SUSAN LEIGH DEPPE, MD, DFAPA
1241 PRIM ROAD, SUITE 201
PO BOX 671
COLCHESTER, VERMONT 05446-0671 USA
1.802.658.7441

4 November 2014

Royal Commission into Institutional Responses to Child Sexual Abuse
GPO Box 5283
Sydney NSW 2001 Australia

Dear Commissioner:

I am writing in support of Mr. Terry O'Connell and the use of restorative practices to promote healing from sexual abuse occurring in institutions. Terry is a pioneer in the use of restorative practices. I've known him for nearly twenty years and attended a number of his workshops. During that time, I've taught extensively about the emotional underpinnings of restorative practices (in Australia, New Zealand, North America, and Europe). I am on the Faculty and Board of Directors of the Tomkins Institute, and am a Clinical Assistant Professor of Psychiatry at the University of Vermont College of Medicine in Burlington.

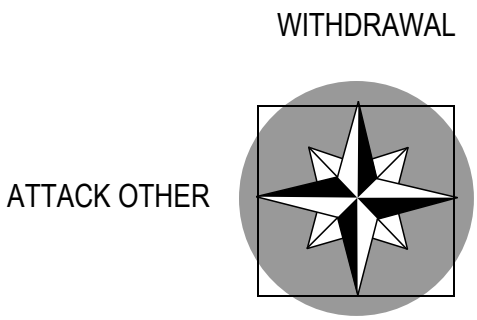
To understand why restorative practices help people heal, we need to understand human emotion. Please permit me to give a brief explanation.

The affect and script paradigm of Silvan S. Tomkins, PhD, and its extension by Donald L. Nathanson, MD, offer powerful tools to understand emotion and help people heal and grow. They help us view people in the context of biology, biography, family, and culture, and explain why restorative practices work. Mobile creatures have affects to tell them what is important in the environment and motivate them to act. There are nine **innate affects** (biological emotion programs), each with a characteristic trigger, feeling, and facial expression. Two feel good, the range from *interest to excitement* and from *enjoyment to joy*. *Surprise-startle* interrupts us and resets the system. Six negative affects feel bad in different ways: *Anger-rage, fear-terror, distress-anguish, dissmell* ("Ewwww!"—-the root of contempt), *disgust*, and *shame-humiliation.* Innate shame occurs when there is an impediment (slowing or partial stop) to the expression of one of the two positive affects, as there often is when we experience failure, rejection, hurt feelings, embarrassment, or when someone does not resonate with our enthusiasm or enjoyment. The affects are amplifiers that make things feel good or bad and **motivate** us. Nothing becomes conscious without affective amplification. We define emotion as feeling an affect, plus memory of prior experience of that affect. Innate affects link with life experience to form **scripts,** powerful emotional rules**,** of which we are usually unaware. Most of adult life is managed by scripts. One of the key roles of parents is to help kids learn to modulate their affects in a culturally-appropriate way. We are wired to want to express and maximize positive affect, express and reduce negative, and get affects out on the table. Personality is the general pattern of scripts used by a person. Scripts may be adaptive or maladaptive. Humans are complex. Tomkins's paradigm has extraordinary power to explain what we see from an individual to societal level. We can study the language of emotion, personality development, different intensities of affect, affect modulation, affect contagion, empathy, intimacy, community, and script change. We can explore how factors such as illness, fatigue, or drugs change the affect system, and some of the reasons why people engage in substance abuse and other risky behaviors. Adults and kids can learn to observe affects and scripts in themselves and others. We can promote healthy parenting and child development, and facilitate healing in those who have experienced harm.

Actions and attitudes are absorbed out of awareness from the emotional milieu surrounding us, whether family, media, faith community, or schools. Our emotional patterns are sculpted by life experience. Dr. Nathanson points out that some of the scripts by which people handle affect, particularly those around shame, cause grave problems for society. Innate shame is triggered by any partial impediment to positive affect, and often, by a glitch in affective resonance with others. Shame itself impedes positive affect. Early in life, it becomes closely linked with self-esteem. When we later experience failure, rejection, insult, or embarrassment, we tend to go to certain libraries of scripted responses without thinking. Nathanson calls these the Compass of Shame. We may engage in *withdrawal* (fall silent, leave the room, leave therapy or a relationship). We may *attack self* by negative self-talk, engage in self-injurious behavior, or even commit suicide. We may try not to feel shame at all, or cover it up with excitement, by going to the *avoidance* pole of the Compass (substance abuse, machismo and sexual acting out, workaholism, obsession with achievement, money, or social class). Or we may *attack other (*bullying, emotional, physical, or sexual abuse, and violence). Please note that behaviors and disorders are complex and may have multiple causes, including genetics, biology, trauma, chemicals, scripts and learning. For example, not all suicides are caused by shame. Shame is a key—-but largely ignored—-link between rudeness, "road rage", drug abuse, domestic violence, murder, child abuse, and other societal problems. Often anger is really about shame. (Many domestic violence-related murders in Vermont have happened just after a shame injury to the offender—she ended the relationship, he lost a job, etc.)

