TALKING InCoheRENTLY

V. 2 #3

dawn patrol Child & Youth Services / Journal Volume 2 #3, 2003

We are immersed so deeply in a sea of moral assumptions that it takes an effort to imagine a world without them. A world without obligations to reciprocate, deal fairly, and trust other people would be simply inconceivable.
- Matt Ridley, *The Origins of Virtue*

Crying Shame

A Convergence of Interests

[1] … The children & youth served in our programs are defined by the fact that they engage in an aberrant kind of behavior we call "criminal". Criminal behavior, unlike a lot of other forms of social abnormality (e.g., mental illness, homelessness, alcoholism, addictive gambling, etc.), involves a *conscious choice* to violate communal norms:[1]

> *… it is the fact that the criminal chooses to engage in the behavior knowing that it can be so labeled that distinguishes criminal choices from other choices. It is the defiant nature of the choice that distinguishes it from other social action … The homogeneity presumed between disparate behaviors such as rape and embezzlement … is that they are choices made by the criminal actor in the knowledge that he is defying a criminal proscription which is mutually intelligible to actors in the society as criminal.*[2]

Furthermore, amongst those forms of action that violate communal norms by *conscious choice*, criminal behavior is better understood as *deviant* than as simply *nonconformist.* By *nonconformist* I mean those pursuits that openly challenge the legitimacy of the rules they violate with the intention of changing them (e.g., homosexuality, nudism, vegetarianism, eco-environmentalism, religious or political extremism, etc.). In contrast, *deviants* admit that their violations are wrong, try to hide them, and try to avoid the sanctions that society imposes. As Jerome Kagan points out: "Ask any thief if stealing is wrong and he will tell you so without equivocation. He knows that stealing is wrong … A thief knows he is behaving improperly and knows his behavior is disapproved by his friends and society."[3] [The criminal might try to *justify* or *rationalize* his misbehavior, but he does not argue that murder, rape, assault, or theft are right and virtuous in themselves.[4]]

It is these aspects of its nature – i.e., that it is a *conscious choice* to commit a *wrongful act* – that make criminality a form of *moral* behavior. In essence, criminality is the deliberate rupture of the *moral consensus* of society. As such, we can expect that our *moral emotions* will be a necessary part of the stage on which crime is played out – and not just the moral emotions of the victim (*revenge*, *forgiveness*) or of the state (*retribution*, *restitution*), but even those of the criminal himself.

[2] … We learned from our survey of effective programming [see ***What Works [Who Works]*** and the *TI Bulletins*] that the single most important aspect of successful therapeutic intervention is Client Factors. No other set of factors correlates as powerfully with successful outcome in therapy (however measured) than this.

Within Client Factors, we can further identify two general sub-sets: (A) those *internal* factors that the client brings to therapy (e.g., values, beliefs, experiences, moods, intelligence, cognitive capacity, etc.); and (B) those *external* factors that influence or support the client outside of therapy (e.g., family, school, peers, adult mentors, hobbies, sports, etc.).[5]

Of course, of these two sub-sets, we CYCs are particularly interested in the first – because it is the therapeutic basis for any *internalization* and *generalization* of positive change [see the preceding article]. At best, changes in the *external* influences on the client (the second sub-set) will produce the kind of therapeutic results that are *contingent* and *contextualized* – i.e., they will be short-lived and specific only to the circumstances in which they are constructed. Our hope as therapists is that the gains we help our client make will be sustained for a long period of time. For that reason, we must give therapeutic priority to the first sub-set (that is, the *internal* Client Factors).

Although it's a crude distinction with many overlaps and exceptions, we can categorize the *internal* Client Factors according to how long-lasting their effects are likely to be on the client.[6] [See Diagram 1] Some *internal* influences affect a client's behavior for only brief periods of time, perhaps only a few minutes – an example is the client's ability to apply *reasoning* and *logic* to a situation or problem. Other influences last a bit longer, perhaps up to an hour or more – for example, strong *emotional reactions* (like anger, anxiety, or fear). Still others can hold sway over the client for many hours, even days –

---

[1] Mainstream criminological theories about the causes and nature of crime seem to be dominated by a behaviorist perspective – i.e., a passive conception that portrays criminal behavior as determined by biological, psychological, or social forces over which the criminal has little or no control. [So, if we want to reduce crime, all we need do is adjust the relevant biological knob, pull the right psychological lever, or engage the proper social gear.] While it is undeniably true that the biological, psychological, and social place real and compelling constraints on an individual's actions, I support a more active conceptualization of criminal behavior in which the individual is conceived as an *agent* capable of free will, personal choice, and self-determination.

[2] John Braithwaite, *Crime, Shame and Reintegration* [New York: Cambridge University Press, 1989/1999].

[3] *Unstable Ideas: Temperament, Cognition, and Self* [Cambridge, MA: Harvard University Press, 1989].

[4] There is a virtual encyclopedia of justifications (he shouldn't have threatened me, she deserved it, I was protecting my own, he was insured, etc., etc.) – and the biggest source of justifications is the behaviorist perspective mentioned earlier (footnote #1): the criminal, it turns out, is the real victim (of all those biological, psychological, and social forces).

[5] The terms "internal" and "external" used here are virtually identical to those used in the preceding article; however, they should not be seen as synonyms for "intrinsic" and "extrinsic".

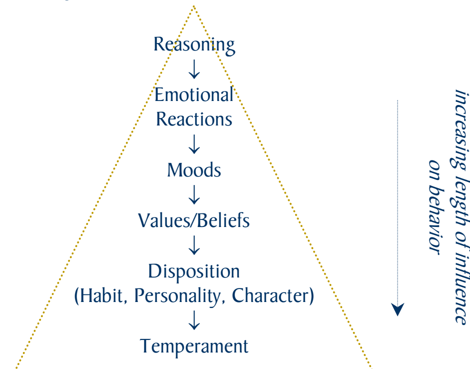
[6] Or according to the timeframe in which these influences change their content.

we usually call such extended emotional experiences *moods*. On the time scale of an individual life, *reason, emotions,* & even *moods* are relatively brief kinds of internal influences. They are important, however, because they permit us human beings to adapt to quickly changing circumstances or to circumstances that may be unique or not encountered very often.

Of course, not all contexts (or environments) to which we must adapt require such rapid-response capacities. For these, we are equipped with internal influences of a more durable nature. For behavioral capacities that must extend for months or years we rely on *beliefs* & *values.*[7] Longer lasting still – and more deeply embedded in us – are our *dispositions.* These include one's *habits, personality,* & *character.*[8] Finally, there is our *temperament* – i.e., those behavioral inclinations that are biologically hard-wired into us constitutionally or genetically.[9]

Any given action (or behavior), then, is a veritable storm of reasons, emotions, mood, belief, value, habit, personality, and temperament.

Diagram I: Internal Client Factors



Which will predominate to gain primary influence? Will they conspire and form alliances? Will they conflict and override each other?

As therapists, we try to work with our clients at all these internal levels of influence – except perhaps at the biologically given level of temperament.[10] We teach problem-solving skills to develop reason, and stress-coping techniques to control emotions. We have unlimited cognitive programs to change dysfunctional moods (especially depression) and maladaptive beliefs.

Of course, the farther down we can reach into these levels of internal influence, the more long-lasting and beneficial will be our help – i.e., the more likely we can accomplish our primary therapeutic goal of helping the client *internalize* and *generalize* positive changes. Which is why we would be profoundly interested in any information that could aid us in working at the level of *disposition.* This is our therapeutic bedrock: *habit, personality,* and *character.* Can this even happen? Can we go beyond reason & emotion, beyond belief & values? Can we help a client change his very *characteristics?*

[3] … Despite compelling evidence showing its relative lack of importance to therapeutic outcome, most clinical practitioners still focus on some specific Model or Technique as the meat & potatoes of therapeutic programming. There are a variety of historical, sociological, and institutional reasons why this misplaced faith continues (and will continue for some time yet).[11] In essence, everyone is looking for an edge – for some way to distinguish themselves from the crowd. Distinction brings attention and rewards. It has become a necessary survival strategy in a service environment of scarce and diminishing dollars. [Of course, distinction also brings "Best Practices" and a legion of imitators determined to nullify your advantage. So, the search for the perfect Model, the killer Technique (aka the Silver Bullet), never ends. At best, one can only be momentarily ahead of the game. This nonsense wouldn't be too bad

---

[7] A person's *reasons* & *emotions* change frequently and quickly during the course of a day; her *beliefs* & *values,* however, tend to persist. It is only when we look back at the different developmental stages or experiences in our lives that we see how much the latter change.

[8] *Personality* and *character* are often construed as synonyms – and, indeed, they may be just the same thing seen from two different historical perspectives. The differences between them, however, are both interesting and informative.

The older term is *character,* dating back to A.D. 1315. It originated from the Greek word *kharassein,* meaning to engrave or inscribe a mark (on the soul). This definition shows the acquired nature of *character*: it is something that is impressed on an existing thing. The modern sense of the word developed in the 17th Century. In a society (and historical period) where people lived in close contact with a small number of other people for most of their lives (or over long periods of time), predictable personal qualities were paramount. As Kenneth Gergen says, such traditional societies "… supported a belief in identity and coherence. People were knowable, understandable, and predictable, and thus relationships amongst persons – in families, the workplace, friendships, and the like – were optimal when each participant functioned as a reliable cog in the machine." [*The Saturated Self* (1991)] Thus, a person's *character* was the virtues (or vices) that he or she could be depended upon to have at all times – e.g., truthfulness, cleanliness, punctuality, dependability, charitableness, licentiousness, laziness, etc., etc.

In contrast, *personality* is a much newer term, dating to the 19th Century (but only really eclipsing *character* at the end of the Victorian era). It originated from the Etruscan word *phersu* (adopted by Latin as *persona*), meaning a mask (as worn by a character in a play). This definition also shows the acquired nature of personality: it is something placed over an existing thing. It became popular in a society (and historical period) where people where becoming highly mobile and relationships more transient. What mattered in such circumstances was not long-standing qualities (like *character* and *virtues*) but superficial qualities that facilitated large-scale interaction based on role-playing rather than intimate interaction. This kind of person was a "… social chameleon, constantly borrowing bits and pieces of identity from whatever sources are available and constructing them as useful or desirable in a given situation." [Gergen, *op. cit.*] Thus, *personality* focused on attributes like appearance, popularity, energy, wit, fashionableness, etc.

It's a little easier to see the difference between them if we consider someone with *no character* and someone with *no personality.* We could trust the latter but not the former – and we might find the former a little more interesting to hang around with than the latter.

The sociologist David Reisman called those with *character* "inner-directed", and those with *personality* "other-directed".

[9] The difference between *disposition* (such as *habit, personality,* or *character*) and *temperament* is that, while both persist over great periods of time and a wide variety of circumstances, the former is *learned* and the latter is *inherited.* [Although we should not be too simplistic about temperament. It is more accurate to say that we inherit a *range* of temperament, which is subsequently modified by experience and learning.]

So, what am I saying by arranging internal factors in this way? Reasons come, and reasons go – but stubbornness lasts forever!

[10] The best we could ever hope to accomplish at this level as CYCs is minor fine-tuning. Anything more substantial requires drug treatment – the legitimate professional arena of psychiatrists.

[11] I outlined most of them (e.g., status, monetary reward, professional identity) in the ***What Works [Who Works]*** article [see the section entitled *They Shoot Horses, Don't They?*].

if the real end result was an increase in therapeutic effectiveness for our clients – but fifty years of research shows this is not happening. We may be getting better and better, but it's better and better at only 15% of what counts!]

Social service agencies are fundamentally no better than individual practitioners: we, too, seek an edge over the competition. We are frantic to be in style, to be empirically-validated. As a result, we are hyper-vigilant for the latest bell or whistle that will set us apart.

[1 - 2 - 3 *crash*] … Question: What happens when the unbecoming desire to gain a programming advantage meets the noble desire to help a client make effective changes in her disposition? And what happens when these two things come together with our interest in the moral emotions that protect us from crime? Answer: We are led to the doorstep of some of the most exciting research that our field has seen in the last twenty years! We are led to the work of June Price Tangney & Rhonda Dearing and a small band of researchers exploring the behavioral implications of *shame* & *guilt.*

Moral Emotions

Man is a social animal. [Well, Woman is a social animal and Man is along for the ride.] As such, we have evolved numerous mechanisms for reconciling the behavior and interests of the *individual* with those of the *group* to which he or she belongs. We can call the creation and maintenance of this harmony of behavior and interests a *moral consensus.* In large part, the moral consensus defines what is *beneficial* to the group and what is *harmful.* On this basis, it sanctions individual behavior: *approving* what is beneficial and *punishing* what is harmful. Since "crime" defines our field of service to children and youth, we are particularly interested in the latter aspect.

