RESTORATIVE PRACTICE AND SPECIAL NEEDS

2022

MARGARET THORSBORNE

1

GREETINGS FROM AUSTRALIA

Acknowledgement of Country

2

PROBLEMS WITH POLICY?

- Punishment doesn't teach new skills
- Definition of *fairness* = all children treated the same way?
- Ignorance about disabilities
- Poor communication with staff around a student's particular needs
- Inaccurate diagnosis
- Lack of support for staff who have to manage these issues
- Failure to act in a pro-active way to prevent issues from arising

3

THE DILEMMA

If Jane doesn't know…

how to read… we *teach* her

how to swim… we *teach* her

how to solve an equation… we *teach* her

how to construct an essay… we *teach* her

OR

how to behave…

how to be honest…

how to get along with others…

how to be considerate, thoughtful…

how to deal appropriately with strong emotions…

we're supposed to ……. *punish* her? What about consequences?

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4

Adapted by George, 2016, from Tom Herner, 1982

4

5

SKILLS THAT FOSTER THE BETTER SIDE OF HUMAN NATURE

Ross Greene, 2019

Ross Greene, 2019

- **Empathy**
- **Appreciating how one's behavior affects others**
- **Resolving disagreements without violence (conflict competence)**
- **Taking another's perspective**
- **Honesty**

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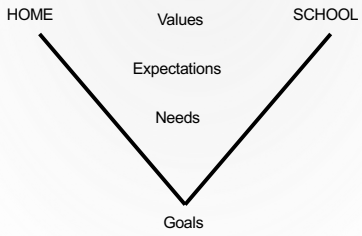
5

Language	**Behaviour Management**	**Behaviour Development**
Misbehaviour is……	An obstacle to learning	An opportunity for learning
Main Theory	Behaviourism – carrots and sticks	Humanistic psychology
Aim	Compliance with rules	Students learn to adapt to fit the demands of the setting
Methods	Rewards and sanctions Hierarchical behaviour systems Zero tolerance	Explicit teaching of behaviours (rehearsal) Modelling Dialogue Collaborative problem solving (Ross Greene's model)
Outcomes	External locus of control Extrinsically motivated	Internal locus of control Intrinsically motivated
End game	**Behaviour for learning**	**Behaviour for living**

Bevington, 2016

6

CODE SWITCHING



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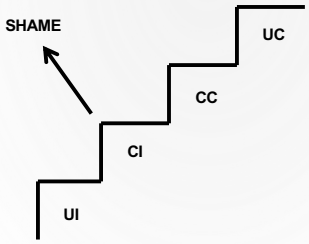
ACQUIRING COMPETENCE



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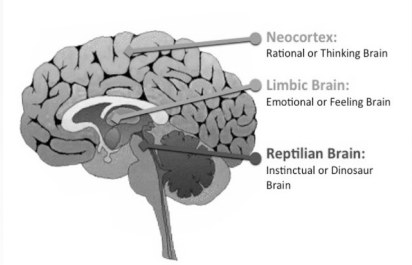

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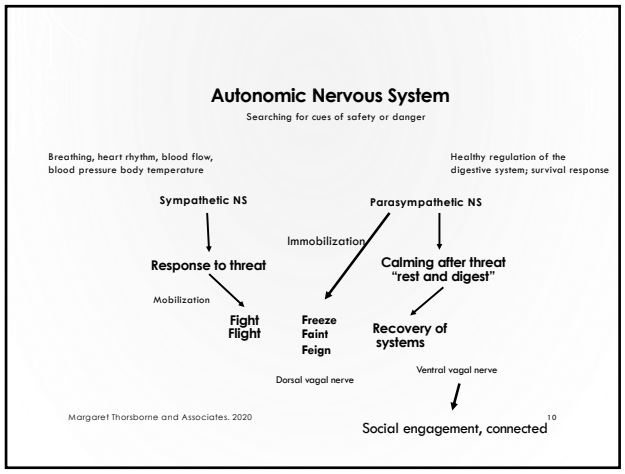
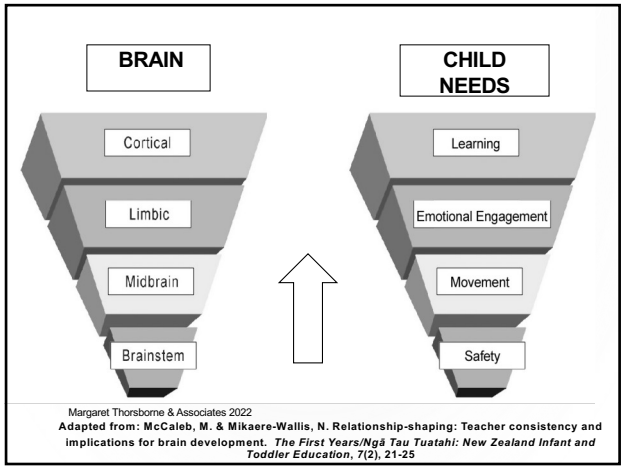
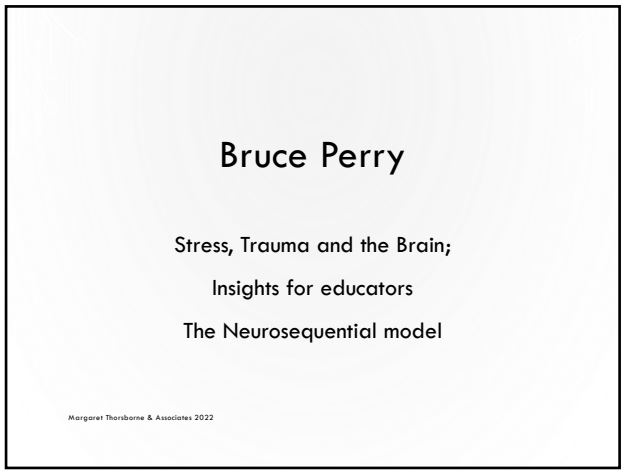

Autonomic Nervous System
Searching for cues of safety or danger
Breathing, heart rhythm, blood flow, blood pressure body temperature
Healthy regulation of the digestive system; survival response
Sympathetic NS
Parasympathetic NS
Immobilization
Response to threat
Calming after threat "rest and digest"
Mobilization
Fight Flight
Freeze Faint Feign
Recovery of systems
Dorsal vagal nerve
Ventral vagal nerve
Social engagement, connected
Margaret Thorsborne and Associates. 2020
10

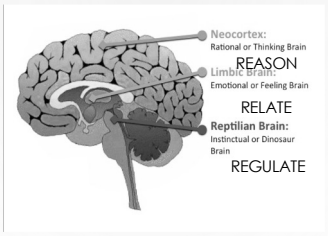
10


BRAIN
CHILD NEEDS
Cortical
Limbic
Midbrain
Brainstem
Learning
Emotional Engagement
Movement
Safety
Margaret Thorsborne & Associates 2022
Adapted from: McCaleb, M. & Mikaere-Wallis, N. Relationship-shaping: Teacher consistency and implications for brain development. The First Years/Ngā Tau Tuatahi: New Zealand Infant and Toddler Education, 7(2), 21-25

11


Bruce Perry
Stress, Trauma and the Brain;
Insights for educators
The Neurosequential model
Margaret Thorsborne & Associates 2022

12



13

CASE STUDY

A teacher takes her group to the library every week for a free-reading session. One of the boys in the class has high-functioning ASD, and he appears to be randomly attacking another child when they are sharing a book about 'Herbie' the car.

- Who's in the story?
- What's the impact of the problem?
- What are the issues and outcomes are we looking for?
- What's the best approach to use?

14

WHAT DO THOSE HARMED NEED?

- To tell what it has been like
- To be understood
- To understand why it happened
- To be validated and harm acknowledged
- To know the wrongdoer is truly sorry
- To be relieved of the burden of their shame
- To be able to heal and let go (forgiveness)

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WHAT DO THOSE RESPONSIBLE NEED?

- A chance to be able to explain themselves
- To be treated with respect
- To be reconnected with their community of care
- To be relieved of their burden of shame
- To be able to participate in deciding what to do
- To be able to heal and let go (redemption)

16

THAT "THINKING" QUESTION

- What was the purpose of that?
- What did you want to happen?
- What were you hoping would happen?
- What were you expecting would happen?
- What was going on in your head when you did that?
- What made you decide to do that?
- What were you saying to yourself when you…?
- If you did know what you were thinking, what would it be?

Anything that gets at motivation and intention without asking WHY!

17

THE RP PROCESS USUALLY INVOLVES

- Telling the story (the what and why)
- Exploring the harm
- Acknowledgement (and apology if lucky!)
- Developing a plan including follow-up
- Close

18

SO WHAT'S SO SPECIAL THEN?

- Communicating our needs
- Telling the story of what's happened
- Explaining our thinking
- Sharing our feelings

19

IMPLICATIONS FOR PARTICIPATION

- Nature of special need
- Verbal - questions
- Awareness of self and others
- Social skills
- Capacity to self-regulate
- Willingness of child to participate
- Willingness of the adults to work in this paradigm

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BARRIERS TO PARTICIPATION

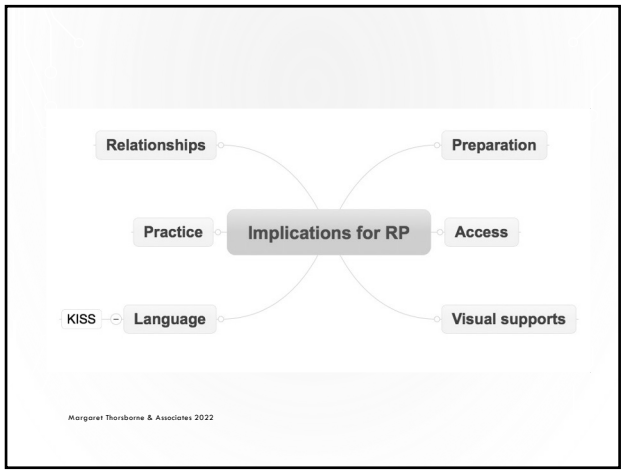
Communication – expressive, receptive, non-verbal

Cognition – story telling, memory and sequencing, understanding of self and others

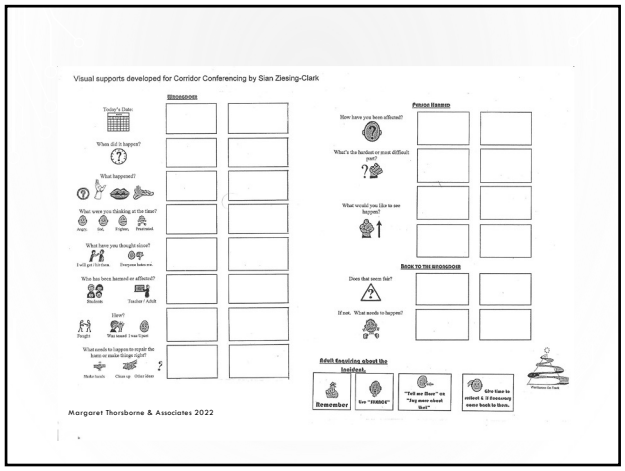
Behaviour – dis-inhibition, sitting still, social skills/relationships

Burnett and Thorsborne, 2015

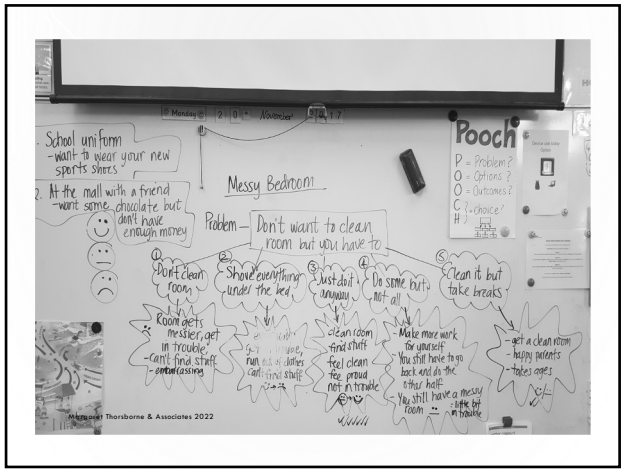
21


Relationships
Preparation
Practice
Implications for RP
Access
KISS
Language
Visual supports
Margaret Thorsborne & Associates 2022

22


Visual supports developed for Corridor Conferencing by Sian Ziesing-Clark
Margaret Thorsborne & Associates 2022

23


Pooch
P = Problem?
O = Options ?
O = Outcomes ?
C = choice
H
Messy Bedroom
Problem – Don't want to clean room but you have to
Margaret Thorsborne & Associates 2022

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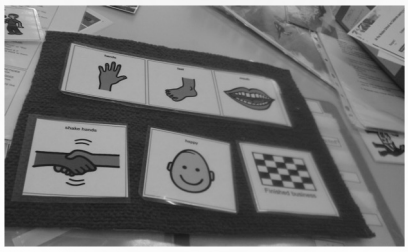


25

26

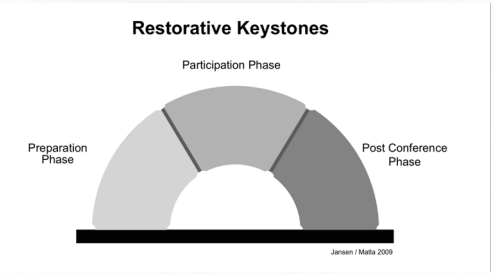
"4 F" RULE

- **'Fess up**
- **Face up**
- **Fix up**
- **Follow up**

Toowoomba SHS, 2014

27

GETTING THE PROCESS RIGHT



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GENERAL ADVICE

Preparation – much greater need for SN situations	**Access** – be creative around c'tion, cognition, behaviour	**Visual supports** - to support memory, c'tion and feelings
KISS principle – keep language simple and explicit	**Rehearsal** – practice makes perfect and helps self-regulation	**Relationships** – especially trusting the facilitator

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THE REPAIR APPROACH

Right approach

Establish needs and outcomes

Preparation

Affect

Integrity

Relationships

Burnett and Thorsborne 2013

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THAT'S a SHAME!

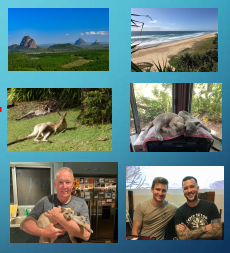
UNDERSTANDING MORE ABOUT THE NATURE OF EMOTIONAL HARM

MARGARET THORSBORNE

2021

1

GREETINGS FROM AUSTRALIA



Acknowledgement of Country

2

MR SMITH IS A RACIST

Writing was found on the wall in the math classroom that said "Mr Smith is a racist". Mr Smith is very shaken by this note and tries to speak to his class about it, encouraging dialogue. Two students, Jake and Ben, come forward after class and say that they saw Chris write it. They also shared that Chris talks openly in the locker room about how much he hates Mr Smith and thinks he picks on him.

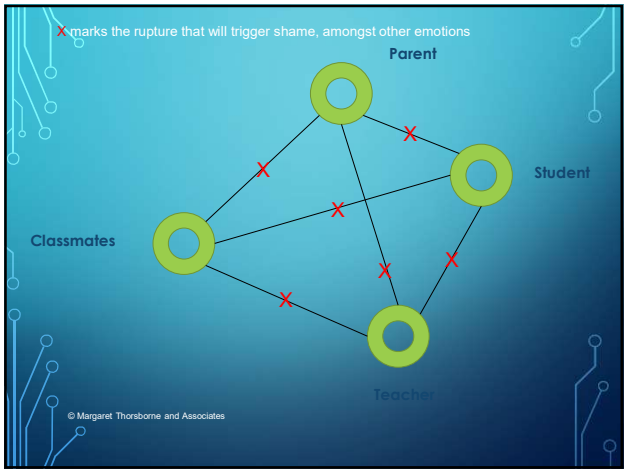
3

LATE TO SCHOOL

Student is late to school and then for class. The teacher tells her to sit down, get her book out and start work. She doesn't have a pen. She says "Where's your pen? You'd better get one quickly". Her reply is a loud "F*** off, you're always picking on me!" and she walks out, slamming the door.

She is referred to the Dean/HOF/DP.

4



5

AFFECT AND MOTIVATION

9 innate affects that we are born with

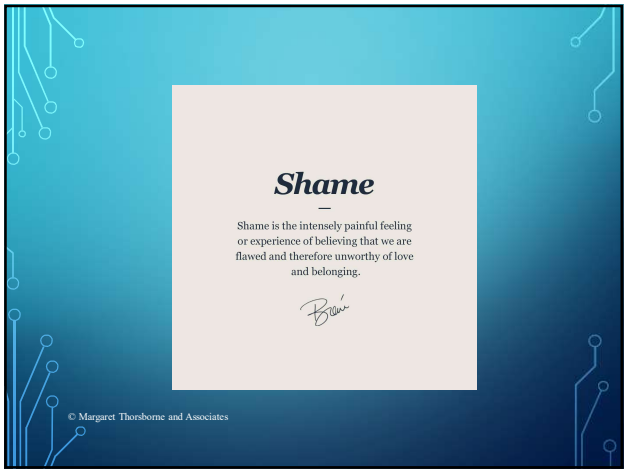
Affect	Motivates us to:
Interest	Engage with the thing or person
Enjoyment	Affiliate with the thing or person
Surprise	Stop. Look. Listen
Shame	Seek to restore
Distress (sadness)	Comfort the one in distress
Anger	Attack (fight)
Fear	Run (flight)
Disgust	Reject after sampling (get rid of)
Dissmell	Reject before sampling (stay away)

Abramson, 2013

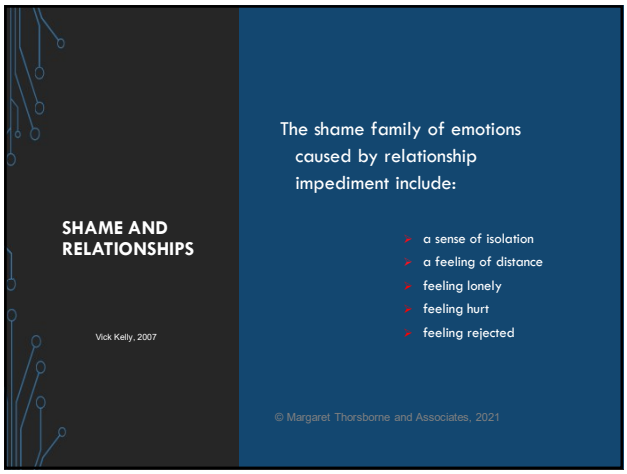
6


SHAME HAPPENS WHEN
• When a disconnection in a relationship occurs
• When something that felt good is interrupted
• It is the "social alarm" signal to let us know there is work to be done to restore that which was good
© Margaret Thorsborne and Associates
Nathanson, 2010

7


Shame
Shame is the intensely painful feeling or experience of believing that we are flawed and therefore unworthy of love and belonging.
© Margaret Thorsborne and Associates

8


SHAME AND RELATIONSHIPS
Vick Kelly, 2007
The shame family of emotions caused by relationship impediment include:
a sense of isolation
a feeling of distance
feeling lonely
feeling hurt
feeling rejected
© Margaret Thorsborne and Associates, 2021

9

PHYSIOLOGY OF SHAME

- **Slumping of shoulders, dropping of head, loss of eye contact**
- **Flush/blush of skin of chest, neck and face**
- **Cognitive shock**

10

THE LANGUAGE OF SHAME

Embarrassed, exposed, dishonoured, mortified, ruined, awkward, shy, abused, humbled, belittled, insulted, diminished, loss of face, rejected, humiliated, disrespected, ridiculed, excluded, patronised

Alienated/rejected/abandoned/isolated
Confused/blank/empty/lost
Ridiculous/stupid/foolish/odd
Inadequate/helpless/insecure/weak/flawed/inferior/worthless/intimidated
Uncomfortable/tense/anxious/uneasy/
Hurt/offended/upset/wounded/sore

11

THE LEGACY OF SHAME

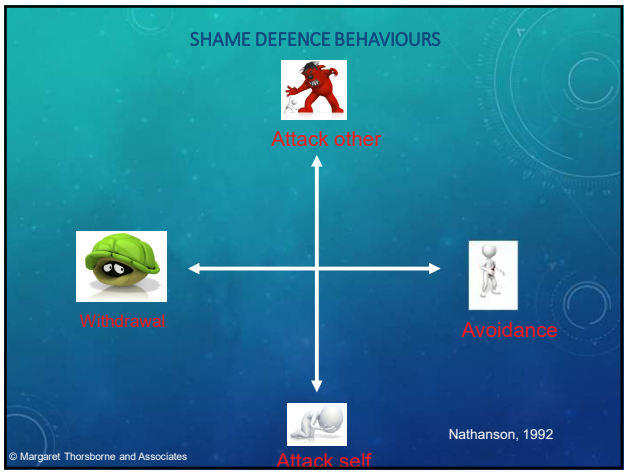
We are wired to live in "good" connection with others

Shame is a built-in mechanism signaling when an impediment has occurred in our relationship with "other" – when a "good" thing is interrupted

Shame *feels* bad, and we are motivated to reduce it

We have developed some unhelpful default behaviours to do just that – one of which involves violence and/or bullying

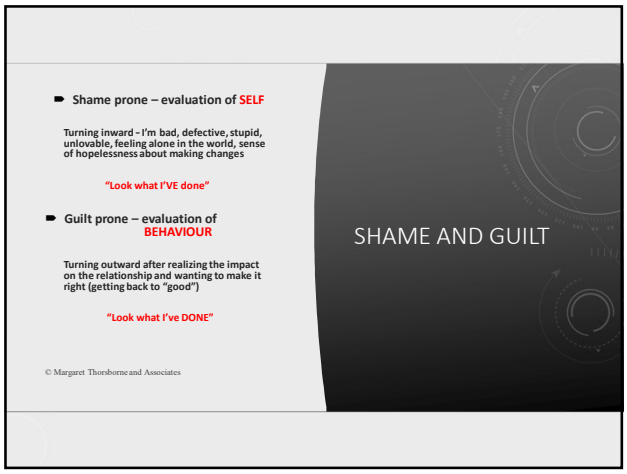
12


SHAME DEFENCE BEHAVIOURS
Attack other
Withdrawal
Avoidance
Attack self
Nathanson, 1992
© Margaret Thorsborne and Associates

13


SHAME AND THE BEARS
Mad
Fight
Be cross
Hurt others
Be cross with others
Be mad at people
(Attack Others)
I Felt Like That Too
Run away and hide
Go to your room
Don't want to play
(Withdrawal)
The Shame Bear
I Felt Like That
I felt like this too
Pretend it's not happening
Don't want to talk about it
(Avoidance)
The Crumpled One
(Shame)
Sad
Feel sad
Hurt yourself
Say I'm Stupid
Do naughty things
to get into trouble
Be Frightened
(Attack Self)
Kelly and Thorsborne, 2014

14


Shame prone – evaluation of SELF
Turning inward - I'm bad, defective, stupid, unlovable, feeling alone in the world, sense of hopelessness about making changes
"Look what I'VE done"
Guilt prone – evaluation of BEHAVIOUR
Turning outward after realizing the impact on the relationship and wanting to make it right (getting back to "good")
"Look what I've DONE"
© Margaret Thorsborne and Associates
SHAME AND GUILT

15

The Emotional Aspects of Learning

www.rpforschools.net

(presentations)

Graeme George, 2017

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CONTACT DETAILS

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Twitter: @ThorsborneMarg
LinkedIn: Marg Thorsborne

17

What happened?

pushed

hit

kicked

took something

bad/nasty words

spat

ignored

upset someone

ran away

broke

scratched

made a mess

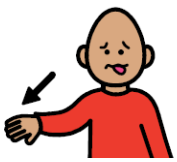
What were you thinking?

