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Abstract: This article examines the extent to which people suffering from major depressive disorder (MDD) should be considered free and morally responsible for their wrongdoings. While moral responsibility literature often deals with delusions and addictions, MDD has not received the attention it deserves. I argue against the view that MDD automatically significantly mitigates (or completely exempts) moral responsibility for wrongdoings. I examine two different approaches to moral responsibility (a control-based theory and a "pluralist"-theory) and suggest that in most cases exemption is not warranted. The first section provides a short overview of the notions of moral responsibility and reactive attitudes. Next, I point out the various effects that depression inflicts on a person's agency and the complexities of assessing how depression might shape our responsibility attitudes toward depressed people. Then, I examine David Shoemaker's account of the moral responsibility of depressed agents. I also examine how a reasons-responsive (control-based) theory of moral responsibility might deal with depressed people. Finally, I argue that, when expressing blame toward depressed people, we need to find a balance between two points. One the one hand, expressions of blame signal to depressed people that they are members of our moral community. This membership is crucial for the development of their agential capacities. On the other hand, depressed people are prone to unjustified self-blame and react strongly to emotionally expressed blame from third parties.

Keywords: Depression, Moral Responsibility, Free Will, Blame.

This article is motivated by the following dilemma. On the one hand, we have good reasons to think that depressed agents have less control over their actions than people who do not suffer from mood disorders. It is well-known that depression tends to make people more akratic and thereby liable to fail to meet normative expectations via neglect and omissions. It seems natural not to hold depressed people responsible when they fail to complete their work assignments on time or neglect the needs of their friends. On the other hand, we have good reasons to think that depressed people are, in fact, responsible for their actions. Most depressed people are capable of moral reasoning and have beliefs about the moral valence of their actions.

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Moreover, depressed people exercise significant control over their actions. Most treatments, like psychotherapies, require a significant contribution from the patients themselves. If depressed people were not in control of their actions, it would be difficult to explain how they can participate in their treatment. So, it seems we have good reasons to exempt depressed people from moral demands and equally good reasons to hold them to moral expectations and duties.

In this article, I look for solutions to this dilemma. I suggest that both horns of the dilemma have something important to say: we should not automatically exempt depressed people from moral responsibility; but we should also acknowledge how various symptoms of depression undermine moral agency. Encountering depression calls philosophers and ethicists to develop more nuanced accounts of responsibility and be more sensitive toward the various contexts where moral responsibility attributions take place.

I begin by outlining a basic notion of moral responsibility and address some challenges that must be faced when considering the responsibility of people with mental disturbances. After that, I examine two theories of moral responsibility and how they deal with depressed agents. I conclude the article by reflecting on the role of desert and forward-looking considerations in grounding blame.

Moral Responsibility

There are two approaches to moral responsibility that I examine in this article. One approach grounds moral responsibility attributions on various capacities that agents possess to express their characters, selves and cares. Another approach seeks to understand moral responsibility in terms of control. To understand these accounts, we need to discuss two issues: the first is about what moral responsibility is, and the second is about what criteria an agent must fulfill to qualify as a morally responsible agent.

Regarding the first issue, many theorists understand the content of moral responsibility in terms of *reactive attitudes*. Following Peter Strawson (2006), holding someone responsible for some action or an attitude consists of considering that agent to be a proper target of various moral attitudes. These attitudes include praise, blame, anger, gratitude, and admiration, for instance (Hieronymi, 2020).

The second issue pertains to the necessary conditions of moral responsibility. Here, we should distinguish between the necessary conditions for morally responsible agency in general and the necessary conditions for the blameworthiness (or praiseworthiness) for some specific action (or an attitude). Oftentimes, relevant criteria have to do with the agent's psychological capacities. But how do we go about determining what capacities are constitutive of a morally responsible agency?

Strawson and others suggest we look for the necessary criteria by examining the kinds of pleas that are ordinarily given for excuses or reasons for exemption in cases of moral wrongdoing. One such plea is the "I did not know"–plea, where the agent admits her ignorance about the moral nature or the consequences of the action in question. Here, the agent claims that she should not be blamed, because she did not have adequate moral knowledge in some particular situation. The "I did not know"–plea suggests that a morally responsible agent must be able to recognize and understand the moral importance of her actions and their consequences. This is often called *knowledge* or *epistemic condition* for moral responsibility. Another important plea is the "I could not help it"–plea. Here, the agent defends herself by suggesting that she should not be blamed for wrongdoing, because she was not in control; she could not avoid committing the wrongdoing. The "I could not help it"–plea points to another condition, *control or freedom condition*. So, a morally responsible agent is an agent that is capable of adequate moral cognition, namely, understanding the moral nature of her actions, and is in possession of a significant amount of freedom of action (sometimes called free will).

Morality is undergirded by many psychological capacities related to moral cognition and action control: empathy, the ability to relate to other people via emotions and embodied practices, moral reflection and deliberation, and executive control, just to mention a few. Symptoms of depression sig-

nal the presence of impairments in many of these mental mechanisms, especially emotional regulation, moral deliberation, and executive control.

We should now examine the distinction between excuses and exemptions a bit more carefully. Strawson uses these notions to shed some light on blameworthiness and moral responsibility (Hieronymi, 2020, pp. 9–10). *Excuses* are reasons given for withdrawing blame, while acknowledging that the agent has indeed committed a wrongdoing. For instance, I might initially be angry toward you for not showing up for a meeting. My anger seems justified, since your failure to show up reveals your disregard for my expectations and interests. However, if it turns out that you were delayed due to a car accident on the way, it is clear that anger is no longer warranted. This would be a case of "I could not help it"–plea. In this sense, excuses are local rather than global: while an agent might have the necessary capacities to qualify as a responsible agent, there is some specific set of circumstances or some specific domain where she is excused from blame. When offering an excuse, the agent is not challenging the normative demands directed toward her, but rather she is saying that she is not blameworthy for the failure to meet them.