Some of the moral consensus mechanisms for dealing with harmful behavior are *external* to the individual – i.e., they are actions or products of the group itself. For example, we have *formal conventions* (laws, rules, penal codes, trials), *institutions* (police, courts, places of incarceration), and *informal interpersonal behaviors* (anger[12], blame, indignation, contempt, revenge, gossip).

Far more powerful for maintaining the moral consensus, however, are the *internal* mechanisms that evolutionary adaptation has built into the individual.[13] These are our *moral emotions:*

> *All children seem to appreciate the actions and qualities their community classifies as good or bad. If they act in a way that deviates from their understanding of the community's belief, the evaluative self feels a lack of virtue and the person will try to behave in a way that will enhance the sense of virtue.* [Kagan, *op. cit.*]

Some of these emotions are clearly directed towards *others* in a *negative* or *disapproving* fashion (e.g., feelings of anger, blame, resentment, indignation, contempt, pity, envy, jealousy, etc.).[14] Some, though – and these are the ones that we are most interested in because of the role they play in fostering or preventing criminal behavior – are directed towards the *self* in a *disapproving* fashion. Included in this set of emotions would be feelings of humiliation, embarrassment, mortification, abandonment, alienation, and intimidation – but the most important ones would be *shame* and *guilt.*

… Shame And Guilt …[15]

Tangney & Dearing define shame and guilt as *self-conscious, moral emotions.* It's worth unpacking this definition a little bit, so we have a solid grasp on what they are talking about. First of all, they are "emotions". This means several things, including:

- They are *not* learned: rather, they are biologically-based *feelings* that are hard-wired right into our brains.[16]
- They have an *hedonic* tone or direction – which is just a fancy way of saying they are either *pleasant* or *unpleasant* (and, in the case of shame & guilt, they are both distinctly unpleasant).
- They come in degrees of *intensity* – in other words, the feelings can range from mild to severe forms.
- They are accompanied by *physiological* changes (e.g., increased heart rate, higher blood pressure, sweating, blushing, etc.).
- They elicit certain *behaviors* designed to alleviate the feeling of unpleasantness.

Second, they are "self-conscious". To put it another way, they involve feelings *about* the self (as opposed to feelings about others) – specifically, an unpleasant feeling that the self has done something wrong. As Tangney & Dearing say: "In the face of transgression or error, the self turns toward the self – evaluating and rendering judgment. Thus, the experience of shame or guilt can guide our behavior and influence who we are in our own eyes." [*op. cit.*]

Third, they are "moral" – because they involve more than just the self: they involve the self *in relationship to others.* If the self is evaluated and found wanting, it is because it has transgressed social norms or caused some form of harm to others. In another sense, then, they are

---

12 Anger is dealt with below.

13 I say these are more "powerful" in the sense that it is hard to understand why people don't commit more crime (thereby affording themselves distinct resource advantages). External constraints may carry a great deal of force and threat, but they are inconsistent, often absent, and relatively easy to avoid or fool. Why is it that most humans most of the time do not avoid or fool them? The answer, I think, has to be the power of these *internal* mechanisms. Given the opportunities we have for immoral behavior, it is nonetheless comparatively rare.

14 We are focused on those emotions that disapprove of harmful behavior, but there are, of course, *positive* moral emotions that help tie the individual to the group through *approval* – e.g., feelings of love, empathy, benevolence, sympathy, gratitude, adoration, etc.

15 The following few sections are a summary of Tangney & Dearing's book *Shame And Guilt* [New York: Guilford Press, 2002]. I take responsibility only for the embellishments.

16 The names we give these feelings (i.e., "shame" and "guilt"), the events or circumstances that elicit them, and the behaviors we manifest in response to them are all indeed *learned*, but the actual biological feeling isn't. It is a naturally-occurring event similar to our experience of colors. We don't *learn* our colors; we only learn their names. Colors, like emotions, are inbred capacities through which we interpret the world. [Nonetheless, just as some people are color-blind, some have different emotional capacities.]

According to evolutionary psychologists, humans have six *unlearned* "primary" emotions – i.e., joy, distress, rage, fear, disgust, and surprise. [See: Dylan Evans, *Emotions* (2001)] Our "secondary" emotions (e.g., shame, guilt, pride, envy) are simply these *primary* emotions applied to socially learned situations. So, for example, *shame* would be *disgust* applied to the socially-constructed concept we call the *self* – and *pride* would be *joy* applied to the *self.*

also "moral" because they guide behavior in response to such transgression or harm.

The purpose of shame and the purpose of guilt, then, are the same: *to make the individual's transgression of social norms an unpleasant experience – so the individual will be inclined to conform.* Indeed, they are so similar in purpose and unpleasantness that it is often quite difficult for people to tell them apart.[17] In most traditional moral theories, they are simply lumped together and used as synonyms. Partly, this difficulty in differentiating the one from the other is because they are provoked by similar situations (i.e., transgressions and harm); partly, it is because, in a lot of instances, we are indeed feeling both. Nonetheless, they are distinct emotions, and they do have distinct impacts on the behavior and development of the individual.

… Shame Versus Guilt …

One common way of distinguishing between shame & guilt has been to use the "public/private" division popularized by anthropologists. According to this approach, "… certain *kinds of situations* lead to shame whereas other *kinds of situations* lead to guilt. For example, there is a long-standing notion that shame is a more 'public' emotion than guilt. Shame is seen as arising from public exposure and disapproval of some shortcoming or transgression, whereas guilt is seen as a more 'private' experience arising from self-generated pangs of conscience." [Tangney & Dearing, *op. cit.*] Unfortunately, careful research and experimentation fail to support such a notion. As it turns out, *guilt is every bit as likely to be experienced in the presence of others* and *shame is every bit as likely to be felt when the person is alone*.[18] [Again, this is a useful piece of professional knowledge to have. It is one more small part of why CYC practice is not just "common sense" – but knowledge based on scientific investigation.]

What truly distinguishes shame from guilt is the role that the "self" plays in the feeling: "Shame involves fairly global negative evaluations of the self (i.e., 'Who I am'). Guilt involves a more articulated condemnation of a specific behavior (i.e., 'What I *did*')." [Tangney & Dearing, *op. cit.*] The difference is in the focus: shame centers on *self;* guilt centers on *behavior*.

In short, shame is an emotion that causes a more painful or unpleasant sensation.[19] It is aimed directly at how the person feels & thinks about her self,[20] creating feelings of worthlessness and a desire to flee, hide, or strike back. To bear the pain of shame, the person must undo some aspect of himself – or deny the pain in some psychologically expensive fashion (which we will explore below). In contrast, guilt leaves the self untouched. It focuses the attention of the person outward – to the feelings of others and to a consideration of what can be done to set things right.

Tangney & Dearing summarize the ways in which shame & guilt are different in the following Table:

	Shame	Guilt
Focus of evaluation	Global Self: "***I*** did that horrible thing!"	Specific Behavior: "I ***did*** that horrible ***thing***!"
Degree of distress	generally more painful than guilt	generally less painful than shame
Phenomenological experience	shrinking, feeling small, worthless, or powerless	tension, remorse, regret
Operation of Self	Self is "split" into observing and observed selves	unified Self intact
Impact on Self	Self impaired by global devaluation	Self unimpaired by global devaluation
Concern vis-à-vis the Other	concern with Other's evaluation of Self	concern with one's effect on Others
Counterfactual processes	mentally undoing some aspect of the Self	mentally undoing some aspect of Behavior
Motivational features	desire to hide, escape, or strike back	desire to confess, apologize, or repair

… They're Different – So What? …

Once research begins to articulate the difference between shame & guilt, it seems hard to understand why people sometimes have difficulty telling them apart. If, in *practical* terms, we don't keep them separate and distinct, is there any real advantage in doing so *theoretically* and *clinically*? As it turns out, there are several good reasons why we should:

[I] First, the two emotions, as intricately bound to each other as they are, have noticeably distinct impacts on *interpersonal relations:*

> *In brief, shame is an extremely painful and ugly feeling that has a negative impact on interpersonal behavior. Shame-prone individuals appear relatively more likely to blame others (as well as themselves) for negative events, more prone to a seething, bitter, resentful kind of anger and hostility, and less able to empathize with others in general. Guilt, on the other hand, may not be that bad after all. Guilt-prone individuals appear better able to empathize with others and to accept responsibility for negative interpersonal events. They are relatively less prone to anger than their shame-prone peers – but when angry, these individuals appear more likely to express their anger in fairly direct (and one might speculate, more constructive) manner.* [Tangney & Dearing, *op. cit.*]

---

[17] Researchers like Tangney had to face this challenge of our general difficulty in telling shame from guilt. Their solution to it is quite clever, and worth reciting because it is based on a technique that can be very useful in our clinical work with clients. Instead of asking research subjects what they were feeling in response to specific instances of transgression or harm (because the subjects couldn't tell the difference between the negative feeling of shame and the negative feeling of guilt), they asked instead about what the subject *might have done differently* to avoid the negative feeling in the first place. This technique is called *counterfactual* thinking, because it involves *imagining* past events that did not actually happen (i.e., were not "facts"). Through such counterfactual imagining, the subject clearly reveals his understanding of what the "actual" situation involved in terms of his emotional reaction. [Try this technique with clients when you want to understand what their underlying interpretations and motives were for some specific act.]

[18] And *both* are more likely to be felt in the presence of others. As well, subjects were as equally likely to experience solitary shame as solitary guilt. [One small difference related to *kinds of situations*, is the finding that people are more likely to feel shame when the transgression is "non-moral" – e.g., inappropriate behavior or dress.]

[19] "Shame is a sickness of the soul. It is the most poignant experience of the self by the self, whether felt in humiliation or cowardice, or in a sense of failure to cope successfully with a challenge. Shame is a wound felt from the inside, dividing us both from ourselves and from one another." Gershen Kaufman (1996), *The Psychology of Shame*.

[20] As the philosopher R.G. Collingwood said: "What a man is ashamed of is always at bottom himself." [*The New Leviathan*]

We can see a couple of important clinical issues for our field (youth in conflict with the law) identified in this brief passage: (a) the impact of shame versus guilt on *responsibility* [the former fosters *blame* and *evasion*, while the latter fosters *acceptance* of responsibility]; and (b) the impact of shame versus guilt on *anger* [again, the former fosters a negative, hostile, bitter anger, while the latter facilitates a more positive, constructive kind]. In service terms, *responsibility* is the social (and personal) good we promote as the outcome of our work and as the yardstick of our effectiveness. And, more than any other client behavior, *anger* is the most pervasive and persistent problem standing in the way of achieving responsibility. If the research on shame & guilt shows that we can learn a trick or two to increase the one and reform the other, then we should pay serious professional attention.

[2] Second, shame & guilt correlate differently with the likelihood that a child or youth will end up in conflict with the law (as well as with the likelihood that the child or youth will suffer other negative social outcomes – e.g., mental illness, suicide, drug & alcohol use, risky sexual behavior, school suspensions). Stated briefly, *the more prone a child or youth is to processing transgressions by means of guilt, the less likely it is that he or she will end up in conflict with the law (or suffering any other negative outcome).* Shame, however, does not work to reduce exposure to negative outcomes – indeed, children that are shame-prone do more drugs, are suspended from school more, and make more suicide attempts (they are also less likely to go to college or engage in positive community service). As Tangney & Dearing say:

> *The pattern is pretty clear cut: guilt is good; shame is bad … There is no evidence that shame inhibits problematic behaviors. The propensity for shame does not deter young people from engaging in criminal activities; it does not deter them from unsafe sex practices; it does not foster responsible driving habits; and in fact it seems to* inhibit *constructive involvement in community service … Guilt, on the other hand, seems to be a powerful moral emotional factor. People who have the capacity to feel guilt about specific behaviors are* less *likely than their non-guilt-prone peers to indulge in destructive, impulsive, and/or criminal activities. They have sex with fewer partners and are more likely to use protection. They are more likely to drive responsibly, to apply to college, and to actively contribute to the community.*

The clinical value of this information is huge, for a couple of reasons: (1) It gives us a clear direction in which to help our clients – i.e., *reduce* their reliance on processing their transgressions by means of shame, and *increase* such processing by means of guilt. (2) It permits us to develop intervention (therapy) programs that can have tangible impact on reducing a client's recidivism *because it opens a therapeutic avenue to a meaningful internalization & generalization of positive change.* Huh? Sorry, that was a mouthful. Let me explain …

When it comes to the issue of reducing recidivism, there are two clinical challenges. The first is that we must develop interventions that permit the *internalization* & *generalization* of positive therapeutic change, rather than simply controlling a client's behavior by external *contingent* & *contextual* methods. [The reason for this was given in the preceding article – and it is basically that therapeutic benefits and gains only become long-lasting and habitualized *if they are internalized* & *generalized by the client.*] The research here shows us how to do that by working "deep" within the client at the level of *dispositions*. [I'll explain this further in the next section.]