What did you want to happen?

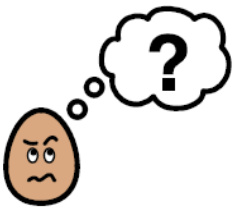
angry

go away

frustrated



don ‘t like…
don ‘t want to…



confused

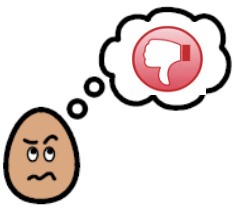
want to play

worried

want to go home

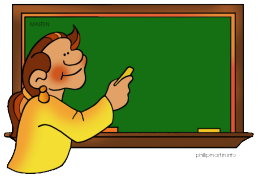
STOP!

need help



not fair

student/child



teacher

school helper

teacher aide

whole class

grandparents

bus driver

mum/dad

Principal/DP

How?
(outside)

hurt head/face

hurt arm

hurt leg

broke something

made a mess

hurt ears

How?
(inside)

made someone
scared

made
someone
cry

made
someone
embarassed

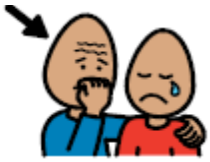
made someone
worried

hurt
someone's
feelings

made
someone sad

give...
give back…

say
something
nice



check if ok

fix…

offer to…

help…

clean up…

say I will…

Sorry..

say

write

show

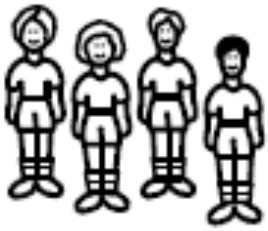
for...

Accepted?

good choices… safe choices…

ignore

walk away



keep hands, feet and objects to myself

get help

stop and think

use my words

share/take turns

calm down

right place, right time

follow our rules

follow adult instructions

5

Case Studies

What follows in this chapter are a number of case studies from practitioners who are finding increasingly creative ways of making RP more accessible to individuals with special needs. These are not meant to be 'perfect' ways of implementing RP and do not cover every type of SN that we have examined but it is hoped that they will give some useful signposts to possible ways forward.

We asked them to structure the case studies around the following questions:

- What's the story/incident?
- How was the RP process modified?
- Implications for future practice?

We owe a huge debt to all these practitioners who, in many ways, were the inspiration for writing this book. Where they have indicated they are happy to be contacted we have given their email address.

CASE STUDY 1: WORKING WITH YOUNG PEOPLE WITH ID AND ASD

Sian Ziering-Clark, sian.ziering-clark@ed.act.edu.au

Sian has had a number of years developing inclusive programs for students with special needs. She has used alternative and augmentative communication (AAC systems and action research

using restorative practices and iPads to improve communication and learning outcomes in the early years classroom.

The story

'Help!' came the cry from a very experienced teacher attempting to resolve behavioural issues, conflicts and disputes between the young people with additional needs in the school, including those students diagnosed with ASD. 'We have tried everything!' The lament continued, 'We have used positive playground expectations, reminders and explicit social stories for some and still this happens!'

The young person had gone to this teacher on playground duty/supervision visibly upset. Having limited communication he was only able to point to a couple of other boys in the same class.

The teacher comforted the young person and followed up with asking the person harmed to 'Show me what happened.' He brought the teacher to the toilet area where he showed the teacher how his head was held down in the toilet bowl whilst it had been flushed. Separately the identified individuals responsible were sought out and invited also to 'Show me what happened' and corroborate the story. The bell rang for the end of the break and there was no time or opportunity to follow up further. All parties were unsettled the rest of the afternoon.

As a result the teacher, in consultation with the year/class coordinator, decided something else needed to be done as just saying the socially acceptable 'sorry' was not and would not be enough.

The process

A modified restorative conference/circle approach was chosen to be trialled with the whole class to resolve the issue. It would bring all parties together and acknowledge everyone's feelings and role in the incident. The process used was developed by Sian

to meet the unique additional social, emotional, communication and literacy needs of these students. For an example of the visuals used, see Figure 4.17.

The process followed the restorative practices principles and questions:

- What happened?
- Who has been harmed?
- How did they feel?
- How do we fix the harm?
- 'Finished business'.

Students were all welcomed to this important meeting to 'talk about what had happened' and how by telling the story they would be able to 'fix the harm' done. They were reminded that:

- only one person could speak at a time (using class speaking totem)
- all those involved would have a turn to tell their story
- the facilitator would lead the talk/discussion
- the teacher would 'storyboard' the incident.

As the student harmed told his story in response to 'What happened?' the teacher drew simple pictures on the white board, added photos of named students, visual symbols (toilet) and actions such as 'pushed' to sequence the storyline.

In turn the two individuals responsible told their version – adding the point at which one of them pushed the victim's head into the toilet. It was when the facilitator asked the question, 'And what happened next?' that the victim's friend called out, 'I flushed the toilet!' Consequently he changed seats! Moving from being the supporter of the victim to being one of the wrongdoers!

The student who was harmed identified by pointing to the images/visual symbols of a 'sad' and a 'frightened' face to tell the perpetrators and class how he felt.

Those who had done the harm were quite engaged in the process and remorseful, wanting him to be 'happy' again and to be 'friends', with one of the students choosing the image/visual symbol to show him.

They all shook hands and agreed not to put his head in the toilet again!

Implications for future practice

Students with special needs are not always viewed by the wider community as being capable of taking responsibility for their own behaviour, resolving difficulties and 'fixing the harm' done to others – restoring their relationships. Given practical and explicit means to understand, and training in restorative practice processes they can successfully 'fix the harm'.

The visual cues and processes described could be used with anyone with language disorders or social or emotional difficulties to communicate with others about the harm and as a tool for preventing further harm. Visual learners attend to information more effectively when they see something and remember what they see rather than what they hear. It is imperative that students, young people and adults with additional needs have a voice, a means to both protect and express themselves as well as tools to take responsibility for their own behaviour.

CASE STUDY 2: WORKING WITH EARLY YEARS WITH ASD

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Jane has spent most of her career as a primary teacher in Western Victoria, Australia. From 2010 to 2012 she worked for the Department

understanding with the use of visuals is also a very important element in the process.

CASE STUDY 5: WORKING WITH INDIVIDUALS WITH ASD AND SLCN AND OTHERS WITH ID

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Rebecca is a full-time Foundation teacher. Her class is made up of five- and six-year-olds. Over the last five years she has managed the Integration Department at Portland North Primary School in Western Victoria, Australia. She is also a mother of two children: Charli who is 11 and has dyslexia and dysgraphia, and Isaac who has an ASD and ID.

The story

Tom was seen by a group of students going through another student's school bag in the classroom locker area. He had two other friends standing beside him. The group of students promptly informed Andy, whose bag it was, who rushed to the locker area and confronted Tom. By the time the teacher was alerted Andy was found standing over a very frightened Tom, yelling in anger and threatening violence. The two boys had no previous history of grievances but it should be noted that Tom had a diagnosis of an ASD as well as a severe expressive language disorder. His two friends also had intellectual disabilities.

The process

The restorative process took the following form. The teacher escorted Tom, his two friends and Andy to a quieter area away from the peers who were observing the incident so that a restorative conference could take place. Andy was very agitated and convinced that Tom was attempting to steal items from his bag.

Tom was very distressed and was not able to contribute much other than sobbing and avoiding eye contact. His two friends attempted to share their opinions of the event but their stories were disjointed and difficult to understand.

In order to determine what had actually taken place and to identify the intention behind the act, the teacher decided to return to the locker room with all of the students and to re-enact the event. Tom was open to the idea and with support from his friends the teacher was able to get the boys to 'replay' the scenario, much like watching a television scene being acted out. Andy was instructed to remain quiet during this process but encouraged to watch so that he too could discover why Tom had chosen his particular bag.

During the re-enactment it became evident that Tom had looked through several bags prior to Andy's. Susan, who was Tom's older sister, was also in Andy's class and she had brought along a special toy for show and tell. Tom had simply wanted to show his two friends the item. Not able to identify which bag belonged to Susan he had simply rifled through bags looking for things that would identify the bag as Susan's. It was at the point when he was looking through Andy's bag that the other students had entered the locker room.

The teacher was then able to use the restorative script and visual cues, such as a clipboard on which she drew Andy with an angry face and Tom as a cartoon thief going through Andy's bag, to help Tom see why Andy had been angry. She was also able to help Andy identify the intention behind Tom's act. Tom was then presented with two possible options for repairing the relationship with Andy. He chose to say sorry for looking through Andy's bag without permission.

Tom was then helped to recognise approaches for future use in similar situations. These strategies were again presented in a visual format and Tom chose one, asking a teacher for help, as his preferred future strategy.

Implications for future practice

The use of visuals and also the need to 'replay the video' of what happened in the context in which it occurred can be very useful for students who have ASD and communication difficulties and are not able to tell a story in a logical sequence.

CASE STUDY 6: WORKING WITH EY AND ID

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Cathie is a school Guidance Officer (counsellor) with the Department of Education and Training, Queensland. Her previous role was Visiting Behaviour Advisory Teacher.

The story

Within our school, a serious consequence for inappropriate behaviour involved lunchtime detention. Students, when on detention, were required to sit and be quiet during this break. All students from Prep to Year 7 (4 to 11 years old) were supervised in a classroom by teaching staff. When analysing students presenting in this group, it became clear that many individuals were involved in lunchtime detention daily, suggesting they were not 'learning' from this consequence. Additionally, many students were not having the opportunity to 'learn' how to socialise and were returning to their classroom after the break time frustrated and with excess energy that often led to further difficulties.

As a trial in the younger years (Prep to Year 3 [5 to 8 years old]), restorative practice philosophies were implemented. This offered staff and students the opportunity to learn from the incident that occurred. Further to this we identified how students were able to take some responsibility for their actions, repair some of the harm and rebuild relationships with both students and staff.

Implications for future practice

One clear point that made a difference in this story was helping Brittany to communicate effectively enough with her teacher and fellow students and they with her (teaching everyone to sign), which enhanced the likelihood that any restorative approach to problem-solving was made possible.

CASE STUDY 8: INDIVIDUALS WITH ADHD AND ASD IN THE EARLY YEARS

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Felicity is Student Management Support Consultant (Early Years) working in schools on the Sunshine Coast in Queensland, Australia.

The story

Both the wrongdoer and victim were young – seven years old. The 'wrongdoer' had a diagnosis of ADHD and ASD and also a speech and language impairment.

The wrongdoer Jack was having a meltdown and had thrown his sensory tool (a plasticine-like ball) at the other child Benji and hit him in the face. Benji's parents were threatening to report the incident as assault to the police unless the school 'did something' as their son had been hit by Jack in Prep and they knew that his behaviour was affecting others. To them, it felt like the school had not addressed it. Jack's father had expressed that he was keen to 'sort things out in the school car park' with Benji's father and initially refused to participate in the conference. He reluctantly agreed at the final hour to participate. Subsequent interviews revealed that:

- Jack had significant trouble recalling events in the correct sequence and maintaining one consistent story.

- Jack had demonstrated difficulty sustaining his attention for long periods, sensory-seeking behaviours, high levels of non-compliance, physical aggression and difficulty regulating his emotions. And he would take flight from a situation if overwhelmed.
- Benji's family were considering police involvement for the 'physical assault' of their son. They had no knowledge of any of the medical and learning issues for Jack and indicated that they felt Jack's parents didn't seem to care about their son's behaviour.
- Jack's family were angry at the threat of police action.

The process

The conference included Benji and his parents, Jack and his parents, the teacher, the deputy principal, the principal and me as the facilitator (I had also worked with Jack and his family as the behaviour support consultant for the school). As the facilitator, I sat next to him during the unpacking of the wrongdoing and supported with the visuals we had practised with. With this support he was able to express what he had done. He used a mixture of verbal and non-verbal communication (visuals and pointing to participants) to make restitution and apologise to the victim and his parents, his teacher and his own parents for what he had done. Jack's mother was quite emotional in expressing her own frustration with her son's behaviour and gave a heartfelt apology to Benji's parents for what her son had done. Benji's mother was equally emotional and stated that once she had learned about Jack's disability and issues she felt she understood more and just wanted to help.

The agreement was amazing! Jack's father offered to take both boys to the local park to kick a footy around to help them become better mates and this was agreed to. Benji asked that Jack keep his hands and feet to himself and he agreed to this.

The teacher offered to use alternative sensory tools that were tied to the desk so that they could not be thrown. The traditional 'breaking of the bread' (refreshments offered at the end of the formal part of the process) brought about some relaxed, friendly conversation between the two fathers who had originally been ready to go to war, and additional apologies were exchanged between the two mothers. The teacher followed up with documentation through a behaviour support plan and progress was monitored by the administration team and the behaviour consultant.

Key elements that helped make the process successful

- *Establishing what happened*: A cartoon strip method (drawing the events in order) was used to establish the sequence of events with the wrongdoer. All parties had been interviewed beforehand, to assist the facilitator in supporting the wrongdoer to piece together the order of events.
- *Interviewing participants*: Consent was given by the wrongdoer's parents to inform the victim's parents of the medical and learning difficulties of the wrongdoer prior to the conference in order to prepare them for the wrongdoer's possible responses and behaviour. They were informed that he might not demonstrate empathy, that he would have sensory tools to assist him to focus his attention, that he would struggle to express himself and that he would be supported to do this with visuals. This was well received and the victim's family indicated that they had a better understanding and had in fact developed empathy for both the wrongdoer and his parents.

- *Rehearsal*: Given that this student had ASD and often found new things quite confronting, he was taken through a 'practice' of the conference and shown where people would sit and told what would be said and what he would be expected to say and do.
- *Sensory tool*: The wrongdoer was given a sensory tool (a soft toy from home) to hold on to for both comfort and as a way to access sensory stimulation and assist him to focus.
- *Visual supports*: A set of visual supports was created for each of the four main questions. The cartoon strip was used for what happened. He was told that he could point, which he chose to do. The facilitator moved next to him on a small stool during this part of the conference to provide reassurance and support with the visuals.

Implications for future practice

- *Provide extensive preparation and practice* particularly when there is a student with ASD.
- *Use a comfort object/sensory tool* which is beneficial for calming and focus.
- *Use a cartoon strip* as it can be difficult for students to accurately recall events. The visual supports[4] allow students to participate and communicate to a level that would not be possible with words alone. These visuals are useful as part of a suspension re-entry process and teaching students about the restorative process.

4 Felicity has developed a range of resources to enable greater access for the individuals with SN to the RP process including images

An Inclusive approach to RP for students with diverse needs

(European Forum for Restorative Justice Newsletter, May 2021, Volume 22, Number 2)

Main Points:

- Restorative practitioners have to be able to adapt processes to allow students with diverse needs access to participation
- These adaptations should be similar to the kinds of work done to maximise student participation in the curriculum
- Prevention strategies include teaching concepts of harm, making things right, apology, self-regulation and social skills in general

Introduction:

Readers who have a background in education and restorative practice are largely familiar with the continuum of practice in restorative responses to incidents of harm in the school community – on one end, the use of formal processes such as restorative conferencing, and at the other, informal processes designed to "keep the small things small" with array of processes in between. What has been a particular challenge to practitioners is the issue of using such processes with those who are neurotypically different and have a wide variety of diverse needs and for whom participating in these processes can be difficult.

This article is best seen as a summary of the messages about what IS possible, contained in our text, Restorative Practices and Special Needs (2015). The authors, Nick and Marg, connected when Nick attended local RP facilitator training in 2013. Nick, having worked extensively in special school/unit settings, saw the possibility of how the processes, underlined by the principles of restorative justice (RJ), might be adapted to meet the needs of a special group of students of all age groups, who are sometimes those responsible for harm, and sometimes harmed by others. Like most of our work, the book developed from a series of well-received workshops with educators – nothing like a powerpoint presentation to become the bones of a book!

We will explore, in general, the nature of the challenges, and provide some guidelines, drawn from practitioners in the additional needs space about how we can remove some of the barriers to participation.

History of RP in schools

Restorative Practice (RP) in schools has developed, since the mid-90's, from a response to serious incidents of harm to reduce the suspension and exclusion rates to a much broader approach that encompasses the need for behaviour *development* rather than a command -and-control approach around behaviour management. Ross Greene (2016) lists a number of particular skills which foster the better side of human nature: empathy, understanding how one's behaviour impacts on others, being able to resolve disagreements without conflict, perspective taking and honesty. This list of skills is exactly what restorative practitioners understand to be what we might hope restorative processes can achieve with persistent, consistent policy and practice. The implication here is the need and challenge of teaching

these skills *before* anything goes wrong – social and emotional competence, and the very important life skill of self-regulation.

In the early years of RP in schools, pioneering efforts were adapted from the youth justice sector and were deeply challenging to the prevailing authoritarian approaches to behaviour management (Cameron and Thorsborne, 2001). Since then, the practices of suspension and exclusion have been shown to contribute to the "School to Prison Pipeline" (Skiba et al 2006) in significant ways – particularly for student populations that are already disadvantaged and include those students with diverse needs. This includes a much clearer picture of brain development across childhood and adolescence and more humane ways of responding to incidents of harm that is informed by this. Thankfully, enlightened schools, school districts and regions are now working in a space around a more relational approach to pedagogy, school wellbeing and positive psychology, and whole school approaches to relationship and behaviour development. We also acknowledge that concepts of "harm" and "making things right" also need to be taught in explicit ways as these notions of healing may well be foreign to some.

The Restorative process

The RP process usually involves:

- Telling the story about what happened (the what and the why)
  What happened? What were you thinking? What were you wanting to happen?
- Exploring the harm done
  What did you think when it happened? How has this been for you? What has been the worst of it?
- Acknowledging this harm (this may or may not include apology)
  What do you think now that you've heard from…….about how it's been for them? Is there anything you could say to begin to make it right?
- Developing a plan to make things right
  What's needed here to make it right?

The process has implications for participation for students who have diverse needs. Participating successfully in such a process will mean particular barriers will need to be addressed:

- The nature of the special need
- The process is largely verbal, involving dialogue with all involved parties
- The level of awareness of self and others
- The social skills of those involved
- The willingness of the young person to participate
- The willingness of the adults to work in this paradigm

In our text, we have suggested these barriers largely fall into three broad groups:

⇒ Communication - expressive, receptive, non-verbal
⇒ Cognition - story telling, memory and sequencing, understanding of self and others
⇒ Behaviour - dis-inhibition, sitting still, social and relationship skills

The authors visited practitioners in a range of settings: special needs units in large primary and secondary schools, individual teachers in regular classrooms teaching students with diverse needs, and special schools. Each of them, as restorative practitioners, had found ways to overcome some of these barriers and had managed to adapt the processes in order to achieve the kind of healing we know is possible. In our text, these case studies showcase these adaptations for a range of diversity that includes Autism Spectrum Disorder, Intellectual Disability, and Speech, Language and Communication Needs.

Guidance for accessibility

From examining all the different elements that can impact on the RP process we believe there are some overarching implications.

- *Preparation* - This is key in any RP process but we would suggest even more important when one or more of those involved in the RP process have special needs. This preparation is for everyone likely to participate – to ready them for the adaptations of process that may be needed

- *Access* - What do we need to provide for the individual with special needs to enable them to access the RP process? This could be special seating, awareness of venue, timelines, something to soothing to hold, role-play, lighting etc.

- *Visual supports* - Even for those students who may not have significant language difficulties we believe the use of visuals to support communication and memory are important – especially around identifying feelings. Common props used include comic strips, social stories, timelines on whiteboards, graphics from such programs as Boardmaker, PECS, emoticons etc

- *Language – KISS* - The language in RP is very important but we need to Keep It Short and Simple. Some of the questions may need adapting to enable the individual with special needs to understand them.

- *Practice* – Repetition and sometimes rehearsal of the process questions and social skills we want to teach the individual within the RP process is advised. At other times, using circle time, and other social skill programs to teach social and emotional knowledge and skills is an effective preventative measure.

- *Relationships* - This is the cornerstone of the RP process and relies particularly on the development of trust between participants and the facilitator, especially true for those participants with diverse needs.

REPAIR Framework

To further assist practitioners, we believe it will be useful to work through the REPAIR Framework below before implementing an RP approach when individuals with diverse needs are involved.

