PAIN AND THE UNSPOKEN EMOTION: SHAME

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Abstract: Anger, fear, and sadness are frequently described emotions that are experienced by many young people in care, but there is another common emotion that is less often named and understood. Shame — the deep sense of not belonging, of being defective or deficient in some way, of feeling unlovable — is a painful and pervasive social emotion that also involves our thinking processes and sense of self-worth. It has been described as a "pit of despair" that "envelops" many young people in care, a toxic force that drives behaviours we struggle to understand including some aggression and self-harm. Referencing Nathanson's Compass of Shame, this article looks at some common coping strategies as well as masks or proxies of shame including the so-called "impostor" phenomenon – even the "drive for normality" described by James Anglin in 2002 could be seen as an attempt to escape from shame's isolating clutches. Strategies for helping young people understand and cope with shame, including the fostering of healthy connections and the judicious use of words, are then explored.

Keywords: shame, child protection, child welfare, trauma, compass of shame, residential care

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There is no agony like bearing an untold story inside you.

Zora Neale Hurston (1942/1996, p. 176)

There are many painful emotions experienced by young people in the care and protection system. Grief, anxiety, depression, numbness, and even terror are just some of those listed by Anglin (2002) in his classic study of residential care. But there is one troubling emotion that is less frequently identified, namely *shame*. It is often omitted from those lists of emotions that are so common in elementary school classrooms; it is not often identified or named by parents, carers, teachers and other mentors when they interact with young people; and it is rarely mentioned by the young people themselves.

Although shame affects all of us at times and has been studied and written about for a long time, it is much more likely to be a consideration in counselling and adult mental health settings than in services such as child welfare, child protection, or youth justice. Yet this emotion is known to be a central driver of many challenging behaviours, such as aggression and self-harm (Gilligan, 1996); it is sometimes experienced as a "bottomless pit of despair in which the self is lost" (Siegel, 2012, p. 327); and it has been suggested that young people in the care system are "enveloped" in it (Hughes, 1997, p. 3).

In contrast to guilt, which is a sense that we may have done a specific "bad" or "wrong" thing, shame is the sense that somehow we ourselves are defective or deficient in a fundamental way. It is a deep sense of not being good enough, of not measuring up, of being damaged goods, of not belonging, of being unworthy, of feeling unlovable. It is commonly attached to themes such as personal appearance or attractiveness, including racial background, height, weight, and skin colour; issues related to competence, including social skills, ethics, values, and empathy; sexuality and intimacy; power and social efficacy; and personal beliefs or religious identification (Nathanson, 1994, p. 316).

Shame is a social emotion: it is generated when we perceive or experience ourselves in a social context, in relation to others — our families, peers, communities, and even countries.

Brené Brown (2012), a researcher and author of several best-selling books, defined shame as "the intensely painful feeling or experience of believing that we are flawed and therefore unworthy of love and belonging" (p. 69).

The Building Blocks of Shame

Nathanson (1994) suggests that brief shame experiences are common because shame (and humiliation, a closely-related construct) is a "built-in", highly aversive affect that occurs "whenever desire outruns fulfilment" (p. 138). It operates from early in infancy when positive drives, expectations, or bids for attention are thwarted. A small infant may orient towards its

mother, expecting a response. The mother may be distracted and fail to respond. The infant experiences a "jolt", "shock", or "burst" of shame (p. 141) which triggers distress.

Usually the caregiver will immediately repair the disconnection because she or he empathises with the infant and does not like either the infant's emotional pain or their own.

As we get older we all experience these brief "cognitive shocks" or "bursts" of shame or humiliation when a social expectation or bid for connection is blocked or ignored. For example, when we are trying to explain something and the listener glances down at their watch. The jolt is such that we might feel the need to immediately apologise for taking the person's time. It is the emotion generated in that school prank where someone gestures to shake your hand, and as you reciprocate they turn away straightening their hair as if it was never their intention to acknowledge you.

And remember that common school experience of the two appointed captains picking players for their scratch game of basketball? As the respective captains pick their team members in turn, starting with those perceived to be the most capable, an ever-diminishing group of potential players is left — not good enough, unwanted, shuffling with downcast eyes, jolted with shame and perhaps internally attempting to rationalise it away ("Well, basketball's not my thing anyway").

