

SO THAT'S WHAT'S GOING ON!
UNDERSTANDING EMOTION IN RESTORATIVE PRACTICES
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Instinct alone cannot cope with complex environments. Affects draw **attention** to what's important and **motivate** us. **Affect amplifies anything with which it is coassembled.** Things don't come to our attention unless amplified by affect.

Innate affect: A brain "program" triggered by a specific shape of neural stimulation. The affect system responds to **qualities** of the stimulus: Increase, decrease, level. **Affects are analogs** of their stimuli. Things happen all over the body to **make that information important.** An innate affect has a specific body feeling, vocalization, skin changes, facial display.

Affect provides communication without language. Babies and animals have the same affects as adult humans. Affect labels are universal.

Drives tell us about the location and nature of a need (e.g., hunger), but need affect to be motivating. **Pain** is both localizing and motivating, midway between drive and affect.

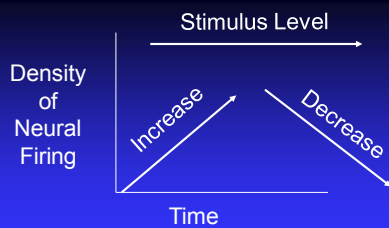
Any affect may amplify any drive, affect, or any mental content or experience.

The Innate Affects: Are urgent, abstract, analogic, general; match their stimuli in profile; correlate stimulus and response.

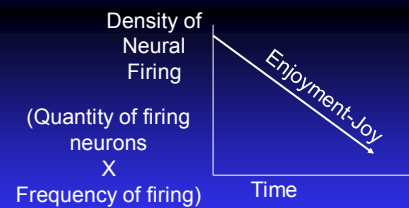
Nine Innate affects	triggers	facial displays
Positive (Inherently rewarding):		
Interest-excitement	optimal increase	Eyebrows furrowed, track, look, listen; mild increase in respiratory and heart rate.
Enjoyment-joy	decrease	Face relaxed, mouth wide, smile, eyes bright, +/-laugh.
Neutral:		
Surprise-startle	sudden onset/offset	Blink, eyes wide, sudden inspiration, "Oh!" Resetting affect.
Negative (Inherently punishing):		
Distress-anguish	steady state overload	Sobbing/wailing; arched eyebrows; tears, red cheeks; flailing arms and legs.
Anger-rage	steady state extreme overload	Generalized muscle tension, clenched jaw, scream of rage, red face.
Fear-terror	too rapid increase	More furrow of brow, blanched, frozen stare, strong increase in heart rate and respiratory rate.
Shame-humiliation	partial impediment to positive affect	Eyes averted, head down, turn, blush, slump; interruption of cognitive and affective processing.
Dissmell (root of contempt)	hunger auxiliary (smell)	Upper lip raised, head drawn back; "Ewww." (Root of racism, prejudice.)
Disgust	hunger auxiliary (taste)	Neck cranes forward, head down; lower lip and tongue protrude.

Innate Triggers for Affect: The Six Neural Firing Gradients

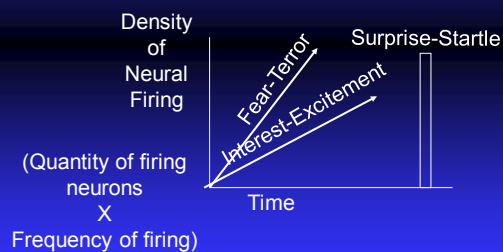
All Possible Neural Firing Gradients



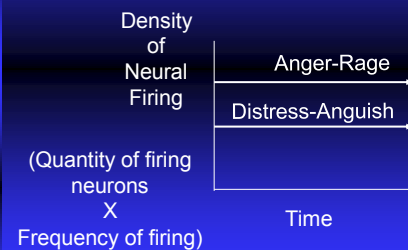
Innate Triggers for Affect: Enjoyment-Joy



Innate Triggers for Affect



Innate Triggers for Affect: Level Stimulus (Overload)



Facial and body feedback are a key part of the experience of affect.

“A second idea . . . then, is that the essence of a feeling may not be an elusive mental quality attached to an object, but rather the direct perception of a specific landscape: that of the body.”

“Were it not for the possibility of sensing body states that are inherently ordained to be painful or pleasurable, there would be no suffering or bliss, no longing or mercy, no tragedy or glory in the human condition.”

Antonio Damasio, M.D. *Descartes' Error: Emotion, Reason, and the Human Brain*. (1994)

The computer model of the emotional system (Nathanson).

Parts interact, mediated via brain.