- **R** – is this the **Right** approach? Establish the outcome needed to determine the approach

- **E – establish Needs** for all involved – what's the one social skill I want to teach as a consequence of this?
- **P – preparation for participation** – what and who is needed to give this its best chance of working
- **A** – paying attention to the **affect** (emotions) for those involved – before, during and after. Also, what are the **actions** needing to happen as a consequence of the RP?
- **I – integrity** – in terms of process, preparation, follow-up and philosophy of RP – is the fidelity around process intact?
- **R** – in the end it's all about the **relationships** – reflecting, repairing and reconnecting, and ensuring the relationship between participants and the facilitator is one of trust

Class Approaches – Additional helpful hints

We will now share some class and school approaches that may prove beneficial if you are working in a setting where there are many individuals with a range of special needs.

- *Use of circle time to teach restorative thinking and behaviours* - At a class level much of the work by Jane Langley (2016) around using RP in the early years is really useful in identifying the need to model, model, model. She identifies that acquiring restorative behaviour is a developmental process that needs modeling, practice and rehearsal.

- *Care not to deliberately humiliate* - As with young people, and depending on the special needs of the individual, disapproval from staff/adults they feel attached to will often be much more powerful than shaming from their peers. Care must be taken though to make sure that individuals are not deliberately humiliated by adults. This will increase the risk of unhelpful behaviours in those targeted and poor outcomes for everyone.

- *Have a range of pro-social photographs/symbols and other calming pictures in the setting* - These can help in using every opportunity to teach individuals the behaviours we want as opposed to responding to those we don't want. Helping individuals manage their moods is an important part of the process and having positive, calming pictures in the class or other setting can be helpful.

- *Hand held self-regulation "tools"* - Another strategy, observed by Bonita Holland and shared in her Churchill report, was each student in a class having a small handheld oblong card split into three sections which they keep with them at all times. Each section had a Velcro circle in it and there is a separate button which can be moved by the student from section to section to indicate their internal emotional state all the way from 'calm' through to 'peak distress or anxiety' as indicated by the colour of the section. If an incident occurs that triggers a student to move their button to the peak position on their Velcro card they can go and stand in front of the 'I' spot, (a thinking space) set up in a few positions around the classroom. Here they spend time reflecting about what's happened, what they think and feel, and they can use the toys and twiddle objects in the box to help themselves move from 'peak' to 'calm' and then to return to their desk or learning activity (Holland, 2012).

- *Centre of calm concept* - Rebecca Jacobson (2015), who has also contributed a case study, is a support teacher at Portland North Primary School in western Victoria, Australia. She is the parent of a child with ASD and has developed and implemented a number of really useful RP strategies. One of which is explicitly talking about RP as a 'centre of calm'. Individuals may feel caught in the grips of anger, terror, anxiety and apprehension but these feelings lie outside the 'calm' circle and so she talks with the student about what he/she can do to get back into the calm circle.

- *Explicit teaching of facial expressions* - She has also found specifically teaching individuals what the faces of people experiencing different emotions look like has proved useful. The importance of using actual photographs as opposed to comic interpretations can be very important for some individuals who find it difficult to transfer visual/cartoon concepts from one situation to real life.

- *Re-enactment* - Rebecca has also found that re-enactment of incidents as a really useful tool to unpack what happened with all the students involved re-playing the incident from start to finish, or, as illustrated in her case study, with her taking the role of the person responsible and being 'directed' by the student harmed to demonstrate what actually happened step by step and what they were thinking at each point. Both of these cases show how important the preparation is in the process.

- *Developing a small number of visual tools for communication* - Another practitioner in Canberra, Australia, who has really pushed the boundaries as to what is possible in relation to RP with individuals with special needs is Sian Ziesling-Clarke. Sian, like Rebecca, has also provided a case study in the book that has more specifics about the approach used in a particular incident and has some thoughts about RP and special needs in general. Sian has taken a number of years to identify the minimum number of symbols that are needed to enable meaningful restorative conversations to take place. From this Sian developed the use of restorative visual cards for use in every situation and this led to a whole school uptake of the RP.

Additional Issues to Consider

Whilst there is not the space within this article to adequately address these, we do think it is pertinent to raise awareness of the need to consider some of these when establishing an inclusive approach to RP. These are namely:

- Restorative Practice after Physical Restraint – Whilst the topic of physical restraint is by its very nature a controversial one, on occasions it is used and we would argue that the best approach to restore and improve relationships is to use a Restorative Practice approach to listening and learning following the incident.
- Working with Families and Staff – the key elements here are around working with parents as partners in the true-meaning of the word; and also recognising the need for additional supports for those staff who are facing regular incidents of violence in their daily work.

We would like to acknowledge the many practitioners we interacted with who were in many ways the inspiration for the writing of the book and who continue to shine the light on how to establish an inclusive approach to RP.

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What is Shame and Why Is It So Difficult to Manage?

Although everyone tends to get really upset by the idea of shame, the word itself, it becomes a lot easier to manage once you begin to think about in the way we'll show you. First we'll look at the biology that underlies it, and then at the sequences of experience that make the experience of shame a little bit different for each of us.

There are two different aspects of shame, two components that blend and become the way it "happens" to us. The first is sheer physiology and is the same in everybody throughout life; the second involves the history of our personal experiences of shame and thus is a bit different for each individual. The physiological type occurs whenever something pleasant is going on, and right at the moment you're having a good time, something interferes with it — even when there was also plenty of reason for the good feeling to continue. Biological shame, therefore, always involves a sequence: 1) a stable, continuing source of Interest-Excitement or Enjoyment-Joy that is 2) interrupted by something that doesn't fit with the positive affect that had been going on, at which point we 3) use the bad feeling that results from the interruption to figure out what it means. Normally, it is the good feeling of the innate affect Interest-Excitement that powers ordinary attention to whatever requires study, and the innate affect Enjoyment-Joy (content-
ment, laughter) that powers laughing, happy attention. Nevertheless, no matter what we had been doing, our immediate reaction to that interference or impediment to the positive affect is a burst of shame affect that pulls us away from whatever had only a moment earlier been a perfectly good trigger for that positive affect. In the video ("Managing Shame, Preventing Violence") we introduced an image of the affect system as a bank of spotlights; here, I'd like you to accept that the spotlight of shame affect flicks on in order to focus our attention toward the source and nature of the interruption.

On the face, shame affect is signaled by the blush, but it is also expressed by a
visible slump as muscle tone in the neck and shoulders is suddenly decreased.
The look we call "shamefaced" includes this slump plus a tendency to turn away from whatever had seemed so interesting only a moment earlier. The Chinese term for shame is "to lose face," because this biologically based interference with the gaze of interest really does cause the face of the shamed other to disappear from view for a moment. And because it was the affect Interest-Excitement that had encouraged us to think hard about whatever was going on, shame produces what I call a "cognitive shock." No one can think clearly in the moment of shame.

A good example is the "hurt feelings" you get when you're telling a story to a
friend who all of a sudden starts to think about something else your story brought to mind. The moment his/her face changed by displaying another

affect, you would very likely feel this change as an interference with the good feeling of communion the two of you had been enjoying. This is exactly what we mean by "an impediment to the continuation of a positive affect that otherwise would have continued." Normally we frown a bit, look quizzically at our friend, who then comes back into the conversation, after which we go back to where we were a moment ago. That hurt feeling we experience when a friend merely looks away or interrupts us when we're telling a story, that deflating feeling itself is the spotlight of pure shame affect. The unpleasant feeling itself calls attention to the interruption and thus motivates us to figure out what happened. As a result, we become more able to evaluate the significance of an interruption that might have gone unnoticed. I often wonder whether some public speakers, professional entertainers, great teachers, courtroom lawyers, or even clergy have developed such an amazing ability to command and maintain attention because they really dislike the bad feeling that an interruption can produce! Maybe that's not the big reason for all of them, but charisma and powerful control over one's audience certainly reduce the degree to which one is interrupted and exposed to this kind of shame experience.

Notice that even brief moments of shame affect have two kinds of effect on us. Yes, they do make us realize that an impediment to our experience of Interest-Excitement or Enjoyment-Joy has occurred, and that realization allows us to figure out what to do next. But it just so happens that those two feelings —being interested and feeling pleasurably content — are the most important in our comfort with other people. We form relationships in order to share these feelings. It is fascinating to note that some of the cognitive or behaviorist theories for shame that are popular in contemporary psychology describe shame as the result of interference with "social joining behavior," as if that behavior had nothing to do with positive affect. I doubt that these theorists ever pay attention to the facial affect displays of the individuals to whom "interrupted social joining" feels so awful!

There is nothing about the biology of shame affect that requires it to deal with relationships. But since we are with people so much of the time, and since it is the two positive affects that do the most to link us with other people, it is when we are around people that we have the overwhelming majority of our shame experiences. Since shame affect can only occur when we are already enjoying something or have an expectation of pleasure, the experience itself contains the expectation and hope that we can get back to the pleasant moment very quickly. For example, sexual activity really isn't just about sexual arousal and satisfaction – without the power lent to it by the affect of excitement, the experience is pretty tame. What we think of as "good" or "exciting" sex play almost always involves sequences of excitement followed by minor shame experiences that are rendered unimportant as we raise the intensity of excitement to the level where it overwhelms the impediment that had triggered shame affect. In a manner of speaking, sexual behavior gets somewhat tame when the participants know each other so well that there is little or no possibility of shame that can then be "blown away" by an increase in excitement. That's why mature

couples enjoy their sex life as an experience of contentment rather than excitement. In general, then, whenever there is a lot of excitement or joy, shame always hovers nearby as a threatening competitor that is usually vanquished.

Nevertheless, something else happens to make shame far more uncomfortable than can be explained solely on the basis of this simple interplay of affects. Since it is the two positive affects that connect us with others, the moment of shame (our reaction to the interruption of a pleasant experience) really does break that connection and separate us from the other person for a moment. In that way it resembles two other negative affects that are very different from shame affect. As babies, it is the protective mechanism of Dissmell that pulls us away from something that smells bad, and disgust that pulls us away from something that tastes bad. As adults, whenever we believe that exposure to some person is going to be unpleasant, we can use the Dissmell strategies learned in order to avoid stinky food and thus avoid that person. And whenever we develop a "bad taste" about people, we feel disgusted with them. Dissmell becomes the cornerstone of prejudice when we become unwilling to check out (mentally "taste" or "sample") the other guy, and Disgust becomes the basis for rejection of someone with whom we've already had a bad experience.

Well, since shame affect pulls us away from interesting or enjoyable others, it comes to merge with the other two affects that come to push or pull us away from otherwise attractive substances or people. In the moment of shame, we start to wonder whether that instant of separation from the other person has been caused by a noxious quality of our own person. Relatively soon in our development from babies to adolescents, the rather mild experience of pure shame affect gets bundled with the far more uncomfortable experience of thinking that others have good reason to treat us with Dissmell and Disgust. Into everyone's personal definition of shame is blended a batch of self-dissmell and self-disgust that make the adult experience of shame into something far more painful than can be explained by any other logic. In the remainder of this discussion about shame, please remember that all of the labels, all of the shame words listed in the beginning of this discussion really involve this terribly unpleasant blend of three very different negative affects.

As I mentioned above, if innate affect is a spotlight calling our attention to whatever triggered it, the adult experience of shame is a compound emotion in which three separate spotlights (and the memory of our experience with each of them) combine to make us terribly uncomfortable. Minor or even major experiences of shame affect happen in so many contexts from earliest life through our adult years that the resulting complex emotion takes on a life of its own. Say that someone merely reminds us of an incident in which we felt that sort of personal deflation plus the self-dissmell and self-disgust that combine as the feeling of personal unworthiness. Immediately, the memory itself comes to trigger a new episode of the feeling in whatever form it has developed for each of us at that period of our development. That's why any unpleasant thoughts

about ourselves bring on even more unpleasant thoughts as shame kicks in. What follows is a list of the eight kinds of experience in which it is normal for any of us to experience shame. You'll see that each of these eight types of experience
can involve that sequence of a good feeling that is turned into a bad feeling.

All of the shame moments we've ever studied fit into this list:

1. Matters of personal size, strength, ability, and skill.
In other words, I'm weak, incompetent, stupid.

2. Dependence and independence — ***feeling shame when helpless.***

3. Competition — ***feeling good if one is a winner but shameful if one is a loser.***

4. Sense of self — ***"I am unique only to the extent that I am defective."***

5. Personal attractiveness — ***"I feel ugly or deformed; the blush stains my features and makes me even more a target of contempt."***

6. Sexuality — ***"There is something wrong with me sexually."***

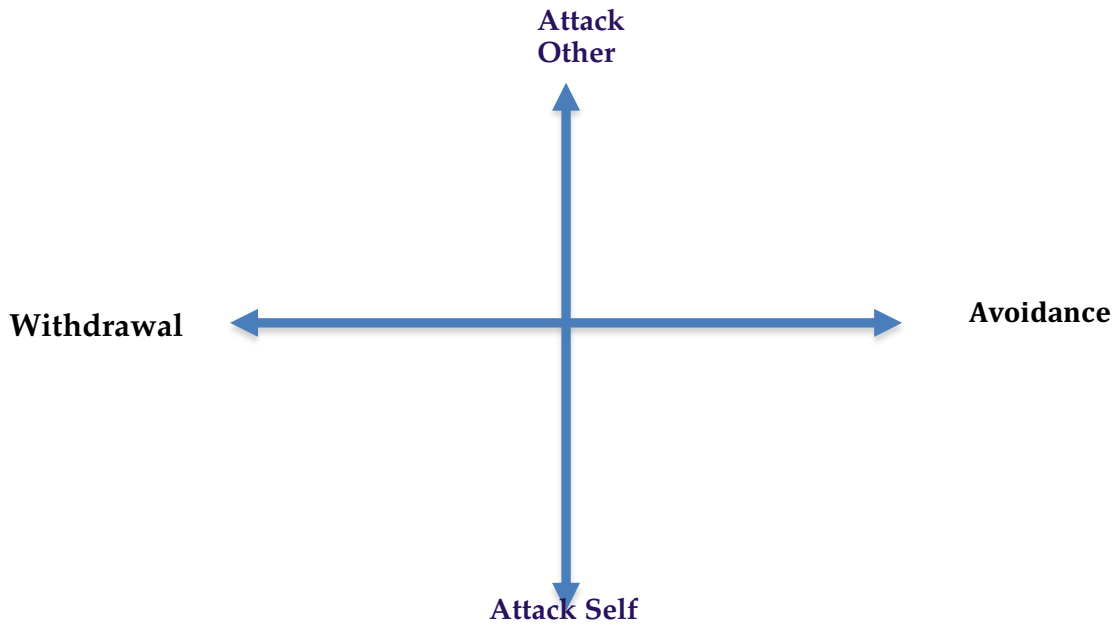
7. Issues of seeing and being seen — ***the urge to escape from the eyes before which we've been exposed; the wish for a hole to open up and swallow us.***

8. Wishes and fears about closeness — ***the sense of being shorn from all humanity; a feeling that one is unlovable; the wish to be left alone forever.***

This list of awful experiences is universal. Everyone has suffered every one of the experiences on this list. Please remember that each of the nine innate affect spotlights shines on and therefore brings to our attention some triggering experience, object, idea, or memory. But when three inborn discomforts get blended into one common basket, the moment of shame can become absolutely awful. True, as soon as we focus our attention where the spotlight falls, our best problem solving brain starts to work on whatever appears. Nevertheless, in the case of shame (the adult form of the emotion), it usually shines on something we'd rather not know or even think about! As a result, most of us learn ways of evading that entire realm of information.

Running Away From the Spotlight of Shame

It turns out that there are only four ways we react when we evade the three-beam spotlight of shame, and I've grouped them as the "Compass of Shame." Each of the four poles of this compass is actually a library of stories and scripts about ways to handle the bad feeling of shame without really paying attention to what set it in motion. Sure, life would be easier if we learned to pay attention to whatever started the process, but whoever said we were trained to do things the best way possible! Real competence at shame management is learned only with a lot of support.
Here is a drawing of the compass:



The Four Poles of the Compass of Shame

Each of the libraries described as a pole of the Compass contains scripts (instructions for specific ways of behaving) that cover the range from quite normal to some that are desperately pathological. Because the vast majority of shame experiences are so frequent and "ordinary," in everyday life we kind of go 'round the compass of shame like the proverbial propeller on a beanie, whirling from one defense to another with no understanding that shame was involved. In what follows, please understand that every one of us does this and that only a relatively small number of people live full time at one or another pole.

Withdrawal:

This is when we try to get away from the eyes before which we've been

exposed, to limit our exposure by disappearing from view. The thoughts that accompany the *Withdrawal* script may involve shyness, thinking about or actually removing oneself from an interaction, becoming silent, spacing out, or turning away from a conversation. We all do this from time to time, but at the pathological end of its range lies the kind of severe depression in which someone once told me that for four years "I could not leave my house for fear of meeting the eyes of another." Much of what psychiatrists describe as "Depressive Illness" is a combination of the sobbing affect Distress-Anguish and the emotion shame. It should not be surprising that many recipes for the treatment of depression encourage physical exercise in a public facility. That places the "depressed" individual within sight of others who are also forced to pay strict attention to the exercise, and it forces one "tone up" the muscles that had been made to slump by shame affect.

Attack Self:

Although *Withdrawal* does reduce the number of people who know that we
consider ourselves defective, unworthy, or deserving of any other shame label, it does pull us away from our social network. That can be a lonely and sometimes very toxic situation (especially for those who fear abandonment), in which case *Withdrawal* produces a new kind of problem. Most commonly, we try to fix this by forming relationships that relieve loneliness but in which we are treated as a defective person who deserves contempt. This makes sense when you realize that as soon as one ignores the spotlight and starts to work from the Compass of Shame, all of the worst qualities that have been bundled into our personal concept of shame are amplified to the maximum.

At the *Attack Self* pole, therefore, are ways we insult ourselves in a private internal dialogue or in the presentation of ourselves to others. The "self talk" here usually involves apologies, putting ones self down ("I am not worthy"), crying or whimpering in the presence of those who view such behavior as disgusting, the feeling that one is stupid or inferior, a sense of hopelessness no matter what remedy is suggested, and a general feeling of personal inadequacy. Often, people who are mired in this personal psychology offer themselves to others in demeaning sexual or physical relationships, ways of being that make the partner feel big and powerful but also validate emotional or physical cruelty. In an older system of psychology, everything we now understand as a reaction to shame at the *Attack Self* pole of the compass was called "masochism" and thought to be purely sexual. Although it does prevent the terror of abandonment, this is a costly and often unstable way of handling shame. *Attack Self* techniques manage shame by increasing mental pain, sometimes to the point when it becomes unbearable and then a trigger to violent behavior.

Avoidance

Frankly, there are some moments in everybody's life when we simply don't want to deal in any way with the actual trigger for shame and need the sort

of strategy that will merely turn off the bad feeling. As an accident of biology, it happens that alcohol works wonderfully to wipe away shame. Sometimes this is called "courage in a bottle." Perhaps you'll remember from the video my remark that "shame is soluble in alcohol and boiled away by cocaine and the amphetamines." The latter two drugs produce enough excitement that whatever had been acting as an impediment simply can't be noticed, can't break through enough be recognized as shame affect. At a more benign level, occasionally it helps to change the subject and focus attention on something neutral, a distraction that takes everybody's attention away from the source of your shame. Lying and denial of the trigger (a "cover-up") make temporary fixes for the pain also. But none of these temporary solutions really works well enough to undo the pain of shame for more than a little while.

Go back to the list on page 37 and concentrate on any one of the shame labels
there. Immediately you'll see that each kind of defect has its own polar opposite, a quality or attribute that usually can be achieved at the cost of some work or money. When you think about "up," you can't help but think about "down." The same for hot/cold, big/little, black/white, rich/poor, heads/tails, and a huge list of other terms. Every one of the shame labels implies a proud other side of the coin. If you fear being seen as bad, you can donate time and/or money to develop a reputation in the community as a good person. If you feel awkward, you can learn the latest popular dance or take lessons in some sport. If you think people consider you a wimp, you can earn a reputation for mountain climbing. That's just for attributes that function as polar opposites! Another quite common strategy is to ignore the category in which you feel or "know" there is something wrong with you, and focus the attention of your audience on some attribute you think admirable. If you are blessed with face or form found beautiful or handsome in your subculture, then you can base an entire personality on whatever attention that attribute can command. One aging entertainer was so proud of her "youthful" flat tummy that she wore clothes cut out to bare her belly. The list of shameworthy labels is exactly equal to an invisible list of counterbalancing praiseworthy qualities.

This system carries with it a few inherent problems. The folks who engage in
behavior from the *Avoidance* pole of the compass do nothing to work on any
single attribute responsible for their sense of shame. Life might be simpler were they to focus attention on whatever might need no more than a moment's thought. The other big defect in this system is that few people do it really well. Most exaggerate their defense to such a degree that they look silly and encourage anyone to figure out what is going on. Equally important, under the influence of the drugs and alcohol so popular at this pole of the compass, they blend into the *Attack Self* group by crying into their beer or into the *Attack Other* group described below by exploding into violent action when drunk or high.

Incidentally, you'll also notice that all three types of pride figure into the *Avoidance* system. We deserve Healthy Pride when we take on a task and

achieve the goal, just as we use Borrowed Pride when our "victory" is accomplished by salaried surrogates, and allow ourselves blatantly False Pride when we undo shame by lying. Nevertheless, it is still a copout to seek pride for an achievement that has nothing to do with what triggered shame.
Every one of us wanders into the *Avoidance* library occasionally, and a little skill at this kind of defense against shame is absolutely normal. The people at the other extreme are called "narcissistic," said to have a "swelled head," or to "think too much of themselves." Those who live at that end of the *Avoidance* spectrum seem totally involved in the search for approval based on the attribute they advertise and the task of protecting from view any possible defect. They fail to learn the skills needed to develop interpersonal openness and therefore have great difficulty forming and maintaining relationships.