Nathanson points out that people in Western societies are handling the shame family of emotions differently now than in the past. In the early twentieth century, people tended to go to *withdrawal* and *attack self* (deference). There was much more stigma attached to being seen as shamed in the eyes of one's neighbors. Now people are more likely to act out in the *avoidance* and *attack other* poles. This is a dangerous change. Those who murder, batter, or bully others express intense shame. Substance abuse raises the risk of violence, due to disinhibition or other impacts on the affect system.

The Compass of Shame

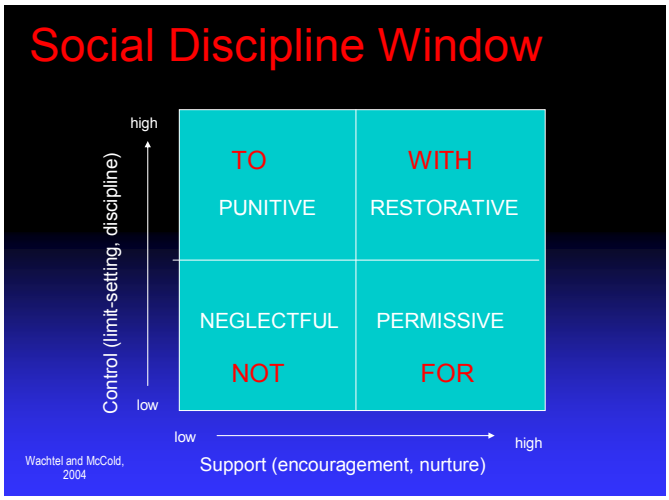


Nathanson, 1992

Note that we can feel shame when we have done nothing wrong. If someone is rude to me, I will feel put down, even if I handled the interaction perfectly. People who have experienced childhood sexual abuse typically feel overwhelming shame, which becomes the core of their self-esteem. Patients have said to me, "If people really knew what I'm like inside, they wouldn't like me."

The healthy response to shame is to tolerate its discomfort; soothe myself; remind myself that I am still a good person; acknowledge any responsibility I might have for hurtful behavior and make it as right as possible; and learn from the experience. However, that mature response isn't easy! Learning it requires a supportive environment and a lot of practice.

We only change when it is safe to look at what shame affect is telling us. Emotionally safe environments are loving and supportive, call us on our behavior when we are out of line, push us to be the best we can be, give positive feedback, respect us, and require us to respect others. (This is doing things *with* people, as in the upper right corner in the figure on the next page—high support and high accountability.) Many families, schools, and faith communities provide these conditions, of course. Sadly, abusive institutions do not.



Trauma is characterized by exposure to overwhelming negative affect which cannot be controlled or escaped. It is bad enough when it is due to a non-human source such as a natural disaster. However, abuse—trauma caused by another human being—is particularly toxic. It involves catastrophic intensities of any of the negative affects (terror, rage, humiliation, anguish, disgust, and dissmell) and their scripting into terribly maladaptive patterns, such as difficulty trusting people, relationship problems, or violence. Substance abuse, sexual acting out, thrill-seeking, self-harming behaviors, idealization and devaluation, withdrawal, excessive anger, and other attempts to manage shame are typical in those who have been abused as children. Indeed, Dr. Nathanson wrote a paper some years ago that showed that virtually all criteria of Borderline Personality Disorder can be accounted for as shame scripts. The same is true for many symptoms of complex PTSD and dissociative disorders I see in my practice. Other affects also play a role, e.g., fear (in anxiety and panic symptoms) and distress, self-disgust, self-dissmell, and shame (in the syndromes we call depression).

Tomkins pointed out that scripts can be validated or attenuated. *Whether an event changes our lives will depend on what precedes and follows it.* For that reason, survivors of child sexual abuse do better if they have family and community support and mental health care. Conversely, revictimization will likely solidify their sense of powerlessness, fear, distress, profound shame, self-disgust, self-dissmell, and maladaptive responses.