Hardware: Brain, body (including hormones, muscles controlling face, vocalization, posture, etc.)

Firmware: Drives and affects

Software: Learning, social conditioning, experience

Components of the Affect System

Sites of Action: Places where we recognize affect as feeling.

Nerves: Carry messages to sites of action.

Mediators: Chemicals that trigger effects at sites of action.

Receptors: Detect affect-related information, which is sent back to the affect system to cause more affect.

Organizers: Prewritten programs that organize these mechanisms into coherent patterns. The innate affects.

Definitions:

Affect: Innate, brain mechanism, genetically transmitted; acts to amplify anything with which it is co-assembled.

Feeling: Conscious awareness of the presence of an affect.

Emotion: Affect + feeling + associations to previous experience of an affect.

Mood: A cyclic phenomenon. Scenes retrieved contain material that is unfinished and triggers more of the same affect. It disappears immediately when a new stimulus for affect appears.

Mood Disturbance: Drug, chemical, or malfunction creates enough of the experience of an affect that it feels like an innate affect has been triggered; we handle it like normal mood. The affect system gets “stuck” in an affect. Examples: panic disorder, hyperthyroidism.

Biological Factors and Affect:

Physical illness: Hypothyroidism, chronic fatigue syndrome, stroke, etc.

Drugs: Alcohol, caffeine, benzodiazepines, lithium, etc.

Drug withdrawal

Mental illness

Fatigue, pain, hunger, etc.

Are a person’s affects providing information, or are they interfering with functioning? We look for intensity or duration out of normal range. Is increased or decreased affect due to script (that is, software glitches needing psychotherapy) or hardware glitches needing medication treatment, or both? Pattern recognition is important---if a syndrome is present, we treat the patient with what works (medication, psychotherapy, or both). If someone is having difficulty functioning due to symptoms, pharmacological treatment should be considered. Ultimately, even psychotherapy and psychosocial factors are mediated biologically. (Kandel, 1998)

We rule out other medical disorders, drugs, medications, etc., that can cause symptoms, i.e., a hardware glitch producing the experience of an innate affect. We must recognize and manage the underlying condition. **Substances** such as thyroid hormone, asthma medications and drugs of abuse influence **affective development**, also. A patient who wipes out adolescence with alcohol or marijuana doesn’t learn adult affect management skills and has to be taught.

Psychopharmacology: The intentional use of chemical substances to return affect physiology toward normal. It may be needed for hardware and firmware defects, or for extreme affect related to problems in living.

Psychotherapy of biological glitches: We help patients understand normal emotion after they have been treated with medications. Patient, and probably family, will need to adapt to the new functioning of the affect system.

Adult affects usually have multiple causes: Illness, stress, drugs, hormones, upbringing, old emotional patterns (scripts), etc.

Life is more **complex** than innate affect. Affects can occur at varying **intensities**, and can be combined. **Any affect may amplify any drive, another affect, or any mental content or experience.** This can result in very different life experiences.

From birth, without realizing it, we begin to link things together, to learn, to try to predict what will happen, so we can try to get more good feelings and fewer bad ones. This is the realm of **script**. Even a one-year-old has many scripts. Most of adult life is scripted, with little pure innate affect. That is why we all may react differently to the same event.

Affective Resonance: We tend to mimic others' facial/body displays, giving ourselves a milder experience of innate affect.

Empathy: Whatever is experienced during affective resonance must be explained. We scroll through our memories to find life experiences producing similar "emotions." Empathy is crucial in all relationships and in how restorative practices work!

The Empathic Wall: To some extent, we learn to shield ourselves from the affect of others.

Affective Attunement: Parent assesses baby's affect display and accepts whatever meaning s/he assigns to it. Before a baby can talk, affect provides parent-infant communication.

Affect Modulation: Innate affect is a spontaneous phenomenon expressed without modulation. All societies require that, by the age of three years, children are able to mute innate affect display so they are less likely to take over our consciousness by this distraction. Parents calm a child by rocking, singing, stroking, distracting, etc. **A primary task of parenting is teaching children to modulate affect according to cultural rules.**

Even in the rewarding socialization of affect, a child must be exposed to, and taught to tolerate, graded doses of negative affect!

The Tomkins Blueprint

Because we have evolved with an affect system with some affects that feel good and some that feel bad, each human is motivated to:

1. Maximize positive affect
2. Minimize negative affect
3. Both of these actions work best when all affect is expressed.
4. Anything that helps the performance of these three rules is good for human life; anything that interferes with them is bad for us.