These extreme examples of the system live linked to the polar opposite *Withdrawal* pole of the compass because neither system of rules allows much in the way of interpersonal life or any degree of intimacy.

Attack Other

For each of us every once in a while, and for a few of us nearly all the time, there are moments when there is absolutely no way we want to accept or deal with any type of shame. Facing what shame might tell us seems unbearably weak. *Withdrawal* becomes unacceptable because it can be embarrassing (as when one feels forced to run away from a fight.) *Attack Self*, with all its self-demeaning language, is absolutely unacceptable because you can't stand even momentarily feeling inferior. These are the instances when even getting drunk isn't enough, and no copout strategy from the *Avoidance pole* of the compass really makes you feel better. At this point, there is only one approach left.

In such a mood, absolutely nothing will bring back a sense of personal power or self esteem other than immediate proof that you're MORE powerful than someone else. Bigger, stronger, meaner, more vulgar, nastier . . . it doesn't really matter. You've got to diminish someone else so that you don't have to deal with your own feeling of personal diminishment. The operating manuals for these tricks are stored in the library called the *Attack Other* pole of the Compass of Shame. In its mildest form, these scripts are about banter, interchanges in which both parties feel safe, but work hard to reduce each other within agreed upon limits. To a friend with a pretty new car, we might say "Is that all you could afford?" And the other guy might respond "Look who's talking — that clunker of yours can't make it up the hill to the bar." Not mean, exactly, but playing at the edge of bearable insults.

At the next level of intensity might come insults coupled with vague threats,
all meant to convey the sense that the speaker is powerful and perhaps dangerous. Sometimes the speaker plays with physical assault, "jokingly" pushing or punching the other guy. The style and form of these insults is carefully choreographed, and a bit different in every social group; it might

**be
dangerous to use some of your best insults in an unfamiliar bar. You know the rest of the ladder — rungs climbing to physical fights, insults that break friendships forever, spouse abuse, child abuse, rape, murder, even attacks on
civic structures ranging from graffiti to desecration and destruction. There is
no end to the list of ways people can "prove" to someone that they are bigger,
tougher, and meaner than others. Every one of these attacks has been conceived and executed in order to produce only one result – brief "proof" that someone has been reduced by an actor unsure of his or her personal worth. The action shifts into the public arena what might have been a private
problem. It establishes the bully as a powerful person to be feared, rather than
someone with secret personal shame. Consider, for a moment, the reality that every one of us gets "annoyed" or "irritable" every once in a while, and that some degree of *Attack Other* behavior is both inevitable and quite acceptable in a healthy relationship.**

But I'm sure you've already figured out that only people who live at the *Attack Self* pole of the compass seem to prefer relationships with bullies. In the psychoanalytic psychology of the past century, *Attack Other* behavior was called "sadistic" and this sort of relationship was known as "sadomasochistic." True, some of this method of dealing with shame is carried out in the arena of sexuality, with issues of dominance and submission of prime importance. But we now know so much more about human emotion that it is unnecessary to link the underlying reasons for such behavior to one small part of its pattern.

Patterns of Relatedness

In the video, we mentioned that throughout history, people have tended to favor either the bundle of *Withdrawal* and *Attack Self* behavior or the bundle of *Avoidance* and *Attack Other* behavior. Each bundle represents a way of refusing to look where the triple spotlight of shame tries to focus our attention: the former makes us prefer a public identity of small and weak, and the latter makes us present ourselves as big and strong. Both presentations of self are misleading and phony because they broadcast information about ourselves that depend on great misunderstanding of our emotional nature. Repair of such misunderstandings is central to many systems of couples therapy, marital encounter weekends, marriage counseling, and conferences to improve relationships in the workplace.

The study of shame is a life task both for each of us as individuals and for all who try to make better the lives of others. It requires constant attention to our own inner lives, and the strength to help others maintain focus on their own inner lives. ……..

Only together can we change a rowdy, uncivil, and increasingly dangerous culture toward one in which we can all live together as a family.

Don Nathanson

From the DVD
"Managing Shame, Preventing Violence"

available from

www.tomkins.org

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Beyond a trauma-informed approach and towards shame-sensitive practice

Luna Dolezal [1]✉ & Matthew Gibson[2]

In this article, we outline and define for the first time the concept of shame-sensitivity and principles for shame-sensitive practice. We argue that shame-sensitive practice is essential for the trauma-informed approach. Experiences of trauma are widespread, and there exists a wealth of evidence directly correlating trauma to a range of poor social and health outcomes which incur substantial costs to individuals and to society. As such, trauma has been positioned as a significant public health issue which many argue necessitates a trauma-informed approach to health, care and social services along with public health. Shame is key emotional after effect of experiences of trauma, and an emerging literature argues that we may 'have failed to see the obvious' by neglecting to acknowledge the influence of shame on post-trauma states. We argue that the trauma-informed approach fails to adequately theorise and address shame, and that many of the aims of the trauma-informed are more effectively addressed through the concept and practice of shame-sensitivity. We begin by giving an overview of the trauma-informed paradigm, then consider shame as part of trauma, looking particularly at how shame manifests in post-trauma states in a chronic form. We explore how shame becomes a barrier to successful engagement with services, and finally conclude with a definition of the shame-sensitive concept and the principles for its practice.

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Introduction

"Shame has ruled my whole life" – Anonymous, trauma survivor

"Trauma leads to shame. Trauma determines the content of shame. Shame pushes the body into a traumatic response. The more I learn about the two, the more I am convinced of their deep connection to one another." – Lucia Osborne-Crowley (Osborne-Crowley, 2020)

Experiences of trauma are widespread, and there exists a wealth of evidence directly correlating trauma to a range of poor social and health outcomes which incur substantial costs to individuals and to society. As such, trauma has been positioned as a significant public health issue which, as Magruder et al. (2017) argue, necessitates a 'trauma-informed approach' (TIA) to public health policy agendas. Shame is key emotional aftereffect of trauma, and an emerging literature argues that we may "have failed to see the obvious" by neglecting to acknowledge the influence of shame on post-trauma disorders (Taylor, 2015). In this article, we argue that effectively addressing the post-traumatic state necessitates a clear understanding of shame, its phenomenology and its effects. We demonstrate that shame is a core aftereffect of traumatic experiences and argue that being sensitive to shame addresses many issues related to trauma, while also supporting good practice for all that come into contact with human services. We outline and define for the first time the concept of shame-sensitivity and the principles for shame-sensitive practice. We begin by giving an overview of the trauma-informed paradigm, then consider shame as part of trauma, looking particularly at how shame manifests in the post-traumatic state in a chronic form. We explore how shame becomes a barrier to successful engagement with services, and finally conclude with a definition of the shame-sensitive concept and the principles for its practice. Offering strategies for shame-sensitive practice, this article highlights the need for shame competence in health, care and social services.

The trauma-informed approach

While trauma has been studied for over one hundred years it was not until the 1980s and 1990s that the topic had sufficient inter-disciplinary support to develop into a field of research and produce a theory of trauma. While there is no unified approach or understanding of trauma, most agree that it entails an event that involves "threats to life or bodily integrity, or a close personal encounter with violence and death" (Herman, 1992, p. 33), and that the experience of this event is overwhelming, resulting in long lasting effects which can encompass significant alterations to one's experience of self, others and the world (SAMHSA, 2014). Particularly significant are experiences of trauma in early life, or Adverse Childhood Experiences (ACEs), such as abuse, deprivation, violence, witnessing of violence, neglect and disrupted attachment, among others (Poole and Greaves, 2012). Also significant are experiences of trauma in later life, such as interpersonal violence, sexual assault, warfare, tyranny under oppressive regimes, natural disasters, domestic abuse, among many others (Pattison, 2000, p. 96). While trauma can lead to post-traumatic stress disorder (PTSD) or other trauma or stressor-related disorders, which are classified as psychopathologies in the *Diagnostic and Statistical Manual 5th Edition* (DSM-V), not all post-trauma states or experiences warrant being classified as pathological or fall under the umbrella of a disorder. Nonetheless, research demonstrates that individuals who have experienced trauma can have adverse outcomes in all areas of life, and that these effects can endure across a lifetime.

The interest in trauma, and its links to health and social outcomes, increased following the publication of the Felitti et al. (1998) paper on ACEs. With a sample of close to ten thousand, it is one of the largest investigations of childhood abuse and neglect, concluding that there is a strong relationship between "the breadth of exposure to abuse or household dysfunction during childhood and multiple risk factors for several of the leading causes of death in adults" (Felitti et al., 1998, p. 245). This study has been influential in subsequent research into trauma and the development of policy for services that seek to address issues related to adversity and trauma. There is now a large body of research that demonstrates that individuals who have experienced trauma can have adverse outcomes in all areas of life, and that these effects can endure across a lifetime. These individuals are significantly more likely to suffer from a range of "social, psychiatric, psychological, behavioural and physical problems" (Knight, 2019, p. 80), such as chronic health issues, mental health problems and substance use problems, as well as being correlated with social outcomes such as homelessness, violence, marital problems and incarceration, among others (Banaj and Pellicano, 2020).

The term "trauma-informed" was introduced by Harris and Fallot in 2001 as a means to integrate an understanding of trauma and its aftereffects into mental health services, following the evidence that a significant number of individuals accessing mental health services were survivors of physical and sexual abuse (Harris and Fallot, 2001). Adopting a TIA attempts to embed an understanding of how experiences of trauma can become central to an individual's life course and life outcomes, having a profound negative effect on social outcomes, emotional wellbeing, mental and physical health, along with health-relevant behaviour (Poole and Greaves, 2012), impeding an individual's ability to seek out and engage with health and social services that are designed to help them (Barrett, 2019). TIAs involve a paradigm shift in how services and professionals respond to patients and clients, attempting to address root causes rather than surface symptoms, reframing the core diagnostic question from enquiring, "What is wrong with you?" to understanding, "What happened to you?" (Kimbery and Wheeler, 2019, p. 42; SAMHSA, 2014). This approach recognises that "any person seeking services or support might be a trauma survivor" and that "systems of care need to recognise, understand and counter the sequelae of trauma to facilitate recovery" (Goodman et al., 2016, p. 748).

Central to the TIA is an understanding that typical emotional, psychological and social aftereffects of trauma directly impede an individual's ability to seek out and engage with the human services that are designed to help them (Barrett, 2019). In addition, when trauma survivors do manage to engage with the services that may help them, the interactions they have with organisations, staff and care providers, who do not recognise and understand their trauma and its aftereffects, may inadvertently lead to a further disengagement and entrenchment of the problems (e.g., substance use, mental ill health) that these services are designed to diagnose and treat. The central contention of the TIA is that applying a 'trauma lens' can powerfully elucidate the root causes of ill health, health-related behaviours and social difficulties, leading to more effective interventions, support, diagnoses and treatments. This has led to the redesigning and reconceptualization of some health, care and social services, using the TIA paradigm as a way to structure the way that care is delivered (Gerber, 2019; SAMHSA, 2014; Wilson et al., 2013).

In a Western context, TIA has gained influence in international policy making circles. For example, in the United States there are many programmes designed to integrate the TIA at federal, state and community levels (Melz et al., 2019). Within the United Kingdom, the Scottish and Welsh Government are seeking to

develop and integrate the TIA into a range of public services. (Scottish Government, 2020; Welsh Government, 2021). This is equally the case in England, with Plymouth leading the way by seeking to become the United Kingdom's first 'trauma informed city' (Plymouth City Council, n.d.). The TIA is not only being advanced geographically but also practically, being applied to an ever-greater range of public services including children and youth, education, and health services, probation, and policing.

Critiques and limitations

The TIA is not without criticism. Conceptually, 'trauma' is a far-ranging concept that covers a wide range of experiences, and also a broad spectrum of outcomes. In considering how the concept of 'trauma' has been advanced in the TIA, Wastell and White (2017) argue that there are fundamental problems with how original research on trauma experiences has been interpreted for policy and practice. They argue that the original science underpinning our understanding of trauma expresses uncertainty and tentative conclusions, but that this inconclusiveness has been removed in the translation to practice in the TIA, resulting in definitive answers and concepts that are no longer consistent with the foundations of trauma research. Their concerns raise important conceptual and philosophical questions regarding how trauma is defined and understood, and how this is translated into practice.

Equally, there are conceptual implications as a result of the link between trauma and the original ACEs study. As the concept of trauma was boosted by the publication and promotion of the ACEs study, the case for the TIA is often justified by the research on ACEs. However, as Berliner and Kolko (2016) argue, not all harmful or stressful life experiences that the ACEs study examined were traumas; the two are not synonymous. Furthermore, there are those who have criticised the concept of adversity used in the original ACEs study to argue that not only do the components fail to identify adverse experiences (a parental separation is considered an adverse experience when this could be a protective one, for example) but that it is also a very narrow concept that misses many other forms of adversity, particularly wider individual, social and community forms of adversity such as chronic illness, or on-going social harms like poverty, deprivation or discrimination (White et al., 2019). There are on-going academic and practical debates relating to how to address the effects of trauma and ACEs. For example, Steptoe et al. (2019) argue there is a need for more information on approaches that address ACEs, while Asmussen et al. (2019) review a range of interventions that seek to address ACE-related trauma. To address such criticisms, some policy makers have included broader forms of adversity in the conceptualisation of the TIA, such as the Trauma Informed Plymouth Network who discuss 'Adverse Community Environments' (Trauma Informed Plymouth Network, n.d.). While such acknowledgements help the policy to address a wider range of experiences, it takes the conceptualisation of the TIA further away from the original idea of addressing 'trauma' per se.

Moreover, there are some criticisms regarding some TIA practices. Within the TIA, there is typically some form of screening used to identify trauma and refer for treatment, and that the screening tool is usually the ACE checklist or an adaptation of it (Schulman and Maul, 2019). Notwithstanding the issues of what the ACEs checklist actually measures (as discussed above), one of the authors of the original ACEs study has since argued that it has been misappropriated and misapplied to service delivery and professional practice, cautioning against its use in such a way (Anda et al., 2020). Furthermore, there is evidence that this medicalised model of screening, referring and treating does not sit well with more socially oriented services, with Kerns et al. (2016) finding practitioners feeling uneasy about the use of screening tools to identify trauma. Joy and Beddoe (2019), meanwhile, criticise the ACE tool for not being sensitive to culture, race, poverty and wider issues of power, while Kelly-Irving and Delpierre (2019) argue the ACE tool is not appropriate for individual level assessment.

Linked to these conceptual and operational issues have been criticisms of how a trauma perspective has been implemented into policy and practice (UK Parliament, 2018). Despite existing guidance that has been given on the TIA (e.g., SAMHSA), Donisch et al.'s (2016) research into the opinions and experiences of professionals involved in working in a trauma-informed way found uncertainty about how to actually implement the TIA in practice. Their research found substantial variation in how the TIA was defined and understood among practitioners, and highly idiosyncratic implementations of practices across systems. As they note, there are "varying terms, [a] lack of common lexicon, and differences across systems in knowledge and skills" related to the TIA, and what is lacking is a unified conceptualisation and operationalisation of the approach (Donisch, 2016, p. 131).

The TIA was developed within a specific context to work with people who had most likely experienced trauma. The wider application of this approach to different contexts and more diverse populations, for whom trauma may not be the main issue, inevitably brings complexities and challenges. Conceptual questions are raised about whether 'trauma' is the most appropriate lens through which to organise practice and services. Furthermore, there are operational and implementational questions regarding how the TIA is successfully put into practice in a consistent manner that is supported by a robust evidence base. The point is not that the TIA is not a useful way to frame policy and practice, but that it may not be the most effective way to frame all policy and practice for all groups. The question is not just what do we gain by using the TIA, but also what is left out?

In what follows, we discuss how a consideration of shame, along with its impacts and effects, is missing in the TIA. We argue that this omission will be detrimental, leading to the potential ineffectiveness of trauma-informed interventions. As a necessary supplement to any TIA, we argue for the concept and practice of shame-sensitivity.

Shame

Shame has recently been included in the diagnostic criteria for PTSD in the DSM-V under the umbrella of "persistent negative emotional states" (Taylor, 2015). Hence, shame has recently come to be identified in the trauma literature as part of a constellation of negative emotions (along with fear, horror, anger, guilt) that are common for trauma survivors in post-trauma states. Understanding shame and its role in post-trauma states is, as shall be discussed below, central to the success of the TIA.

Shame is a defining and central feature of human experience and all human relationships, intimately linked to one's self-perception, social worth, identity, relationships and position within a social group, while also being connected to social control and power through the normative boundaries which determine what is shameful and what is not in a particular society or culture (Dolezal, 2015a, p. 107). Because of its significance and prominence in both personal experience and within social life, shame is considered by many to be the "master emotion" (Scheff, 2004). Shame is commonly characterised as a negative self-conscious emotion; it is an experience that arises when we are concerned about how we are seen and judged by others. We feel shame when we are seen by another or others (whether they are present, imagined or simply a viewpoint that has been internalised) to be flawed in some crucial way, or when some part of our core self is perceived to be inadequate, inappropriate, or immoral.

The term 'shame' should be considered an umbrella term that refers to a whole range of experiences, including cognate emotions such as embarrassment, chagrin, mortification and humiliation. As James Gilligan usefully notes, in the same way "that we use the term 'flower' as a generic term to refer to a wide variety of different but related plants" then the term 'shame' encompasses a wide range of experiences including: "feelings of being slighted, insulted, disrespected, dishonoured, disgraced … demeaned … treated with contempt, ridiculed … mocked, rejected … feelings of inferiority, inadequacy … of being a failure, 'losing face', and being treated as if [one is] insignificant, unimportant or worthless" (Gilligan, 2003, p. 1155). What is common to all of these experiences is a sense of being judged negatively by others, and a feeling of being worth less than others.

During a shame experience, we can feel deeply and often irreparably flawed, unworthy and unlovable, and that our social position and our social bonds are under threat. Shame can provoke powerful feelings of despair, inferiority, powerlessness, defectiveness and self-contempt, to name a few. In addition, shame itself is shameful and taboo. As such, shame is an "iterated emotion," (Dolezal and Lyons, 2017, p. 258); its experience can lead to an intensification or multiplication of itself, leading to a "feeling trap" (Herman, 2011, p. 266) where "one can become ashamed because one is ashamed" (Taylor, 2015). For these reasons shame is usually avoided, shunned or kept secret at all costs, both individually and collectively.

While shame is a negative experience for an individual, it is an inevitable and necessary part of human life. Healthy shame can lead to the expression of positive attributes such as modesty, humility and gratitude, along with respect for oneself and for others. It can also be a powerful motivating force for personal growth and change, and in forging harmonious and meaningful relationships with others (Ng, 2020; Sanderson, 2015). However, healthy shame is very easily distorted and can become 'unhealthy', "maladaptive" or "destructive" (Sanderson, 2015, p. 22). As John Bradshaw notes, "shame as a healthy human emotion can be transformed into shame as a state of being… [which] is to believe that one's being is flawed, that one is defective as a human being. [Shame] becomes toxic and dehumanising" (Bradshaw, 2005, p. xvii). Toxic shame, Sanderson notes, "paradoxically severs connections, destroys social bonds and can lead to antisocial behaviour" (Sanderson, 2015, p. 22). Toxic shame is corrosive and pernicious, and can lead to a pervasive and enduring sense of inferiority, inadequacy, defectiveness, along with a sense of not being worthy of respect, love or connection. It is an experience that can be organise one's self, life and world, having a deep significance and impact on an individual and their life chances.

A typical shame response involves being overwhelmed with an intense feeling of conspicuousness and a strong sense of being judged by others, along with painful and negative emotions centred around one's feelings of inadequacy, all triggered by a mishap, mistake or transgression which has been 'witnessed' by others (whether they are present, imagined or internalised). This sort of shame response is commonly called "acute shame" (Dolezal, 2015a), insofar as it is a discrete emotional reaction in response to a trigger or event. In contrast, the toxic or pathological shame described above has a very different phenomenological profile, usually occurring in a chronic form. While chronic shame shares many of the painful features of acute shame, such as emotional pain, self-consciousness, a sense of visibility, it is not experienced as a discrete reaction of emotional torment and hyper-self-consciousness. Nor, as the term might imply, is it a state of perpetually feeling shame. Instead, chronic shame is frequently characterised, firstly, by the nagging and persistent *possibility of shame*, and secondly by a persistent sense of inadequacy, defilement, failure and lesser self-worth. Chronic shame can be characterised by what Leon Wurmser terms a "shame attitude" (Pattison, 2000, p. 85), where one's entire personality and character is structured around shame and shame avoidance.

Chronic shame is an elusive experience for several reasons. First, while 'chronic shame' is a term that appears in psychological, psychiatric and psychotherapeutic literatures, there is no clear definition of what constitutes chronic shame and it has been described through a variety of terms including "dispositional shame," (Leeming and Boyle, 2004) "shame-proneness" (Harris-Perry, 2011), "toxic shame," (Bradshaw, 2005) and being "shame-based" (Lloyd and Sieff, 2015), among others. There is no clear epidemiological data regarding the prevalence of chronic shame, nor is there any clear diagnostic criteria through which individuals can be 'diagnosed' as suffering from chronic shame, or understand their 'symptoms' to be mild, moderate, serious or severe (Pattison, 2000, p. 96).

Second, chronic shame is commonly characterised by the nagging and persistent *possibility of shame*, where, for the most part, shame itself is not necessarily realised in experience. Instead, what comes to dominate experience is a pernicious form of anticipated shame, or a persistent and heightened "shame anxiety," of which an individual may, or may not, be aware (Dolezal, 2021; Pattison, 2000). Shame anxiety appears in experience as a corrosive, undermining and persistent fear or anxiety about being objectified, judged, labelled and rejected by others; it is a persistent "fear of disgrace and being looked at by others with contempt" (Wilson et al., 2006, p. 125). This shame anxiety ultimately becomes connected to negative self-beliefs and self-conceptions; one comes to believe that the "core-self is defective, inadequate and unacceptable to others" (Sanderson, 2015, p. 24). It is important to note that shame anxiety may not be experienced as shame. Instead, it may be dominated by shame avoidance and, as such, characterised by emotions such as fear, anxiety, self-consciousness, stress or powerful impulses to hide, avoid or escape, along with negative feelings about the self, characterised by a sense of inadequacy, defilement or deficiency in relation to others.