The second clinical challenge relates to *practicality* and *therapeutic relevance*. Most factors that correlate with reduced recidivism are what researchers refer to as "tombstone" or "static" variables – i.e., they are variables that can't be adjusted for the individual client either because they have already happened (e.g., unstable family life, school truancy, separation from parents, having a parent with a criminal record, age of first arrest, prior convictions, etc.) or because they are an enduring part of the person which is not amenable to short-term change (e.g., intelligence level, temperament, brain injury or damage). Only factors that have a current or ongoing influence on a client have the potential for modification by treatment. These "dynamic" factors include such things as: alcohol or drug use, level of education, employment experience, and problem-solving skills. Making changes in these dynamic variables will change the client's *future* recidivism rate. A client's proneness to shame or guilt fits into this latter category as well (i.e., it is a dynamic variable). Consequently, not only will changes in these factors affect recidivism, they are also *workable* within the practice of therapy.[21]

[3] The third reason that this distinction between shame and guilt is important to us as CYCs is that it gives a valuable insight into the counselling process – specifically, it speaks to why so many of our clients in the youth justice system find counselling an unacceptable solution to their life problems. As Tangney & Dearing point out: "… shame-related reactions very likely account for many failures in treatment, including pervasive resistance and premature termination of therapy. In developing a 'third ear' for shame-related processes, the therapist can enhance his or her effectiveness with many clients, particularly those who are prone to shame." [*op. cit.*] What is true in this respect for therapy clients in general is doubly true for those clients in therapy for serious moral transgressions or harm (i.e., those clients, like ours, that have committed a crime).

But why should there be this negative relation between counselling and shame? A big part of the answer lies in the fact that clients referred to our programs have been identified as "deficient, defective, and in need of repair" [Tangney & Dearing, *op. cit.*]. It's reasonable to assume that this is how they think others see them – as "faulty, weak, and unable to cope with life on their own." Worse, they are forced to play out their deficiency in front of a model of perfection – the *counsellor who has all the answers!*[22] So, counselling is easily perceived as an attack on (or exposure of) the client's deficient "self" – on his weaknesses and inadequacies. In, short, it is seen as a way of shaming the client. As we shall see, one of the most common reactions to such an attack is avoidance or denial. The simple way to cope with the attack that counselling represents is to avoid therapy (or terminate early, or fail to engage it seriously). As CYC practitioners, we need to be mindful of this dynamic – or it will undermine any relation we attempt to build with the client.

---

[21] As opposed to workable within general social policies that may reduce the recidivism rate across the board (e.g., supporting families, offering alternatives to custody, making income more equitable, etc.), but won't benefit our individual client.

[22] We shouldn't forget that there may also be *social* forces affecting the client that have a basis in shame. Counselling is a process in which intimacies and secrets are made public (within the context of "confidentiality" – which may not be perceived as trustworthy). Accordingly, family and friends might put a lot of pressure on the client to avoid counselling because they don't want their dirty laundry (i.e., shameful behavior) exposed to the therapist.

… It's Not So Much the Feeling As the Proneness …

In the preceding section, I managed to slip in a term that has important implications for understanding the impact of shame and guilt. It's not the *feelings* of shame or guilt *per se* that affect the development of our sense of responsibility or that contribute to long-term outcomes like criminal activity or mental illness. Rather, it is a person's *proneness* to such feelings – i.e., the general tendency that a person has to experience such feelings in response to certain situations (in this case, those situations of moral transgression and harm).

What difference does a *feeling* compared to a *proneness* make? Well, a *feeling* of shame or guilt is a short-lived emotional state, a momentary experience. In addition, all normal people *feel* shame and/or guilt from time to time.[23] If you look back at my scheme for ordering the *internal* Client Factors [see Diagram I], such *feelings*, or *emotional reactions*, influence a person for only a short time, often just minutes. In contrast, *proneness* to shame or guilt is a pattern of emotional response (in other words, a *disposition*) that can only be detected over a long period of time. It is the *frequency* of shame or guilt reactions that a person exhibits in response to situations of transgression or harm. Most importantly, people differ widely in terms of this frequency – and it is this frequency that correlates with developing responsibility or experiencing negative social outcomes (like criminal activity or mental illness), not the actual feelings.

The clinical implication is that working on a client's *proneness*, rather than on the *feeling* itself, carries the promise of greater therapeutic gains – in other words, it can bring about changes that will be longer-lasting and more *generalized* because they take place deeper in the client. [Helping a client with his *reasoning* skills, with *stress coping* mechanisms,[24] with *values* clarification, or with cognitive restructuring of his *beliefs* are all important clinical goals. However, by themselves they won't take us very far down the therapeutic path - for not only must a client *have* such abilities, but he must also *be willing* to apply them. In other words, he must be *disposed* to use them *unconsciously*. They must become *habits*. Otherwise, they will not be truly *internalized* and *generalized* – so they will emerge only in *contingent* situations or *contexts* that call them forth. [See the preceding article.]

… Aside: Therapy is About Willingness To Change …

Old Joke: *how many therapists does it take to change a light bulb?*
Answer: *Only one – but the light bulb has to be willing to change.*

I wish I could give you a magic formula for achieving this deep level of internalization & generalization, but therapy is hard work, not easy work. All I can say is that it doesn't lie in the "programs" or "models" or "techniques" that we use: it lies mostly in the *relationships* we build with clients and with our readiness to approach the world through the client's eyes. So, the road to making dispositional changes (i.e., changes in ingrained habits, in internalization & generalization) lies in how well we *relate to* and *engage with* the client. Programs, models, & techniques impart valuable knowledge and sometimes valuable skills, but *relationships* (e.g., the therapeutic alliance) foster *willingness to change* - and working within the client's perceptions fosters *meaning*.[25] Change doesn't happen simply because one acquires new knowledge or skills. Before a person will take change to heart, it must make sense (i.e., be *meaningful*) and he must *be willing* to apply the new knowledge and skills.

So exactly why is it that *willingness* resides in relationship? Well … Some relationships are forced upon us by nature – e.g., parent/child or sibling/sibling. Some are forced upon us by society – e.g., teacher/student or supervisor/employee. Others, however, we *choose* from the myriad possibilities that life and social interaction offer. Whatever its outward form, the fundamental essence of *any* relationship is the desire to be *attractive* to the other person. When we are in a relationship with someone else (and I am *not* restricting this to only sexual or physical relationships), *we are highly motivated to display those characteristics that we believe the other person will be attracted to*. This is doubly true for those relationships we voluntarily choose. [Obviously *what* characteristics we want to display depend upon the nature and context of the specific relation.] Conversely, we are attracted into relationships by those characteristics we find attractive. *Wanting to be attractive* supplies the *willingness* to make changes.

Forming a therapeutic alliance, then is a two-step process. First, the counsellor must make himself attractive to the client. This is accomplished: (a) by displaying those characteristics valued by the client (e.g., empathy, genuineness, trust, being 'cool', etc.); and (b) by affirming or respecting the client's perspective (we are all attracted to people who validate or reflect back to us our basic values & with whom we feel an affinity). If the first step gels, the client will take the next step – i.e., he will give back to the counsellor those characteristics he believes the counsellor finds attractive (which, if we do our job right, will be the knowledge & skills we have been trying to impart). As Gad Czudner says in *Small Criminals Among Us* (1999):

> *Whenever a child is brought to me for treatment because he steals, lies, disobeys adults, and is aggressive, my first task is to gain the child's respect and* ***make sure the child likes me****. Building a relationship with a problem child may be made easier because many of them strongly desire approval. Once this rapport has been established and a strong relationship develops, such a child will generally want to please the adult. At this point, the child is still externally motivated; responsibility comes later.* [emphasis added]

In this way, a counsellor is a kind of *external* conscience or "ego-ideal" calling a client's *better self* into existence. As the client explores the *intrinsic* benefits (see preceding article) of his better self, he will adopt it as habitual behavior (i.e., it will be *internalized* & *generalized*). If, however, the counsellor reinforces the better self with only *extrinsic* rewards, it will at best be only *contingent* & *contextualized* behavior – meaning that the better self will only emerge in the immediate presence of the counsellor, and its influence on the client will recede rapidly when therapy terminates.

---

[23] The exception, of course, is the *psychopath:* "A psychopath is … an outwardly normal person with an apparently logical mind who happens to be an emotional cipher … the psychopath is the extreme case of the nonsocial personality, someone for whom the ordinary emotions of life have no meaning. Psychopaths lie without compunction, injure without remorse, and cheat with little fear of detection. Wholly self-centered and unaware of the emotional needs of others, they are, in the fullest sense of the term, unsocial. They can mimic feelings without experiencing them." [James Q. Wilson, *The Moral Sense* (1993)]

[24] Which, as I understand them, are contextual methods for controlling strong *emotional reactions* by identifying their triggers and sequence of physical & psychological impacts.

[25] Needless to say, when a change is perceived by the client to be *meaningful* (as opposed to *senseless* or *frivolous*), it is more likely to be accepted and solidified as something that should be done.

Guilt & Moral Standards

Besides the distinction between *feelings* and *disposition* (i.e., *proneness*), it's also important to distinguish between *disposition* and *values/beliefs.* Again, the development of responsibility and a person's vulnerability to long-term negative outcomes (like crime or mental illness) relate more to one than the other – and as therapists we should understand and capitalize on this difference. Since there are important but different points to be made about how a proneness to guilt and a proneness to shame relate to one's values/beliefs, let's take each separately, starting with guilt.

Unfortunately, most research (and most therapeutic programming) does not distinguish between a *disposition* to feel guilt and the person's *moral standards* (i.e., the beliefs & values about what should make one feel guilty). As Tangney & Dearing point out, however, these are not the same things:

> *Although feelings of guilt generally arise from some failure or violation of moral standards, proneness to guilt (an* affective disposition*) is conceptually distinct from moral standards (a* set of values*). Proneness to guilt is an emotional style – a tendency to experience guilt (as opposed to something else) in response to one's failures or transgressions. Moral standards are the set of* beliefs *against which people judge their behavior. It's not clear why the degree to which an individual is guilt-prone would be directly tied to the* content *of that individual's standards for moral conduct.*

Failure to distinguish between the emotional tendency to feel guilt (i.e., what, following Tangney & Dearing, we can call a *moral style*) and one's *moral standards* leads to the erroneous assumption that the *content* of one's beliefs determines: (a) whether one will feel guilty or not, and (b) whether one will act responsibly or criminally.

We can see this faulty assumption at work in those kinds of therapeutic programs that attempt to reduce a person's involvement in criminal activity by elevating his or her "level" of moral reasoning.[26] Most such programs use some form of Kohlberg's Stages of Moral Development [see Diagram 2]. In part, this approach is bolstered by research on the moral development of delinquents – which shows conclusively that, compared to a normal population sample, delinquents tend to use lower levels of moral reasoning. The idea, then, is to reduce recidivism (and criminal activity) by increasing the client's moral reasoning abilities (i.e., by pushing him to a higher level on Kohlberg's scale).

If the reasoning behind such an approach to therapy with criminals were sound, then we could expect that such programs would indeed reduce recidivism. The reality, however, is that they don't![27] Again, Tangney & Dearing point out:

> *How does level of moral reasoning relate to people's behavior? The very strong assumption among moral developmentalists is that people who reason at more sophisticated levels behave better, but the available evidence suggests only a modest link between moral thinking and moral action.*

Diagram 2: Kohlberg's Stages of Moral Development

LEVEL	Stage	ORIENTATION	REASONING
Post-conventional	6	Universal Principles	*What is right is determined by universal, absolute principles & ideals!*
	5	Social Contract	*What is right is what includes everybody and is agreed upon by everybody!*
Conventional	4	Law & Order	*What is right or wrong is determined by rules and laws!*
	3	Interpersonal Concordance	*What is right is what pleases others and make them approve of me!*
Pre-conventional	2	Instrumentalism	*What is right is what satisfies my needs!*
	1	Obedience & Punishment	*What is right is what I can get away with. What is wrong is what I get punished for!*
	0	Egocentric	*What is right is what I like!*

Within our specific field (criminal justice), Andrews & Bonta corroborate this assessment:

> *In summary, although a relationship between delinquency and moral reasoning has been demonstrated, the relationship may not be particularly strong. First, there is little evidence of the predictive and functional validity of moral reasoning … Interventions that challenge moral reasoning can influence movement to a higher developmental level, but convincing links with reduced criminal behavior are few. Second, there are significant proportions of offenders who score at the conventional and even the principled levels of moral development.*[28]

---

[26] The term "reasoning" is being used here in a slightly different context than I was using it earlier (see Diagram 1). Moral reasoning is not rational calculation (which is the gist of the earlier term) but simply the articulation of one's moral values & beliefs. It's important that we not confuse these uses of the word.