Shame is not necessarily a destructive or negative emotion and the brief "shocks" can highlight the need for connection and the imperative to belong. It has a powerful positive role in bonding us with our close attachment figures, integrating us into social groups and, especially, reintegrating us when things go wrong. According to Louis Cozolino (2016), "appropriate shame supports development of conscience, deepens our empathic abilities, and allows us to have mutually supportive relationships" (p. 122). A step up from brief jolts of shame are those experiences in which we feel humiliated in a social context — perhaps when we are ignored or publicly criticised, when our ideas are ridiculed or our wishes overridden. Or it could be that some aspect of our appearance, ability, ethnicity, or belief system is referred to sarcastically or in a joke and others giggle in agreement.

As galling as these everyday experiences tend to be — and such painful shame memories can last a lifetime — with positive social support and validation we can usually recover our emotional equilibrium: the acute social pain dissipates, and we get on with life. But when such shame experiences are frequent and unresolved we start to expect rejection and exclusion. Shame begins to colour our lived experience and we are at risk of internalising a sense of being deficient, different, and isolated from our peers. This can have an insidious and corrosive effect on our sense of self; in such cases the shame becomes "toxic" (Silvan S. Tomkins in Demos, 1995) and chronic (DeYoung, 2015). It has now evolved into a painful, complex, and often destructive emotion that involves troubling feelings, a fragile sense of self-worth, and negative self-talk.

Shame and the Maltreated Child

The experience of shame has long been recognised as a common outcome of the abuse and neglect of children. Dan Hughes (1997) described traumatised children in the care system as being "enveloped by shame" (p. 3) and struggling to free themselves from this pervasive sense of being different in a "less than" sense.

Liz Murray's (2010) biography *Breaking Night* describes her fraught journey from a drug affected, profoundly neglectful home life, to academic success. Here she is reflecting on her time in elementary school:

> In ways that I couldn't quite put my finger on, the other kids seemed far more together than I was, in the sense that they were actual kids.… [I felt] scattered, full of holes. Different. It was the feeling that I was different that gnawed at me in the classroom, pressing me deeper into my exhaustion.…I was always grateful for the end of the day, when I could finally go. (p. 59)

Later in the book she describes her sense of being "different" to "everyday people":

> …on the train, the smart students … the functional families, the people who went away to college — they all felt like "those people" to me. And then there were people like us: the dropouts, welfare cases, truants, and discipline problems. Different. (pp. 248–249)

Many maltreated children experience what Cozolino (2016) calls "core shame", which results from early experiences of neglect, abuse, and abandonment. The impacts of this early maltreatment become embedded in a range of developmental processes, affecting many aspects of one's physical, emotional, cognitive, and social well-being, including self-image and sense of self-worth (Cicchetti, 2013; Cook et al., 2005). Cozolino (2016) described core shame as a "deep emotional experience of being ashamed of who and what you are … an inner certainty of being a defective person combined with the fear of this truth becoming public knowledge" (pp. 122–123). The pain of core shame stimulates "the same brain regions activated by physical pain and fear" (p. 128), and is so aversive that we must find ways to avoid, disguise, or bury it.

For some it is not outright maltreatment per se, but a chronic lack of parental attunement (perhaps because of depression or substance misuse) that results in children's needs and feelings being ignored and their bids for communication being missed. A chronic lack of adult attunement, validation, and reciprocity is also the lot of children raised in other settings such as some boarding schools or hostels where expressions of sadness, anxiety, or yearnings for parents and home may be suppressed by fears of "being shamed or humiliated by peers, older pupils and staff" (Sanderson, 2015, p. 54).

For children whose feelings, wishes, and emotional needs are chronically neglected or suppressed, Cozolino (2016) suggested that their "sense of self is experienced as fundamentally defective, worthless, and unlovable" (p. 122). He went on to observe that:

> …the absence of adequate parenting is interpreted by their young brains as an absence of their own value. The belief is, "If I were worthy of love, my parents would have given me what I needed." (p. 123)

This deep sense of unworthiness is apparent in the words of many graduates of the care system when they reflect on their lives. The academic and author John Seita spent much of his childhood in foster care and residential treatment. Here he is reflecting on visiting the homes of school friends in the local community:

> I always felt different. Not good different; not unique-in-a-positive-way different; not proud different as in marching to my own drum; but shameful different. I felt as if I was somehow less in nearly every way than my peers. (Bath & Seita, 2018, p. 39)

Trauma and shame are intertwined. At the heart of the early relational trauma that many of our young people have experienced is a sense of disconnection and isolation, a defining feature of shame. Bessel van der Kolk (2014) put it like this: "The essence of trauma is feeling godforsaken, cut-off from the human race" (p. 335).