Exemptions function differently. According to Strawson, *exemptions* are offered in order to show that some normative demand is not appropriate in the first place. It is inappropriate, because the wrongdoer lacks the prerequisite capacities for responsible agency (Kozuch & McKenna, 2016, p. 92). In the literature on moral responsibility, mental disturbances are often considered reasons for exempting an agent from moral wrongdoing. Strawson (2006, p. 3, pp. 8–9) himself thinks that agents should be exempted from moral responsibility altogether if they suffer from schizophrenia or dementia. In what follows, I suggest that such a blanket exemption in the case of depression is not warranted.

From a Strawsonian point of view, practices of expressing and responding to reactive attitudes are constitutive of our interpersonal relationships. To excuse someone is to continue to relate to that person via reactive attitudes, while constraining them in some cases. To exempt someone is to consider that person to be beyond the pale of a normal human relationship. The person is no longer a proper target for reactive attitudes, but the target of an attitude where the person is an object of treatment and policy, rather than an equal partner of morality (Strawson, 2006, pp. 9–10). We could express this by saying that moral responsibility is a relational phenomenon (Visala, 2021).

I want to highlight one crucial issue to conclude this section. We should avoid black and white conceptualizations of moral agency. Agents usually possess agential capacities to some degree or another and their opportunities to exercise those capacities change from situation to situation. Capacities exist on a wide spectrum, and individual agents can be positioned differently on that scale over their lifetime. Moreover, agents are able to exercise those capacities in different situations to one degree or another (Vargas, 2018). We also need to remember that moral demands and expectations depend on the nature of the relationship. If I am a friend of a depressed person, my moral demands and expectations toward the depressed person are quite different from a clinician or a psychotherapist.

Given all this, it makes little sense to classify depressed people simply as responsible or not responsible at all. We often recognize that reactive attitudes should be mitigated and curbed to some degree given the situation and the capacities of the agent. These judgments are very context sensitive. This complex attitude is vindicated by practice, and we should look for theoretical frameworks that reflect it. The reason why we need a theoretical framework at all has to do with the justification of our attitudes. Clinicians have learned ways of expressing and withholding reactive attitudes in a constructive way in their dealings with depressed people. However, clinicians seldom reflect on the justification of these attitudes: does the depressed person really deserve it or is such an attitude only justified because of pragmatic reasons? I return to these issues in the last section of the article.

Major Depressive Disorder and Moral Responsibility

Before I go on, it is useful to provide a brief overview of the nature and symptoms of the major depressive disorder (MDD)—especially as it pertains to those capacities relevant to moral responsibility. The word 'depression' can refer to a low mood, but I use it in this article to refer to the psychiatric category of MDD. So, I am interested in cases where the person fulfills the diagnostic criteria of MDD. We should also acknowledge the great variety of symptoms and their expression in the diagnostic category. People diagnosed with MDD vary greatly in what symptoms they exhibit and the degree to which they undermine agential capacities. Indeed, two individuals might suffer from MDD and have no symptoms in common. The symptoms also exhibit changes over time: usually the episodes last several months. So, two people could be diagnosed with MDD, while one is going through a depressive episode and the other is not. So, we must be careful in generalizing over MDD patients.

Nevertheless, we must say something general about depression (Rottenberg, 2022). According to *Diagnostic and Statistical Manual of Mental Disorders*, MDD is a syndrome in which low mood lasts longer than two weeks and is accompanied by a number of other symptoms in different combinations (American Psychiatric Association, 2013, pp. 160–161). Cognitive psychologist Aaron Beck is a prominent depression researcher and the developer of one of its important forms of treatment, cognitive-behavioral therapy. Beck and Alford (2009, p. 13) divide the symptoms of depression into four different categories. The first category includes symptoms related to *affect and mood*, such as low mood, inability to experience satisfaction, pleasure, and other positive emotions (anhedonia). The second category consists of *cognitive symptoms*, such as low self-esteem, self-blame, and decision-making problems. The third category of symptoms concerns *motivation*. Lack of willpower, "paralysis of the will" and the inability to control one's own actions are classic symptoms of depression. Finally, depression can be accompanied by a number of *behavioral and physiological* symptoms, such as, avoidant behavior (the person withdraws), insomnia, loss of appetite, fatigue and sexual reluctance.

I want to highlight some of the typical cognitive distortions, as they will be crucial for assessing moral responsibility (Baune, 2021). According to Beck and Alford's (2009, pp. 227–231) cognitive account of depression, the first group of cognitive distortions has to do with how the person interprets her experiences. These interpretations are negatively biased. It is typical, for instance, for people suffering from depression to interpret even small setbacks as insurmountable obstacles. For this reason, they easily form false beliefs about their own competence and potential. The second group of cognitive distortions has to do with the person's self-concept. People suffering from depression easily attribute their failure in a situation to their essentialist, negative character traits. The self-concept is often resistant to change and is strongly negatively colored, leading to feelings of guilt, shame, and inadequacy. Finally, the third group of distorted interpretations consists of beliefs about the future. Oftentimes, depressed people interpret their future in bleak and fatalistic terms. No positive change seems possible.