[27] One of the most popular treatment programs in the criminal justice system (both youth and adult sectors) is Moral Reconation Therapy® (MRT®). MRT® is based principally on this idea that criminal activity and recidivism can be reduced by increasing the client's level of moral reasoning: "The moral development approach suggests that individuals with higher levels of moral reasoning are better able to choose to engage in behavior which is 'right' rather than behavior which is considered to be 'wrong'. (Arbuthnot & Gordon, 1988) … The MRT system assumes that most substance abuse and sociopathic behavior is caused by inadequate reasoning. The system uses a series of structured exercises and tasks to foster development of higher levels of reasoning." [see MRT® website]

MRT® claims to have a high success rates in reducing recidivism – *and it does!* But not because it increases moral reasoning. In fact, if you examine the actual success rates, you'll find that they aren't much different than any other successful therapy (e.g., Multi-Systemic Therapy or our own HACP). What works in MRT® is not anything *specific* to its treatment model – *but what it shares with all successful therapy: the Common Factors!* [see ***What Works [Who Works]***].

[28] *The Psychology of Criminal Conduct* (1994/1998). Andrews & Bonta go on to make a couple of important points: (1) "… almost all the studies have used extreme groups designs comparing officially adjudicated and often incarcerated offenders with nonoffenders. Extreme groups maximize the likelihood of finding differences" and (2) "In brief, the developmental stages of moral development and their related assessment and treatment need to be more clearly differentiated from the construct of antisocial

Simply put, then, the *content* of one's moral values/beliefs has no real effect on one's behavior. Having highly developed moral sentiments does not mean that those sentiments get translated automatically into action. Conversely, having lower level moral sentiments does not mean that one automatically behaves less responsibly. If we think about this matter from the perspective of our common-sense experience, we are all familiar with:

- People who have highly *unconventional* moral standards but who nonetheless do not commit crimes and feel extreme anguish (whether shame or guilt or both) when they violate them.
- People who have high standards but who also frequently violate them. [There is no dearth of hypocrisy in the human situation.]
- People who have low standards but who rarely, if ever, commit crimes.

In fact, moral behavior involves three related but distinct moral capacities:

> *Moral Standards* – knowledge of what constitutes right and wrong conduct.
>
> *Moral Reasoning* – the ability to apply the knowledge & principles inherent in Moral Standards to behavioral situations.
>
> *Moral Emotions* – the affective disposition (whether shame or guilt) that accompanies the application of Moral Reasoning (or even just the anticipated results of such an application).

Of these three moral capacities, the last (*Moral Emotions*) is the most directly influential on human responsibility and criminal activity.

Shame & Self-Esteem

Just as *proneness to guilt* is not the same thing as *moral standards*, neither is *proneness to shame* the same thing as low *self-esteem.*[29] *Self-esteem*, like *moral standards,* is a *value* or *belief* – specifically, it is our *evaluation*[30] of our own *self:*

> *One can certainly imagine how proneness to shame might contribute to problems with self-esteem (and vice versa), but these are nonetheless distinct constructs. Global self-esteem is a stable trait involving a person's general evaluation of the self, largely independent of specific situations … self-esteem is essentially a* self-*evaluative construct.* [On the other hand …] *Shame is an emotion – an affective state. The corresponding trait or disposition is shame-proneness – a tendency to experience the emotion shame (as opposed to, say, indifference or guilt) in response to specific negative events.* [Tangney & Dearing, *op. cit.*]

As Tangney & Dearing indicate, there *is* a small relationship between *self-esteem* and *shame-proneness:* people who are high on the first are slightly more likely to be low on the last, and vice versa.[31] And we can speculate as to reasons why there might be such a relation. For example: "… frequent and repeated experiences of shame are apt to 'chip away' at one's general level of self-regard over the long haul." [Tangney & Dearing, *op. cit.*] Or, going the other way: "… it seems likely that low self-esteem sets the stage for frequent and repeated experiences of shame." [*ibid.*] The important points, however, are that: (a) these two things are distinct human capacities; and (b) the relationship between them is, at best, only modest.[32]

Therapies that try to effect change in clients by "increasing self-esteem" make the same mistake as therapies that try to improve behavior by bettering the client's *moral reasoning* or *moral standards:* feeling good about one's *self* (or having a good *self-image*) does not ensure that one will behave responsibly or avoid criminal activity – any more than elevating one's ethical principles or ethical reckoning does.

Again, if the common-sense assumption about improving behavior through improving self-esteem were true, we would expect that treatment programs based on such a principle would have significant success rates. Unfortunately, they don't:

> *Compelling research from around the world lends empirical proof to the traditional claim that achievement precedes self-esteem. There is, in fact, almost no correlation between low self-esteem and any number of social pathologies, including poor school performance, drug abuse, and teenage pregnancy.*[33]
>
> *Studies on issues from smoking to violence, along with comprehensive reviews of the entire self-esteem literature, not only cast doubt on the benefits of high self-esteem but suggest that it might even be harmful … A comprehensive review of the self-esteem literature found that: "the associations between self-esteem, and its expected consequences are mixed, insignificant, or absent. This nonrelationship holds between self-esteem and teen age pregnancy, self-esteem and child abuse, self-esteem*

---

attitudes. We expect that specific attitudes, values, beliefs, and rationalizations supportive of crime are much more strongly correlated with criminal conduct than are the stages of moral development."

[29] There is a tendency to confuse "consistently feeling ashamed of oneself" with "having low self-esteem". The confusion has a certain common sense – after all, *why* would someone persistently feel shame unless he had a pretty low opinion of himself?

[30] It's fairly easy to see the connection between self-esteem as an evaluation and moral standards. In effect, self-esteem is the measure of our *self* compared to a specific moral standard – i.e., an *ideal* self, the self we think we *should* be. If we fall short of this ideal self, we suffer low self-esteem. If we match or exceed it, we feel high self-esteem. Thus, the feeling of self-esteem is comparable to moral reasoning – i.e., it is just matching up our knowledge (a standard) with how we believe things really are.

[31] For the statistically-astute, the correlation is $r = -.42$. "Although people who are inclined to feel shame in response to specific negative events are also, on balance, somewhat likely to have low self-esteem, this is not a one-to-one relationship. The modest correlation allows for various individual combinations of shame/self-esteem attributes." [Tangney & Dearing, *op. cit.*]

[32] Tangney & Dearing surmise that there are 3 classes of factors that mediate the relationship between *self-esteem* and *shame-proneness* (1) those factors other than *shame-proneness* that influence *self-esteem* (e.g., IQ, competency level, minority status, academic success, respect or disapproval of significant others, physical attractiveness); (2) those factors other than *self-esteem* that influence *shame-proneness* (e.g., temperament, socialization experiences, cultural rules); and (3) those skills or attributes that directly permit the individual to cope with any threats to *self-esteem* arising from *shame-proneness* (e.g., corrective self-talk, externalization, reframing). [Therapeutic programs aimed at increasing *self-esteem* focus primarily on factors 1 & 3.]

[33] Nina H. Shokraii, *The Self-Esteem Fraud* (www.ceousa.org). See also: ***What Works [Who Works]***, particularly the sections on Andrews & Bonta and Lipsey & Wilson – where the ineffectiveness of self-esteem programs for changing criminal behavior is reported.

and most cases of alcohol and drug abuse." [A. Mecca and N. Smelser, The Social Importance of Self-Esteem][34]

*In looking for more recent research relevant to the question, I turned up nine studies (including three dissertations) published since 1980. On prosocial measures that ranged from sharing among children to agreeing to donate one's organs after death, and from experiencing "feelings of benevolence" to rescuing Jews from the Nazis, the data offer more reason to doubt than to affirm the relevance of self-esteem. Most of the studies found the relationship between how people felt about themselves and how likely they were to reach out to others to be either weak or nonexistent … **In sum, high self-esteem appears to offer no guarantee of inclining people toward prosocial behavior - or even steering them away from antisocial behavior**.*[35] [emphasis added]

Shame, Guilt, & Self Constructs[36]

M*oral standards* and *self-esteem* aren't the only *values/beliefs* that have strong implications for understanding shame and guilt. One key factor in human behavior is the beliefs[37] that are *constructed* about the self:

Although not typically articulated, people develop implicit psychological theories in many domains of human experience. These "theories" then guide each person's interpretations of events, shape his or her affective experiences, and influence interpersonal interactions. [Tangney & Dearing, *op. cit.*][38]

Within such *constructs* (or "theories"), the most relevant beliefs related to shame & guilt concern those that define the relationship between one's *self* and one's *behavior.* [Remember: in the face of transgression or harm, *shame* is a focus on *self*, while *guilt* is a focus on *behavior*.] In this respect, we can identify two polar extreme types of belief:

1) The conviction that the self is *fixed* [not to be confused with *neutered*] – i.e., that its traits or characteristics are so deeply embedded that *behavior* is necessarily a true reflection of what kind of person the *self* is. People who believe such a construct are called "entity theorists" – and they are said to have "high self/behavior congruence".[39]

2) In contrast, there is the conviction that the self is *malleable* – i.e., that traits and characteristics are flexible and can change over time or in response to different circumstances. Consequently, *behavior* is not seen to be a very good indicator of what the self is really like. People who believe this construct are called "incremental theorists" – and they are said to have "low self/behavior congruence".

The difference? Well: "… when faced with failure in achievement settings, entity theorists often 'hit the wall,' experiencing high degrees of negative affect, feeling helpless, and withdrawing from the task at hand. In contrast, incremental theorists tend to respond to failures with a problem-solving focus, remaining motivated to overcome their initial errors, exerting greater effort, and flexibly experimenting with alternative strategies." [Tangney & Dearing, *op. cit.*]

Logically, *if one believes that beliefs guide interpretations, affective experiences, & interpersonal interactions,* one would assume: (a) that "entity theorists" would be more prone to experience *shame* in the face of transgression or harm (because *behavior* would be understood as an indication of a rotten *self*); and (b) that "incremental theorists" would be more prone to *guilt* (because *behavior* would stand as its own concern, totally divorced from any implication about the *self*). As it turns out, however, logic doesn't quite get it right.

Indeed, there is a *partial* connection between being an "incremental theorist" and being *guilt-prone,* in that "people prone to feelings of guilt about specific behaviors … [tend] to view the self as relatively flexible and amenable to change." [Tangney & Dearing, *op. cit.*] On the other hand, there is "no relationship between self-behavior congruence beliefs [i.e., being an 'incremental theorist'] and proneness to guilt." [*ibid.*] It would seem, then, that the causal arrow only goes one way – i.e., being prone to guilt may make one an "incremental theorist", but being an "incremental theorist" definitely doesn't make one more prone to guilt.

Worse yet, there isn't *any* connection between being an "entity theorist" and being *shame-prone.* Having a belief that the *self* is *fixed* and inflexible does not correlate with the tendency to experience *shame* in the face of failure or transgression. Conversely: "Shame-prone people [are] no more or less likely to view the self as fixed, and they [are] no more or less likely to believe 'You are what you do.' Such cognitive beliefs are apparently insufficient by themselves to render people vulnerable to affective shame reactions." [Tangney & Dearing, *op. cit.*]

Again, the clinical implications of this research are extremely important to our practice as CYCs. My contention is that *the more deeply anchored a behavior is, the more likely it is to be internalized and generalized – i.e., the more likely it is to become a reliable habit.* If the causal arrow could be shown to be pointing from *values/beliefs* to *dispositions*, then we would be able to accomplish the therapeutic goals of internalization & generalization by helping a client change such *values/beliefs*. *However, the evidence really doesn't support the idea that deep dispositions (or even habits) can be changed by changing values/beliefs.* Consequently, there isn't much of a basis for the idea that cognitive restructuring of a client's *values/beliefs* is an effective way to achieve internalization & generalization. Our programming should take this information fully into account.

… Aside: Are Values & Beliefs Not Important? …

Understanding the implications of the research presented in the preceding section requires subtle inference and patient analysis. It is, therefore, quite easy to misinterpret the underlying message. I am *not* reporting here that it is a waste of time to challenge, redirect, or otherwise attempt to intervene in a client's *value/belief* constructs.

---

[34] Michael R. Edelstein, *The Trouble With Self-Esteem* (www.threeminutetherapy.com).

[35] Alfie Kohn, *The Truth About Self-Esteem* (Phi Delta Kappan, 1994).

[36] I chose the term "construct" because I believe it reflects most accurately the idea that Tangney & Dearing are referring to. The term comes from George Kelly's Personal Construct Theory: "The term *construct* is particularly well-chosen, because it reflects the concept's dual role. On the one hand, your constructs represent the view you have **constructed** about the world as you experienced it. On the other hand, your constructs indicate how you are likely to **construe** the world as you continue to experience it. Your construct system is your history and your predisposition to perceive." [see: www.enquirewithin.co.nz/HINTS/skills2.htm]

[37] As opposed to the *values* that are constructed about the self – e.g., *self-esteem.*

[38] By the way, it's hard to imagine a more succinct summary of *cognitive-behavioral* theory than this quote.

[39] "High self/behavior congruence" simply means that the person believes that *how a person behaves* is a true representation of *what kind of person they are,* and vice versa.