Coping with Shame

Shame is one of the more painful emotions because it arises when those most foundational of human needs, the need to feel safe and the need to belong, remain unmet. Because it is so painful, we are compelled to find ways to avoid it if possible, to manage it when we must, and, if necessary, to neutralise it. Donald Nathanson (1994) described what he called the "Compass of Shame", identifying as the compass points the four characteristic ways people cope with toxic and chronic shame (see also Elison, Lennon, & Pulos, 2006). Within the Compass of Shame we find a range of pain-based behaviours.

The Compass of Shame

Withdrawal: Starting at the North point of the compass, Nathanson (1994, pp. 315–325) observed that withdrawal is one of the characteristic ways of managing shame — removing oneself from the social interaction, not engaging verbally, turning away, hiding from others. If this becomes habitual and characteristic it can evolve into serious depression and despair because we all need social connections.

Attack self: This is the Eastern point of the compass (Nathanson, 1994, pp. 326–334). Withdrawal takes us away from socially toxic interactions but isolation and loneliness are also painful. This can sometimes be relieved by people derogating themselves in abusive or manifestly unequal relationships; they signal, "I live willingly with the shame of being lesser than you, but I

have guaranteed that you are unlikely to attack me and will not reject me" (p. 330). The propensity to "attack self" may also take a more literal form in the shape of physical self-harm like cutting, bruising, or burning one's body. Some may also deal with shame and self-loathing through extreme tattooing, the insertion of objects under their skin, or engaging in painful and risky physical activities (Scaer, 2005, pp. 89–90).

Avoidance: At the Southern point of the compass are various means to avoid, override, or mask the pain of toxic shame (Nathanson, 1994, pp. 336–359), including resorting to alcohol or drugs, promiscuous sex, or extreme risk-taking. Many discover that shame, along with fear, is "soluble in alcohol" (Nathanson, 1994, p. 356).

Avoiding shame can also be achieved by other more socially appropriate defensive strategies such as an intense involvement in "doing good or looking good"; a "public self may emerge at these times to avoid the dreaded state by meeting the needs of others" (Siegel, 2012, p. 328). Such self-sacrificial actions may be praised by others but can become problematic because they may be compulsive, may lead to a lack of authenticity and the emergence of a "false self", and do not deal with the underlying feelings of shame.

Another form of avoidance is joining with others who feel excluded and who represent an alternative or "new normality" — a subcultural group that defines itself by being different, whether in philosophy or belief, values, appearance, dress, behaviour, or a combination of these. The person avoids shame by identifying with the new social group and its norms. This may involve a healthy alternative identity or a problematic and ultimately destructive one, as in the case of many gangs.

Attack Others: This is at the Western point of Nathanson's (1994) compass. Where the other strategies are not palatable or workable for an individual, or where they have discovered how powerful aggression can be, attacking others (pp. 360–377) can provide immediate results and temporary relief from the pain of shame. It provides proof that you are more powerful and competent than you feel. Attacking others can take myriad forms, from the use of an army to desolate and subjugate a country, or the use of fists or weapons to harm another, through to a "contemptuous sneer" (see Nathanson, 1994, p. 366–367), or, more recently, removing a person from your social media "friends" list. It can also involve acts of vandalism and desecration.

Although the majority of those who struggle with feelings of shame do not resort to violence, many school shootings do appear to be perpetrated by those with painful experiences of social exclusion. Shame and social exclusion are also common themes in the histories of the so-called "lone-wolf" terrorists and suicide bombers. James Gilligan (1996), a prominent psychiatrist and commentator on violence in the USA, observed:

> I have yet to see a serious act of violence that was not provoked by the experience
> of feeling shamed and humiliated, disrespected and ridiculed, and that did not
> represent the attempt to prevent or undo the "loss of face"… the emotion of shame

is the primary or ultimate cause of all violence whether towards others or toward the self. (p. 110)

Increasingly, social media platforms are providing a means for people to attack others under the cloak of anonymity. Cyberbullying and trolling can provide a form of redress for perceived shaming by others and also an illusion of power and control.

Disguises of Shame

Some emotions such as anger, fear, and sadness are relatively easy to identify, name, and respond to when observed in others; shame, on the other hand, is difficult to detect, and more rarely named (DeYoung, 2015, Ch. 1; Nathanson, 1994, p. 16).Given its pervasive nature, it is more challenging to address. Shame comes in many guises (Nathanson, 1987); here, I discuss a few of the most common.