I mentioned earlier the variety of psychological capacities constitutive of moral agency. We can now see how MDD might affect many of them. Regarding moral deliberation and decision-making, MDD patients often suffer from various cognitive biases that make it difficult to form justified beliefs about their values, future options, and prospects (Baune, 2021). In combination with the lack of motivation, this manifests as indecisiveness and decision-making problems. Many symptoms of MDD point to significant impairments in executive control. Anhedonia constrains the extent to which depressed people feel motivated by emotions. Lack of willpower, or "paralysis of the will," means that depressed people have difficulties in initiating and sustaining long-term goal directed actions. Other symptoms, like avoidance behavior and overall fatigue, make it very difficult for the depressed person to motivate themselves. Initiating and maintaining actions is more difficult than normal, so depressed people cannot resist akrasia very well and often give up on their plans in the face of slight resistance.

All of this suggests that there is no clear-cut relationship between being diagnosed with MDD *per se* and moral responsibility. Matt King and Joshua May (King & May, 2018; May, 2023, pp. 105) make this point well. They construct their argument by contrasting two views, the naïve view and the nuanced view. According to the naïve view (May, 2023, p. 96), "having a mental disorder itself implies something about one's freedom or moral responsibility (and thus blameworthiness or praiseworthiness)." The reasoning behind the naïve view is as follows. It is natural for us to understand moral responsibility in terms of agential capacities. It also seems obvious that mental disorders impair or prohibit the functioning of such agential capacities. So, it is natural to conclude that simply having a mental disorder will impair or prohibit the functioning of agential capacities, which in turn undermines moral responsibility.

Against this, King and May (2018, pp. 18–19) argue for a nuanced view. On this view, there is no connection between mental disorder and moral responsibility. The category of mental disorder is too heterogeneous to allow for a general connection between mental disorders and moral responsibility. This is because the symptoms of mental disorders vary so significantly in terms of severity, timescale, context, and impact on agency.

I think we need to accept the nuanced view at least in the case of MDD, because of the great amount of variation that MDD patients exhibit. First, MDD comes in various degrees of severity: mild, moderate, or severe. Moreover, people diagnosed with MDD vary greatly in what symptoms they exhibit and the degree to which they undermine agential capacities. So, the general diagnosis of MDD does not say much about the actual symptoms or their strength.

Second, the symptoms of MDD are defined in relation to the baseline or "normal" status of the patient, not in relation to some general standard (American Psychiatric Association, 2013, p. 160). It is a fact that there is significant variation between "normal" individuals regarding the degree to which they are proficient at initiating action, exhibiting positive and negative moods and degrees of self-esteem, just to mention a few factors.

Consider executive control in general and the initiation of action in particular. Suppose Frank is normally capable of flexible and efficient action control. He seldom suffers from weakness of will and, overall, he is the kind of person who "gets things done." Now, imagine Mary, whose personality is quite different from Frank's. Mary from time to time suffers from weakness of will and struggles to initiate actions, especially when they involve new things. Both Frank and Mary are "normal" in the sense that the variation they express regarding action control falls within normal distribution of this trait. Both are fully responsible for their actions and omissions.

Suppose now that Frank begins exhibiting symptoms of MDD. These involve impairment in the capacity to initiate actions. The impairment is defined here in terms of the degree of Frank's normal functioning, which is, as we stipulated above, rather high. So, Frank might have MDD, have his capacity to initiate actions impaired and still be capable of initiating actions as well (or even better) than Mary. In other words, Frank's agential capacities are impaired (compared to his baseline), but they nevertheless fall under normal variation. If we stipulate that Mary is a normal and fully responsible agent, I see no reason to exempt or even mitigate Frank's responsibility for an action or an omission caused by his struggles to initiate action. Frank's capacity to initiate action is impaired by MDD for sure, but the impairment does not damage the capacity to the extent that would justify exemption or excuse. After all, Frank is able to control her actions as well as Mary and we consider Mary a fully responsible agent.

Although the nuanced view is obviously correct about MDD, it is still the case that people with MDD exhibit similar patterns of cognitive and behavioral impairment. It is not the membership of the MDD category *per se* that makes a person less responsible, but rather the impact of depression on the person's moral capacities at a given time. So, being diagnosed with MDD says very little about the extent to which the person should be considered morally responsible. However, people diagnosed with MDD exhibit patterns of thought and behavior that signify some impairments of moral agency, which could be considered as reasons for holding depressed people less blameworthy in some situations.

MDD and Moral Responsibility Pluralism

I suggested above that our moral responsibility intuitions are divided in cases of MDD. Pluralist theories of moral responsibility seek to explain this vacillation by postulating various types of moral responsibility attitudes that target different aspects of moral agency (Jeppson, 2022). So, our fluctuating intuitions toward marginal and impaired agents might reveal how our responsibility attitudes actually work. David Shoemaker's three-partite theory of moral responsibility (2015) is inspired by the work of Gary Watson (2004) and Peter Strawson (2006). Shoemaker's account consists of three kinds of responsibility, which target different features of the agent's capacities: 1) character (*attributability*), 2) judgment (*answerability*), and 3) regard (*accountability*).

Let us begin with attributability. When an agent acts, her actions may fall under a specific pattern. When an agent acts consistently across some circumstances, we might say the agent has a certain character trait or feature. An agent can be, for instance, trustworthy, honorable, courageous or cowardly. According to Shoemaker (2015, pp. 48–49), some of our responsibility attitudes target the character of an acting agent. He understands characters in a rather permissive way: it includes the cares and commitments of the agent as well as her patterns of action. If an agent has a certain good moral quality, we might respond to that with admiration. However, bad moral qualities are often met with disdain. When we can attribute the agent's action to her moral character, the agent becomes an apt target of disdain and admiration.