Quite the opposite: the research is extremely helpful in aiding our understanding about what is the *best* way to go about such intervention.

What we learn here is that expecting to change deep *dispositions* and *habits* simply by tinkering with *beliefs* or *values* is a non-starter. The causal arrow simply doesn't point that way.[40] [At best, any such changes would be anchored (and therefore only activated) in the external *contingencies* and *contexts* in which the tinkering was done.[41]] Instead, there is far more evidence that the causal arrow goes the other way – i.e., from *dispositions* to *values/beliefs*.[42]

The conclusion we should reach, then, is that *if we want to change values/beliefs, we must first change dispositions or habits!*

Of course, this conclusion presents two dilemmas: (1) If we can change the deeper level *dispositions*, then why bother with changing *values/beliefs?* And (2) *How* do we go about changing *dispositions?*

The second question was answered earlier:[43] we change *dispositions* by forming *therapeutic relationships.* The answer to the first question is that we care about changing *values/beliefs,* even though they don't directly impact *dispositional* change, because:

(a) *Values/Beliefs* facilitate *dispositional* changes by becoming the *focus* of the *therapeutic relationship.* The counsellor and client must have a "content" to their alliance – a set of themes, problems, decisions, etc. that permit the counsellor to map a direction for *dispositional* change. It is by challenging a client's dysfunctional *values/beliefs* **after forming a therapeutic alliance** that a counsellor establishes what behavioral and/or *dispositional* changes are *attractive.* [In this way, the client has a concrete understanding of how to be "more like"[44] or "more likeable to" the person he is in an alliance with.][45]

(b) In addition, changed *values/beliefs* create a new set of *constructs* [see above] that reinforce *dispositional* change. New constructs act as new mental channels for the expression of *dispositional* change – and they serve as internal signals or signposts that the client now has different options when faced with moral choices.[46]

So, why is it that so many intervention programs seem to be based on the idea that deep *dispositional* changes can be made by tinkering with a client's *values/beliefs,* rather than the other way around? Another way of asking this question might be: So, why is the importance of first establishing a *therapeutic alliance* overlooked? I can surmise three possible types of answer …

First, to be gracious, perhaps the answer is that the need to form such a therapeutic alliance is simply taken for granted. Maybe the knowledge that establishing one is so commonplace, so obvious, that it doesn't have to be spelled out. It would be like reminding a student driver that a car can't run without gas. Maybe – but, personally, I doubt it. My own experience with CYC practitioners and other therapists is that I've seen a lot of cars stuck in the parking lot because no one took the time to fill up.

Second, there is not much professional interest in the therapeutic alliance because it is one of the Common Factors in therapy – i.e., it is not something that can be easily packaged into a "model" or into a "manual" and sold as a training curriculum. As a result, it isn't "sexy" - it doesn't feed into the field's status and prestige hierarchy.[47]

Third, from a philosophical perspective [and this is a perspective that annoys a lot of CYCs, so feel free to skip to the next section], perhaps the answer lies in a bias we have in our thinking about the relation between *ideas,* on the one hand, and *reality*, on the other. The belief that we have many "implicit psychological theories" that guide our interpretations and behavior (as expressed in the earlier quote from Tangney & Dearing) is an example of the *correspondence theory of truth*[48] combined with a mechanistic understanding of human conduct. On the basis of this bias, we believe that behavior must be controlled by these "theories" in much the same way it is controlled by a map when a person is following its directions:[49] change the markings and the subsequent routes taken by the person must also change. The clinical implication of this bias is that behavior can be changed simply by altering the person's internal maps (i.e., *values* & *beliefs*).

While this *correspondence* or "map" view of human behavior is useful in many ways, it is nonetheless an incomplete understanding of what it means to be human. We are *agents* capable of exercising choice

---

[40] By which I mean: changes in *values/belief* do not cause changes in *dispositions* or *habits*.

[41] The best example of what I mean by this was given in the preceding article [***Prisms, Pink Waistcoats, Praise & Punishment***]. When a client adjusts his *values/beliefs* in order to cope with the demands of a program that controls his behavior through external rewards (e.g., level systems, point systems, token economies, etc.), his behavior is not internalized or generalized. Instead, it is made *contingent* to the specific *context* in which it was learned (i.e., the program). As a result, when the client leaves the program, he returns to his pre-treatment behavior.

[42] Certainly this is true for the relation between *guilt-proneness* and the constellation of *belief* called "incremental theorist". However, it is **not** true for the relation between *shame-proneness* and "entity theorist" *or* "incremental theorist". This lack of relation is puzzling. [I will try to cast some light on it in the following sections – so it will be less of a puzzle.]

[43] See the section entitled *Aside: Therapy is About Willingness To Change*.

[44] In psychoanalytic terms, a client has two general ways of forming a bond with another person: *objectification* and *identification.* The former is based on exhibiting qualities that the other finds appealing; the latter is based on imitating the qualities of the other. In CYC practice, we call *identification* by the term "role modeling".

[45] In the ***What Works [Who Works]*** article, I identified the importance of structure and focus for successful outcome (they account for approximately 15% of successful outcome). Programs that lack such structure or focus have extremely poor outcomes. Cognitive-behavioral programming shows itself to be moderately more successful than other types of programming. The reason for this success is, I believe, because this type of programming brings a clear focus to the client's *values/beliefs* - in the way I have outlined here.

[46] In a sense, our *values/beliefs* are a function of *consciousness.* Consciousness is a biological adaptation that, as Tor Nørretranders explains in *The User Illusion* (1998), does not initiate action (behavior) but rather vetoes action initiated unconsciously: "Consciousness is not a superior unit that directs messages down to its subordinates in the brain. Consciousness is the instance of selection that picks and chooses among the many options nonconsciousness offers up. Consciousness works by throwing suggestions out, by discarding decisions proposed by nonconsciousness." If this is the case, then the mechanism that consciousness uses to reject/accept nonconscious suggestions is our *values/beliefs.*

[47] See the section *Toppling the Pyramid* in ***What Works [Who Works]***.

[48] That is, the proposition that ideas supposedly *represent* or *mirror* or *reflect,* hence *correspond to,* things in the world. Our ideas, beliefs, concepts, etc, are therefore like *maps* we can follow. [If the map is correct, then we say it is "true" – if it's incorrect, we say it is "false" or "wrong".]

[49] Actually, another common metaphor for this perspective is the "computer program" – our internal mental theories are like software programs in a computer. If we want different behavior as the output, we simply have to change the software code or routines.

and free will.[50] We are not fleshy robots programmed to behave according to instructions, no matter how sophisticated. The "map" metaphor ignores a prior step in human psychology – namely, the step in which we choose which map to use when and where.

I think a better (but still not perfect) metaphor for understanding *values* & *beliefs* is that *they are tools we use for certain specific purposes.* Their effectiveness lies not in how well they reflect or represent reality, but in how well they work to get things done. "Tools", not "maps". This is the *pragmatic theory of truth.*[51] This pragmatic bias at least respects human agency: it is *we* who determine which *beliefs* and *values* to apply to any given circumstance, and therefore it is *we* who ultimately and originally decide our behavior (and not our *values* & *beliefs* that determine it).

The clinical implication of the pragmatic bias strikes me as extremely important. It unmasks the illusion that *behavior* is in some mechanical way determined by our *values* & *beliefs* (and it can therefore be "programmed") – and it focuses our attention on the possibility that both *values/beliefs* and our *behavior* stem from our innate capacity to be agents with free will. In essence, it denies that *behavior* is constructed by our *values/beliefs,* and instead contends that both *values/beliefs* and *behavior* are constructed by our *agency* as human beings. This shift displaces our clinical focus on *cognitive-behavioral* programming with a clinical focus on *relationship-building.*

Walk a Mile in My Shoes & Seeing Red

The difference between shame and guilt shows up not just in the above-mentioned interactions with *values/beliefs,* but also in the different ways they are related to other *emotional reactions* [see Diagram I]. In particular, they have noticeably contrasting effects on our other social or moral emotions – i.e., empathy and anger.

In principle, our moral emotions (shame, guilt, empathy, & anger) are biological capacities designed to keep us and others on the "straight & narrow", to facilitate the *moral consensus* that reconciles individual interests with group interests. One would expect, then, that the moral emotions, having this same general goal, would support – or, at least, complement – each other. Again, our expectations shrivel in the cold shower of research results.

Let's start with empathy … Empathy is, as we know, "… understanding so intimate that the feelings, thoughts, and motives of one are readily comprehended by another." [*American Heritage Dictionary*][52] "With other-oriented empathic responses, the observer is able to take the other person's perspective, and vicariously experience similar feelings." [Tangney & Dearing, *op. cit.*]

As is the case with shame and guilt, people vary considerably in their ability to empathize with other people. In other words, some people are more *empathy-prone* than others. (Thus, *empathy-proneness* like *shame-proneness* and *guilt-proneness* is a *disposition.*) So, how do these various *pronenesses* relate to each other? Tangney & Dearing explain:

> *… the shame-prone person is not an empathic person. That is, individual differences in proneness to shame are inversely related to a dispositional capacity for empathy; conversely, proneness to guilt is positively correlated with empathic responsiveness.* [*op. cit.*]

Oh, oh! It looks like shame catches the short end of the stick once more. Rather than supporting the good moral emotion of empathy, it actually interferes with it. Guilt, on the other hand, looks pretty good: it actually promotes empathy. "[A]lthough guilt and empathy may work together in a mutually enhancing fashion, shame can actually interfere with an other-oriented empathic connection." [Tangney & Dearing, *op. cit.*]

If you think about it, we shouldn't be terribly surprised by this finding. After all, guilt focuses on *behavior,* which carries with it concern about one's effect on *others*; but shame focuses on the *self,* which carries with it concern about how the *other evaluates* or *judges* the *self.* They both contain an "*other*-orientation", but the quality of such orientation is dramatically different: "By its very nature, guilt forms a bridge to other-oriented empathic concern … Shame [on the other hand] is an acutely painful experience, involving a marked self-focus that is incompatible with other-oriented empathic reactions. The tremendous preoccupation with the self draws one's focus away from a distressed other, thus short-circuiting other-oriented feelings of empathy." [Tangney & Dearing, *op. cit.*][53]

The clinical implication seems patently obvious: *if we want to increase a client's empathic capacity* (and we do!), *then we must: (a) promote his proneness to guilt and (b) reduce his proneness to shame.* No doubt, as in the case with *moral reasoning* programs, some therapists will attempt to directly build a client's empathy skills.[54] This research indicates, however, that unless the client's proneness to shame is also addressed, it will continue to present a barrier to empathy.

Maybe things will work out a little better for shame when it comes to anger … No doubt, of all the informal social mechanisms we have for keeping transgressors in line, anger is the most common - but it is also one of the most complex. As Carol Tavris points out:

> *Anger, like love, is a moral emotion … People everywhere get angry, but they get angry in the service of their culture's rules … anger is the sign that someone has broken them. It announces that someone is not behaving as (you think) she or he ought … Anger, with its power of forcefulness and its threat of retaliation, helps to regulate our everyday social relations: in family disputes, neighborly quarrels, business disagreements, wherever the official law is too cumbersome, inappropriate, or unavailable (which is most of the time) … in*

---

[50] And I mean this in a more profound way than just being able to choose different routes to different destinations specified on our internal maps, or different subroutines in our internal programming.

[51] As best articulated in the work of William James and John Dewey. [From the pragmatic perspective, the "truth" of a belief is whether it works or not – not how well it pictures reality.]

[52] People often associate or confuse *empathy* with *sympathy* – which is a *concern* for the feelings of others, but not an emotional matching or vicarious experience of emotion.

[53] We could even go a little further in this explanation and point out that, from the perspective of the person feeling shame, another person's evaluation or judgement is *exactly the opposite of empathy!* In this case, the *other* offers no understanding, sympathy, or vicarious identification – just the sting of a judgement that finds the person wanting. [We can see here why being *non-judgemental* and *empathetic* are key requirements for therapists. In effect, they constitute the fundamental building blocks of the *therapeutic alliance.* Again, we can understand why Probation Officers – the "eyes and ears of the court" - cannot be therapists. The very nature of their role is an institutionalization of judgement and evaluation. Of course, this is not to say that there is no role for POs or for shame in the therapeutic process. We'll get to that later.]