The Quest for Normality

James Anglin (2002) found that the drive or quest to feel and be perceived as normal was a prominent theme in the thinking of young people in residential care. In mainstream society we tend to value uniqueness; we admire those who are distinctive, the trail blazers and the innovators; we fear being merely "normal". But it is interesting that so many children and young people in care do not quite see it this way. Here are quotes from young people reflecting on their in-care experiences:

Once I began to realise what normal people do and compare myself to them, I learned to lie to myself and others about who and what I was.

Everybody wants to be normal, whatever that is.

(Bath & Seita, 2018, pp. 75 & 105)

Young people with such feelings have often been raised by people who are not their natural parents: they may live with unrelated peers, they may move frequently between caregivers, they may have to meet regularly with case managers, and they may not have extended family they can interact and identify with. Many go to special schools that also reinforce their "less than" evaluations of themselves. These young people are acutely aware of so many things that mark them out as being different to those they perceive to be "normal" peers.

In her autobiography, *The Glass Castle*, Jeanette Walls (2005) writes about her upbringing in a chaotic, neglectful, peripatetic family. Feeling abnormal is a theme throughout as she recounts numerous frightening, perplexing events — and even humorous ones — as the family wanders around the southern states. In one instance, her sister is invited to attend a summer camp and returns a changed person:

> She burst into the living room, duffel bag over her shoulder, laughing and belting out one of those goofy summer-camp songs kids sing at night around the fire.… She positively glowed as she told me about the hot meals and the hot showers and all the friends she'd made. She'd even had a boyfriend who kissed her. "Everyone assumed I was a normal person", she said. "It was weird." (p. 218)

As a young youth worker, I remember the sense of shame and abnormality our young people used to feel when they were driven around in a minibus with the details of both the residential facility and the donor organisation emblazoned on the side panels. They naturally felt like exhibits, objects of pity or curiosity. Even when we removed the donor details, they felt uncomfortable being dropped off at school with a group of others. We negotiated to drop them off a block away so they could arrive at school on foot, singly or in pairs, and thus appear to be "normal" kids.

The strong desire to feel and be perceived as normal could be interpreted as an escape from shame because, in a fundamental sense, to be normal is one's passport to belonging.

Dr John Seita, social work professor and former young person in foster and residential care, tells the story of being sent from his residential placement to basketball camps at a university in order to hone his promising skills in the sport. These camps were successful for John, in part because he was athletic and took to the game, eventually winning a basketball scholarship. However, in John's mind the greatest benefit of the camps was that he started to feel like a "normal" person; he was no longer John the orphan in care, but John the basketball player, a normal member of the community (J. Seita, personal communication, 28 June, 2014).

Impostor Phenomenon

The impostor phenomenon (also known as the impostor syndrome) was first identified in 1978 with a focus on the experiences of high-achieving women (Clance & Imes, 1978), although it clearly affects both men and women. It describes the deep sense of being undeserving that some people experience when they are successful. They may feel like frauds, and feel that their success is due to mere luck or chance and that they are unworthy of their achievements.

As with shame itself, those affected may also experience a range of negative emotions, including anxiety and depression, and may tend to disengage or "aim low" rather than pursue success in their activities or careers. This phenomenon represents more than a lack of confidence. It is a deep sense of being unworthy and fraudulent that saps motivation and healthy ambition — at its worst it can lead to self-sabotage.

Young people enveloped in shame are particularly prone to experiencing the impostor phenomenon and this "impostor" theme can be found in the biographies of many of those from abusive or neglectful backgrounds who have beaten the odds. Liz Murray (2010) recalled the time she found herself accepting a lift in a car belonging to what she perceived to be a "normal" family.

She could not enjoy the experience because she remembers thinking to herself "at any moment I might get caught, my presence discovered as fraudulent" (p. 273).

Another high-achieving survivor of a stressful, abusive, and neglectful upbringing, Tara Westover (2018), described a turbulent childhood and adolescence in her autobiography, *Educated*. When she finally broke free of her suffocating survivalist and rigidly fundamentalist family at 16 years of age, she attended a regular community school and gradually discovered a talent for academics. Eventually she found herself attending a course at Cambridge University but struggled to accept that she deserved to be there.