While chronic shame has many causes (e.g., societal expectations, stigma and discrimination, psychopathology), it is clear that a significant cause of persistent chronic shame is trauma, where childhood relational trauma and traumatic experiences in later life are strongly correlated with experiences of chronic shame and shame anxiety (DeYoung, 2015; Kalsched and Sieff, 2015; Pattison, 2000). There is also evidence that chronic shame plays a role in PTSD symptom severity (Cunningham, 2020; La Bash and Papa, 2014; Lee et al., 2001). In fact, common defensive scripts or shame-avoidant behaviours seen among those who live with maladaptive chronic shame "bear a strong resemblance," as Taylor notes, "to the prominent symptoms and behaviours" associated with PTSD (Taylor, 2015). And many experiences related to shame, such as chronic rumination, flashbacks, emotional avoidance, intrusions, hyper-arousal, dissociation and fragmented states of mind are similar to experiences associated with trauma and post-trauma states (Budden, 2009, pp. 1035–1036; Theisen-Womersley, 2021, pp. 210–211).

Shame and trauma

There is a growing literature that explores the centrality of shame for individuals who have experienced trauma (Budden, 2009; Cunningham, 2020; DeYoung, 2015; Goldblatt, 2013; Herman, 2011; Lee et al., 2001; Øktedalen et al., 2014; Plante et al., 2022; Saraiya and Lopez-Castro, 2016; Sieff, 2015; Taylor, 2015; Theisen-Womersley, 2021; Wilson et al., 2006). Trauma research has seen the recent development of the idea that "shame and trauma

are inextricably linked" (Theisen-Womersley, 2021, p. 211), where some argue that "post-traumatic shame" is a key experience that shapes post-trauma states (Theisen-Womersley, 2021), while others have come to theorise and describe PTSD as a "shame disorder" (Herman, 2011; Salter and Hall, 2020), with evidence demonstrating that chronic shame plays a role in PTSD symptom severity (Cunningham, 2020; Lee et al., 2001). Overall, this body of research argues that shame is a world-organising affect for many trauma survivors and that shame is behind much of the maladaptive behaviour associated with trauma, PTSD and other post-trauma states.

The cause of shame in post-trauma states is complex, but there seem to be a multitude of overlapping factors which render shame a predominant, if not the dominant, emotional experience following trauma. Research demonstrates that shame can brought on by: the traumatic experience itself (Budden, 2009; Lloyd and Sieff, 2015); incorrect or inaccurate feelings of blame or responsibility for what happened in the traumatic event (e.g., "it was my fault…", "this wouldn't have happened if I had just…") (Bhuptani and Messman, 2021; Kalsched and Sieff, 2015; Wilson et al., 2006); feelings of defilement and unlovability as a result of neglect or abuse, particularly in childhood (Pattison, 2000); rumination about one's behaviours, actions and reactions at the time of the trauma (Lee et al., 2001); the sense of being damaged or defiled as a result of having experienced trauma or having a trauma diagnosis, such as PTSD (Herman, 2011); the symptoms of PTSD or a post-trauma state (Lee et al., 2001); the labels attached to one's identity as a result of trauma and post-trauma outcomes (e.g., "victim", "survivor", "addict", "homeless") (DeYoung, 2015; Theisen-Womersley, 2021); the coping mechanisms one engages in to cope with trauma (Herman, 2011; Taylor, 2015); fear of judgement by others if they discover one's trauma (Øktedalen et al., 2014); the social taboos associated with the trauma that one has experienced (e.g., childhood sexual abuse by a family member) (Banaj and Pellicano, 2020); revealing trauma in clinical and psychotherapeutic encounters (DeYoung, 2015; Goldblatt, 2013; Lanksy, 2000); falling short of one's own ideals and standards (Goldblatt, 2013; Kalsched and Sieff, 2015); and because of the taboo and shameful nature of shame itself (Herman, 2011; Taylor, 2015; Wilson et al., 2006). Hence, in addressing the impact of emotions for trauma survivors, for the treatment of PTSD, and within the TIA, Taylor's question "have we failed to see the obvious?" with respect to "the influence of shame on posttrauma disorders" seems particularly pertinent (Taylor, 2015).

Understanding shame, and in particular chronic shame, as a keystone sequela of trauma experiences has the potential to elucidate the root cause of a range of maladaptive behaviours associated with trauma. The lack of trust and empathy within intersubjective encounters suggested by some to be characteristic of trauma survivors (Wilde, 2019) are accounted for affectively through understanding shame as central to post-trauma states. However, as noted above, chronic shame is difficult to identify and 'diagnose'; it is an elusive experience that is often 'disguised' or 'camouflaged' by other experiences and feelings. The relational psychotherapist Patricia DeYoung notes that what those who suffer from chronic shame, "may not daily or consciously expect to be annihilated by shame. However, the threat is always around somewhere, just out of awareness, kept at bay" (DeYoung, 2015, p. 19). DeYoung describes chronic shame as "silent," where some of her clients who suffer from chronic shame do not even know that they are anticipating shame (and related strategies to avoid shame) with debilitating frequency. What they live with is not shame, but "what it costs them to keep from falling into shame" (DeYoung, 2015, p. 19). Bradshaw concurs writing that for those living with toxic shame, "everything is organised around preventing exposure" (Bradshaw, 2005, p. 139). As a result, what characterises the experience of chronic shame in post-trauma states is not enduring or repetitive experiences of shame but rather an atmosphere of anticipated shame, or shame anxiety, that leads to compensatory behaviours or experiences.

In this way, in experiences of chronic shame, shame *itself* often becomes invisible and what dominates experience is other behaviour or feelings which are used to help circumvent or avoid shame, or to mask or cope with the pain of shame. As Pattison notes, individuals who experience chronic shame "live their lives trying to avoid occasions and relationships that might provoke painful shame experiences" (Pattison, 2000, p. 83). DeYoung concurs: "the pain [of shame] can be unbearable. To save ourselves, we push shame away as fast as we can, covering for it with more tolerable states of being" (DeYoung, 2015, p. xii). Helen Block Lewis discusses this experience as "bypassed shame" (Lewis, 1971), where the self is not conscious of feeling shame directly, and instead bypasses or 'displaces' shame for other emotions, states or experiences (Brown, 1998, p. 146).

As a result, living with chronic shame can lead to a range of compensatory behaviours; these are powerful "defensive scripts" (Kaufman, 1993, p. 113; Pattison, 2000, p. 111), "strategies" (Sanderson, 2015, p. 24) or patterns and habits of interaction, which make it possible for an individual to avoid the social threat, pain and emotional anguish that comes with shame and its chronic anticipation. Lanksy links these to the experience of living with trauma, stating the "posttraumatic state gives rise to shame and to defences that keep shame arousing awareness from consciousness" (Lanksy, 2000, p. 133). Wilson et al. concur, noting that, "the powerful emotions of posttraumatic shame … are associated with a broad range of avoidance behaviours: isolation, detachment, withdrawal, hiding, nonappearance, self-imposed exile, cancellation of appointments, surrender of responsibilities, emotional constriction, psychic numbing, emotional flatness, and non-confrontation with others" (Wilson et al. 2006, p. 138). These avoidance behaviours help an individual protect themselves from shame through avoidance, or "by placing it outside of conscious awareness" (Sanderson, 2015, p. 24). In this way, shame can, as Wilson et al. note, "operate unconsciously in trauma complexes and initiate self-destructive and self-defeating modalities of behaviour" (Wilson et al., 2006, p. 129). Hence, instead of shame, what is seen externally are other reactions, responses and behaviours that "mask the shame" (Ng, 2020, p. 30).

The psychiatrist Donald Nathanson theorises "the compass of shame", where shame-avoidance behaviours follow four common patterns: withdrawal, avoidance, attack other and attack self (Nathanson, 1992, pp. 305–377). Common defensive behaviours include a variety of different reactions, all of which are damaging both to oneself and to one's social bonds, such as anger, aggression, hostility, violence, narcissism, depression, perfectionism, apathy, withdrawal, avoidance, excessive deference, among others (Nathanson, 1992; Pattison, 2000). These common defensive reactions to shame are, as Taylor notes, "consistent with many of the symptoms and comorbidities of PTSD" and post-trauma states, including anger, violence, addiction, isolation, feelings of hopelessness and helplessness which can progress to depression and even suicide ideation (Taylor, 2015). What becomes problematic in understanding and treating trauma and the post-trauma states is that these avoidance behaviours for shame are "easily misread" (Theisen-Womersley, 2021, p. 212) and shame often becomes invisiblized and, consequently unacknowledged, in efforts to provide care, treatment and support.

In fact, it has been demonstrated that shame is a "potent treatment barrier" for trauma survivors (Saraiya and Lopez-Castro, 2016), leading to outright avoidance, and to dropping out and attrition once engaged with care and services. As Plante et al. note, shame "generates an urgent need to hide and conceal the

defective self from exposure" (Plante et al., 2022). Indeed, there is ample evidence that the 'necessity' to avoid shame or shameful exposure can interfere with individuals accessing healthcare (Dolezal, 2015b; Dolezal and Lyons, 2017; Lazare, 1987), and also prevent individuals from reporting traumatic incidents such as abuse, sexual assault and violence (Hlavka, 2017; Weiss, 2010). In addition, shame prevents the reporting of shame itself, as individuals "in clinical settings are sometimes reluctant to disclose feelings of shame out of fear from being exposed and rejected" (Øktedalen et al., 2014, p. 600). In these complex and overlapping ways, shame experiences lead to concealment and avoidance, consistent with the "hallmark symptoms" of PTSD and post-trauma states (Saraiya and Lopez-Castro, 2016).

Hence, in the context of seeking help through health, care or social services, individuals who are chronically anxious about shameful exposure may avoid seeking help in the first place, may regularly miss appointments, may avoid disclosing honest details about traumatic events, lifestyle or circumstances, may fail to follow through with treatments, and may conceal diagnoses and coping behaviours from friends, family and professionals (Dolezal and Lyons, 2017). In fact, not only is shame a barrier to accessing services, it is very easily exacerbated and incited in the context of seeking help from professionals; professional practice and public policy are frequently "vectors of shame, humiliation, and inequality" (Salter and Hall, 2020, p. 10). Moreover, shame is a relational emotion that is frequently present in clinical and care encounters (Dolezal, 2015b; Lazare, 1987). Interactions with care professionals can compound feelings of shame, as these interactions often involve unequal power relationships, a fear of being judged, the scrutiny and exposure of one's potentially 'shameful' past, circumstances, lifestyle, coping behaviours, body, illnesses, along with other vulnerabilities. Despite shame's ubiquity and its obvious impact in encounters with health and care professionals, there is evidence that addressing shame is routinely avoided in clinical and therapeutic encounters, as practitioners themselves are reluctant to acknowledge shame or address experiences which may lead to shame or embarrassment (Lewis, 1971).

It seems clear that being attuned to experiences of shame and chronic shame, along with the common 'scripts' and 'strategies' deployed to avoid shame and shameful exposure, becomes central to achieving trauma-informed practice, and in fact central to facilitating individuals to seek help and engage with health, care and social services. However, a consideration of shame, along with its impacts and effects, has not been part of the conceptualisation of the TIA, nor an explicit focus in its practice. Indeed, shame is rarely even mentioned in the academic and grey literature about the TIA.

To address this lacuna, we argue for shame-sensitivity to be central to the theory, policy and practice of any TIA. However, the relevance of shame-sensitivity is by no means limited to the TIA. As everyone experiences shame or is vulnerable to shame, shame-sensitivity is of general benefit to all populations and provides a unified framework for good care when working with people more humanely. We do not argue that shame-sensitivity should replace a 'trauma lens'. Rather we argue that shame-sensitivity, and using a 'shame lens', is both necessary for, and has wider application than, the TIA.

Shame-sensitivity

Shame-sensitivity is a concept and practice for health and human services. There are three central components to the concept. The first is that shame is inevitable. We all have the capacity to experience shame (with a debate about a very small number of individuals (Kosson et al., 2015)), while many vulnerable people live with chronic shame. Interactions with services can, and often do, evoke shame in the people who engage with those services. Second, because shame is a highly unpleasant experience, humans have evolved and developed strategies to avoid shame, and these strategies influence an individual's thoughts, behaviours and social interactions, usually for the worse. Third, it is incumbent upon services that work with people to acknowledge and respond appropriately to people's shame in order to mitigate its potential negative effects and impacts. In other words, services need to be shame-sensitive.

While there are a variety of ways to implement shame-sensitivity in practice, and these should be tailored to the specificity of the service provision in question, we outline three key principles for shame-sensitive practice, which we refer to as the 3As: acknowledging shame, avoiding shaming, and addressing shame.

Acknowledging shame.

Individual understanding of shame: Practitioners working in human services must have 'shame competence'. They must have a theoretical and practical understanding of what shame is, how it operates, how it is evoked, how it can be hidden, and understand the behaviours that are used to cope with shame. Not only must individual practitioners be sensitive to the experience of shame in others, but they must also be sensitive to shame within themselves, understanding how shame experiences can affect their own thinking, actions, behaviour and attitudes towards others. Practitioners must also have an understanding of how shame circulates between individuals and within organisations, and also be able to understand when shaming is present in policy and practice.

Organisational understanding of shame: Individual shame competence cannot take place without a system of support that accepts the existence, importance, and significance of shame; both for the practitioners themselves and for patients/clients/service users. This involves the fostering of emotional communication within professional practice, where speaking about and understanding emotions, and their effects, within professional practice becomes commonplace (Gibson, 2014). In particular, the taboo regarding shame, and shameful or stigmatised states and experiences, must be directly addressed. An organisational perspective not only recognises the possibility for the evocation of shame by individuals but also the possibility that organisational policies and procedures can evoke shame in staff and patients/clients/service users.

Appreciating the differential experience of shame: A significant part of individual acknowledgement of shame is understanding how people come to experience shame, knowing that the boundaries for what is considered shameful can vary for individuals and for different groups. There are variable pressures, standards, contexts, histories and expectations placed on individuals and groups, which can result in shifting signification of what is considered 'shaming' or 'shameful'. By ensuring there is meaningful engagement and collaboration with different communities and groups to understand their particular sensitivities to shame, along with common behavioural responses to avoid the experience of shame, organisations can support individual and collective knowledge and understanding.

Recognising shame and shaming: Acknowledging shame moves beyond knowledge of shame theory to also include being able to recognise shame and shaming in experience and practice. Not only is shame frequently hidden and notoriously difficult to admit to, but it is also taboo and shameful. People go to great lengths to hide shame and what they consider to be shameful. Practitioners and organisations must become adept at using a 'shame lens' to identify shame through both

physiological, psychological and social indicators. Practitioners must become aware of common verbal, paralinguistic, and nonverbal cues that may indicate a shame state (Gibson, 2015; Herman, 2011; Retzinger, 1995). These include postural and embodied cues (e.g., covering the face, blushing, downcast eyes, etc.), common terms used instead of shame (e.g., 'self-conscious', 'embarrassed', 'foolish', 'worthless', 'inept', 'inferior', etc.), paralinguistic cues (e.g., stammering, silence, long pauses, etc.). Practitioners must also become adept at recognising bypassed shame, through knowledge and recognition of common avoidance behaviours for shame (cf. 'the compass of shame'). Practitioners must also become alert to shame dynamics within interpersonal encounters, recognising that shame is a "two-way street" and "contagious" (Theisen-Womersley, 2021, p. 212). This means it can transfer from client, patient or service user to the practitioner, infecting an entire interaction. Practitioners must also have an understanding of how shame circulates within professional organisations and institutions and be able to identify, and also address, implicit and explicit shaming in policy and practice.

Avoiding shaming.

- *Avoiding individual shaming:* Any individual can explicitly seek to shame another person, whether this is a manager to manager, manager to employee, employee to manager, employee to employee, employee to patient/client/service user. With knowledge and understanding of shame and shame dynamics, individuals within a shame-sensitive organisation, practising shame-sensitivity, would actively seek to avoid shaming others. However, they should also be sensitive to the potential for implicit shaming, recognising that any relationship where there are power differences can be inherently shame-inducing (Dolezal, 2015b; Lazare, 1987; Ng, 2020). Individuals engaging with services are expected to expose their vulnerabilities (including their physical bodies, their lifestyle, their illnesses, mental health status, and potentially share intimate details about their past, their families, their feelings etc.), which are then the subject of scrutiny and professional assessment. Practitioners must remain alert to, and continuously assess, how the language they use, their demeanour, questioning style, emotional expression and other interpersonal dynamics may inadvertently produce a shame response (Ford et al., 2021). Furthermore, consideration must be given to interpersonal dynamics, based on gender, race, ethnicity, language-spoken, disability, age, religious identification, along with other factors in particular situations (e.g., a female police officer may be the most 'shame appropriate' practitioner to interact with a female victim of sexual assault). Practitioners should also avoid stereotyping, labelling and other stigmatising ways of engaging with individuals. It is imperative to remain responsive to individuals and their unique circumstances and to genuinely acknowledge distress.
- *Avoiding collective shaming*: Many initiatives rely on shame as the affective driver of the change they hope to promote (e.g., shame is frequently used in public health campaigns, for example, to combat obesity or improve hygiene (Brewis and Wutich, 2019)). Such shaming attempts are examples of how whole groups of people can be targets for shame. While there are some initiatives that have an explicit aim to shame groups of people, there are many other initiatives, policies and procedures that have the effect of shaming groups of people, even when this is not intended. Avoiding collective shaming involves being alert to how shaming may become implicit within policy and practice, for instance through the use of stigmatising language, or through creating dynamics of blame and individual responsibility for circumstances or conditions that may be resulting from structural conditions (e.g., poverty, obesity) or that may stem from a post-trauma coping behaviour (e.g., addiction, mental ill health).
- *Evaluating impact of practice for shaming*: Not all proactive attempts to avoid shaming will be successful. To ensure that there is a reflexive feedback system to inform the proactive shaming avoidance attempts, organisations and practitioners must conduct and engage in a process of ongoing evaluation of the impact of their practice, policies, and procedures on the people they come into contact with; both within (employees) and without (patients/clients/service users) of the organisation (Dolezal et al., 2021). This involves vulnerability, and requires critical reflection on past and future practice. There must be willingness to admit mistakes, openness to critical reflection and flexibility to make responsive changes in policy and practice. Furthermore, organisations must create and systematise nuanced and collaborative understandings of how shaming is produced, and how shame is experienced, as a result of their policies and practices, avoiding attributing blame and shame to individuals where there is a disconnect between policy and operational capacity, especially in cases of chronic underfunding. Collective accountability for shame-sensitive or shame-reducing practice begins with mutually-agreed goals and frames of reference; such as an institutional code of conduct, or a shame-proofing toolkit (Dolezal et al., 2021). Cultures and practices of shaming and blaming must be avoided within organisations (Creed et al., 2014). Cultures of dignity, openness, learning and emotional intelligence should be fostered.

Addressing shame.

Addressing individual shame: Being able to address individual experiences of shame requires an understanding of how and why a person experiences their shame and finding ways to work through or around it. This, firstly, means understanding the person in their context and personal history, which will highlight the reasons for the shame experience. Secondly, it necessitates creating a sense of emotional safety (Gibson, 2019), where individuals feel able to talk about their experiences without fear of judgement, criticism, or ridicule, and also with a belief they will be understood and accepted for sharing their feelings. Thirdly, issues related to the experience of shame must be directly discussed in an empathetic and sensitive manner. Language and terminology must be carefully chosen, as the term 'shame' can itself be shame-inducing. Alternative phrasing might be more appropriate (e.g., 'feeling judged', 'feeling self-conscious', 'embarrassment', etc.). Unacknowledged and unspoken shame can give the "toxic beliefs that are inherent in shame" some legitimacy (Gibson, 2015, p. 339) and bringing these beliefs out in the open provides the opportunity to unburden the person from shame and reduce the influence it has on interactions. Furthermore, such sensitive discussion of shame requires attentiveness to the person's needs for support and connection after sensitive disclosures of shame or shame-inducing states, events or circumstances.

Supporting shame resilience: While attempts to address shame can occur in any interaction, the effects of shame and disclosing shame can have longer term consequences (Dearing and Tangney, 2011). The experience of shame can leave individuals to "feel isolated … and shy away from reaching out to people who may be able to offer help for fear of rejection and further shame" (Gibson, 2015, pp. 339–340). Shame-sensitive practice, organisations, and systems, therefore, need to embed shame resilience into the ways they address shame. At the heart of shame resilience is the development and deepening of social bonds (Brown, 2006). It is imperative that practitioners engage in practice that creates and promotes sustainable relationships with and within any organisation (Gibson, 2015). Organisations and services need to ensure continuity with individual practitioners so meaningful relationships grounded in familiarity, trust and empathy can be developed. Practitioners and services need to be proactive in reaching out to individuals, especially when they disengage. Individuals should not be made to feel cut off, disconnected or discarded from services. Structural factors such as the availability of appointment times, accessibility of clinical spaces, ease through which one can contact the service, length of waiting lists, duration of service, continuity between services, must be continually assessed to ensure that individuals feel supported and a sense of connection is maintained. Furthermore, friend and family networks must be supported so that individuals have sustainable networks of support. In addition, practitioners must be supported by their organisations and institutions to have the time, support and resources to engage in genuinely relational practice, fostering connection, empathy and trust with the individuals they are working with and supporting.

Actively fostering the conditions for shame-sensitive practice: Organisations must actively work to create the conditions, policy and practices that promote shame-sensitivity, where relationships based on dignity, respect, empathy and trust are the first priority within workplaces and when delivering services. Practitioners must be supported within organisations to have the personal, professional and operational capacity to work in a shame-sensitive manner.