[54] Gad Czudner in *Small Criminals Among Us* offers an interesting way to go about doing this with preschoolers.

the absence of a formal judiciary, anger operates as a personal one." [*Anger: The Misunderstood Emotion* (1989, revised)]

Since we deal a lot with anger in our field, it's also worth considering the following observation about it:

> *Anger and blame are strongly related, and putting the blame on something as nebulous as a situation simply doesn't provide the intellectual or emotional satisfaction that justified anger at an individual does. A situation cannot cause itself to change. We believe individuals can do that. In addition to carrying a statement of blame, anger carries a call for change. Fixing responsibility and deciding that you are at least partially justified in doing so constitute two necessary and interwoven components of feeling anger. The more mature we become, and thus better able to listen and to empathize, the less likely it is that we are able to assign unequivocal responsibility for an uncomfortable event.*[55]

When we are angry with someone, then, we tend to lash out with blame. In their research, Tangney & Dearing assumed that when faced with such anger & blame, a person will react with either a feeling of shame or guilt. [Five minutes with our clientele might have quashed this rather naïve assumption – 99 times out of a hundred, if you confront a young offender with anger & blame, you don't get either shame or guilt back: *mostly you just get a bigger dose of anger & blame, and sometimes you get aggression!*] Accordingly, they wanted to see what difference these two reactions make.

Let's start with guilt … Tangney & Dearing found that a lot of good things were associated with a guilt response:

> *Guilt-proneness was generally associated with constructive means of handling anger. Proneness to … guilt was positively correlated with constructive intentions and negatively correlated with all indices of direct, indirect, and displaced aggression. Instead, compared to their non-guilt –prone peers, guilt-prone individuals were much more likely to report that they would engage in constructive behavior such as nonhostile discussion with the target of their anger and direct corrective action. Guilt-proneness was also associated with reported attempts to diffuse the feeling of anger (e.g., by engaging in some distracting activity) and with cognitive reappraisals of the target's role in the situation (e.g., "Maybe he didn't mean to do it") and the self's role in the situation (e.g., "Maybe I had something to do with the situation"). Finally proneness to … guilt was associated with respondents' assessment of positive long-term consequences as a result of the entire episode of anger.*

Wow! If you've ever run an Anger Management program, you'll recognize a lot of desired service outcomes in this statement: constructive intentions, reduced aggression, nonhostile discussion, corrective action, diffusion of affect, cognitive reappraisal, and positive long-term consequences. All facilitated by a disposition to process anger & blame through a guilt response. This gives us a serious clinical option: we could work on each of these things separately and directly *or* we could prepare the ground for them by focusing on the client's proneness to guilt.[56]

If a person responds to anger & blame with a shame reaction, however, the picture changes dramatically:

> *Across all ages, proneness to shame was substantially correlated with anger arousal … shame-prone individuals are not only more prone to anger, in general, but they are also more likely to do unconstructive things with their anger, compared to their less shame-prone peers. Shame-proneness was related to malevolent and fractious (e.g., a desire to "let off steam") intentions as well as a likelihood of engaging in direct physical, verbal, and symbolic aggression, indirect aggression (e.g., harming something important to the target, talking behind the target's back), all kinds of displaced aggression, self-directed aggression, and anger held in (a ruminative unexpressed anger) … shame-prone individuals were not particularly inclined to discuss the matter with the target of their anger in a nonhostile, constructive fashion. Rather, they were more likely simply to walk away from the situation … Finally shame-proneness was associated with negative long-term consequences as a result of the entire episode of anger.* [Tangney & Dearing, *op. cit.*]

Tangney & Dearing found the above outcomes surprising because they assumed that the natural inclination for a *shame-prone* person in the face of anger & blame would be to simply withdraw: "… we thought that a shamed person would be so focused on his or her 'bad self', turning blame inward, that the question of the others' blame would be moot. He or she would thus be unlikely to experience anger directed towards others. Furthermore, one could reason that for the person well acquainted with shame, just the risk of a shame reaction would inhibit anger and aggression." [*op. cit.*]

It's hard to imagine a prediction that has been more off the mark. In trying to unravel the reason for their misconception, Tangney & Dearing reveal a picture of the internal dynamics of a *shame-prone* individual that is profoundly relevant for those of us working in the juvenile justice system. It looks something like this …

When faced with anger & blame from another person or persons, the first inclination of a *shame-prone* individual is to turn that "hostility" inward toward the self. For a variety of reasons, shame-prone individuals are highly sensitized to the negative evaluations and disapproval of other people: "A shamed person is acutely conscious of what other people might be thinking about them." [*ibid.*] This inward hostility is "… an extremely painful and devastating emotion. When people feel shame over a particular failure or transgression, they are berating themselves not just for the specific event; rather they are damning *themselves* – the core of their being – as flawed, useless, despicable. In this way, shame experiences pose a tremendous threat to the self." [*ibid.*]

Confronting such a threat, a *shame-prone* individual has very few options. The means available to a *guilt-prone* individual – i.e., correcting one's future behavior, acts of contrition, attempts to compensate or fix, etc. - will not work for the *shame-prone* person: "In fact, these efforts at remediation miss the whole point because the shamed individual is still stuck with the problem of a hopelessly defective self. And, of course, a shamed person can't change fundamental aspects of the self overnight." [*ibid.*]

Consequently, some people *withdraw* (which is Tangney & Dearing's first assumption). They want to escape the shame-inducing situation and hide the "horrible self" from the view of others. [A universal

---

55 Plas & Hoover-Dempsey, *Working Up A Storm* (1988).

56 Again (like for the *fiftieth* time) my point would be: *if we want to make long-term, internalized & generalized change, we need to work at the dispositional level.* If we simply address techniques for stress reduction, cognitive reappraisal, corrective action, etc., we run the risk of simply making the client's anger management dependent upon external *contexts* and *contingencies*.

gesture of shame is to hang one's head and cover one's eyes.] Of course, such withdrawal is only a partial answer for dealing with the pain: "In reality, the shamed, withdrawn individual is still saddled with a loathsome self. When it comes to a shamed self, there is some truth to the notion that 'You can run but you can't hide!'" [*ibid.*] Persistent withdrawal creates the condition we call *depression* (and the likelihood of low self-esteem).[57]

Other people (including the vast majority of the clientele we serve), however, cope with the pain of anger & blame by "turn[ing] the tables and shift[ing] the blame outwards." [*ibid.*] Either because the *self* is too fragile to withstand the painful assault of shame or because high self-esteem will not permit criticism of the *self*,[58] blame is handled by deflecting it away from the *self*. Apparently, this psychological inversion is made possible by shifting focus away from the *content* of the blame (i.e., the painful message) to the *source* of the blame (i.e., the accuser). *Shame-prone* individuals are by nature highly attuned to the other person as a source of disapproval/evaluation. For them, then, it is a short psychological step to see the *cause* of the pain emanating not from the *message* but from the *person*.

No doubt, this externalization of blame[59] is also made easier by complementing this subtle shift in causal focus with what Bandura *et al.* (1996) call "mechanisms of moral disengagement". These include:[60]

- *Moral justification* – "It's all right to fight/lie/steal in order to protect your friends/to take revenge for your family."
- *Euphemistic language* – It is all right to fight/steal/take drugs when you are just joking/giving someone a lesson/just borrowing property/doing it once in a while."
- *Advantageous comparison* – "It is all right to fight/lie/steal when others are doing worse/other acts are worse."
- *Displacement of responsibility* – "You can't blame me, if I live under bad conditions."
- *Diffusion of responsibility* – "You can't blame me, when the whole gang was involved/friends asked me to do it."
- *Distorting consequences* – "No one was really hurt."
- *Attribution of blame* – "If I misbehave, it is the fault of my teachers/parents."
- *Dehumanization* – "It is all right to hurt those who deserve it."

Between the externalization of blame and the mechanisms of moral disengagement, the *shame-prone* individual can effectively protect his ego from assault and paralyzing pain. But externalized anger has even more benefits:

> *… as a further bonus, the accompanying feelings of self-righteous anger can help the shamed person to regain some sense of agency and control. Anger is an emotion of potency and authority. In contrast, shame is an emotion of the worthless, the paralyzed, the ineffective. Thus, by redirecting hostility, by turning their anger outward, shamed individuals become angry instead, reactivating and bolstering the self, which was previously so impaired by the shame experience.* [Tangney & Dearing, *op. cit.*]

What Tangney & Dearing have described here is possibly the single most common psychological dynamic in the field of youth justice: the highly self-focused, self-involved adolescent who carries the burden of a devalued self (which he is loath to admit), who has lost his sense of agency & control (or, at least, feels it constantly under threat), and who responds to society's moral demands with surprising anger and counter-accusations, while disengaging himself from the moral reality of his actions. And at the heart of the problem, forbidding reconciliation and positive change, is the black worm of shame.

So, again we see a vast difference in outcome between those who process their transgressions and harm with shame and those who do so with guilt – and the therapist finds yet further justification for distinguishing clearly between them and finding ways to foster the latter and avoiding the former.

At the risk of being repetitive, it's worth letting Tangney & Dearing summarize the differences in the relation between shame, guilt, and anger:

> *What allows guilt-prone individuals to make constructive use of their anger? First, guilt-prone individuals are apt to* construe *anger-eliciting situations differently than shame-prone individuals. Because guilt involves a negative evaluation of a specific behavior, somewhat apart from the global self, guilt experiences are less likely to involve severe threats to the self and hence are less likely to invoke a defensive, retaliative sort of anger. In short, guilt-prone individuals are not typically saddled with irrational shame-based anger aroused in a desperate attempt to rescue a devalued self. Rather, their anger is more likely to focus on reality-based violations and infractions committed by themselves or others.*

What's Bred in the Bone

So far, we have considered how the *disposition* to respond to transgression or harm with either shame or guilt relates to some of the other levels of our behavioral capacities [see Diagram I]. In particular, we have looked directly at their relation with certain *emotional reactions* (empathy, anger) and with certain *values/beliefs* (self-esteem, moral standards). We have even looked briefly at their relation with *reasoning* (moral reasoning, mechanisms of moral disengagement) and with certain *moods* (depression). But what about *temperament,* the biological bedrock of our behavior?

Once again, it turns out that shame and guilt are highly differentiated:

> [B]*iological factors may come into play in the development of shame-proneness and guilt-proneness …* [One scientific study] *found a relatively strong genetic component for shame, with*

57 In studies relating shame and guilt to depression, Tangney & Dearing found that shame was positively correlated with depression but guilt wasn't: "To the extent that characterological self-blame (the tendency to make internal, global, and stable attributions for negative events) has been theoretically and empirically linked to depression … the attributional literature is consistent with the notion that there may be a special link between proneness to shame but not proneness to guilt." [*op. cit.*]

58 There is a common belief in our field that anyone that commits a crime must have *low* self-esteem – and, therefore, be the first kind of person that deflects blame (i.e., the kind with a fragile self). In keeping with this conviction, kids that exhibit apparent high self-esteem are believed to be simply masking low self-esteem. However, rather sophisticated attempts have been made to unmask and measure this latter type of low self-esteem – and they have been unsuccessful. We, therefore, need to face the probability that many criminals are just what they seem: high in self-esteem.

59 As therapists, we should also be aware that the externalization of "anger" and "blame" aren't the only ways a person has to avert the painful feeling of shame. As Tangney & Dearing point out: "… painful feelings of shame seem to promote self-destructive behaviors (hard drug use, suicide) that can be viewed as misguided attempts to dampen or escape this most punitive moral emotion." [*op. cit.*]

60 As reported in Andrews & Bonta (1998, *op. cit.*).

correspondingly weak shared environment effects. For guilt, the opposite pattern was observed. Individual differences in guilt-proneness appear more strongly tied to shared environment and less affected by genetic factors. [Tangney & Dearing, *op. cit.*]

If proneness to shame is tied to certain *temperamental* qualities do we know what they are? Unfortunately, research in this area is quite thin. However, Tangney & Dearing do make an educated speculation:

> *Dimensions of temperament that may be of special interest to understanding the development of shame and guilt include fearfulness, a propensity toward negative emotions in general, problems with self-regulation and shyness. One can imagine how a child who comes into the world with a biologically "hard-wired" fearfulness or sensitivity to negative emotions in general may be especially vulnerable to later tendencies toward shame and negative self-evaluation. Add to that biologically based difficulties with self-regulation and you may have a recipe for a shame-prone child.* [*op. cit.*]

This is, of course, both good news and bad news for clinical practice. The good news is that *guilt-proneness,* being correlated with environmental influence, can be *learned.* Therefore, we *can* find ways to incorporate its benefits into our programming. On the other hand, the bad news is that *shame-proneness* is probably well-anchored in our biological *temperament* – so it may be quite difficult to dampen its negative influence clinically. [Keep in mind, however, that *temperament* is not an absolute quality: nature has permitted every *temperament* to have a limited "range" that can be set by environmental experience. Thus, a realistic clinical goal would not be to help the *shame-prone* client move from "fearfulness" to "fearlessness", or from "poor self-regulation" to "disciplined control", or from "shy" to "outgoing" – but it may be realistic to set one's clinical sights on "confident", "restrained" (and I don't mean this in the PMAB sense!), and "assertive".]