> Breakfast the next morning was served in the great hall. It was like eating in a church, the ceiling was cavernous, and I felt under scrutiny, as if the hall knew I was there and I shouldn't be. (p. 271)

Her early encounters with her professors were coloured by that same deep sense of unworthiness:

> "I've been teaching in Cambridge for thirty years", he said. "And this is one of the best essays I've read."… I was prepared for insults but not for this. Professor Steinberg must have said more about the essay but I heard nothing. My mind was consumed with a wrenching need to get out of that room.…
>
> I could tolerate any form of cruelty better than kindness. Praise was a poison to me; I choked on it. I wanted the professor to shout at me, wanted it so deeply I felt dizzy from the deprivation. The ugliness of me had to be given expression. If it was not expressed in his voice, I would need to express it in mine. (p. 277)

A young person's reluctance to believe in or to promote their obvious skills and talents, to join in group activities, to apply for awards and scholarships, or their tendency to withdraw when on the brink of success, may well be a reflection of the impostor phenomenon at work along with its emotional engine, shame.

Decoding Shame

Shame-Related Symptoms and Behaviours

DeYoung (2015) has observed that "our troubled clients protect themselves from feeling chronic shame with a stunning variety of emotional symptoms and behaviours" (p. xiii). The quest for normality and the impostor phenomenon are just two examples of these guises. The behaviours described in Nathanson's Compass of Shame, including substance abuse, self-harm, withdrawal, and aggression, are also examples of common behaviours that may be indicative of shame-related processes. Other responses and behaviours that may be indicative of shame include "seeking-to-please, arrogance, and grandiosity" (Sanderson, 2015, pp. 99–100). Cozolino (2016) identifies

others including, in a school context, "maladaptive perfectionism, reduced pride in response to success, fear of negative evaluation and intense shame in the face of failure" (p. 123).

Because those who experience shame also struggle with emotions such as anger, fear, and hopelessness, we can often focus on these more obvious emotions and miss the underlying emotional driver behind them all.

Words and Shame

Then there are the challenges in finding words for shame. Apart from the fact that even raising the topic of shame may arouse troubling feelings and resistance, it is difficult to grasp the phenomenon conceptually, to describe it and to help young people understand it.

Although the word "shame" is not used by most children and young people, "code" words and phrases can suggest that shame may be the underlying painful emotion. Here are some statements that hint at their emotional source:

I'll never be able to do that.

Why would I audition for the play?

I don't want to go to the party.

No one would want me for a friend.

I feel like an outcast.

I'm not clever/smart/pretty enough to do that.

But there may also be more confronting comments like:

Who does he think he is, I'll show him!

I'm not going to let anyone push me around.

They deserve what's coming to them.

In isolation, any of these might represent a lack of confidence, low self-esteem, or even a healthy assertiveness, but where such words along with common shame-related behaviours become consistent themes, shame may be lurking.

Dealing with Shame

Behaviours as Coping

There is no silver bullet for dealing with shame, but the research and clinical literature gives us some solid pointers. Awareness of the ubiquitous nature of shame and its different guises,

particularly amongst young people in care, is a good starting point. It involves a willingness to accept that many challenging symptoms and behaviours may well be coping strategies rather than "bad" or "manipulative" behaviours — that they may indeed be pain-based behaviours. As Bloom and Faragher (2013) have pointed out, "The things we call 'symptoms' or 'behavioral problems' are the best solutions our clients have been able to come up with to help them manage unendurable feelings." (pp. 175–176).

This is echoed by Felitti and Anda (2010), lead researchers for the hugely influential Adverse Childhood Experiences (ACE) studies. They have observed that many of the adverse health outcomes among people who have experienced chronic early adversity could rightly be understood as resulting from efforts to cope with shame:

> Our most intractable public health problems are the result of compensatory behaviours such as smoking, overeating, and alcohol and drug use, which provide partial relief from the emotional problems caused by traumatic childhood experiences … which are lost in time and concealed by shame, secrecy and social taboo. (p. 86)

Healthy Connections

Shame is a social emotion representing the loss of connection. For our young people, this loss of trust and interpersonal connection is seen as one of the most significant outcomes of their exposure to early trauma (Baker & White-McMahon, 2011; Bath & Seita, 2018, Ch. 5; Freyd, 1996; Purvis, Cross, Dansereau, & Parris, 2013). Seita and Brendtro (2005) suggest that many such young people have become "adult wary". It stands to reason, then, that healthy connections must be at the heart of our response. DeYoung (2015), who developed her therapeutic strategies for shame around this imperative, observed that "shame is a relational problem; it has relational origins and it desperately needs relational attention" (p. xiii).