Combating the systemic causes of shame: The systemic forces which shape and define what is considered shameful or stigmatised are not immutable. In addition, many causes of trauma (e.g., social deprivation, domestic abuse) have their roots in societal and structural conditions which can be changed and improved. Practitioners, along with leaders and managers within organisations, must be given the resources and encouraged to be engaged in making meaningful changes. This will happen through creating cultures of engaged practice and political activity, where individuals are encouraged to write to local councillors or Members of Parliament, carry out research, engage with academic partners, become involved in local and national political campaigns, engage with media outlets, etc., with the overall aim of advocating and agitating for more humane and shame-sensitive changes in law, policy and practice (Gibson, 2019, p. 199).

Conclusions

Having the capacity, on the levels of policy, organisations and individual practitioners, to address shame directly is imperative considering the how impactful shame can be for those who have experienced trauma and post-trauma states. Being attentive to shame, and acknowledging its significance for individuals, in health and social care contexts, can improve both engagement and outcomes. Using a 'shame lens' alongside a 'trauma lens' is necessary for TIAs to achieve the goal of redesigning services to be more sensitive and supportive, with the ultimate aim of avoiding retraumatisation and any additional harm. As a result, TIAs must begin to integrate shame-sensitive practice. There are obvious overlaps and synergies with the main principles which guide TIAs, however focusing through a 'shame lens' will reveal significant affective dynamics that are otherwise occluded, overlooked or ignored.

Shame-sensitivity and using the 'shame lens' within organisations will enable more humane services which address and acknowledge a significant affective dimension of seeking help, namely shame and self-consciousness. Following the evidence that shame is a significant force within encounters with professionals within health, care and social services, introducing a 'shame lens' to the way these services are conceptualised and conducted, has the potential to transform interactions between professionals and patients/clients/service users, as well as among colleagues within services and organisations. The emotional intelligence that shame-competence affords will give practitioners greater awareness of social dynamics which will help manage interactions and relationships within encounters with more empathy, humanity and sensitivity. Having more awareness of emotions and emotional dynamics within workplaces has been linked to a range of positive outcomes, such as ability to handle stress, improved job performance, job satisfaction and leadership skills (Magny and Todak, 2021, p. 958). Understanding shame, in particular, can uncover and unlock a range of usually occluded dynamics between individuals and within institutions that have negative or damaging effects (Creed et al., 2014).

While shame-sensitive practice is essential for the TIA, it should be acknowledged that shame is a universal experience, and that shame-sensitive practice should be integrated into all service delivery, and not just seen as an accompaniment to trauma-informed care. All individuals experience shame, and this can be easily exacerbated in contexts where there are unequal power relations, such as in encounters with doctors, social workers, police and other health and care professionals. In addition, shame-sensitive practice is not intended to be a solution for the social ills that lead individuals to need to engage with services. The integration of this approach must be within broader societal efforts to reduce conditions that produce chronic shame, stigma and trauma, such as poverty, destitution, deprivation, long-term unemployment, violence, sexual assault, domestic abuse, displacement, etc. These principles for practice will be most effective in environments that have long-term viability and also are also well-resourced, where there is also widespread public confidence in services and organisations.

Offering an outline of the concept and the practice of shame-sensitivity, this article has highlighted what is needed for human services to effectively face shame and shaming and mitigate their negative impacts and effects. We argue that principles of shame-sensitivity, and the practice that goes along with it, are the starting point for any interactions, organisational changes, and policy developments. The corollary of this is that these principles and practices should precede a TIA, that they will address many of the issues that people face following trauma, but where additional care and support is needed these principles should be integrated into the TIA.

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SHAME

re-define it

A MANIFESTO FOR

THE ANTI ANXIETY REVOLUTION

Shame is part of the human experience. No one is exempt. Dirty Shame destroys humanness. Our capacity for creativity, passion and soulfulness is what is impacted. When you understand shame in yourself and others, you can redefine your relationship with shame and turn it from self punishment and self sabotage into love, remorse and compassion.

Chapters

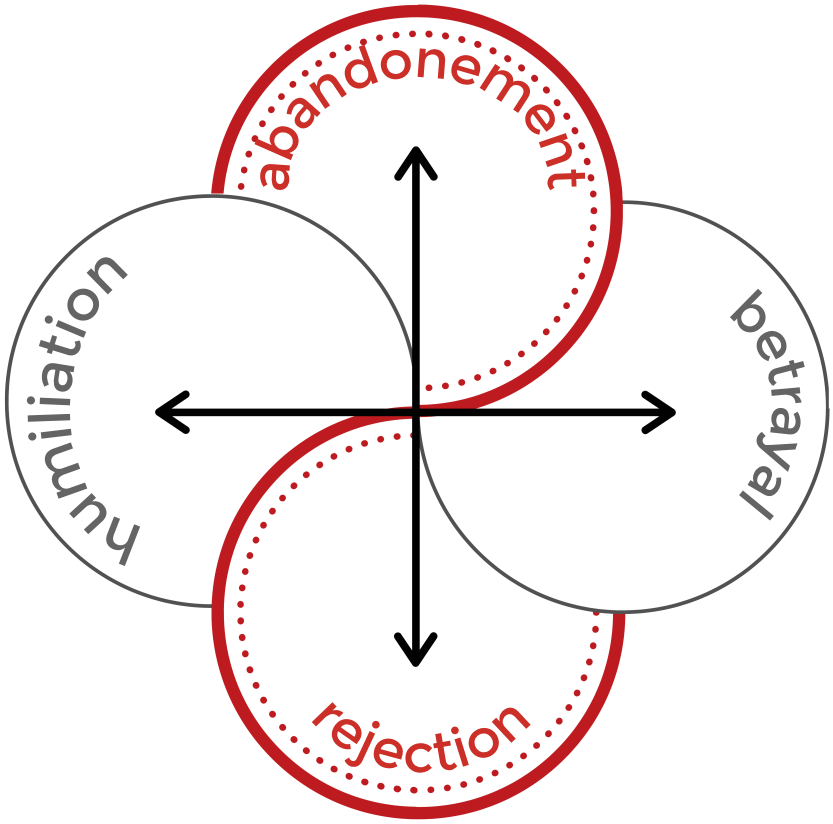
UNDERSTANDING AND HEALING SHAME - MADE SIMPLE

Shame is a part of the human experience. No one is exempt. We all need attention. Positive attention is felt as love and interest. When attention and interest is withdrawn it feels like shame. Shame says: there is something wrong with me. Unfortunately for most of us, the profound need for attention is often thwarted or insufficiently met. Instead of love and attention we are often met with the frustrations of betrayals, humiliations, rejections and abandonments. There is too much shame in our families, religious and educational institutions and political bodies. Shame-based individuals create shame-based systems and so shame is perpetuated. This is a major contributor to the endemic problems in mental health. One in three westerners suffer from generalised anxiety and depression. What we have is a catch-22. It becomes harder and harder to ask for attention, either in the form of a need being met or simply interest, and even desire, being shown.

Our shame inhibits our natural reaching out. We develop cognitive biases where we expect to be shamed. The feeling of shame is delivered through experiences of betrayal, humiliation, abandonment and rejection and the feeling strikes at the part of us that wants to love the world and be loved in return. A big part of the shame we feel when we are hurt is shame at being simply human, with human needs for love and attention. Think of each person as a block of wood. Shame is a 9-inch nail and the hammer is in the hands of the people, tribes and culture we find ourselves in. Over time the hammer connects with the nail through a myriad of small and large betrayals, humiliations, abandonments and rejections, which push the nail further into the wood. Once the nail is solidly in the wood, you are a shame-based person. Obviously, this happens over different periods and different intensities for everyone, for example, one big event can knock the nail into the wood.

COGNITIVE BIAS

Our brains like linearity; recognisable patterns. Your brain soon learns to recognise the shape and structure of a table and to know that it is a reliable shape to put an object on. Our brains are also taking in enormous volumes of information through our senses. Literally everything you see, smell, taste, hear, feel and intuit is stored in your brain. The amount of information is extraordinary. In order to cope with the volume of data and not cause an overwhelm, the brain does something called 'cognitive bias'. Bias filters out all unnecessary data. For example, if you open your facebook page, the amount of information coming at you off the page is too much to take in, so you will only see and be conscious of what you are looking for. When you go to a mall (an intense sensory input) to buy some clothes, your brain will do the same thing. It will filter out all the stimuli not related to the reason you are there. Shame becomes a bias too. It is way too painful to cope with all four shame streams and as soon as we are able, at approximately mid adolescence age, we unconsciously pick a bias. This manifests as any and all shameful experiences being processed through one bias. It looks like this: If your bias is humiliation, then when you experience a betrayal or rejection, it will feel like a humiliation.



SHAME BY ABANDONMENT

Most shame starts with abandonment. The core of all shame for a child is dependency. The intense feelings of dependency for a child are naturally shame inducing. The child soon learns it is absolutely dependent on the adult for its very survival. It is highly probable that you were crying in your crib, and no adult heard or came. This feels like abandonment. When you don't have your dependency needs met consistently as a child (and it is unlikely your needs were consistently met) you will feel a deep craving or emptiness for something unnameable. You feel alone in the big scary world. As an adult with the shame of abandonment as your primary lens, you have a cognitive bias that keeps looking for ways of belonging, to people, to places and to things. You will attempt to fill yourself up with your relationship to these.

We are abandoned in the following generic ways:

- The Abrahamic religions leave the children of God abandoned by The Father; left to fend for ourselves and find our way back to Him.
- You will wake up in the middle of the night, cry for attention, and no one will come, or they will come after what seems like an eternity.
- Adults will fail to notice when you have a need that requires meeting or will not have the emotional or financial means to meet it.
- A lack of ritual and rite that welcomes a child into a tribe and passes on the customs and traditions that denote a place of belonging.
- Through abuse of any kind

One of the first questions that needs to be asked and answered for an empowered life is "where do I belong, and to whom?"

The adult-child with the primary lens of abandonment will spend their energy looking for the place and the people they feel they can belong to, who they can come home to. Once this has

been determined, they will hang on for dear life. They will demand absolute loyalty. They need to be the centre of the relationship and to feel most important. They will be controlling and possessive because of the fear of loss. At the same time, this person will never quite feel 'at home' and have a restless, wandering spirit. They will be future oriented, always looking for someplace else or better whether that is a new job, country or mate in their desire for absolute belonging. Alternatively, they will be very nostalgic, archiving their pasts and hording memories.

BUT you belong to no one and no thing or place. Just like our children do not belong to us, we are all just passing through. The only place you belong is TO YOURSELF. Every path you ever take will lead you back to yourself. No man or woman is coming to rescue you from your under-lived life. Women, no man is going to protect you. Men, no woman is going to save you from your emptiness. No one can change you. No one can halt the passage of time for you. No one can carry you over obstacles. "I love you" is not a promise – it's a statement of hope.

Mystics say: "we are all just walking each other home." Mystics are right. We should trust them more. Sometimes, we have to wait patiently if our partner/friend, falls behind, and we hope they will wait for us too, if we slip and fall, or take a dangerous path. Home is where YOUR heart is. You are home when you can hold yourself with forgiveness in your own heart. Every path you take, every choice you make, will lead you back to you. There is literally nowhere else to go. This is not a downer, it is freedom. This is not romantic, it is intimacy. This is Truth. Truth to power. It is true that you were abandoned as a child and adolescent and that you were powerless to prevent it. You are now an adult and have your power back. Stop abandoning YOURSELF. No one has the capacity to abandon an adult who is taking responsibility for themselves.

SHAME BY REJECTION

When your bias is shame through rejection, it is your very authenticity that is being disavowed by others. The highest potential for you in your relationships and career is determined by how individuated and authentic you can be. Oscar Wilde said, "be yourself, as everyone else is taken". The movement of individuating is inherently shameful because you have to reject the ideas, beliefs and paradigms of others to come to know your own, while at the same time, you have to feel like you belong in order to survive, and belonging means following the rules of your family, club, peer group etc. It's a juxtaposition: how do I become myself yet not be rejected? Any kind of tribe, be it a family or a book club or soccer club, gets its strength from all the members following the rules, like eating the same foods, living in particular areas, dressing a particular way, studying the same subjects, praying to the same God etc. Because the need to belong is connected to very powerful primitive survival instincts, we learn very early on to reject parts of ourselves in order to have a place in our tribes and to survive.

In order for a tribe to stay solid, it will reject you, from early childhood, anything that threatens, questions, and brings into doubt the natural orders of the tribe. As a child, this shame will be taken into adulthood as the feeling and thought that no one wants your authenticity and that no one wants you for yourself alone and you have to sacrifice parts of yourself and your desires in order to be loved and accepted.

We are rejected by our tribe in the following generic ways:

- Our sexuality is rejected
- Our creativity and self-expression, expressed through fashion, music and ideas is rejected
- Our spirituality, the way we choose to commune with nature and divinity is rejected

The adult whose lens is shame through rejection, is putting everyone else first, trying to be the best, sacrificing themselves for others' dreams and aspirations and not taking opportunities that may empower them; stifling their essential self, for fear of further rejection; rejecting before they are rejected. In essence, the shame of rejection causes cowardice, and that cowardice leads to a 'half-life'. You will never reach your highest potential, in any area, as long as you need the approval of others to feel good about yourself and to trust yourself.

BUT no one can reject you if you stop rejecting yourself. No one can come to know the whole you if you have repressed huge parts of yourself. Those you love are in a relationship with someone who has supressed parts of themselves through self-suppression. Stop rejecting yourself. Start giving those parts of yourself a voice. Use a journal, some creative pursuit, or a seeking journey to collect the fragments of yourself you rejected in order to fit it and be accepted.

SHAME BY BETRAYAL

Betrayal is part of the human experience. We have all betrayed people and been betrayed. And it is likely that it will happen more than once. Betrayal exists because humans struggle with honesty and fairness. We demand and expect fairness but find honesty and integrity a challenge. As children, we have no choice but to put our trust in our parents and other adults like teachers. At some point we are going to perceive that we are being lied to. It is very frightening for a child to discover that adults and the adult world are untrustworthy. The very foundations of our security are rocked. The child will begin to doubt herself for not intuiting the truth and become distrusting of the adult world and what it says it stands for. Betrayal is one of life's great losses. When you are on the receiving end of a betrayal, what you lose is your innocence. You lose trust in yourself, in others and sometimes in Life herself.

If betrayal is your shame lens, then you will have a problem with trust *per se*. The most devastating part of this is not so much that you cannot trust other people but that you cannot trust yourself. You will make promises to yourself and break them repeatedly. You will let others down by using people pleasing strategies, saying yes to others to avoid a possible trust issue but inevitably letting them down. If you cannot trust people, then you may control them or control yourself so they don't leave you (or both). The best way to ensure you don't lose someone is to shame them. Make them feel smaller and less empowered and they are less likely to push back and or leave. In your career and external life, the shame of betrayal will make it difficult to expand and grow because we all need the help of others to be greater than ourselves, and the inability to trust anyone will keep your ambitions small and tightly wound.

Fundamental to trusting yourself is a healthy relationship with your intuition. Your intuition is there to keep you safe. It is constantly telling you who and what you can trust and who and what you can't. Shame by betrayal breaks this relationship you have with your intuition. As an adult, you cannot be betrayed without your permission. Rather, you are betraying yourself by refusing to trust yourself. When you ignore signs and symptoms of lying, cheating, obfuscating etc. in others, you are betraying yourself and your attention should not be on the deliverer of these experiences but rather on your denial of what you know to be true. You will further betray yourself by not keeping others secrets, stealing (money/time/energy/attention) from others and being covert and secretive in your dealings.

We are betrayed in the following generic ways:

- Lies about who the true biological parent is
- Lies about how life works – e.g. God made the world in 7 days
- The lie that as children we will be protected by the elders of the tribe
- Being told that good things happen to good people and bad things happen to bad people

BUT to work positively with the shame of betrayal you must acknowledge and then mourn the loss of your innocence. You must practice trusting your intuition and behaving with honour. Through this practice of grieving and trusting yourself you will reclaim your trust in a more profound and empowered way than before the betrayal. You will realise that the betrayals you experienced as a child were not personal but. rather, shame-based behaviours of un-resourced adults who didn't know how to be and do better. You will realise as an adult that there were many signs that the betrayal was inevitable, but you chose to ignore them. You will remember that your body was giving you warnings, through intuitive hints, repeatedly. With this awareness you will realise that you can trust yourself because you 'knew' and that you can therefore trust others again because you can rely on yourself to warn you in the future, and hopefully this time you will listen.

SHAME BY HUMILIATION

Parents and adults humiliate children in many ways. The humiliation can be covert or overt – here are some generic examples:

- Being sexually inappropriate with each other in front of their children
- Remarking on their children's burgeoning sexuality and body changes
- Humiliating the child for their perceived weaknesses (bad grades, sporting attempts etc.)
- Making the child feel powerless so they can feel empowered
- Making the child take care of their needs (alcoholic parent)
- Mocking the child for being sensitive and having magical ideas
- Telling the child they are sinful for exhibiting natural tendencies

Teachers and peers will do similar things.

A humiliated person has low self-worth. Their cognitive bias is that they are useless and worthless. There are a number of strategies the adult-child shamed through humiliation will resort to. The common denominator is to humiliate themselves before anyone else can.

- They can be perfectionists – in this way, no one can see how ashamed they are because from the outside, everything appears 'perfect'.
- They can be self-deprecating. Calling attention to their deficiencies before anyone else can.
- They can be very self-righteous, arrogant and bullying, making sure to humiliate first (Donald Trump is a classic example) which prevents anyone from getting too close to them for fear of a scathing attack or violence.
- They can wear their shame on their skin, being very obese or anorexic, covered in tattoos and piercings or dressed in a self-humiliating way. It is so obvious; no one will attempt to humiliate them more.

If this is your lens, work around self-worth is vital. Learning to take responsibility for your actions and thoughts is a good place to start; doing things that make you feel good about yourself – most powerfully, helping others in some capacity.

Now that you understand how you continue to shame yourself as an adult and what these behaviours look like, let's address why we perpetuate what seems to be such a self-defeating strategy. Think about it like this: When you get a splinter in your foot and your friend is trying to remove it for you, the anticipation is excruciating. You can't see what they are doing and you can't predict how much pain they will cause. If you took the splinter out yourself, you could psyche yourself up, stop when it became too painful and control the process.

Our shame bias works the same way. We expect shame to be coming in indefinitely and we make an unconscious decision to shame ourselves before anyone else can, in order to control the pain and suffering. We know best our tolerance for shame. Once you identify this strategy of

'false protection' in yourself, you can stop it by behaving with more honour, kindness, courage and acceptance towards yourself. Just seeing this is 50% of the cure.

SHAME IN RELATING

Our intimate relationships work like mirrors. We see our shame reflected in the significant other. In this sense, relationships offer opportunities to truly see ourselves and heal our shame. Abandonment and rejection are two sides of the same mirror and humiliation and betrayal are another mirror of each other. It is likely that you will 'fall for' and be attracted to someone who mirrors your shame bias. Self-abandoners are attracted to self-rejecters and self-humiliators are attracted to self-betrayers. If you have correctly identified your shame bias, you should see a clear pattern of this in your relationships.

This dynamic is unlikely to change over the course of a lifetime. What can and does change when you stop shaming yourself is that you attract a partner who is at the same level of healed shame as yourself.

SHAME IN SEDUCTION

In order to succeed and thrive in life we must be able to persuade and seduce. In order to seduce others, we must learn to make them like and love us. There is no exception to this rule. We all do it. We seduce through the flip of our shame. In a sense we give to others the best of what we have and in order to do that we must turn our shadow shames into traits that are desirable. This strategy is a counter intuitive desire to heal our OWN shame. The strategies we employ to win the love of others is the EXACT thing we should be offering ourselves to heal our own shame. Each shame bias seduces differently.

Abandoners and Rejecters have low self-esteem

Low self-esteem is the inability to take responsibility or to take too much responsibility. It sounds like: "I am not responsible for the way my life looks and feels. It is other people's fault that this happened or that I feel this way. When they fix themselves or 'it' I/we will be ok".

Low self-esteem in the mind of the abandoners' self-critic sounds like this in their internal dialogue: I am right they are wrong/I am misunderstood/I am not appreciated/I am overwhelmed by unbelievable demands/I have more responsibilities than everyone else/one day they will see I was right etc.

Low self-esteem in the mind of the rejecters' self-critic sounds like this in their internal dialogue: I am unseen/no-one wants me for myself alone but rather for what I can offer/I had better repress my authenticity/I had better repress my dark side/I cannot show or even allow negative emotions to be seen or expressed/I must be perfect etc.

When an abandoner wants to seduce, (s)he will tell their potential mate, client, friend: I am your soul-mate, I am your home/this relationship is fated/destiny/I loved you from the moment I met you/there was an instant connection/I will love you forever/I don't need anyone, I am totally self-sufficient but for you I will make an exception etc.

When a rejecter wants to seduce, (s)he will tell their potential mate, client, friend: I love your flaws/I have no problem with your wounds and dark side/let me help you heal/I admire your strength/your fortitude in surviving is inspirational/I will rescue you etc.

Once you have seduced your target and are now safely ensconced in relationship, the dark side of your shame will begin to arise. You will stop hiding your self-abandonment and self-rejection from your partner. We all know how this story goes…

Humiliators and Betrayers have low self-worth.

Low self-worth manifests as a need for approval and reinforcement. It sounds like "I need the approval of others to feel good about my decisions and choices around clothes, career, ideologies, plans and goals because I don't trust my own authority and intuition; If I have approval I can act (albeit not with much confidence)".

Low self-worth in the mind of the humiliator's self-critic sounds like this in their internal dialogue: I am fat/ugly/unintelligent/useless/incapable/less than others etc.

Low self-worth in the mind of the betrayer's self-critic sounds like this in their internal dialogue: I cannot trust myself, or other people or Life herself.

