms, it seems likely that they have found a behaviour that provides a singularly powerful solution to the problem of expressing or coping with overwhelming feelings (Babiker & Arnold, 1997). They may also be prepared to accept the consequences, such as loss of blood, permanent scarring and even alienation from others. It is only when they come in to contact with a system that attempts to control their behaviour that its consequences become unacceptable. This is because the psychiatric response, through removing power and control, creates "the very circumstances that are likely to have led to the need to self injure" (Johnstone, 1997, p.425).

There may also be times when violence represents a solution whose consequences are acceptable both to the individual and also to a wider society, in particular in resistance to oppression. For a soldier being tortured in a prisoner of war camp or a member of an oppressed minority, the consequences of violent resistance may be aversive but they may accept them, given the already aversive conditions of their life. Their resistance may also be approved or even applauded by the rest of their society or culture of origin. For many users of psychiatric services the experience is one of oppression and violent resistance may be the result (Coleman, 1999).

In the first two examples, the persons expected to take responsibility are detained under the Mental Health Act. In the third example some part of the Act may well still apply, such as a guardianship order, (this will become increasingly likely if community care orders are introduced with the proposed reforms to mental health

legislation). This seems to imply that as a result of their mental disorder, they are unable to control their behaviour, and cannot thus be responsible for it. Indeed, had the man in the second example killed someone because of his belief that they were poisoning him he would be found not guilty of murder on the grounds of diminished responsibility. Under these circumstances a service user might well ask "how can I take responsibility when you won't give me any?". This is an example of what Smail (2003, p.48) calls the "paradox of responsibility": being told to change and, simultaneously, that you cannot do so.

In the third example a person is told to "take responsibility" for her own problems rather than contacting her Community Mental Health Nurse to ask for help every time something goes wrong. Contacting a key worker at times of crisis can easily be seen as taking responsibility, by turning to the people who (apparently) are employed to help. There seems to be an attitude in a number of CMHT workers (including psychologists) that their job is to "make themselves redundant" by promoting self sufficiency, rather than just being supportive. At all costs, workers must never promote dependency. It seems to us contradictory to dissuade users from asking for help at times of crisis and to encourage them to solve their own problems. In describing what they found helpful about involvement from professionals, service users have identified the importance of continuity and developing a strong relationship as well as on-going accessibility and availability (Faulkner & Layzell, 2000). Especially for service users with informal support networks that are themselves sources of stress, turning to professionals for help seems an appropriate and constructive problem solving strategy.

In order to be judged to have taken responsibility then, what service users (or prisoners) must do is simply what the system wants. Although they may not be responsible for their behaviour, they can take responsibility for it by engaging with the system, through taking medication or participating in therapy, to prevent it happening again. The subtext of the phrase taking responsibility is thus "do what I as the more powerful person expects of you," The apparent desire to get someone to take responsibility (or doing what they are told) may be more about conformity or punishment than helping them to lead a more fulfilling life. Smail (2003) further suggests that a positive correlation exists between position in the power hierarchy, sense of personal virtue and a belief that the less powerful need to be more responsible.

Responsibility and social control

A psychologist working with one of these three service users might well set taking responsibility for their own distress and its expression as a therapeutic goal. In achieving this they would also achieve the internalisation of the normalizing gaze (Foucault, 1977), which seeks to identify and correct deviance, as a form of social control. When a therapist teaches a client self-control, they are promoting a highly efficient form of social control: conformity that is imposed upon the individual by themselves.

There has been a recent move towards adopting a recovery based approach within mental health services, with an associated emphasis on self-management of distress. This can be seen as a welcome move towards allowing individuals in

distress to use the strategies that are most acceptable to them, to take back control from mental health professionals, to genuinely take responsibility for their lives. The Royal College of Psychiatrists' (2004) press release endorsing the "recovery ethos" identifies as a guiding principle "therapeutic risk taking to promote personal responsibility". Such a position appears to us to continue to suggest that the experiences and behaviour of people in distress are socially unacceptable and need to be controlled (Beresford & Hopton, 2003); this time, however, people must control themselves. Self-management thus, again, represents an internalisation of social control (see also Rose, 1999). It seems to us ironic that, in industry, the best kind of management is a hands-off approach, allowing workers autonomy and space for creativity. Despite using the business argot, the self management implied by psychologists and others is a far more authoritarian affair.

Responsibility and power

The recovery approach situates the cause of distress, and the focus for action, within the individual. Smail (1993) argues that concepts like responsibility that are used to describe the internal psychological operations of individuals, and thus provide proximal explanations for individual distress, function to divert attention from the way in which distress is caused by the operation of power in the social environment. It is thus impossible for someone to take responsibility for addressing their distress, as its origins are beyond the limit of their power. For people sectioned under the Mental Health Act the position becomes untenable; their "Get out of jail free" card (Holmes *et al*., 2001) has been played, they are deemed to lack responsibility and, in consequence, hospitalised. They are then frequently urged to "be more responsible", criticized for not "taking responsibility" and so on. Beresford and Hopkins (2003) argue that rather than a recovery model what is needed is "a rights-based" approach, involving policy changes to provide the support, public attitudes and access to allow service users to live the lives they choose.

In the examples given at the start of this paper there is a tacit assumption that the processes of admission and incarceration do not affect individuals' ability to learn (or practice taking responsibility as defined by the prison or psychiatric systems). Thus, living in entirely new ways (alongside prisoners or those diagnosed as mad, being labelled, having one's day ordered by sometimes invisible authority figures and rule makers who one has not chosen; even through voting) is not seen as changing the person, or at least only as having socially desirable consequences. The extraordinary lack of power now experienced by incarcerated individuals is likely to mean that the new system will impact on them in both intended and unintended ways. How does one protest about ward rounds, prison warders, hospital food? "Going on the blanket" during the dirty protests at the Maze prison is but one example. Self harm may well seem a powerful means of protest – and an entirely responsible means – if contrasted with a little used suggestion box or barely visible complaints procedure. If the consequences of actions are some reduction in privileges, this is likely to feel insignificant to the already experienced loss of freedom and autonomy.

It seems that what service users need to take is not responsibility, but power. A limited number of ways have been identified in which psychologists can promote

this empowerment. These seem relatively weak when set against the forces of the established order: they include working with individuals and communities, enabling user-led research and taking political action (Smail, 2003; Willoughby, 2003). The Internet suggests innumerable opportunities for sharing information with the general public and thus improving informed consent for prospective service users (see, for example, www.shropsych.org). The psychologist working with the three service users described at the beginning of this paper could at least help them to become aware of the distal influences on their experiences and provide "compassionate acceptance of who they are" (Smail, 2003, p.58). They could refer them to a peer group, where they could experience support from and solidarity with others with similar experiences. Equally they could write a paper to try and raise awareness of the issues involved. Trying to address the power imbalance may be a way in which the more powerful can take responsibility for the lives of the less powerful.

If those in power have some control in the system (for example, as psychologists working on in-patient wards), then recognition of Strawson' point is vital: if we expect people to take responsibility we must make the experience of their new environments as conducive to familiar "reactive attitudes" as possible. Adults used to being treated *as* adults must receive the same in their new surroundings. Condescension, criticism and worse will not provoke responses construed as "responsible". Simply telling people to be more responsible won't help at all.

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