Shoemaker argues that we should mitigate or exempt depressed agents from attributability responsibility. The reason is that most depressed agents have difficulties in initiating actions and following through. It is quite typical that depressed agents fail to clean up their home or even fail to take care of their personal hygiene. These failures do not point to not caring about personal hygiene, but rather to the difficulty of initiating actions. Attributing a bad character and bad attitudes to a depressed agent in such a situation is unwarranted. The apparent vice of laziness or inadequate care for norms and expectations are not expressed in her behavior. Her actions might not be in line with her cares and valuations, because the underlying depressive disorder makes her tired and unmotivated (Shoemaker, 2015, p. 127). Therefore, we should not respond to the depressed agent's uncleanliness by attributing character vices to her.

Another kind of responsibility targets the agent's moral reasoning and moral judgment. Here, the target is the way in which the agent conducts her moral thinking and judgment in relation to normative standards. Shoemaker calls this *answerability* responsibility and discusses it from a first-person perspective. This kind of moral responsibility targets, for the most part, the agent's attitudes that lead to action. Specifically, the target is the extent to which the agent's attitudes are in line with her moral judgments. Moral judgments of this kind can be more successful or less so. When the agent evaluates her attitudes and actions in some circumstances, she might realize that they are appropriate and correspond to her values. The response to valid moral judgments from a first-person perspective is typically pride. Furthermore, if an agent fails to consider her actions and attitudes properly, she might respond to this with regret ("how stupid of me to do that"). Answerability requires that the agent could have accessed better moral reasons and drawn better conclusions than she did.

Shoemaker (2015, p. 129) deals with answerability responsibility and depression only in one footnote, where he concludes that sometimes depressed people can make judgments about "instead of" reasons and sometimes they cannot. Answerability warrants more discussion, but I do not have the space to engage with it here. Suffice it to say that I think it is quite typical of philosophers to disregard the cognitive effects of MDD that impact the person's ability to reason. I already pointed out how some of the cognitive effects of depression might lead to misjudgments about what the person finds valuable. This could widen the gap between the person's moral judgments and her moral attitudes leading to feelings of shame. So, it is quite likely that we should somewhat mitigate our answerability demands with respect to people with MDD.

Finally, the third type of responsibility is the most demanding one, *accountability*. Shoemaker understands accountability as the act of holding the agent to account for her actions, usually by way of blame and relevant emotions, like agentive anger or resentment. In this sense, accountability is a form of confrontation (unlike attributability and answerability). We could even understand accountability as a kind of emotional communication whereby one party communicates to the other by way of blame and anger (in negative cases) and demands a response (McKenna, 2012).

The target of accountability responsibility is the agent's capacity to consider the interests and cares of others; the regard the agent's actions express toward others. In Strawsonian terms, the target is the "quality of the will" the agent directs toward others. Ill will or indifference can be met with anger and good will with gratitude. According to Shoemaker, expressing one's will in action might require various capacities, first and foremost empathy. First, there is the capacity for the kind of intellectual or moral empathy, whereby the agent mentally puts herself in the position of the other agent. This allows the agent to consider how things look like from her point of view—especially from the point of view of her normative reasons and demands. Second, there is the more emotional side of empathy, by which the agent is susceptible to feeling what others are feeling and reacting to that.

According to Shoemaker, it is likely justified to hold depressed agents accountable for their actions. This is because MDD seems to keep empathy mostly intact:

> many depressed people are, surprisingly, quite able to empathize with others, often at normal levels, and sometimes at elevated levels. . . . their empathy (and subsequent regard) is both evaluational and emotional: they fully recognize, feel, and appreciate the pain of others, say, and the pain of others both seems to be a reason to resolve it and is something they typically go on to judge to be a reason of significant worth. The tripartite theory would thus seem to predict that they are eligible for accountability and fitting agential anger. (Shoemaker, 2015, pp. 126–127)

It seems that many depressed agents are capable of taking into account the cares and interests of others. Indeed, it is typical of depressed agents to obsess about imagined failures to live up to the standards and expectations of others. Many depressed people believe they have let other people (and themselves) down. This gives rise to one of the most common symptoms of depression, self-blame. All this indicates that although depressed agents might be wrong about failing others, they clearly have the basic capacity to respond to the expectations of others and imaginatively put themselves in the position of others. According to Shoemaker's account, this will secure basic accountability.

Given the above, it seems that most depressed agents would be apt targets of agential anger and related attitudes. However, this seems like the wrong result. At least some of our intuitions support the belief that depressed agents *should* be exempted from agential anger. If this is correct, there might be something wrong with Shoemaker's theory. Shoemaker's solution is to argue that there might be something wrong with the emotional side of empathy in the case of MDD agents. Although depressed agents might be able to intellectually empathize with others, they might have problems with emotional empathy, feeling the emotions of others. This is because one central symptom of depression is anhedonia (or apathy). Because of this, it might be that the suffering of others will not move depressed agents emotionally. This could leave intellectual empathy intact but severely limit the ability of depressed agents to generate motivations to act on behalf of others. Such impairments might not be grounds strong enough to exempt the depressed agent from accountability, but they might, nonetheless, offer enough reason to consider some sort of excuse.

Let's run a test case to evaluate the plausibility of this. Suppose John is my friend, who suffers from medium MDD. Normally, John is reliable and expresses adequate regard for me. We agree to meet at a specific time to work on a joint project, which is particularly important to my career. This time, however, John fails to show up, I fail to finish the project in time, and this causes me significant trouble. All this makes me angry with John. I go

on to confront him about this and he points to his depression as a reason for not showing up. Now, is John offering his depression as an excuse or an exemption? John's response hardly qualifies as a plea for exemption. There is nothing about MDD that would completely undermine John's capacity for empathy and understanding what it means to make promises, why it is good to keep them and the consequences to me, if I fail to finish the project on time. So, I do not see enough grounds for exemption.