When a humiliator wants to seduce, she/he will tell their potential mate, client, friend: you are so beautiful, smart, capable, interesting, sexy etc.

When a betrayer wants to seduce, she/he will tell their potential mate, client, friend: you can trust me, I will never let you down.

Once you have seduced your target and are now safely ensconced in relationship, the dark side of your shame will begin to arise. You will stop hiding your self-humiliation and self-betrayal from your partner. We all know how this story goes…

THE STRATEGIES FOR HEALING YOUR SHAME

Rejection – have the courage to be authentic
Abandonment – come home to yourself
Betrayal – keep your word to yourself and others
Humiliation – practice humility and gratitude

Rejection – from the Great Pretender to the courage to be authentic

When you stop rejecting yourself before your (presumed) rejection by others, you have changed the shame game. Your healing lies in coming to truly know yourself, in the shadow and the light, and embracing your shadows (early rejection wounds) so you can begin to heal and transform them. It's learning to be vulnerable and to see vulnerability as the great form of courage that it is. It's understanding that you will occasionally be rejected, and not everyone is going to like you, just as you won't like everyone. Rejection isn't the suffering; the real pain is the denial of parts of ourselves so that we will be accepted and the prostituting of ourselves to avoid being rejected.

Abandonment – from seeking and wandering to coming home to yourself

Home is where your heart is. Every path you take will lead you back to YOU. The grass is greener on the other side because you are not on the other side yet. Wherever you go, there you are. We belong to ourselves first and foremost, and then we can find our tribes and the places that resonate with who we really are. You must belong to yourself first. From the place of self-belonging you can build strong, healthy tribes, friendships and family.

ABANDONMENT AND REJECTION ARE A CRISIS OF SELF-ESTEEM

Low self-esteem sounds like this (dirty shame): Everything that has gone wrong, or Is going wrong, is not my fault. It is the fault of the weather, the economy, my parents, my ex, the church, the group etc – It is never me, it is always them. Because it is not my fault or my choice, I can't change it. I must wait for the 'other' to acknowledge it is their fault and responsibility and fix it. Only then can I change things for the better. I am a victim.

High self-esteem sounds like this (clean shame): I take 100% responsibility for my life. My life looks and feels the way it does because of the CHOICES I HAVE MADE AND THE CONSEQUENCES OF MY CHOICES, because I am an ADULT. If I don't like how something is, I change my choices to change the situation. I never blame others. If someone hurts me, and it is honestly 97% their doing, I focus only on the 3% that is mine, taking responsibility for that 3% and working to change it for my own empowerment.

Betrayal – keep your word to yourself and others, cultivate honour

Stop making promises to yourself and others and then letting yourself and them down. Commit your word to action or don't commit until you are sure you can follow through. If you fail, forgive yourself and recalibrate immediately. Don't be a people pleaser (saying yes to everyone) because ultimately you will eventually let them down. Check in with how you are passive-aggressive. Work on trusting your intuition

Humiliation – practice humility and gratitude

Try this exercise: write down how you talk to yourself, all the self-effacing, self-critical, self-abusive things you say about yourself. Now say these things (or imagine saying them) to someone you like. Would you ever talk to another person like that? You cannot heal your shame of humiliation by re-shaming yourself. You are effectively re-traumatising your inner child and adolescent who had no defences against the humiliation coming in. Be kind to yourself. When you catch yourself criticising yourself, immediately change the self-talk to something kinder and more compassionate. Be humble with yourself and others, understanding that we are all very sensitive inside to all forms of shame, and everyone hurts, even if on the outside they appear immune. Focus on what it is about yourself that you can appreciate, and do more of those things. Set small goals of treating yourself with more respect and compassion. All change starts and ends with you.

HUMILIATION AND BETRAYAL ARE A CRISIS OF SELF-WORTH

Low self-worth sounds like this (dirty shame): I need the approval of 'everyone' before I can trust myself and make important decisions. If everyone approves of my choice, I might just avoid betrayal. If everyone likes my choice, they won't reject me.

High self-worth sounds like this (clean shame): I do not need the approval of others to feel good about myself or my choices. If 'they' reject and humiliate me because of my choices, as painful as that is, I acknowledge and understand that it is not personal and says more about them than me. Although rejection is very painful, I will not allow the feeling of rejection to stop me from making my own life, in my own way. The thing I trust most in this world is MY intuition which is the only thing that has authority over me. I accept the consequences of my choices.

CLEAN SHAME

If shame is so devastating why do we still have it in our reality? Why haven't we evolved beyond it? The answer is that at this point in our evolution shame is still the only way we humans learn to feel remorse and compassion.

A human being has a conscience. A conscience is an inner 'knowing' without having to be taught, that cheating, stealing, lying etc. is wrong. The conscience starts to assert itself at around 5 years old. Most adults can remember, viscerally, the first time they 'sinned', by stealing a sweet, or consciously lying to a parent. When we are betrayed, abandoned, humiliated or rejected, it triggers our conscience with a sense of guilt, and we feel sad. We physically and spiritually feel the loss of interest, attention or love as it is withdrawn through humiliation.

If there are normal levels of shame, like your mother being overly stressed and rejecting your need for approval, or your father not being aware and humiliating you about your low grades, you feel remorse for yourself at the loss of interest or love. This is healthy in appropriate doses. There is no other way we can develop a strong conscience and compassion for ourselves and others. If there is too much shame, our conscience, instead of developing healthy radar for guilt, turns guilt into shame. The result is someone who can feel some remorse and compassion for others but cannot feel any for themselves. To shame oneself is to act without remorse or compassion. To shame others is to be remorseless. We are capable of remorse in direct proportion to our healthy or unhealthy levels of shame. Normal levels of shame build stamina in our conscience whilst unhealthy levels of shame create remorselessness.

Too much shame causes a lack of conscience and means nothing is sacred and everything can therefore be exploited, like other people, the environment and the natural laws that function in perfect balance. We can see the result of this in the breaking down of our cultures, religions, politics and economics. It is lack of compassion for the self and the other that is the base line of the systemic collapses. Guilt says: "I did something wrong. I made a mistake." Shame says: "I am wrong. I am the mistake". Healthy guilt is a healthy conscience. Unhealthy shame is self-punishment. We must learn to turn our shame into guilt. Healthy guilt strengthens our conscience which is an aspect of our soul or highest self. Shame makes us refocus on our own trauma and inadequacy, which is self-indulgent and inevitably re-traumatises. Guilt makes you focus on the other(s), who you are hurting with your shame. Our worldviews create our worlds.

Heal your shame and you add your drop of compassion into the oceans of the world. Heal your shame and you will stop shaming others. That is the only power you have. It's a small thing that is huge.

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Positive psychology is not the first thing people think about when they think of criminal offenders, nor are values and mindfulness. In our program of research, however, we have found multiple lines of research from positive psychology useful at enhancing inmates' reintegration into the community. In this chapter, we describe three forms of intervention that we have been implementing and evaluating in the context of a larger program of longitudinal research on moral emotions and moral cognitions (Tangney, Mashek, & Stuewig, 2007). We first describe the Impact of Crime (IOC) workshop, an innovative group intervention that draws on a "guilt-inducing, shame-reducing" restorative

justice model. Next, we describe our efforts to import components of Acceptance and Commitment Therapy (ACT) into a values-based mindfulness group intervention designed for inmates nearing community reentry. Last, we describe the ways in which we have modified motivational interviewing (MI) procedures to best meet the diverse needs and concerns of "general population" jail inmates.

Across the board, these interventions take a positive approach to cognitive and behavioral change. Inmates are encouraged to take responsibility and commit to their values rather than to simply avoid negative behavior. They are encouraged to take positive action rather than simply avoid further antisocial behavior. Our experience supports the effectiveness of this positive psychology approach in this high-risk population. Moreover, we believe this approach is applicable across many other contexts—at school, in the workplace, anywhere where rules can be violated, harm can be done, and there lurks the possibility of shame.

The Impact of Crime (IOC) Workshop: A Restorative Justice Inspired Group Intervention

The Impact of Crime (IOC) workshop is an innovative group intervention rooted in restorative justice principles. Restorative justice is an alternative to the philosophy of retributive justice (the punishment-focused approach that dominates the criminal justice system in the United States and in many other parts of the world). Rather than focusing on legal processes and punishment of the offender, restorative justice theory emphasizes the harmful effects of crime. Crime is viewed as a violation of the victim and the community rather than a violation of the state. Accountability is defined in terms of taking responsibility for actions and repairing harm caused to the victim and community through restitution, competency development, and community service. In effect, restoration, or making things right, becomes the highest priority of the system rather than the imposition of punishment for its own sake. By taking accountability for their actions, offenders begin to understand the harm they cause to victims and communities, deterring future offenses.

The restorative justice approach aims to initiate significant, lasting change in how offenders *think* about crime, victims, and personal responsibility. The IOC workshop explicitly encourages offenders to reevaluate distorted "criminogenic" beliefs and to shift from a self-centered, egoistic orientation toward a broader appreciation of one's place and role in the community.

The IOC workshop is a voluntary group intervention, providing a cost-effective means of providing a restorative experience to 15-20 offenders at one time. Delivered over the course of 8 weeks, this 16-session workshop is part educational and part experiential. Incarcerated participants have the opportunity to reexamine the ways in which various types of crime (property crime, sexual assault, domestic violence, drug use and distribution, etc.) affect victims, families (of both victims and offenders), and the community as a whole. Participants learn pertinent crime statistics and facts, complete a series of workbook exercises and group discussions about the victim experience, and interact with guest speakers—victims of crime who discuss how specific crimes have affected their lives and those around them. With the aid of a trained facilitator, participants process their reactions to the new information and presentations, drawing connections to their personal experiences. Throughout, the facilitator emphasizes and integrates restorative justice notions of community, personal responsibility, and reparation. An important component of the IOC workshop is the opportunity for offenders to communicate to the community their acceptance of responsibility and their desire to repair the harm done. This is done in powerful discussions with guest speakers and via a joint community service project designed and implemented by each group, over several sessions. A recent IOC group, for example, constructed a calendar with poems, drawings, and messages about the consequences of crime for victims, offenders, and communities. It was distributed to boys' and girls' probation homes with the aim of making a formal apology, actively taking responsibility for their actions, and warning youth about the negative effects of criminal activity. Another group created key chains with a message about the prevalence of drunk driving casualties and gave them to youth at a driving school, encouraging new drivers to consider the impact their behavior has on others.

As inmate participants grapple with issues of responsibility in the IOC workshop, the question of blame inevitably arises.

Upon re-examining the causes of their legal difficulties and revisiting the circumstances surrounding previous offenses and their consequences, many inmates experience new feelings of shame, guilt, or both. Most intriguing to us, restorative justice is essentially a "guilt-inducing, shame-reducing" approach to rehabilitation. Offenders are encouraged to take responsibility for their behavior, acknowledge the negative consequences to others, empathize with the distress of their victims, feel guilt for having *done* the wrong thing, and act on the consequent inclination to repair the harm done. Facilitators model empathy in group (and often one-on-one) discussions about circumstances leading to past offenses and then actively encourage participants to identify ways of repairing the harm they have caused. Using affirmations and highlighting steps offenders have already taken toward reparation shifts the focus from past negative acts to future opportunities for change and restoration. Additionally, group members are encouraged to empathize with and support each other in order to foster openness, collaboration, and sharing of ideas for restoration. Offenders, however, are actively discouraged from feeling shame about *themselves*. In fact, restorative justice approaches eschew messages aimed at condemning and humiliating offenders as "bad people." The emphasis is on bad behaviors that can be changed, negative consequences that can be repaired, and offenders who can be redeemed.

Why is this guilt-inducing, shame-reducing characteristic of the IOC workshop (and restorative justice approaches, in general) so important? Research from our lab, and many others, has shown that shame and guilt are distinct emotions with very different implications for subsequent moral and interpersonal behavior (Tangney, Malouf, Stuewig, & Mashek, 2012; Tangney, Stuewig, & Mashek, 2007). Feelings of shame involve a painful focus on the self—the humiliating sense that "*I* am a bad person." Such shameful feelings are typically accompanied by a sense of shrinking, of being small, by a sense of worthlessness and powerlessness, and by a sense of being exposed. Ironically, research has shown that such painful and debilitating feelings of shame do not motivate constructive changes in behavior. Shamed individuals are no less likely to repeat their transgressions (often more so), and they are no more likely to attempt reparation (often less so) (Tangney, Stuewig, & Hafez, 2011). Instead, because shame is so intolerable, people in the midst of a shame experience often resort to defensive tactics, or what ACT refers to as experiential avoidance. They may seek to hide or escape shameful feelings, denying

responsibility. They may seek to shift the blame outside, holding others responsible for their dilemma. And not infrequently, they become irrationally angry with others, sometimes resorting to overtly aggressive and destructive actions. In short, shame serves to escalate the very destructive patterns of behavior we aim to curb.

Contrast this with feelings of guilt, which involve a focus on a specific behavior—the sense that "*I did a bad thing*" rather than "*I am a bad person.*" Feelings of guilt involve a sense of tension, remorse, and regret over the "bad thing done." Research has shown that this sense of tension and regret typically motivates reparative action (confessing, apologizing, or somehow repairing the damage done) without engendering all the defensive and retaliatory responses that are the hallmark of shame (Leith & Baumeister, 1998; Tangney, Stuewig, & Mashek, 2007; Tangney, Youman, & Stuewig, 2009). Most important, guilt is more likely to foster constructive changes in future behavior because what is at issue is not a bad, defective self but a bad, defective behavior. And, as anyone knows, it is easier to change a bad behavior (drunk driving, theft, substance abuse) than to change a bad, defective self.

Many offenders come in to treatment with a propensity to experience shame rather than guilt. Some are so defensive that they feel little of either emotion. The IOC workshop utilizes cognitive-behavioral techniques to foster a more adaptive capacity for moral emotions by (a) using inductive and educational strategies to foster a capacity for perspective taking and other-oriented empathy; (b) encouraging participants to broaden their vision through a better understanding of the impact of crime and a greater taking of accountability, cutting through minimization and denial of criminal actions; (c) understanding the relationships between victims, offenders, and the community; (d) encouraging appropriate experiences of guilt and emphasizing associated constructive motivations to repair or make amends; and (e) explicitly avoiding language that may be construed as condemning or humiliating inmate participants as "bad people." Instead, the strong message is that redemption is possible.

The IOC curriculum begins with discussions of crime, its consequences, and how to repair the harm caused, in the abstract. Over time, the completion of workbook exercises, group discussions, and interactions with guest speakers prepares participants to look at their own actions honestly and to use their newfound understanding to change

their behaviors. Recently, one participant revealed that he was experiencing intense shame about his history of drunk driving. He spoke very little in class but responded thoughtfully to homework exercises and responded well to the facilitator's written and verbal praise of his efforts. As he began to speak up in class to support other participants' attempts to understand and change their behaviors, he likewise received empathic and encouraging responses that allowed him to confront his past actions and identify ways to repair the harm he caused. A turning point occurred for him during the lesson about drunk driving, when the guest speaker, the mother of a girl killed by a drunk driver, explained that the one thing that she would want from the man who killed her daughter would be for him not to drive drunk again. For this participant, the idea that restoration is possible allowed him to view himself as someone who could change and redeem himself. At the end of the workshop, he led the group in a community service project that petitioned Congress for a law to make built-in breathalyzers mandatory in cars in an effort to curb drunk driving casualties. In short, the intervention emphasizes that inmate participants can take steps to repair the fabric of their relationships and the community, and they can make lasting positive changes in their behavior moving forward.

Currently, we are conducting a randomized clinical trial to assess the efficacy of the IOC workshop in reducing postrelease reoffense and in enhancing adjustment in the community. A key hypothesis is that the IOC workshop will reduce recidivism via its impact on moral emotions and cognitions—that is, by enhancing adaptive feelings of guilt, reducing problematic feelings of shame, and restructuring criminogenic beliefs.

The Re-Entry Values and Mindfulness Program (REVAMP)

Research has shown that a majority of jail inmates have significant psychological and behavioral problems. Upwards of 70% of jail inmates in our sample had clinically significant elevations on one or more symptom clusters. For example, 47% scored in the clinical range for drug problems, 26% for alcohol problems, 10% for anxiety, and 19% for depression (Drapalski, Youman, Stuewig, & Tangney, 2009; Youman, Drapalski,

Stuewig, Bagley, & Tangney, 2010). Additionally, a remarkable proportion (31.7%) report clinically significant symptoms of borderline personality features (Conn, Warden, Stuewig, Kim, Harty, Hastings, & Tangney, 2010). Few of these inmates have sought or received traditional mental health treatment in the community, and there are limited resources for mental health treatment in jails (Drapalski et al., 2009; Meyer, Tangney, & Stuewig, under review; Youman et al., 2010). While anecdotal evidence suggests that few inmates perceive themselves as living a rewarding life in accordance with their own values, little empirical research in this population has investigated positive psychological outcomes. It is as if the possibility that inmates might have a sense of meaning, happiness, optimism, or gratitude hasn't been considered.

With an awareness of the need to reduce symptoms and enhance value-based living in this population, we developed a short-term group intervention specifically designed for jail inmates nearing reentry to the community: the Re-Entry Values and Mindfulness Program (REVAMP). This program, derived primarily from Acceptance and Commitment therapy (ACT), empowers the individual and is flexible enough to address the diversity of problems and life experiences encountered in a jail population (Hayes, 2004; Hayes & Smith, 2005). In addition to ACT, REVAMP draws tools from several mindfulness- and acceptance-based interventions, notably mindfulness-based relapse prevention (Bowen, Chawla, & Marlatt, 2011), dialectical behavioral therapy (Linehan, 1993), VA Maryland Health Care System ACT group manual (VAMHCS ACT Therapy Team, 2007), and skills for improving distress intolerance (Bornovalova, 2008).

REVAMP is distinguished from other jail-based programs by its acceptance-based approach to symptom reduction and its focus on values in action. Psychological interventions for inmates generally only focus on reducing symptoms of psychological distress and/or behavior problems. However, REVAMP aims to both reduce symptoms, *and* improve individuals' ability to lead a values-driven, personally meaningful life. These dual aims of reducing symptoms and enhancing valued action are intrinsically linked. Symptoms often serve as barriers between individuals and their values. In turn, values serve to motivate the behavior change necessary to reduce symptoms. Thus, enhancing valued action and reducing suffering represent two major overarching, interconnected themes throughout the REVAMP program. We discuss each in turn, outlining

how both reinforce each other and highlighting how each serves to overcome treatment barriers for this challenging population.

Focus on Values-Based Action: Clarifying Values and Setting Goals

The REVAMP program begins with a focus on personal values. By starting with an identification of personal values, defensiveness is decreased and personal investment in the program is heightened. This also appears to be a refreshing change for individuals who are used to being judged and who are accustomed to being told what to do and when to do it by the correctional system. REVAMP facilitators emphasize that there are no "right" or "wrong" answers and encourage participants to say what they really believe rather than what they think we want to hear.

One might wonder what sorts of values inmates generate and if this might be a foolhardy or even dangerous endeavor. Given their often extensive criminal histories, might inmates' values orient them in a direction that would be harmful to the community? For example, inmates might value material wealth attained by any means necessary or risky sexual behavior.

Our experience with multiple groups of inmates over the course of the treatment is that they consistently identify prosocial values. Inmates' values often not only reflected a desire to achieve well-being for themselves but also to positively contribute to others (see Table 1). In fact, across program participants, there were no examples of clearly antisocial values (though a few mentioned different sets of values they had at younger ages that they now see as misdirected).

Table 1: Example of Inmate's Values and Goals

Values	Goals
Be a friend and partner for my spouse	Find activities that we both enjoy and do them
A close family	Talk to my relatives at least once a month
Be a man who protects, provides for, and shelters his wife	Get and keep a good-paying job
Live drug and alcohol free	Sobriety one day at a time
Help uplift my community	Coach a little league team
Be a person who respects other people's thoughts	Listen more to other people
Live my religion	Attend church every Sunday

Once values are generated, REVAMP leaders facilitate a refinement of these values to an appropriate level of specificity. For example, a participant might identify "family" as a personal value. He or she would be encouraged to elaborate—e.g., "providing for my family" or "making my family proud." A helpful values metaphor is to have participants imagine themselves as a bus driver with the value as the direction they want to drive their bus (Hayes & Smith, 2005, p. 153). At the end of the first session, inmates are asked to write their own epitaph. This exercise, which is employed in ACT and other acceptance-based interventions, focuses inmates on defining their intended legacy, what they want their lives to stand for (Hayes & Smith, 2005, p. 170). During the second session, inmates expand this by identifying their specific personal values with a worksheet listing major life domains (e.g., career, family, health) and prompts to identify a value in each domain (Hayes & Smith, 2005, p. 170). They rate the importance of each value to help prioritize the values they would like to begin working toward. Inmates then set goals consistent with their values, or in terms of the bus metaphor, stops they want to make on the journey toward their values.

Barriers to Values: Bridge from Values Enhancement to Reduction of Suffering

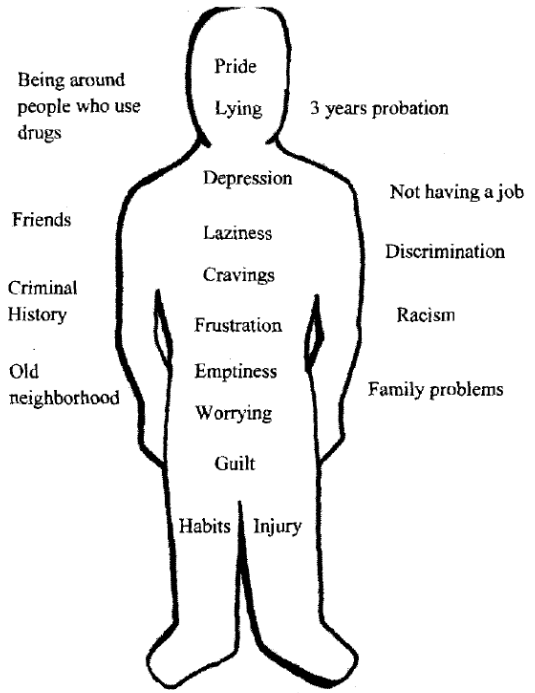
Inevitably, these values exercises begin to raise awareness of discrepancies between inmates' values, their recent behavior, and their current situation. In fact, a key aim of Sessions 1 and 2 is to highlight the discrepancies between where inmates are and where they want to be heading. In group, having identified a broad list of values, the perceived barriers (e.g., "yeah, buts...") begin to flow. Participants focus on the genuine difficulties they anticipate facing when they return to the community (e.g., poor economy, stigma related to a criminal record, racism, disappointed family members, logistical requirements of probation that complicate maintaining successful employment).

