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In her commentary, Kennett helpfully reiterates Pickard's criticism of Strawsonian theories of blame (Kennett, 2020). Angry forms of blame like resentment are, according to Pickard, characterized by a sense of entitlement and are counterproductive to therapy. Some disagree that entitlement is a necessary condition for emotional blame, but also more permissive understandings of Strawsonian emotional blame have been considered inappropriate and counterproductive *in* a therapeutic relationship and *on* a psychiatric ward.

We proposed to bracket definitional issues about the meaning of emotional blame and instead looked at the possible therapeutic role of negative affect in clinical settings. Our paper conceptualizes nurturing reproach as therapeutic expression of negative affective responses to service users. A further conceptual question is whether these forms of reproach can ever be described as blaming or can be responses that track blameworthy persons (Brandenburg, 2019). In our interviews the clinicians insisted that they were not. Indeed, nurturing reproach seems to be quite distinct from Strawsonian reactive attitudes as they are defined by Pickard, Kennett, and others. Yet, some of its justification resonates with the Strawsonian story; congruence, recognition, and arguably the fostering of agency, are values that are also central to his participant stance and are provided as justifications for blaming (Strawson, 2008). Yet, these values are arrived at via other means than expressions of blame.

Another way in which nurturing reproach differs from the Strawsonian story is in its appropriateness towards persons who do not (yet) have sufficient control and understanding to be considered blameworthy for harm. Reproach can be appropriate towards agents who are yet to acquire the understanding and control that is needed for regulating their own behaviors and carrying full responsibility. We, for example, express such reproachful affect towards young children as well. This observation is not made to compare service users to children. What it suggests is that negative affect can nurture agency when a person's agency falls below the threshold deemed necessary for responsibility and blameworthiness for harm.

It is an open question whether a similar distinction can be made between our and Pickard's approach. As Kennett pointed out, our approach has a different starting point. When engaged in nurturing reproach, one does not attribute blameworthiness due to doubt about their level of agency with regards to the transgression. In contrast, Pickard maintains that service users with addiction or borderline personality disorder, typically have sufficient agency (Pickard, 2013). They have choice and control and are therefore responsible for harm. But, on her account, this is not to say they are always *also* blameworthy for harm and most certainly does not render blame an appropriate response.

It may be that there are differences in the levels of agency within the patient populations that in-

formed these two approaches. Nurturing reproach may be appropriate for persons who are not yet (fully) responsible for harm, whereas the clinical stance tracks persons who *are* responsible for harm. Another possible explanation for this difference is conceptual disagreement about the level of agency that suffices for being responsible for harm. The threshold of agency required for being responsible and blameworthy is both vague and contested. What matters for practical purposes is that a nurturing stance is not only distinct from emotional blame but also suspends more cognitive attributions of blameworthiness entirely.

As Kennett suggests, the interesting and as of yet unanswered next question is: what renders the different therapeutic approaches appropriate for particular persons in particular contexts? We spend quite some time on discussing the particular commitments of the service user as one possible indication for using one approach over another. Kennett rightly points out that responsibility without blame is employed in treatment programs that both the service user and clinician are committed to. Why then did we spend some time exploring this? Some clarification is in order.

First, we do not believe that either of these two therapeutic approaches should be conceived as belonging specifically to one or other particular treatment program. Rather, our bet is there will be a place for both in most programs, depending on the characteristics of the person, and the specific situation at hand. For example, the patients Pickard discusses are committed to a treatment program, but their commitment may waver throughout the program itself. She points out that patients may—as she calls it—lack "the will to recover" (Pearce & Pickard, 2010). A person's will to recover may be (momentarily) absent due to reasons like, a lack of hope for a better future, a lack of trust in the help that one is offered, or a lack of self-confidence. We suggest that *when* these reasons explain why a person transgresses a norm within a treatment program, a clinical stance may, whereas nurturing reproach may not be a helpful response.

Second, situations where the patient's commitment is at stake are interesting for our purposes, because it addresses responsibility at a slightly different level: not (merely) directed at the norm transgressing behavior, but (also) at the patient's *attitude towards* that behavior. We wanted to explore whether this difference might shed light on the appropriateness of detached blame versus nurturing reproach in therapeutic contexts: even in the case a patient is not considered blameworthy for the norm transgressing behavior, she may still be held responsible for her lack of commitment towards therapy. This responsibility might render detached blame the more appropriate response.

All this is informed speculation, of course. Kennett is surely right that there are other possible explanations. Her additional hypothesis about (self-)stigma is an interesting line of further enquiry. She writes that stigmatized persons with addiction and personality disorder carry a high burden of shame and self-hatred. She, furthermore, rightly points out that the intense fluctuating emotions and intensely negative self-talk characteristic of Borderline Personality disorder makes these patients very sensitive and vulnerable to expressions of affective reproach, even in mild form. This would indicate that they may not benefit from nurturing reproach—it may in fact be harmful (Kennett, 2020).

We agree that these considerations are central to determining the appropriateness of the two therapeutic responses. But although diagnostic features can give us some direction here, we are wary of generalizing on the basis of *Diagnostic and Statistical Manual of Mental Disorders* diagnoses alone. People with autism spectrum disorder too are often subject of stigma, and can also experience severe emotion regulation problems, extreme negative self-talk and hypersensitivity to mild expressions of negative affect. It is worth pointing out that many of service users the interviewed clinicians worked with were misdiagnosed with borderline personality disorder in the past and/or had a history of trauma and addiction problems. It is the specific *kind* of hyper- or hyposensitivities, mentalization problems, and interpersonal difficulties that matters. *Diagnostic and Statistical Manual of Mental Disorders* diagnoses can be informative, but the psychology, phenomenology, background and biography of the individual service user give us much more to go by.

The adage "when you've met one person with autism, you've met one person with autism" seems appropriate here (Shore, 2018). Service user's experiences of growth and recovery are a rich and untapped resource that is essential for further research. Essential because predictions and anticipations that are made on the basis of a diagnosis alone are not reliable.

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