Maybe there are enough grounds to excuse John or at least mitigate our responses. In the case of excuses, I am right in expecting John to show up and contribute as he has promised, and John recognizes this. However, the problem is not John's lack of regard, but rather his inability to act on it. My demand for John is justified, but I should not be too angry if he fails to live up to it. This is due to his difficulty in initiating actions and his apathetic situation: John's lack of emotional empathy means that he has very little emotional resources to draw on to motivate himself and muster enough willpower to overcome his fatigue. It follows from this that while I should hold John accountable for his failure and acknowledge it as morally wrong, I should, nonetheless, adjust my anger toward him. However, some anger might still be appropriate. John could have recognized his situation and not made the promise to help in the first place. Moreover, John's reaction to his not showing up will also make a difference: will John recognize his mistake or claim that he need not keep his promises? All these factors should factor into the potential justification of my anger.

To summarize, Shoemaker's theory supports my overall claim that blanket exemption is not warranted in the case of MDD. In terms of attributability, Shoemaker argues we should exempt or mitigate our responses toward people with MDD. He also suggests that people with MDD should probably mitigate their responses of answerability toward themselves. Finally, the depressed person's ability to act accountably is also impaired to some extent, but this does not justify complete exemption.

Control and MDD

In their joint article, Benjamin Kozuch and Michael McKenna (2016) assess the moral responsibility of agents suffering from mental illness in the light of a control-theory of moral responsibility. Their main argument is that the mere fact that a person suffers from a mental disorder, by itself, does nothing to show that the person is also suffering from a significant lack of control, which would undermine moral responsibility. The causal sources of the person's action might be affected by depressive symptoms, but the person could still retain a significant degree of control over her actions to ground responsibility attitudes. So, whether the degree of control is high enough to ground moral responsibility attributions must be determined on a case-by-case basis. However, they seem to imply that in many cases MDD patients do have enough control to be considered morally responsible for their actions and attitudes.

Kozuch and McKenna (2016, p. 92) focus on accountability responsibility and argue that control is a necessary criterion for justified confrontation, blame and (perhaps) punishment. We must now look more carefully at the notion of control at play here. Control is cashed out in terms of *reasons-responsiveness* (Fischer & Ravizza, 1998). The core notion of reasons-responsiveness is that

> When an agent acts freely, she acts from causal sources that are sensitive to reasons. To put it a bit more precisely, she acts from causal sources that are expressive of her sensitivity to reasons. (Kozuch & McKenna, 2016, pp. 98–99)

The notion is designed to distinguish morally responsible agents from non-responsible agents: responsible agents are responsive to moral reasons and are able to guide their actions in their light.

McKenna and Kozuch illustrate reasons-responsive control with a case of obsessive–compulsive disorder. Suppose that Ann and Beth have muddy hands. Both have a good reason to wash their hands. Beth washes her hands, because she has a good reason to do so, whereas Ann is suffering from a compulsion to wash her hands. Instead of acting for a reason, Ann washes her hands due to the compulsion. There could be all sorts of reasons and circumstances that lead Beth to have

good reasons to wash her hands. If such reasons are present, Beth will wash her hands. However, that does not apply to Ann: her hand washing is not responsive to reasons. She will wash her hands whether she has good reasons or not.

According to the reasons-responsive theory, responsiveness comes in degrees and is domain-specific. Ann might be responsive to reasons to a low degree in some particular domain. If the reason not to wash her hands is strong enough, like a threat to her life, Ann might be able to abstain from washing her hands. Conversely, Beth might not be optimally or fully responsive to reasons: there might be some circumstances where Beth also washes her hands without a good reason. No human agent is always perfectly or fully responsive to reasons. So, the control over action that reasons-responsiveness provides is best seen as a matter of degree. Consequently, we need a way to specify the required threshold of responsiveness for responsibility.

To specify more carefully the different aspects of responsiveness, Kozuch and McKenna distinguish between receptivity and reactivity. The agent is *receptive* to reasons insofar as she is capable of recognizing relevant reasons for action. *Reactivity*, on the other hand, refers to the agent's capacity to act on the basis of her reasons. Like receptivity, reactivity comes in degrees as well. Fischer himself does not offer extensive treatment of mental disorders. However, he seems to associate failures of reasons-receptivity with disorders that produce delusional or otherwise disordered beliefs (Fischer & Ravizza, 1998, pp. 41–42). In such states, a person's capacity to recognize good reasons is severely impaired. Moreover, he associates the lack of proper reactivity with disorders of volition and action control, like phobias and compulsions.

So, if we assume the reasons-responsive account of moral responsibility, we look for the effects of MDD on reasons-receptivity and reasons-reactivity. Kozuch and McKenna offer a number of suggestions. Consider a depressed patient. They (2016, p. 104) hold that depression

> is liable to affect her motivation, and so her ability to form intentions that align with what she judges best to do. It is also likely to affect her deliberations, since her ability to assess others and her environment, as well as her own needs, will be colored by her negative outlook. Hence, it will also affect her ability to judge what it is best to do. As such, it is liable to affect both one's reasons-receptivity and her reasons-reactivity.

Receptivity might be undermined by cognitive distortions related to value judgments and false beliefs about the agent's own possibilities and abilities. Reactivity, on the other hand, could be undermined by symptoms that have to do with impaired action control.

To highlight some of the effects that MDD might have on moral agency, let us consider a prototypical case of decision-making and action. Kozuch and McKenna (2016, pp. 101–102) distinguish between different component parts of a conscious decision-making process leading to action:

> Deliberation usually begins from a situation where the agent is (a) uncertain about what she should do. This triggers a (b) process of deliberation, where (c) reasons begin to occur in the agent's mind. With at least some reasons present in the agent's consciousness, she begins the (d) process of practical reasoning, which consists of conscious weighing of reasons and values leading to a conclusion about what the agent should do. Typically, there is also some measure of (e) motivational conflict. The desires and preferences of the agent might not be in line with the conclusion of her practical reasoning. She is tempted to act against what she considers to be the best course of action. This temptation might be resisted (f) with willpower and self-control. If this is successful, the agent (g) forms an intention and sets her will. Finally, she (h) controls her body and other features of the environment in order to act out the intention.