Inmates may also acknowledge obstacles to their values that involve their own behavior. However, inmates are often ambivalent about their own role in contributing to these difficulties. They may acknowledge partial responsibility, yet often externalize blame to flaws in the legal system, discrimination, or other circumstances beyond their control. Perceptions of unjust treatment associated with their current incarceration may exacerbate inmates' defensiveness, heightening their awareness of external obstacles and increasing reluctance to focus on the role that they have played in their own suffering.

Given that the immediate jail environment can further elicit defensiveness, REVAMP is careful not to imply judgment, while still encouraging a focus on one's own behavior. This is accomplished by openly probing for perceived barriers to valued action and validating the emotional response to these barriers (e.g., frustration). Next, the program provides psychoeducation about the distinction between "external" obstacles (problems in the environment they are returning to) and "internal" obstacles (one's thoughts, emotions, and behavior). Facilitators present the outline of a person and ask participants to classify the obstacles they identified as either internal or external (see Figure 1). When external obstacles are identified (e.g., burdensome probation requirements) they are written outside of the outlined figure, and facilitators probe for related internal obstacles (e.g., frustration, missing meetings), writing these in the interior of the figure. Often, participants spontaneously recognize connections between internal and external obstacles.

(These connections are also incorporated into the figure, providing visual emphasis.) Following the group discussion, participants identify the internal and external obstacles they will face as individuals. Because both values and obstacles are defined by the participant, the perception of judgment or blame is minimized.

Figure 1: Internal and External Barriers



In a collaborative process, REVAMP facilitators acknowledge that participants' ability to achieve a values-driven, meaningful life is hampered by both external and internal barriers, which often are interconnected. However, REVAMP directs attention to that which individuals can directly impact while still incarcerated: the internal barriers.

Reducing Suffering: Confronting and Breaking Barriers to Values

Given that jail inmates are diverse, there is substantial variety in both the internal and external barriers they face. Therefore, a successful reentry program must provide flexible tools to prepare participants to overcome a range of behavior problems and life challenges.

The theoretical underpinning of REVAMP provides such flexibility. REVAMP identifies and focuses on a common factor related to many of the psychological and behavioral problems experienced by inmates: the maladaptive avoidance of emotional pain (Hayes, Wilson, Gifford, Follette, & Strosahl, 1996). Pain is understood as a normal and inevitable part of life. Although many essential aspects of life involve pain, individuals may try to avoid or escape pain. This unwillingness to experience pain can manifest as a variety of problematic avoidance behaviors, such as substance abuse, social isolation, and risky sexual behavior. In turn, problematic avoidance behaviors result in additional pain (e.g., health problems, loneliness, strained relationships). This "extra" pain resulting from one's own attempt to avoid pain is referred to as "suffering." Over time, patterns of problematic avoidance behavior may become habitual and difficult to break (Hayes & Smith, 2005, pp. 1-16).

This conceptualization is applicable to a variety of distinct problem behaviors found among inmates. To illustrate, consider two examples. Inmate A reports that he began to drink heavily soon after the unexpected death of a loved one. He describes his drinking as becoming "out of control," leading him to lose his job and straining his relationship with his surviving family members. Inmate B describes being "addicted" to the power and quick money of selling drugs, which he attributes to his impatience for the slow pace it takes to improve one's status through education and entry-level positions. Following previous incarcerations, he has tried to maintain employment but says he cannot tolerate the mundane routine of the type of job that he can attain given his criminal record. He adds that his daughter has "expensive tastes" and pressures him to provide her with expensive things.

As shown in Table 2, these vignettes illustrate that a common element of two different problematic behaviors (alcohol abuse and illegal activity) can be conceptualized as avoidance behavior. While each inmate faces

Table 2: Pain and Suffering Conceptualization

	Difficult Situation	Pain	Avoidance Behavior	Suffering
Inmate A	Death of a family member	Feelings of loss	Excessive alcohol use	Legal trouble Unemployment Strained relationship with family members
Inmate B	Long history of incarceration and separation from family Daughter asking for money	Feeling of powerlessness, frustration, shame	Selling drugs to make quick money	Legal trouble Separation from daughter and loss of her respect

different situations and experiences different emotional reactions, both attempt to escape their pain through risky avoidance behavior. In REVAMP, one's relationship with pain is a major target of treatment. In this way, the program's focus is on the common element of different problem behaviors. By focusing on one's relationship to affective experience, rather than on specific types of experiences, REVAMP is able to accommodate the diverse group of participants represented in a jail setting.

During session 3, inmates are provided with psychoeducation about the difference between acceptance and avoidance of pain, and the relationship with suffering. Two metaphors often employed in ACT are used to illustrate these concepts: quicksand and Chinese finger traps (Hayes & Smith, 2005, pp. 3-4, p. 37). First, participants are asked to imagine their reaction if they were to find themselves caught in quicksand. Most imagine that they would panic and would try to pull, swim, or run out. In quicksand, the more you struggle the more you sink, so these frantic movements would cause someone to sink deeper and deeper. It is clear that, for most people, acting on the first impulse would serve to make a bad situation worse, which illustrates the concept of suffering. Next, participants are provided with Chinese finger traps—woven straw tubes just large enough to insert an index finger into each end. The tubes are constructed to "trap" the inserted fingers when one quickly attempts to pull out the fingers directly. But by pushing in, the finger trap relaxes allowing the fingers to become freed. Inmates are asked to imagine that the finger trap represents pain. Inmates experience how their first impulse, which usually is to jerk the fingers apart, serves to tighten the trap and restrict their flexibility. The Chinese finger trap allows inmates to experience, in a physical way, the paradox of acceptance. By allowing the fingers to go further into the trap, essentially doing the opposite of one's immediate avoidance impulse, more space and flexibility are created, which ultimately allows escape. While some might be skeptical that criminal offenders would appreciate the abstract nature of metaphors, our experience has been that inmates readily identify with these metaphors. Several have generated additional metaphors to illustrate their own futile struggle with pain (e.g., swimming against a riptide). Both in group and individually, participants reflect on their own experience of suffering resulting from impulsive avoidance behavior. Individually, by completing worksheets, inmates reflect on how acceptance would allow them to lead a life more in line with their values.

After the rationale for pursuing a healthier way to react to pain is established, participants are taught concrete skills to better manage pain. Sessions 4, 5, and 6 cover three major classes of skills: present awareness, short-term distress tolerance, and defusion skills. During session 4, which is devoted to present awareness, participants are taught about the concept of automatic behavior, action without awareness, and automatic pilot mode (Bowen et al., 2011, pp. 32-47). During automatic pilot mode, individuals' behaviors are influenced by their thoughts and feelings without conscious awareness of this process, such that a situation can trigger harmful automatic reactions. Facilitators explain that awareness is necessary in order to respond to internal states with intention and choice, rather than automatically. Participants engage in several exercises to bring awareness to their experience. First they complete a body scan (Bowen et al., 2011, pp. 42-43), which involves focusing on sensations experienced in each part of the body, without reacting to them. Participants then bring awareness to their thoughts by writing what goes through their minds, or their "mental chatter," for 2 minutes (Hayes & Smith, 2005, p. 55). Later, participants further raise nonattached awareness of their thoughts with a mindfulness exercise in which they picture their thoughts as leaves floating down a stream (Bowen et al., 2011, pp. 140-141).

Session 5 focuses on adaptive management of emotional pain. In this session, group leaders acknowledge that bringing acceptance to pain is not an immediate fix. Similar to other acceptance-based interventions, REVAMP takes the stance that sometimes taking healthy action to temporarily reduce the pain can be the best option (Linehan, 1993). The difference between adaptive and maladaptive coping action is explained in reference to the outcome of the behavior; adaptive coping behaviors have positive outcomes, while maladaptive coping behaviors have negative long-term outcomes. Participants brainstorm examples of each type of coping behavior and identify the consequences. In an individual exercise, participants monitor changes in their distress as they practice several coping behaviors (Hayes & Smith, 2005, p. 28). These short-term distress tolerance skills are presented as quick fixes to be used during times of intense pain rather than as permanent solutions. Session 6 presents a long-term strategy to manage distress by transforming the relationship participants have to their own thoughts and feelings. Inmates are provided with psychoeducation on observer perspective and

defusion. Group leaders explain that taking a step back from thoughts and emotions and adopting an outside perspective can reduce the automatic impact on behavior. To illustrate this, group leaders present an ACT metaphor of a chessboard (Hayes & Smith, 2005, p. 96). Inmates are instructed to imagine their internal struggle as a chess game with positive and negative thoughts and emotions as two opposing teams of chess pieces. Group leaders then ask the inmates which part of the metaphor represents them (e.g., the pieces, the player, or the board). Participants usually immediately respond that they are the pieces or the player. Group leaders explain that the board represents an observer perspective; it holds the internal content (e.g., thoughts and emotions) but is not a part of the struggle. Inmates then participate in a visualization-based centering exercise referred to as the mountain meditation (Bowen et al., 2011). In this meditation, an image of a mountain is used to represent a grounded, unmoving, nonreactive presence.

The worksheet assigned at the end of session 6 integrates distress-monitoring material from sessions 4-6. Participants are first instructed to identify their own past maladaptive reactions to distress. Then they are asked to reflect on the distress that they will likely experience in the future and describe alternative adaptive reactions. This allows participants to apply the material related to present awareness, short-term adaptive coping, and/or observer perspective to their own anticipated distress (Bornovalova, 2008).

Session Structure

REVAMP is designed to have a consistent structure across sessions to provide a challenging, yet predictable, group experience. Session 1 differs from the other sessions due to the need to orient participants to the program by presenting its purpose and goals, enhancing curiosity and interest in the remainder of the intervention, creating a safe environment to promote personal participation, and introducing centering exercises for the first time. Sessions 2-8 each follow the same pattern:

- Centering exercise
- Review/discussion of previous assignment

- Curriculum beginning with bridge from last class and often including a new or expanded metaphor
- Exercise that illustrates the lesson of the day
- Discussion of the curriculum and exercise
- Assignment of worksheet to be completed prior to the next session to personalize the lesson for each inmate and/or practice putting the lesson into action
- Distribution of a take-home message providing the curriculum in a succinct phrase or two
- Centering exercise

For example, session 7, which focuses on integrating values-based living with distress tolerance skills, begins with the mountain meditation for the centering exercise, followed by a review of the distress-monitoring worksheet assigned at the end of session 6. Next, group facilitators present the curriculum, which focuses on valued action, goal setting, and overcoming barriers. Group facilitators utilize the bus metaphor to reinforce material on values (direction the bus is heading), goals (stops along the way), internal barriers (distracting passengers on the bus), and external barriers (traffic jam). An exercise in which participants set short-term achievable goals is followed by a discussion of overcoming barriers in the community. Participants are then given a worksheet to identify potential barriers and strategies to overcome these barriers. Next, participants are provided with a "take-home message": "Practicing mindfulness and trying new things can help you live the life you want to live." Finally, participants complete a present awareness-based centering exercise.

The final group, session 8, follows the same general structure as sessions 2-7, with a few differences to promote reflection of what has already been presented and how the group experience can help each person when he or she reenters the community. We start with a centering exercise, as usual, but the group chooses one of three previously used exercises. We also review the worksheet assigned during the previous session. Then, instead of introducing a new lesson during the curriculum section, we review: the goals of the program; the theoretical rationale for each goal; and how each goal was promoted in the lessons, exercises, centering techniques, and discussions. Instead of having one

discussion section after the curriculum review, we discuss the personal application of each course goal for each individual. We also distribute a compiled list of all of the take-home messages. Finally, the group again selects a final centering exercise from a menu of previous centering exercises.

Acceptability

Outcome data are not yet available from our pilot randomized clinical trial, but evidence suggests that REVAMP is well received by a diverse group of inmates. All participants were given anonymous feedback forms to complete. Overall, feedback has been very positive. Participants provided ratings on a scale of 1-4 of the intervention's quality (M= 3.3), usefulness (M= 3.5), and their overall satisfaction with the program (M= 3.6). Retention throughout the program has been strong for a jail-based program, comparing very favorably with attendance observed in other multiweek programs and interventions offered at this jail.

Applicability

REVAMP was designed to be generally applicable to a broad range of inmate participants that are diverse in terms of age, ethnicity, criminal history, values, and barriers (e.g., mental health concerns, substance abuse problems, etc.). Accordingly, participants in REVAMP were eligible for the study if they met basic requirements meant to ensure the ability to participate in the program (e.g., were assigned to the general population, had remaining sentences long enough to participate in the program, would be released directly to the community). Participation in REVAMP was entirely voluntary. Thus far, participants in this program have ranged in age (from 18 to 81), criminal history, and type of instant offense.

In sum, the 8-session REVAMP treatment has dual aims of reducing distress and enhancing values-based living. REVAMP is specifically tailored to the jail setting, and preliminary feedback suggests that it has been well received by a diverse group of inmates. We are in the process of collecting empirical data on REVAMP's effectiveness.

Motivational Interviewing with "General Population" Inmates

What Is Motivational Interviewing?

Motivational interviewing (MI) is a brief intervention developed by Miller and Rollnick (2002). Often, MI is used as a "pretreatment" intervention, typically delivered in 1-2 individual sessions just prior to the initiation of treatment. In other contexts, it is provided as a stand-alone intervention, in anticipation of treatment or change.

The goal of the motivational interview is to enhance a person's motivation to change. MI is especially useful for "resistant" or "uncommitted" clients—people in need of treatment who are ambivalent about change or who are not committed to change. Using a directive, yet client-centered approach, the MI clinician: (a) probes to make the client's goals and personal values salient; (b) highlights discrepancies by helping the client identify ways in which his or her current behavior and life circumstance are at odds with those values and goals, and (c) helps the client utilize dissonance arising from recognition of such discrepancies as a source of motivation for (and commitment to) positive change. In the MI interview, the clinician works from the client's perspective, expresses empathy, highlights discrepancies in the client's current circumstance and future goals, reframes resistance, and supports the client's sense of self-efficacy. Initially developed for the treatment of alcoholics, MI has evolved into a broadly applicable technique and associated theory, complete with specified mechanisms of action including motivation for change, stages of change, "change talk," and "commitment talk" (Miller & Rollnick, 2002).

Although not explicitly developed within the context of positive psychology, motivational interviewing techniques stem from positive psychology principles. MI techniques to enhance self-efficacy focus on the client's positive individual traits (e.g., "What strengths do you have that will help you make this change?"). Additionally, MI techniques to enhance motivation focus the client on the positive results of enacting a change (e.g., "If you make the change, what would be better about your life?").

Empirically, How Has Motivational Interviewing (MI) Fared in the Community?

Motivational interviewing techniques have been employed in conjunction with many different kinds of treatment aimed at changing behavior in a variety of domains. There is now an impressive body of research documenting MI's effectiveness in increasing treatment motivation and subsequent behavior change. Three meta-analyses, each of somewhat different study samples, converge—MI yields medium effects across diverse samples and in a variety of problem areas, both when evaluated as a stand-alone intervention *and* when assessed as an additive effect in combination with a focal treatment (Burke, Arkowitz, & Menchola, 2003; Hettema, Steele, & Miller, 2005; Rubick, Sandbaek, Lauritzen, & Christensen, 2005).

Why Is MI Especially Relevant to Inmates?

Some limited research with individuals who are incarcerated or on probation has yielded promising results (Ginsburg et al., 2002; Walters et al., 2007). For example, a motivational enhancement intervention with domestic violence offenders increased readiness to change substance use (Easton, Swan, & Sinha, 2000). Among incarcerated adolescents, motivational interviewing reduced the frequency of postrelease drinking and driving, and being a passenger in a car with someone who had been drinking, especially among those with low levels of depression (Stein et al., 2006). In addition, MI appears effective with individuals who are angry or oppositional and with individuals who are not motivated to change (Hettema et al., 2005; O'Leary Tevyaw & Monti, 2004). Moreover, a meta-analysis found that the effects of MI are significantly larger for minority samples than for Caucasian samples (Hettema et al., 2005), especially relevant to a jail setting given that minorities are disproportionately represented in jails and prisons.

Special Challenges in Using MI with Prerelease Jail Inmates

MI is typically employed in contexts where the actual target of change is unambiguous (e.g., among individuals referred specifically for substance abuse treatment, among adolescents with eating disorders, among clients seeking mental health treatment for depression). In most contexts, the ultimate focus of change is clear from the outset—to both client and interviewing clinician.

In contrast, jail inmates nearing community reentry, especially those with comorbid substance dependence and psychiatric disorders, face myriad challenges and a long list of potential targets for change. For some, the primary goal is to obtain employment and find a place to live. For others, abstinence from substance use is paramount. For others, continuation of psychotropic medication (often first prescribed during incarceration) and supportive therapy is at the top of the list. In the absence of MI, inmates typically express a fervent wish to live life differently from their pre-incarceration days, but plans to reach and maintain these goals are underdeveloped or entirely absent. In short, the use of MI procedures with jail inmates, especially those with comorbid substance dependence and psychiatric disorders, is complicated by the need to clearly identify achievable goals (emanating from personal values) and to then move on to the prototypical MI business of enhancing motivation, delineating plans for action, and bolstering self-efficacy for implementation.

Having obtained extensive training in MI procedures and having piloted these procedures with jail inmates nearing reentry into the community, we are convinced that the use of MI in this context is necessarily quite different from its use in more conventional contexts (e.g., substance abuse treatment programs). Conventional approaches must be modified because of the need to identify idiographic targets of change. There is a diversity of potential goals and targets of change among general population offenders (e.g., reducing or eliminating substance use, gaining employment, strengthening family ties, desisting from criminal activities). It is also especially important to minimize the potential for inmates to feel judged, stigmatized, or even shamed by the MI clinician.

Our initial efforts to probe to identify person-specific targets of change appeared to do just that. We tried opening our interviews by

saying "Mr. X, you're due to be released from the ADC in XX weeks. Thinking about rejoining the community, what kind of changes would you like to make to avoid being incarcerated in the future?" The interviews fell flat. We met with considerable resistance. A number of inmates bristled at the idea that they needed to make changes to avoid re-incarceration. Many responded with stories about external factors—especially how the system had failed participants. Others stated categorically that they weren't going to return to jail. They'd already made all the changes they needed to make. In effect, we communicated our assumption that participants *needed* to make changes. Our opening question inadvertently implied that inmate participants were deficient in some fundamental way and that we knew they needed to make changes (and likely that we knew best what needed to be changed).

We spent several months piloting a number of strategies, and one approach clearly emerged as more effective than the rest: tapping into inmates' personal values and goals right from the outset. We now begin MI interviews with inmates by thanking them for meeting with us and asking, "So Mr. X, what kind of things are most important to you? What do you value most?" Using this approach, the way opens like magic. As in the REVAMP program, inmates have no difficulty coming up with personal values—values that are, almost without exception, positive prosocial values that most of us share. The interview opens on an upbeat note. Rapport is readily established, as inmate participants feel respected and valued as individuals.

Having identified personal values, it is a short step for the MI clinician to note how a criminal activity and incarceration have interfered with pursuing personally relevant values and associated goals. "Developing discrepancy," a key MI technique, is a natural transition—done in a way that inmate participants experience as not threatening or judgmental but rather as supportive and caring. Targets of change are much more readily identified. Inmate participants readily move through one or more stages of change. And the interview concludes on a positive note, reaffirming the participant's own values and goals and the changes she identified that would pave the way toward reaching these personally relevant goals.

Summary and Conclusion

There is a tremendous need for psychological interventions tailored to the needs of inmates and the constraints of the jail or prison environment. Because of their severity and potential danger to society, a focus on inmates' psychological and behavioral problems may seem more important than a focus on positive outcomes. And in fact, whereas recent years have seen a growth in empirical research on positive psychological interventions in clinical and community settings, little work has focused on translating this research into interventions for inmates.

In this chapter, we described three treatment approaches designed for "general population" jail inmates. Several common threads run through each of these interventions. First, these approaches are shame-reducing in nature. Each intervention takes a slightly different response to the inevitable shame resulting from inmates' reflections. Consider, for example, this inmate's expression of shame: "Now that I am clean and sober in jail I see how my substance use has hurt myself, my family, and my community. I am so stupid for having let this go on for so long." IOC encourages inmates to take responsibility and to develop and carry out a reparative plan. REVAMP encourages acceptance and refocusing on valued action. In MI, therapists express empathy, reframe and affirm clients' strengths and values, and encourage a sense of self-efficacy in order to enhance motivation. While these approaches are not mutually exclusive, they help illustrate ways in which each treatment can address clients' experiences of shame.

Second, these treatment approaches share an emphasis on making positive change for the future. Modifications were necessary for both MI and the ACT-inspired REVAMP. Pilot testing of both led us to anchor the intervention in an initial discussion of personal values and goals.

Our work has emphasized that encouraging "the positive" and curing "the negative" are not necessarily mutually exclusive. Our experience across interventions has shown that inmates' motivation to change is strongest when it is driven by positive motivations (e.g., a valued goal or restoration following an offense) rather than by simple avoidance of shame, further punishment, and re-incarceration. In sum, working to enhance values and reduce symptoms can be complementary and mutually reinforcing in this population. Offender rehabilitation could be

substantially enhanced by a greater consideration of constructs and interventions emanating from the field of positive psychology.

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