The Tomkins-Kelly Blueprint for Intimacy

Intimacy requires a private interpersonal relationship within which two people obey the following four rules:

1. Mutualize and maximize positive affect
2. Mutualize and minimize (metabolize) negative affect
3. Intimacy is only possible when each person agrees to express all affect so the first two rules will work.
4. Anything that helps the performance of these three rules fosters intimacy; anything that interferes with them is bad for intimacy.

The Tomkins-Nathanson Blueprint for Community

A community is a public system of individuals who agree to:

1. Mutualize and maximize positive affect
2. Mutualize and minimize (metabolize) negative affect
3. A community holds together only if it has a forum for the public expression of affect.
4. Anything that helps the performance of these three rules fosters the sense of community; anything that interferes with any of these rules places the life of a community in jeopardy.

Script Formation: From birth, we begin to link things together. To get more positive affect and less negative, we try to predict and control situations. A baby has normal reflexes (e.g., sucking) and facial displays (e.g., smiling). He tries to suck and smile voluntarily to improve his life (autosimulation). After age six months, a baby can connect events further apart in time. A one year old who has previously had shots will cry at the sight of a doctor and needle. He has begun to link prior affect-laden scenes together (psychological magnification). In other words, he has formed a script.

We go through life having affects triggered, and **learned triggers** accumulate. Other things become linked to affect sequences and patterns. If stimulus-affect-response sequences happen over and over, we develop **emotional "rules"** for managing such families of scenes; the rules are called **scripts**. Most of adult life is managed by scripts. We are rarely aware of their operation. Script theory helps us view people in the **context** of family, neighborhood, and culture.

If sequences happen repeatedly, or trigger very intense affect, we tend to group them and develop an emotional reaction to the whole bundle of them. **Scripts are rules** for the management of scenes; both the rules and the scenes themselves can be magnified by new affect. This new affect can now become part of other scripts. The magnifying affect may or may not be the same affect as that in the scenes. Scripts can include future or past, similar or contrasting. There is an infinite number of possible scripts, and they may be combined. They vary in how complete or abstract they are, and often need outside information (e.g., driving requires vision). Scripts involve compression and expansion of information.

Nathanson (1996): "The function of a script is to simplify the process through which any mental content may be analyzed for its resemblance to prior experience and to provide rapid deployment of strategies for its management."

Distortion: Scripts improve efficiency of information handling, but we tend to try to fit new material into our existing scripts, distorting the information. We may have trouble seeing new situations as novel.

All humans have scripts. Many are adaptive and useful. Some are maladaptive and cause difficulty for the person or for others. The more intense the relationship, the more powerful the scripts. Transference in psychotherapy is evidence of scripts.

Scripts become far more important than the scenes from which they come. Scripts may be **strengthened by analog formation**, or **disconfirmed**. A highly magnified script requires little reminder of the past; it's **easily triggered and involves very intense affect**.

Some Types of Scripts: Ideological; Affect Management (Sedative, Pre-Addictive, Addictive); Limitation-Remediation (Commitment, Acceptance, Hope, etc.); Celebratory, positive and negative; Macho; Shame (Damage-Reparative); Affluence.

Macho Script: Innate affects are arbitrarily segregated as gender-labeled. Anger, dissmell, excitement are masculine. Fear, shame, distress, and enjoyment are feminine. (Moshier and Tomkins)

Personality: For any individual, the pattern of scripts used in interpersonal interaction. Personality formation depends on the differential magnification of affect within family, subculture, or culture and on life experience.

Emotional Health: Affective **plasticity** due to normal affect biology, plus culturally appropriate, **adaptive scripting** enabling optimal functioning in all areas of life.

Script evolution is a lifelong task (parenting, education, psychotherapy, learning through life experience, personal or spiritual growth . . .)

Script change requires intense affective experience, often repeated.

ONE STEP AWAY FROM HEAVEN: THE EXPERIENCE OF SHAME

The Sequence of Shame: Triggering source, Physiological Phase; Cognitive Phase; Decision Phase; Reactive Phase

Source: Any stimulus that partially impedes (slows) the expression of interest-excitement or enjoyment-joy.

Physiological Phase: Eyes down and turned away; face averted; slump; blushing; cognitive shock; interruption of whatever positive affect had been in progress, interruption of affective communication.