Let us now consider how the various symptoms of depression might interfere with the component parts outlined above. First, I highlighted several cognitive biases that are symptomatic of MDD. These might shape (c) and (d) parts of decision-making in various ways. Given negatively colored future expectations and low self-confidence, the depressed person might easily evaluate her possibilities of success as lower than they are. The cognitive biases might also lead the agent to draw wrong conclusions about what she values. The

depressed agent might, for instance, easily end up disvaluing some personal relationship that she would otherwise value highly. Moreover, the negatively biased attention of the agent might also shape her ability to identify and process reasons in the first place.

Many symptoms of MDD have to do with implementing and controlling actions. Typically, the depressed agent feels that she knows what she should do but nevertheless lacks the willpower and resolve to get going and actually do it. This gap between action and practical reasoning is often experienced as a significant source of shame and self-blame. These symptoms might undermine parts (f), (g), and (h) of the process. Although the depressed agent might form a firm intention, her inability to initiate action might prevent her undertaking the appropriate action or to easily give up at the sight of even the slightest obstacle.

Let me illustrate these effects by returning to the case of John, who failed, despite his promise to help me with my project. Suppose that John is suffering from mild or medium MDD, which impairs his receptivity and reactivity. Despite the impairments, John knows that not helping me with my project and failing his promise are wrong. John also recognizes the effects of my failure to finish the project on time for me. We should conclude that John is still responsive to a wide range of reasons to act, so a complete exemption does not seem justified. Nonetheless, the symptoms of MDD might constitute a good reason for mitigating the blame we should direct toward John because of his failure.

Suppose now that depressive symptoms undermine his reasons-receptivity. Cognitive biases cause John to disvalue his friendship with me. Typical reasoning might go something like this: "Aku does not even like me that much, so why should I bother helping him." Without the negative bias, John would not misjudge my evaluation of him as a friend. Consequently, John's ability to reason about the value of our friendship would be diminished. Moreover, depressive symptoms are also undermining John's capacity for reasons-reactivity. Given the fact that the project we are supposed to be doing together is rather tedious and requires willpower and grit, John's cognitive distortions lead him to judge the effort needed much greater than what is needed. This will lead him to be less motivated to engage in helping behavior.

All the above suggests that John's degree of reasons-responsiveness is lower than it would normally be in his case. Compared with his baseline, MDD causes him to lose some degree of control over his actions. However, I already noted above that the fact that John's degree of control is lower than normal does not mean that John should be exempted or that his degree of control automatically offers good grounds for excusing him. In other words, MDD lowers degree of control compared with the person's baseline, but it does not follow that the person should be exempted from responsibility or excused from blame automatically. Instead, we must evaluate John's responsiveness considering some general standards. However, establishing this general standard will be difficult for reasons-responsive theories. As Kozuch and McKenna (2016, pp. 105–106) argue, there could be individuals, who in their normal condition exhibit the same degree of reasons-responsiveness as John with his MDD.

What Kind of Blame and Why?

We can now summarize the discussions above in terms of a simple lesson. While the diagnosis of MDD says very little about the person's moral responsibility, many typical symptoms of MDD indeed undermine the person's moral agency. However, the theories examined do not support complete exemption but rather suggest that we mitigate our blaming responses when depressed people fail to live up to moral standards and expectations.

In this section, I want to focus more carefully on the issue of blameworthiness and its grounds. The first issue pertains to the grounds of blame and the second to its nature. Let us start with the grounds of blame.

Depressed people are often in a vulnerable position: they struggle with their life as their symptoms undermine their ability to think and act. We must think very carefully about whether our treatment of depressed people is fair and whether it will help them to deal with their symptoms. So, we have two

broad grounding reasons to consider: the fairness of blame and the usefulness of blame. The theories I outlined in the previous sections were mainly interested in the issue of fairness: do depressed people deserve to be blamed for their wrongdoings? If it turned out that depressed agents could not fulfill many of the normative expectations that apply to non-depressed agents, it would be unjust and unfair to blame or punish them for their wrongdoings.

There are other ways to ground responsibility and blame than considerations of desert and fairness. We often ground our blaming and punishing practices by invoking the forward-looking effects of these practices. In the case of mental disorders in general and depression in particular, these effects of holding someone blameworthy are particularly significant considerations. As I highlighted earlier, reactive attitudes are constitutive of our interpersonal relationships. If we withhold those attitudes, we are bound to relate to the target person very differently, more like an object than a subject. Kozuch and McKenna (2016, pp. 94) write:

> To exempt someone because of mental illness, it would seem, is to deny that the person is a participant in the system of morality within which adult humans normally participate. As has been pointed out (---references omitted---), this risks robbing the person of both their dignity and autonomy, and stands to undermine their effectiveness as moral agents, perhaps running contrary to therapeutic goals.

The worry is this. I have already suggested that the symptoms of depression undermine agency in different ways. So, the therapeutic goal would be enhancing the agency, not undercutting it. If we exempt the depressed agent from moral responsibility, we actually might be diminishing her chances of retaining her agency.