The Development of Proneness: Family Context (The Past)

To their credit, Tangney & Dearing attempt to analyze the factors that might be involved in creating a person's *proneness* or *disposition* to either shame or guilt. In brief, they identify the family as the key factor – and the family influences *disposition* in three inter-related[61] ways:

- *Parents' Affective Style* – Besides passing on a *genetic* legacy that determines *temperament,* the day-to-day interaction between parents and child provides powerful *role modeling* of emotional reactions. Repeated behavioral patterns and learned cognitive responses are frequently mimicked by the child and incorporated into his or her capacities.
- *Family Environment* – General aspects of a family's relational and communication structure (e.g., level of cohesiveness, enmeshment, codependence, dysfunction) dispose family members toward identifiable behavioral, cognitive, and emotional patterns.
- *Parental Practices* – "Guilt-prone children perceive that their parents use behavior-focused messages and empathy induction[62] when disciplining them. In contrast, shame-prone children report that their parents use person-focused disciplinary messages, express disgust, tease, communicate conditional approval, and use love-withdrawal techniques." [Tangney & Dearing, *op. cit.*]

The Development of Proneness: Therapeutic Context (Here & Now)

From a therapeutic perspective, the early development of *proneness* to either shame or guilt in a family context is – as was pointed out earlier – "water under the bridge". The therapeutic context cannot directly change the client's experiences with *parental role-modeling*, *family system*, or *disciplinary practices*. Such intervention may be the stuff of future prevention/early intervention programs, but they are not particularly helpful in dealing with adolescent (or older) clients. What, then, does the research presented by Tangney & Dearing suggest as true therapeutic possibilities in the here-and-now? How can *proneness* or *disposition* be changed *after* family influence has done its work?

In assessing Tangney & Dearing's suggested answers to these questions, I think we should keep three important things in mind: (1) Tangney & Dearing strike me as researchers first, clinicians second. The purpose of their research doesn't seem to be intended as a basis for therapeutic intervention so much as it is intended for the advancement of scientific and conceptual knowledge. Consequently, their observations necessarily have a limited clinical scope. (2) This focus on guilt *versus* shame is a relatively new frontier. Nobody really knows a lot about it, and there are dozens of important questions still to be researched. In addition, connecting this research to any ideas about how we *as therapists* can facilitate *dispositional* change is my agenda, not Tangney & Dearing's. They bear no responsibility for my delusions. Finally, (3) whatever Tangney & Dearing have to say, we must judge it by what we know the research on therapeutic effectiveness reveals [as reported in ***What Works [Who Works]***] .

With these cautions in mind, what do Tangney & Dearing recommend to therapists? Well, first of all, they focus almost exclusively on the therapeutic tasks of recognizing and diffusing *shame* – rather than on any procedures for inducing or promoting *guilt.* This is both odd and not odd. It's odd because so much of their research clearly shows that if people respond to their transgressions and harm with *guilt,* good outcomes happen – e.g., destructive anger is avoided, relationships are improved, and positive long-term consequences are more likely. One would expect, then, that Tangney & Dearing would want to promote some form of *guilt* induction.[63] It's not odd, however, when one considers that there are some serious ethical concerns related to making a client feel guilty, or even helping a client to learn to make himself feel guilty.[64] Discretion suggests that

[61] Which means that the factors below not only influence the child's emotional *disposition,* but also each other.

[62] Empathy induction: insisting that the child consider and articulate how his transgression or harm makes the other person feel.

[63] To be fair to Tangney & Dearing, they do prescribe certain guilt-inducing procedures for *parents* - just not for therapists.

[64] In our culture, especially since the development of post-Victorian psychoanalytic theory and its amplification in the "sexual revolution" of the 1960s & 1970s (combined with a general decline in respect for authority), guilt is seen as a negative, even destructive emotion. Part of the value of Tangney & Dearing's work is that their discrimination of guilt and shame shows that most of our cultural dislike for the former might have more to do with the latter.

it's probably better to stay out of that minefield – especially if it might distract from the more fundamental message of their research.

In brief, Tangney & Dearing recommend five sorts of intervention aimed at diffusing shame:

1) *Verbalization* – "As clients translate into words their preverbal, global shame reaction, they bring to bear a more logical, differentiated thought process that may compel them to spontaneously reevaluate the global nature of the shame-eliciting episode." [Tangney & Dearing, *op. cit.*]
2) *Reevaluation & Reframing* – actively exploring the *verbalizations* for the purpose of reframing them – i.e., placing them in a new conceptual *context:* "… in the process of exploring the shame-eliciting episode, the therapist can further assist the client in making such cognitive reevaluations … Shame … is associated with many irrational beliefs and dysfunctional thoughts that are amenable to cognitive restructuring." [*ibid.*]
3) *Conceptual Differentiation & Education* – "… therapists can encourage such 'contextualization' by explicitly educating the client about the difference between shame and guilt. A surprising observation from our clinical work is that many clients really have not considered the difference between condemning a behavior and condemning the self. Given an explicit choice, many spontaneously shift the focus of negative judgments from the global self to a specific behavior." [*ibid.*]
4) *Unconditional Positive Regard* – "Therapists may not positively regard or condone every action of a client, but therapists *can* provide a warm accepting climate for the client as a person … An important component of the therapist's role is to help clients value themselves as individuals, independent of their presenting psycho-pathology. The upshot is that as clients reveal their secret shame-eliciting fears, flaws, and foibles over the course of treatment, the therapist's reaction provides clients with an alternative to the self-disgust and self-disdain inherent in the shame experience." [*ibid.*]
5) *Humor* – "Light-hearted humor, by its very nature, normalizes individual shortcomings, thus placing them in a more realistic perspective … the levity inherent in playful humor is incompatible with the harsh, deadly serious self-condemnation of shame." [*ibid.*]

These suggestions, as we know from our reading of the research on effective therapy, will not produce positive or long-lasting change by themselves. They necessarily depend upon a pre-existing *therapeutic alliance:* (a) to create a condition of *trust* & *acceptance* in which the episode can be revealed & discussed (and in which the unconditional regard can be believed and humor allowed), and (b) to motivate the client to change in the direction of *attractiveness*. They also depend on our ability to form such an alliance on the foundation of the *client's perspective,* rather than expecting the client to conform with our model of change and change language.

On the whole, however, it's easy to feel a bit let down by these clinical prescriptions. After all, what do they boil down to? "*Well, if you have a client that is* shame-prone, *get him to talk about it. Help him see things in a new light. Teach him the difference between feeling ashamed and feeling guilty in response to his transgressions. Oh, yeah, and because you are dealing with shame, make sure you let him know that you accept him* as a person – *it's just his* behavior *that needs improving. And try to throw a little (appropriate) humor in whenever you get a chance – it helps lighten things up.*"

I don't mean to be facetious or to discount Tangney & Dearing's suggestions. There is nothing in the above prescriptions that is not good practice or not sound clinical advice. It's just that they don't seem to capitalize on or live up to the innovative power of the research results, at least not to the extent we might hope. Having shed new light on one of the most fundamental psychological dynamics of human behavior, they have encouraged our expectations to race far ahead of our abilities. However, what we can *reach*, as the poet reminds us, we cannot *grasp* – so it's not Tangney & Dearing's fault that we find ourselves let down and restless.

Indeed, from another perspective, it is probably a good thing that Tangney & Dearing haven't both mapped out the territory *and* provided blueprints for action. There is already too much of a tendency in our field to resist the challenge of *thinking-for-ourselves.* Curiously, we prefer to be guided by experts – even when such guidance diminishes our own expertise and leads us ultimately to mediocrity. We have even institutionalized this *resistance to thought* in our surrender to "best practice", pre-packaged programs, and manuals.

For the sake of our own professional tempering, then, it's best that Tangney & Dearing haven't filled in the new therapeutic slate with too much of their own thinking. In this way, the freshness and originality of their research on the differential impact of shame & guilt can directly stimulate our own innovation and creativity. It can – hopefully – provoke us to generate and construct novel therapeutic interventions based on *our own* imaginative capacities, mental skills, and clinical experiences, rather than relying on predigested material. So, if we are seeking an answer to the question, "What do we do with this new knowledge?", the journey shouldn't take us into the mountains to sit at the foot of a wise man; it should first lead us to a mirror.[65]

Gaining Perspective on Shame

I think it's a fair assessment of Tangney & Dearing's work to say that guilt comes off looking pretty good, while shame takes a beating.[66] An earlier quote – "The pattern is pretty clear: guilt is good, shame is bad …" – seems an appropriate summation of their book's theme. Of course, such a conclusion begs a number of fairly huge questions, for example: *Is there no such thing as "bad" guilt? Is there no such thing as "good" shame? If shame & guilt are both biological emotions, how has it worked out that one is adaptive and the other maladaptive?* Let's take these questions in order …

… "*one endless round of thought*"[67] …

Is there no such thing as "bad" guilt? Actually, guilt doesn't get off completely scot free. Tangney & Dearing do identify circumstances under which it is definitely maladaptive. There are times when people develop what Tangney & Dearing refer to as "ruminative guilt" – i.e., "the gnawing, repetitive guilt that just won't go away." [*op. cit.*] Such

---

[65] Upon consideration, I think the best method for developing innovative programming is hinted at rather strongly in an earlier article – i.e., ***The Earth, the Sun, and the Exact Location of the Professional Soul***, *Talking Incoherently*, v. 1.

[66] I think a large part of their agenda is to restore a little luster to guilt at a time when our society sees it as a destructive emotion.

[67] T.S. Eliot's description of that "pain in the skull" called guilt (from *Murder in the Cathedral*).

guilt appears when a person can't seem to envision or accomplish any positive means of redressing the transgression or harm. Partly, this ruminative guilt happens because the person lacks certain abilities (e.g., to envision future possibilities or counterfactual conditions); mostly, however, it happens because the person has a misplaced sense of responsibility (i.e., he assumes responsibility for actions that were not really under his control).

Still, if you think about this for a moment, guilt once again slips out from under the heavy hand of blame. After all, the real problem with ruminative guilt doesn't seem to be guilt so much as the person's inability to envision alternatives or his misplaced sense of responsibility. Fix those and the guilt is non-problematic.

If Tangney & Dearing had been truly interested in seeing the maladaptive side of guilt, they would have been better off researching its connection with *manipulation.* One of the fundamental principles of Assertiveness Training is that *people are manipulable because they can be made to feel guilty.* From this perspective, guilt is maladaptive when it promotes one person's interest (the manipulator) at the expense of the other's (the manipulated). [True, Assertiveness Training would benefit hugely from Tangney & Dearing's distinction between shame & guilt – because the one is often confused with the other. But the point still stands: *guilt in the service of manipulation is maladaptive* – and it leads to unhealthy interpersonal outcomes (e.g., resentment, depression, avoidance, exploitation, etc.).]

… keeping watch on virtue[68] *…*

Is there no such thing as "good" shame? While *shame* is definitely the villain in Tangney & Dearing's psychodrama, not everyone theorizing in the modern study of the moral emotions sees it that way. In fact, one of the most influential new schools of criminological theory[69] is based very much on the inherent goodness of shame. Restorative Justice and its offshoots (e.g., Justice Circles and Family Conferences) stand firmly on a foundation of *shame.* As the founding father of Restorative Justice, John Braithwaite, explains: "The key idea was that societies which have lower crime rates are the societies that are more effective at shaming."[70]

So, if shame is good, does it work? Or, more precisely, do the Restorative Justice programs based on *shaming* work? Consider the following:

- *There is not, to our knowledge, a single review of controlled studies on the effects of the criminal penalty (diversion, probation, custody, restorative) that has found evidence of consistent effects on recidivism.* [Andrews & Bonta, 1998, *op. cit.*][71]
- In their meta-analysis of effective programming for juvenile offenders, the leading researchers (Mark Lipsey and David Wilson) lump restorative programs under diversion, and conclude that they are "weak or no effects, consistent evidence".[72]
- *Although research into restorative measures suggests that satisfaction levels of participants are high, outcome results from restorative practices, particularly with young non-violent offenders, are still modest (Sherman et al, 2000). On their own these methods are unlikely to help turn around the life of a young person with multiple difficulties and much has still to be learned about how and when best to use them.* [Criminal Justice Social Work Development Centre for Scotland]
- *The results from the literature review found that* ***restorative justice*** *programs had a small effect on offender* ***recidivism****. Based on 46 studies with nearly 23,000 participants,* ***restorative justice*** *programs, on average, were associated with a decrease of three percent in* ***recidivism****. Contrary to expectations, the programs were more effective with adults (8% reduction) than with youth (2% reduction).* [Bonta, J., Wallace-Capretta, S., Rooney, J., & McAnoy, K. (2002). An outcome evaluation of a restorative justice alternative to incarceration. *Contemporary Justice Review, 5.*]

From this evidence, the best we can say is that if shaming works, it only works a teensy bit. Notably, this conclusion is confirmed by *Stats Canada.*[73]

Looking at such discouraging results, Tangney & Dearing conclude that Restorative Justice falls prey to the psychological illusion that most of us fall for – *it fails to distinguish between shame and guilt in its programming.* Making this mistake, the "good" effects of guilt-induction are undercut by the "bad" effects of shaming. The result is a virtual wash.[74]

On the surface, Tangney & Dearing appear to have a point. Braithwaite himself deliberately pooh-poohs any difference between shame and guilt:

> *Developmental psychologists sometimes like to make distinctions between socialization by shaming and by guilt-induction. Shaming, according to this distinction follows transgressions with expressions of the lower esteem the offense has produced in the eyes of the external referents like parents and neighbors; guilt-induction responds to transgressions with*

---

[68] Edmund Burke: "Whilst shame keeps its watch, virtue is not wholly extinguished in the heart."