Cognitive Phase: As we recover from the cognitive shock, we scan memory for previous experience of this affect. All possible experiences of shame may be grouped as follows:

- | | |
|--|-------------------------------------|
| A. Matters of size, strength, ability, skill | E. Personal Attractiveness |
| B. Dependence/independence | F. Sexuality |
| C. Competition | G. Issues of seeing and being seen |
| D. Sense of self | H. Wishes and fears about closeness |

Decision Phase: Now filled with uncomfortable memories and feelings, we decide whether to add this new experience to our list of defects and failures, or to defend against it. Acceptance would require revision of our sense of self.

The healthy response to shame, of course, is to tolerate its discomfort, soothe myself, acknowledge any responsibility I might have for hurtful or inappropriate behavior, remind myself that I am still a good person, and learn from the experience. But that's not what we usually do!

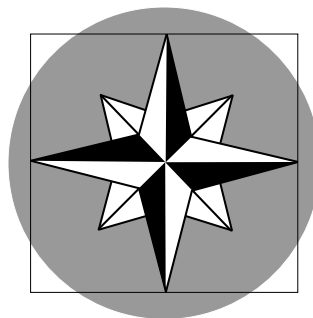
THE COMPASS OF SHAME

Nathanson, 1992

WITHDRAWAL

Falling silent, leaving therapy or relationship; isolating, etc.

ATTACK OTHER
Verbal attack; physical, emotional, sexual abuse; violence, torture.



ATTACK SELF
Negative self-talk; self-injurious behavior; some suicides, etc.

AVOIDANCE
Drinking, drugs; machismo; dissociation; workaholism; snobbishness; thrill-seeking, etc.

Note: You could draw a compass of the common script libraries for managing any affect.

Western societies have moved from withdrawal and attack self to avoidance and attack other over the last hundred years, a very dangerous shift. Those who batter or bully others express great personal shame. Substance abuse raises the risk of violence, due to disinhibition of anger or other affects.

The healthy response to shame is to tolerate it, soothe myself, acknowledge any responsibility I might have for hurtful or inappropriate behavior, remind myself that I am still a good person, and learn from the experience. But that mature response is not 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, hold us accountable, push us to be our best, give positive feedback, respect us, and require us to respect others. Many families, schools, and communities provide these conditions, of course. We need to make them available to all. A whole school (or community) restorative approach does that.

Restorative Practices are an extension of restorative justice. They developed as a response to punitive, ineffective justice (which isolates offenders and does not help communities to heal). They build empathy, relationships, and social capital, integrating people instead of alienating. Everyone is heard. Affect is expressed. Those involved decide how to heal harm or solve problems. People are held accountable to those affected by their behavior. Restorative practices range from formal (e.g., structured restorative conferences, which include support people of participants) to less formal (group, circle, or small, impromptu conferences) to least formal (affective questions and statements). **Restorative practices are most powerful when used as a way of life**, not an occasional intervention. They are used worldwide, in prisons, schools, neighborhoods, faith communities, criminal justice, sentencing, etc. They enable **fair process**, including engagement, explanation, and clarity of expectation, increasing the chance of success.

Restorative practices **make safe spaces for healing, connection, and “re-scripting.”** They create places where people can share and increase positive affect, share and work through negative affect, and minimize excessive shaming and other sources of affect inhibition. (Tomkins’s Blueprint.) They script relationship skills and build community.

Restorative practices allow people to tell their stories, express underlying affect, and practice empathy. In the process, participants typically move through more distancing and toxic emotions, (rage, fear and dissmell) first, then surprise, distress, and shame. People (“offender” and others) feel their responsibility for what happened, and shame for hurting others. Shame serves as a barrier to connection with the group. It is only triggered when there is a positive bond, and signals openness to heal or repair. People feel shame without being pushed out of the group. Marie Fitzgerald calls the moment of the shift “collective vulnerability”. Participants begin to feel the need to make it right with each other. Finally, they move into the positive affects of interest and joy as they agree on how to make things right.

Some approaches to bullying and violence do not work; they are treating symptoms. Underlying the problems is the inability to manage emotion. Cognitive “education” does little to change the largely unconscious but powerful scripts by which we function. For the same reason, insight does not guarantee change in psychotherapy. To shift powerful scripts requires intense affective experience and repetition. To learn healthy emotion, people **really have to live it**. The younger we start, the better. “Band-Aid” solutions will not reverse the cultural shift toward *avoidance* and *attack other* shame scripts. The answer is prevention: **explicit affect education** and long-term **immersion in a restorative milieu**. It is a highly ethical, scientifically-based “vaccine” against violence and conflict. Benefits include big drops in problem behaviors, crime, and conflict, and better school and community cultures. Healthier, more resilient kids become healthier adults.

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