The core assumption behind this reasoning is that holding someone morally responsible and including that person in our moral community are crucial for building up her agency. Indeed, one could even argue that a person needs to be included in the circle of moral treatment in order to develop the capacities necessary for moral responsibility in the first place (Vargas, 2013). If we exempt the depressed agent from moral responsibility, we give up on the normative demands and cease to direct reactive attitudes toward her. Instead of seeing that person as an equal and rational conversation partner, we adopt what Strawson calls an objective attitude toward her. Strawson (2005, pp. 9–10) writes: "To adopt the objective attitude to another human being is to see him, perhaps, as an object of social policy; as a subject for what, in a wide range of sense, might be called treatment." When a person is targeted by an objective attitude, that person is no longer considered a participant in normal moral relationships. We might be tempted to see the person's expression of will and reason not as outputs of rational agency, but rather as symptoms due to underlying disorder or illness. When a person is dehumanized in this way, her cares, wants and reasons do not have the same kind of weight as ours and elicit no rational response from us. The objectified agent is not an equal partner of rational exchange, but rather a mechanism to be adjusted, controlled, and fixed. The dehumanization of mental health patients has not been rare in Western tradition (Pietikäinen, 2015). We know how detrimental it is to the individuals in question (not to mention wrong), so we should avoid it as much as possible.

On the other hand, forward-looking considerations also weigh heavily on the side of excusing or mitigating depressed people from blame. We must be particularly careful with blame in the case of MDD. This is because depressed agents often have low self-esteem and unjustified guilt and shame. This is why depressed people are typically very sensitive to negative information about the self and easily disregard the positive, thereby propping up their negative self-concept even further. Given that we want to avoid this, we should carefully adjust our expressions of blame.

So, it seems that with respect to forward-looking considerations we must weigh between two different goods. On the one hand, holding someone accountable and expressing blame will signify their membership in our moral community, which will help the person to develop and foster her agential capacities. On the other hand, expressions of blame might be inappropriate in cases of MDD, since people suffering from this disorder are struggling with self-blame already.

To highlight the difficult balance between desert considerations and forward-looking considerations, I want to look at a debate between two accounts of blame that draw from psychiatric clinical practice. These accounts are formulated by philosophers but are based on interviews with clinical staff. Unfortunately for me, neither account draws from clinicians working on depression. Rather, the first account draws from clinicians working with personality disorders, and the second from autistic patients.

The first account, *the clinical stance*, is by Hanna Pickard (2013). Her basic contention is that mental health patients should not be exempted from moral responsibility. Indeed, holding people morally responsible is essential for personalizing and humanizing treatment. However, emotionally loaded blame, like anger and emotional blame, are neither appropriate nor useful in fostering the agency of mental health patients. Therefore, she outlines a moral responsibility attitude, the clinical stance, where patients are held accountable for the harm that they cause, but without emotionally charged blame and anger.

Pickard points out that the counter-therapeutic effects of anger and blame are well known. Not only does emotionally charged blame undermine the therapeutic relationship, but it also undermines the agential capacities of the patient. To solve the problem, Pickard (2013, pp. 1139–1140) distinguishes between basic moral responsibility and blame. Holding someone responsible should not automatically include, she argues, moralizing attitudes, like anger and blame. Indeed, she sees this as a more general problem for Strawsonian theories, like that of Shoemaker: they identify responsibility with the appropriateness of reactive attitudes. Against this, Pickard argues that mental health patients deserve moral treatment, because they are agents with sufficient control over their actions. However, due to their mental problems, they might not be appropriate targets of certain kinds of blaming responses.

Pickard (2013, pp. 1145) outlines a form of detached blame that does not seek to produce in its target "the sting of blame." The sting of blame is the negative emotion that standard, emotionally charged blame is meant to produce. Holding a person responsible for wrongdoing can proceed without the intention of causing this emotional effect. It might involve something like pointing out the wrongdoing, making clear the harm that the wrongdoing causes, and administering the appropriate punishment.

Daphne Brandenburg (2017; Brandenburg & Strijbos, 2020) has developed an alternative to Pickard's account. She points out that basic desert grounding is necessary for Pickard's clinical stance. Against this, she (Brandenburg & Strijbos, 2020, pp. 382) advocates a kind of agnosticism about basic desert, but claims that we should hold mental health patients blameworthy, because of forward-looking considerations. In the *nurturing 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 & Strijbos, 2020, p. 384). Here, the suggestion is that mental health patients might deserve an exemption from blame. However, we should treat the patients blameworthy to some extent anyway, because the treatment will help them to develop toward fully responsible agents.

Brandenburg also challenges Pickard's suggestion that anger and blame automatically challenge the therapeutic relationship. She (Brandenburg & Strijbos, 2020, p. 385) writes: "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. . . . having some such negative affective response to harmful conduct toward others shows involvement with the service user as opposed to detachment." So, Brandenburg suggests that emotional responses can also communicate engagement and respect toward the wrongdoer.

I want to conclude this section by reflecting on the issue of the variety of different relationships. When we see moral responsibility as a way of relating to one another, we see that different relationships might have different normative expectations and demands. The demands and expectations of friendship are different than those of a therapeutic relationship. For instance, it might be prudent for a mental health professional to take into account the fact that certain forms of blame might jeop-

ardize the relationship with a depressed patient. Both Pickard and Brandenburg discuss the issue in the context of clinical relationships, and they seek to develop a form of blame that is applicable in those circumstances. However, the demands and expectations of friendship or the relationship between coworkers might be different from clinical relationships. In clinical relationships, a certain professionalism is appropriate. Expressions of blame and anger might jeopardize a clinical relationship much easier than, say, friendship or a relationship with a relative. So, the extent to which we should consider a depressed agent as a proper target of moral responsibility attitudes will depend on the context as well as the status of the person holding the depressed person responsible. The focus on the forward-looking considerations about the benefits and harms of blame brings the interpersonal relationships in question to the fore.