Young people in care need carers who actively seek to re-establish trust by being trustworthy (honest, reliable, and available) and who find ways to establish warm, healthy connections. In her summary of the resilience research, Bonnie Benard (2004) found that a defining feature of young people who were able to overcome early adversity was that they were able to connect with adults such as teachers, youth workers, foster carers, and other mentors in relationships marked by "trust, warmth, availability, and kindness" (p.xx).

These relationship qualities however, were not enough. Benard found that those young people characterised as resilient had mentors who communicated that they believed in the young people, who gave them hope, vision, and motivation to succeed. Moreover, they also ensured that there were opportunities to succeed, to lead, to actually experience success. Examples of such healthy relationships are often found in the memoirs of those who journey from childhoods characterised by adversity and risk to success in their various careers (e.g., Murray, 2010;

Westover, 2018). In her review of the factors that underpin resilience, Luthar (2006) concludes that "resilience rests fundamentally on relationships" (p. 760).

There are many publications and therapeutic strategies that explore ways to establish and build on healthy connections. These include Brendtro and du Toit (2005); Garfat and Fulcher (2012); Purvis, Cross, Dansereau, and Parris (2013); and Seita and Brendtro (2005).

Giving Shame a Voice

If shame is the "unspoken emotion" it makes sense that giving it a voice will be a central part of any therapeutic process, and this is indeed the case (see, for example, DeYoung, 2015). Sanderson (2015) notes that "in not being able to give voice to shame individuals are forced to suffer in silence, which intensifies shame and the need to mask it" (p. 13). She goes on to observe:

> It is only when clients are given a voice with which to break the silence and secrecy surrounding shame that they can be released from its crippling effects. This together with compassion and empathy, is the most powerful antidote to shame. (p. 14)

The therapeutic unmasking of shame is best left to the counselling room. For those who interact with young people where they live, learn, and play, the focus should be on understanding and providing acceptance and support. The first need is to attend and attune to the behaviours and words of our young people; then, where it is appropriate, one can help them find words for their feelings.

Recent research by Lieberman's group at the University of California, Los Angeles (Burklund, Creswell, Irwin, & Lieberman, 2014; Lieberman et al., 2007) has found that the process of consciously labelling troubling emotions, by others or by the clients themselves, results in a reduction in emotional arousal. Being able to stimulate the language centres of the left brain seems to moderate excitation of the threat-sensitive amygdala. In other words, feelings of emotional pain can be relieved by the judicious use of language. In fact, this "affect labelling" proved to be more efficacious in taming amygdala arousal than more formal cognitive behavioural therapy techniques such as "cognitive reappraisal" (Burklund et al., 2014).

The word "shame" itself does not always need to be used with children or young people. In fact, its use in itself may sometimes engender further anxiety and shame. Even with some adults in treatment, DeYoung (2015) noted that the word "shame" may never be spoken explicitly (p. xiv), but we can still find acceptable words to describe their experience. For young people in care, finding words to express feelings of shame may look something like this:

> Sometimes you feel like you don't belong in that team.

> You worry that people will laugh at you.

> You really don't feel good about yourself.

It makes you feel that you are not as clever as other kids.

You don't want them to know that you don't live with your mum.

You feel like hurting them because of the pain they caused you.

Of course, this also provides the opportunity for positive affirmation and support, and a gentle challenging with alternative, more positive scripts, but only when the young person feels understood and accepted. In time, and with the development of trust, the young people themselves will gradually feel comfortable enough to describe their own inner worlds.

With chronic and core shame, deeply ingrained feelings and self-talk can be highly resistant to change. As Cozolino (2016) observes, trust is necessary if young people are going to accept a healthy version of reality, and "they are going to make you work very hard to earn their trust" (p. 126). It will take resolve and a relentless commitment to both establishing trust and to positive and validating messaging to succeed in the face of challenging pain-based behaviours.

In his masterwork on trauma, Bessel van der Kolk (2014) observed, "While trauma keeps us dumbfounded, the path out of it is paved with words" (p. 232).

Conclusion

Shame is often a hidden, unspoken emotion, difficult to understand and harder to identify and name than many others. Yet it is a defining burden for so many young people in our care, protection, and youth justice systems. There are many challenging pain-based behaviours that have been linked with the experience of shame and efforts to contain and manage it. With an understanding of the pervasive and corrosive effects of toxic shame, we can develop empathy in place of anger or outrage, ensure that we avoid the use of secondary pain responses (Anglin, 2002, p. 55), and provide words for the feelings to help address the needs of our young people for insight, emotional self-management, and connection.

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