Restorative Practice is a new field of study encompassing, but not limited to, restorative justice. The latter developed as a response to punitive, ineffective models of justice, which isolate offenders and do not help communities to heal. Restorative practices build empathy, relationships, and social capital, integrating people instead of alienating. Everyone is heard. Affect is expressed. Those in a conversation decide how to heal harm or resolve conflict. People are held accountable to those affected by their behavior. As you can see (above right), restorative practices involve high levels of support and accountability. Restorative practices range over a continuum. At one end are formal, structured restorative conferences, which include support people of participants and more preparation. Then there are less formal groups, circles, or small, impromptu conversations. Least structured are affective questions and statements. For example, a teacher might pull two kids aside in the hall to have them discuss the effects of their behavior. Healthy parents, teachers, and leaders do lots of informal restorative practices. Restorative practices are **most powerful when used as a way of life**, not an occasional intervention. They are used worldwide, in prisons, schools, neighborhoods, criminal justice, sentencing, faith communities, etc. Restorative conversations engage people with questions such as those below. They work because they are based on how people function emotionally. Restorative practices enable **fair process** (engagement, explanation, and clarity of expectation).

Questions for those affected by others:

What was your reaction when you realized what had happened?
What has been the impact on you, your family and friends?
What has been the hardest thing for you?
What do you think needs to happen to make things right?

Questions for those in conflict or those whose behavior has hurt others:

What happened?
What were you thinking at the time?
What have you thought about since?
Who has been affected by the incident/behavior? How?
What do you think needs to happen to make things right?

(Adapted from Terry O'Connell)

Restorative processes work because they conform to what Tomkins called the Central Image or the **Blueprint** (as expressed by Nathanson):

Because we are wired with some innate affects that feel good and others that feel bad, we are motivated to:
1. Share and maximize the positive affects;
2. Share and reduce (metabolize) the negative affects;
3. Minimize affect inhibition and get affects out on the table (for example, reduce shame, an inhibitor of affect expression); and
4. Anything that helps 1-3 above (such as restorative practice) helps us; anything that works against the above is detrimental.

The practitioner creates a space for conversation that is as safe as possible, where positive and negative affects can be expressed and mutualized, and where inhibitors to affect expression such as shame are minimized.

Since the adult experience of shame includes feeling put down, embarrassed, like a failure, rejected, not heard, not understood, inferior, and so on, *all experiences with the institution where the abuse occurred are important.* You can see how meeting with someone who is stern, silent, or unkind would make things worse, because that would increase shame, inhibiting expression of positive and negative affects and making it very hard to tell an already difficult story. In contrast, talking to someone like Terry O'Connell, who asks questions that gently draw out your story and listens with great empathy and kindness, is beneficial in and of itself. Being given a choice about whether to hold further conversations, and whom to involve, empowers the survivor further and conveys respect and confidence.

Cognitive "education" alone does little to change the largely unconscious but powerful scripts by which we function. To shift these powerful emotional rules requires intense affective experience. This is provided by the facilitated conversations Terry O'Connell is doing. While completely "healing the harm" is usually not possible in a meeting or two after a severe trauma, it is clear from the examples Mr. O'Connell has given you that people often feel markedly better and enjoy more emotional support after talking with those they care about. Tomkins noted that the more intense a relationship (more potential for positive affect), the more powerful the scripts. Matt Casey has pointed out that the person people would *least* want to tell about their drink-driving incident is usually mother or grandmother (lots of positive affect means high potential for shame). On the other hand, Leon Wurmser once noted that the experience of shame becomes safer in the presence of love. So the people we care about should be involved in our healing if possible, unless they are abusive in any way.

According to the American Academy of Child and Adolescent Psychiatry, support from parents, school, and peers is important. "Children who are listened to and understood do much better than those who are not. The response to the disclosure of sexual abuse is critical to the child's ability to resolve and heal the trauma of sexual abuse." Adults benefit from that same support from those who love them.

Good restorative practice always involves careful preparation and awareness of emotional and physical safety. O'Connell typically talks with people individually before bringing them together. This minimizes the possibility of re-victimization. Participation is voluntary. It is important that these facilitated conversations are controlled by those participating, not by mental health, social service or law enforcement professionals. The reduction in stigma, shame, and isolation is profound. Encouraging people to involve those who are important to them is crucial, and results in much stronger connections with families or communities, who will be there when the professionals are no longer needed. And families have their own needs for healing, as do churches, schools, and other

groups. In the cases of Daniel and Marie, both felt they were no longer defined by the abuse after they had shared with the people they loved. A different and profound emotional experience in relationship led to a change in self-image. This is part of what happens in psychotherapy, but it is even better if bonds with family, friends, and faith community can be strengthened.

In summary, I wholeheartedly support the restorative work of Terry O'Connell (and Matt Casey) with survivors of sexual abuse in institutions. Their restorative practice is grounded in human biology, connection, and empathy, and based on the needs and voices of participants. This appears to be a brilliant way to facilitate healing in people and communities affected by sexual abuse. Further research and training of additional facilitators would be useful.

I would be delighted to provide further information or teaching about Tomkins's affect and script paradigm. Combined with compassionate and skillful restorative practice, it offers enormous potential for both healing and prevention of sexual abuse and violence.