Objections and Concluding Reflections

I have suggested in this article that we have no good reason to automatically exempt MDD patients from moral responsibility. Although MDD patients often exhibit patterns of impaired moral cognition and executive control, we cannot jump from this fact to the conclusion of blanket exemption. Instead, I have suggested a more nuanced approach, where we consider the individual patient and her context. It might be more appropriate to hold the depressed person less blameworthy than she normally is without exempting her from responsibility altogether. Indeed, I have highlighted exclusion and dehumanization as potential dangers of blanket exemption.

In this section, I consider some objections to my argument. One objection is this. From the point of view of many or most MDD patients, it appears that their capacities to control their actions are significantly impaired. Given that MDD patients feel that they are not free and qualified to carry moral responsibility, we should exempt them from moral responsibility.

This counterargument can be supported by phenomenological considerations. For instance, Matthew Ratcliffe (2013, 2015) has provided an insightful analysis of the phenomenology of depressive experiences. According to Ratcliffe, depressed people often lack the experience of alternative possibilities in their environment. In depression, the person might intellectually acknowledge the value and meaning of some object or a goal but nevertheless lack the "feeling" of significance of that object or a goal. There is no felt attraction toward a goal or an object, so the depressed person has great difficulties in representing alternative possibilities for action. Anastasia Scrutton (2012, 2018) has used Ratcliffe's analysis to argue that depression significantly lowers the degree to which a person has free will. If a person feels that she is not free, we can take this as evidence that she is not, in fact, free. Given that the depressed person has no free will or has her free will constrained to a significant degree, we should not hold her morally responsible.

I have two responses to this line of reasoning. First, I agree with Scrutton that we should normally take a person's experience of freedom as evidence of their freedom and vice versa. However, we have reasons to be careful with this in the case of MDD. This is because the person suffering from MDD is prone to various cognitive biases and unreliable interpretations of her own capacities and abilities. The depressed person's experience of her inability to act does not necessarily reflect her actual situation. She might feel that there are no possibilities for action and that her actions have no significance, but these feelings could very well be caused by her underlying cognitive biases. So, there might be meaningful and significant opportunities available to the person even while the person might easily disregard them.

Second, I also want to point out that, although Ratcliffe's phenomenological analysis is insightful, it is far from being a total description of the depressed person's phenomenology. I do not think that Ratcliffe means to say that depressed people *always* feel a *complete* lack of unfreedom. Rather, he seeks to describe typical and distinct features of depressive phenomenology, which change from time to time. If a person always and all the time experiences a complete lack of meaning and potential for action, an exemption would be warranted. But Ratcliffe's analysis does not establish this. So,

I do not think that his account gives a reason for blanket exemption.

The second objection to my conclusion has to do with its potential detrimental effects on the depressed person herself. If it is the case, as I suggest, that at least some depressed people retain their capacities of moral agency and thereby qualify as morally responsible agents, it seems to follow that they are to some extent blameworthy for their condition. In other words, if a depressed person qualifies as a morally responsible agent, her attitudes, emotions, moods and actions are under her control, which means that she could be blamed for not controlling them. This is Scrutton's worry, which leads her to reject voluntaristic accounts of depression (2018). It would be counterproductive and unfair to blame the depressed person for her depression.

I agree with Scrutton on this point. I am very sensitive to this worry, but I do not think that blanket exemption is a good solution to the problem. If we say that the depressed person has no control over her moods, emotions and actions, we are saying that there is nothing she can do to change them. This is very counterproductive in terms of treatment, and it is false. There are courses of action available to her, and she does have control. Because the depressed person's moral agency is to some extent intact, she can exercise control over her symptoms to some degree. However, she is not blameworthy for failing to control those symptoms, because the cognitive and physiological effects of depression make successful control very difficult. So, instead of an exemption from the demand to exercise relevant control over her moods and actions, we consider her excused from blameworthiness—or at least moderate our blaming responses.

Let us examine what this would mean from a first-person perspective. Suppose I am suffering from depression that includes excessive self-blame, guilt, and shame. Not only do I feel that I constantly fail to live up to common moral standards, but I also feel that I am to be blamed for being depressed in the first place. I carry a kind of double guilt. A blanket exemption means that I should no longer hold myself to the same moral standards as others. This would absolve me from self-blame. Against this, I have argued that the depressed person should hold herself to account for the same moral standards as others. This seems to leave the door open for self-blame, as Scrutton points out. However, I would suggest that the difficulty of managing one's actions and moods when depressed should provide an excuse (not an exemption) for the failure to satisfy moral standards. So, as a depressed person I should not exempt myself globally from moral expectations but rather excuse myself from blame, when I fail to meet moral standards (by the same time acknowledging that I am subject to the standard). I understand that this distinction is subtle, but I think it is important.

To conclude, I want to reflect upon the limitations of general theories of moral responsibility in dealing with difficult cases, like MDD. General theories of moral responsibility are designed to explain our responsibility intuitions and practices. However, in cases of MDD and other mental disorders the intuitions and practices are unstable, context dependent, and varied. This makes the theories rather blunt instruments when we consider real-life cases. Similarly, empirical results about the cognition and emotion of MDD patients are constantly changing. These reasons might give us reasons to be somewhat skeptical of whether the results of any general theory are reliable in cases of MDD.

This conclusion should lead us to assign higher weight to forward-looking considerations than backward looking, desert considerations in judging the appropriateness of blame. Attempting to decide which theory of moral responsibility is the best and then applying it to MDD might be very difficult. It might be easier to come to an agreement about the potential benefits and harms of blaming practices. This is why I find Brandenburg's nurturing stance rather attractive in MDD: it offers us good reasons to hold depressed agents blameworthy in a certain way, while remaining agnostic about desert. More work is needed to develop this idea further.

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