[69] To the proponents of this school, designating it as "new" indicates an ingrained cultural bias, even an arrogance. Indeed, they see this criminological theory as pre-dating all others.

[70] Interview comment from *To Hurt Or To Heal* [2000: CBC *Ideas* Transcript]. Braithwaite's *magnum opus* and primary source of Restorative Justice is his book *Crime, Shame and Reintegration* [1989: Cambridge University Press].

[71] Andrews & Bonta go on to add more optimistically: "From the earliest to the latest reviews of the research literature, only the studies on the delivery of direct human service have shown promise – promise evident across a variety of settings, including nonjustice settings, diversion programs, probation and custody."

[72] See: Lipsey, Wilson, & Cothern, Effective Intervention for Serious Juvenile Offenders, *Juvenile Justice Bulletin* [April 2000]. Both the Lipsey group and Andrews & Bonta divide interventions into three broad categories: (1) those intended to interfere with crime before it develops as a possibility in a child's life (*prevention*); (2) those intended to respond to a child who has committed a crime with formal or informal judicial proceedings (*custody, probation, diversion*); and (3) those intended to provide direct therapeutic programming (*rehabilitation*). While there is evidence that 1 & 3 are effective, 2 either has no effect or works to increase criminal activity.

[73] See: Latimer, Dowden, & Muise, The Effectiveness of Restorative Justice Practices: A Meta-Analysis [2001, Research and Statistics Division, *Statistics Canada*]. To give Restorative Justice proper credit, it does show a record of high victim and participant satisfaction, and increased levels of restitution.

[74] Of course, there is another explanation for this wash: the "bad" effects of shame might be undercut not by covert guilt-induction but by other types of positive therapeutic intervention. Not all restorative programs are "pure" – they often are combined with more traditional human services (like counselling, family counselling, or mediation).

admonitions concerning how remorseful the child should feel within herself for perpetrating such an evil act. The distinction is rather too fine for our theoretical purposes because 'guilt-induction' always implies shaming by the person(s) inducing the guilt … For our purposes, to induce guilt and to shame are inextricably part of the same social process. [Braithwaite, *op. cit.*]

From this quote, it's easy to see that Braithwaite has a slightly different definition of shame & guilt than that proposed by Tangney & Dearing: shame is presented as something that takes place in the "eyes of the external referents", rather than as an internal, painful judgement about the self; and guilt is presented with emphasis on its "feeling" of remorse, rather than with emphasis on its actions of reparation. In these slight changes in emphasis, Braithwaite completely loses sight of the more useful distinction between shame & guilt as proposed by Tangney & Dearing. If we look a little deeper, however, we find that the back door of his theory is open – and a familiar distinction has managed to sneak in and leave its paw prints all over the place.

Having tossed the shame/guilt distinction out, Braithwaite quickly goes on to make another distinction that he claims is absolutely vital to his theory – *viz.*, the distinction between *stigmatizing shaming* and *reintegrative shaming* – because he himself came to realize that not all shaming was a good thing:

But this being effective at shaming seemed like a complex thing because there are all sorts of ways in which shaming seems to be counterproductive and make things worse and threaten peoples' identity and cause them to reject their rejecters. And that kind of shaming I ended up defining as stigmatization, which is an outcasting, rejecting kind of shaming, a disrespectful kind of shaming … there's a sort of permanency about the stigmatization, with stigmatizing shaming. And stigmatizing shaming makes things worse in terms of crime – and I think there is a lot of evidence for that – whereas reintegrative shaming, which often makes things better, is a respectful form of disapproval and its respectful by focusing on the act, on disapproving the act rather than disapproving the person as a bad person or an evil person. So, it's disapproval of the act, communicated within a continuum of approval for the person as an essentially good person. [CBC interview, *op. cit.*]

Focus on the *act*, not the *person!* Does this sound familiar? It seems to me that Braithwaite's distinction between *stigmatizing shaming* and *reintegrative shaming* is exactly the same as Tangney & Dearing's distinction between *shame* and *guilt*, respectively.[75] [So, by algebraic substitution, we are once again back at Tangney & Dearing's overall theme: *shame* is "bad"; *guilt* is "good". Maybe there truly isn't such a thing as "good" shame, after all.]

Of course, this puts us on the horns of a horrible dilemma – *if Restorative Justice theory does make a distinction between good guilt (which it calls reintegrative shaming) and bad shame (which it calls stigmatization), then why aren't it's programs more effective in reducing recidivism?!* I can surmise at least one possible answer:

In failing to make a strong distinction between two different *psychological* processes (i.e., by assuming that there is just *one* process – shaming - applied in either a good or bad way), Braithwaite left open the door to too much confusion. His examples of shaming in different cultural contexts display this confusion. Acts of humiliation and ridicule in these different cultural contexts are clearly aimed at the *person,* not simply *behavior.*[76] In fact, this person/behavior distinction is probably not a distinction that is made in other cultures – indeed, it is only a recent distinction in our own. What prevents these shaming processes from becoming stigmatizing in other cultures is a complex network of post-shame healing rituals and strong community ties. But these rituals and ties are precisely what modern society lacks! In providing us with this template of good shame/bad shame, Braithwaite has overlooked our social inability to provide the very conditions that make good shame possible. As a result – and combined with the natural tendency to confuse shame & guilt anyway – restorative justice programs are probably contaminated with too much covert shaming, thereby compromising the effectiveness of any guilt-based reintegrative work.

… the urban war on shame …

If shame & guilt are both biological emotions, how has it worked out that one is adaptive and the other maladaptive? It doesn't seem likely that nature would equip us with a capacity (i.e., shame) that isolates us from positive social interaction, thereby making us less attractive and less successful at reproducing. What's the story here?

Braithwaite notwithstanding, it's very difficult to find any credible academic research support for the positive virtues of shame. Still, I *personally* believe that shame can't be all bad. In fact, unless I am deluding myself profoundly (which is always a possibility), I find shame to lie at the core of my own moral reasoning. Like most parents, I have often found myself in conversations with my youngest child that deal with moral values. It's reassuring to hear her articulate the expected stages of Kohlberg's schema … *"So, dear, why isn't it okay to steal from other kids or to poke them in the eye?" "Because, daddy, I'd get in a lot of trouble!"* Later, it became: *"Because, daddy, it's not fair – everybody should play by the rules!"* Most recently, it's: "*Because, daddy, I wouldn't want that to happen to me! It would make the other person feel really bad."* Of course, there has always been that aspect of the kid's thought that leaks shame: *"Because, daddy, anyone that did that would be a bad person!"* Like most modern parents, my wife and I quickly reassure her that there is no such thing as a bad person, just bad behavior. We get positively obsessive about making sure she understands this distinction. But then a curious thing happens when she turns the tables on me and wants to know why *I* don't steal or fight: *"Um, er, well, dear, it's not because I might get in trouble and not because it's against the rules. It's not even because I don't want those things to happen to me. No, I don't steal or fight because I simply don't want to be the kind of person that steals or fights. While I care a little bit about what other people think about me, mostly I'm concerned with what I think about myself."* Maybe I can get a job as the poster-boy for shame.

---

[75] It is no criticism of Braithwaite that he was unable to make the fundamental distinction between shame and guilt. After all, he developed his work in a different academic context than Tangney & Dearing – a context that was heavily influenced by the *anthropological* distinction between (public) shame and (private) guilt, and not a *psychological* distinction. The fact that he was able to discern between his own concept of bad shame (stigmatization) and good shame (reintegration) speaks well of his observational and analytic skills. This small misstep aside, he remains (in my mind anyway) the single most impressive thinker in criminological theory in contemporary writing.

[76] In particular, I am referring to his examples of the treatment of Roman criminals, the naval tradition of the "Captain's mast", and the Crow Indians' "buying-of-the-ways".

Of course, as we saw earlier, there is no relation between moral behavior and moral reasoning – so my own actions probably don't have a whole lot to do with my beliefs or values (however articulated). If I am moral, it no doubt has far more to do with how "guilt-prone" I am than with how "shame-based" my reasoning is – and this distinction is probably not something I'm completely aware of. [As was noted earlier, humans have difficulty in separating out guilt reactions from shame reactions. If I truly wanted to be clear on what controls my actions, I would have to pose the dilemma as a *counterfactual* – i.e., "Having stolen from someone or poked him in the eye, what would I have had to do to ensure that such a thing hadn't happened in the first place?" If my answer is "Be a better person!", then I am shame-prone. If it is "Put myself in the other person's shoes and think about how he would feel!", then I am guilt-prone. Here the superiority of my daughter's position is clear (assuming that this is *really* what informs her behavior).]

It's speculative, but here's my attempt to sort out why it is we are biologically equipped with both shame and guilt …

From a traditional "evolutionary" perspective, shame is a bit of a conundrum. Shame – the desire to hide from the group, to flee, to isolate oneself in humiliation – seems a truly anti-social act. In extreme, it often leads to suicide – think of the *inseki jisatsu,* the Japanese ritual of atonement through suicide. Such behavior hardly ensures that one's genes get passed on to the next generation. From the individual's point of view, shame provides no evolutionary benefits. So, who does benefit? One answer (admittedly contentious) is: *the group!*[77] By ridding itself of individuals prone to shameful behavior (through isolation or suicide), the group ensures that upstanding (i.e., conformist) group members have an adaptive advantage – they can access both greater social resources (i.e., help in times of need) and greater sexual resources (i.e., socially approved mates with whom to have children). So, shame is adaptive in that it removes the burden of anti-social behavior from the group.

Of course, such an advantage really only makes sense in a context where one's "behavior" is virtually synonymous with one's "character" – where *what one does* defines *who one is*, and vice versa. Such a context is the small face-to-face hunter/gatherer group (approximately 100 – 150 people) that constitutes the bulk of human history. Once interactions grow more numerous and complex (i.e., as we evolve beyond the "tribe" level of hunting & gathering to farming-based "states" and industry-based "cities"), however, the age-old link between character and behavior begins to fray. People start interacting more and more on the basis of "roles" - i.e., fragments of self, limited behavioral prescriptions defined by what a person does rather than who he or she is. Isolation or withdrawal prompted by shame (to say nothing of extreme shame behavior like suicide) doesn't make much sense in this context – social withdrawal would affect *all* the person's roles when behavior may be problematic in just one of them. Therefore, people prone to guilt would have the adaptive advantage: they would be inclined to repair the relationships on which their role depended. There would also be an adaptive advantage of guilt at the group level: groups that could maintain more complex interpersonal interactions could access higher non-zero-sum resources (i.e., all the win/win benefits that come from cooperation rather than competition).

Actually, we might even be able to take this argument a little further. Probably, in biological terms, what we are dealing with is not two separate genetic mechanisms (one called guilt, the other shame) – but a single undifferentiated emotional capacity: sort of a "shame-guilt". The "self" (which forms the basis for both emotions) is, after all, a *social* construct, not a *biological* one. Our "selves" have discernible histories, and they vary in their social forms from time to time and place to place. As the definition of what constitutes a "self" varies (e.g., the transformation of Victorian "character" to Edwardian "personality" to postmodern "protean self"), so does the definition of what constitutes "shame-guilt". In our modern culture, since we strongly differentiate between self-as-a-state-of-being (*who I am*) and self-as-individual-activity-in-the-world (*what I do*), we must also find concepts to differentiate the underpinning associated emotions.[78]

If the foregoing argument has any validity, then the whole conundrum of guilt-as-adaptive versus shame-as-maladaptive goes away. What is adaptive is the underpinning biological capacity. The distinction between guilt and shame is a conceptual/social one, not a biological one – and, therefore, not grist for the *evolutionary* mill but grist for the *historical* one. Poof! Problem solved! [Of course, this will drive people who think the "self" is a biological entity (like our liver or lungs) crazy.]

- Terry Henry

[77] This thesis is presented in Howard Bloom's *The Lucifer Principle* [New York: Atlantic Monthly Press, 1995].

[78] We could look at the development of "envy" and "jealousy" in the same way. The underpinning emotion (i.e., biological capacity) is probably the same – that is, they are rooted in a single biological capacity. We recognize this in common usage when we confuse the terms with each other – indeed, we have difficulty separating them in our minds just like we have trouble separating shame & guilt. One, however, seeks a gain for the self (envy), while the other fears a loss (jealousy). But since the "self" that is seeking or losing is itself a social construct and not a biological reality, the distinction is ultimately conceptual and not biological.