Thank you very much for your consideration.

Sincerely,

Susan Leigh Deppe, MD, DFAPA
Faculty, The Tomkins Institute: Applied Studies in Motivation, Emotion, and Cognition
Secretary, Board of Directors, The Tomkins Institute, Lewisburg, Pennsylvania, USA
and
Clinical Assistant Professor of Psychiatry
The University of Vermont College of Medicine
Private Practice, Colchester, Vermont

Email: deppe@together.net
Phone: 1.802.658.7441
Fax: 1.802.658.7441
Mobile: 1.802.343.2325
www.tomkins.org
Twitter @TomkinsInst

A Word about Prevention: Communities and schools struggle with crime, bullying, rudeness, and violence. No one should expect them to repair all of the damage caused by severe neglect, trauma or mental illness. But we can do a great deal. The answer is prevention, starting as young as possible: **explicit affect education** and long term **immersion in a restorative milieu.** Children can learn to identify, understand, and manage their affects. They can use restorative practices to build community and script the emotional skills for good relationships throughout life. Benefits include big drops in problem behaviors, crime, conflict, and better school and community cultures. Healthier, more resilient children become healthier adults. Some excellent work is happening in Australia, and restorative communities are developing worldwide.

References and Resources

http://www.aacap.org/aacap/Families_and_Youth/Facts_for_Families/Facts_for_Families_Pages/Responding_To_Child_Sexual_Abuse_28.aspx

http://www.aacap.org/aacap/Families_and_Youth/Facts_for_Families/Facts_for_Families_Pages/Posttraumatic_Stress_Disorder_70.aspx

Abramson L (2013). Emotional Dynamics in Restorative Justice (Online Course). The Tomkins Institute: Applied Studies in Motivation, Emotion, and Cognition. 28 March 2013. www.tomkins.org. See also www.communityconferencing.org.

Abramson L, Moore DB (2002). The psychology of community conferencing. In: Perry J (Ed.), (2002). Repairing communities through restorative justice. Lanham, Maryland: American Correctional Association.

Damasio AR (1994). *Descartes' error: Emotion, reason, and the human brain*. New York: Avon Books.

Demos EV (Ed.), (1995). *Exploring affect: The selected writings of Silvan S. Tomkins*. New York: Cambridge University Press.

Kelly VC (2012). The art of intimacy and the hidden challenge of shame. Rockland, Maine: Tomkins Press. www.shameandmarriage.com

Kelly VC, Thorsborne, M (2014). *The psychology of emotion in restorative practice: How affect script psychology explains how and why restorative practice works.* London, UK: Jessica Kingsley Publishers. http://www.jkp.com/catalogue/book/9781849059749

Nathanson DL (1992). *Shame and pride: Affect, sex, and the birth of the self.* New York: Norton.

Nathanson DL (1993). Toward a new psychotherapy. Presented at the first annual colloquium of the Silvan S. Tomkins Institute, Philadelphia, Pennsylvania (and other lectures of Dr. Nathanson, used by permission).

Nathanson DL (1994). Shame, Compassion, and the "Borderline" Personality. *Psychiatric Clinics of North America* 17:4:785-810.

Nathanson DL (1994). From the executive director. *Bulletin of the Tomkins Institute* 1:1-3.

Nathanson DL (1995). Crime and nourishment: Sometimes the tried and true becomes the tired and false. *Bulletin of the Tomkins Institute* 2:25-30.

Nathanson DL (1996). What's a script? *Bulletin of the Tomkins Institute* 3:1-4.

Nathanson DL (1996). The philadelphia system. *Bulletin of the Tomkins Institute* 3:21-26.

Nathanson DL (2003). *Managing shame, preventing violence: A call to our clergy* (DVD). Philadelphia: The Silvan S. Tomkins Institute. www.tomkins.org

Nathanson DL, Levin, G (2000). *A conversation with Donald Nathanson.* Behavior Online. http://behavior.net/2000/03/a-conversation-with-donald-nathanson/

Tomkins SS (1962). *Affect, imagery, consciousness*. Vol. 1: *The positive affects*. New York: Springer.

Tomkins SS (1963). *Affect, imagery, consciousness*. Vol. 2: *The negative affects*. New York: Springer.

Tomkins SS (1991). *Affect, imagery, consciousness*. Vol. 3: *The negative affects*. New York: Springer.

Tomkins SS (1992). *Affect, imagery, consciousness*. Vol. 4: *Cognition*. New York: Springer.

Umbriet MS. What is restorative justice dialog?

Wachtel T, McCold P. What is restorative practices? Website of the International Institute for Restorative Practices, www.iirp.edu

Zehr H (2002). *The little book of restorative justice*. Intercourse, Pennsylvania: Good Books.