

Developing a shared case conceptualization when working with highly self-critical and shame prone clients

Human beings are fundamentally social creatures. For most of the last several million years, humans evolved in small bands of individuals and we are adapted to that context.

For our ancestors living in these tribal environments, being part of the tribe was essential for survival. Those people who got kicked out of the tribe died. As a result, we evolved to be very fearful of being out of the tribe. And our brains still respond as if we were living back in these older times.

Essentially, our brains treat social exclusion as if it were a potentially life-threatening event. Rejection or ostracism are amongst our worst fears and most painful experiences. When we lose an important member of our tribe, we can be severely affected. Our tribal nature means that we generally don't function well outside of context of at least one close, connected relationship. We need relationships and a sense of belonging.

A big part of why shame is so painful and difficult is that it recreates the fear and pain of disconnection or ostracism from the tribe. When we feel ashamed, we feel like different, cut off, damaged, rejected, or otherwise unacceptable. For people who are chronically shame prone, this tendency to feel outside the tribe interferes with their sense of belonging at a fundamental level and can result in feeling very fragile and unstable.

Early in life, we learn to arbitrarily compare and contrast pretty much anything, including comparing ourselves to others, or comparing ourselves to an imagined ideal version of ourselves. We construct our sense of self informed by our perceptions of how others view us. Shame is tied to this sense of self and our awareness of our place in our social group. When we feel shame, our sense of belonging is threatened or ruptured. Self-criticism emerges from some of the most basic functions of language and cognition and serves to protect us from potential rejection and exclusion from the tribe. While self-criticism can function as a way to keep shame at bay, it unfortunately can feed a shame-bound sense of self and can also keep us stuck in chronic arousal and feed narrow, threat-based ways of responding.

This document describes the method that we have developed at actwithcompassion.com for conceptualizing how to work with people who are highly shame prone and self-critical. We have found that working together with clients to understand the causes and consequences of their shame and self-criticism can be a hopeful process. A primary function of a shared conceptualization is to set a de-blaming platform for working with shame and self-criticism. This is the difference between, "I am crap," and, "I notice the belief that I am crap shows up when I start getting close to someone. That makes sense because I have been treated poorly before by people I was close to." Shared case conceptualization may also help the client begin to recognize that a

new self-to-self relationship is possible. We have had many experiences with clients being surprised by the question, “Who treated you with warmth in your childhood?” because nobody has ever before expressed interest in their being treated warmly. Therapy presents a new opportunity for the valuing of warmth and closeness that was not previously possible. For some clients, the process of case conceptualization also increases hope as relational and other resources are identified.

Of course, turning toward shame and self-criticism isn’t a walk in the park. Case conceptualization work is typically infused with pain. We are deliberately bringing awareness to shame - one of the most excruciating emotional experiences possible. The emergence of grief is also common when clients realize the historical lack of compassion or connection in their lives. This is courageous work for both parties in the room. Shared conceptualization demonstrates from the get go that we are in this together.

Validation and reconceptualization

Case conceptualization begins with understanding the presenting problem as the client sees it. As people who are highly self-critical and shame prone are often very sensitive to invalidation, it’s important that the client has a sense that you are seeing the world from her or his perspective. This includes validating and empathizing with the emotions that are aroused as the client talks about what he or she is struggling with. Careful attention to validation is also important in establishing a therapeutic alliance, as it is during early phases of therapy that roadblocks to developing an effective working alliance are likely to show up. Quite frequently, the initial case conceptualization needs to include a focus on the therapeutic alliance and barriers to developing an initial working relationship and adequate amount of trust to discuss delicate personal material involving shame.

While on the one hand it’s important to validate the client’s current viewpoint, on the other hand the case conceptualization needs to move beyond the client’s current understanding of the presenting problem, as it is often precisely the client’s story of what is “wrong” and what needs to be “fixed” that is part of what is keeping them stuck in an unworkable patterns of living. For example, shame prone and self-critical clients have inevitably exerted massive effort and suffered mightily in their struggle with what is troubling them. However, it’s often these very efforts that are part of the system that keeps them stuck and buying into attempts to “fix” problems can actually feed shame and self-criticism. Thus, the case conceptualization needs to validate and recognize this effort and simultaneously help the client to examine the workability of what seems like a very reasonable strategy. Thus, case conceptualization needs to include a re-conceptualization, a new vantage point from which the client can begin to see themselves and the difficulties.

In this reconceptualization as it relates to shame and self-criticism, it is the client’s relationship with him or herself that becomes central. Most clients who are highly self-critical and shame prone are not even aware of the possibility of having a new relationship with themselves. Rather, they are typically fused with a sense of self as inadequate, damaged, broken, or otherwise deeply flawed- a self that needs to be “fixed” or in some cases destroyed. The idea that they even *have* a relationship with themselves is typically a novel one. Instead, they see themselves as like an

object that is broken or damaged. It is not apparent that the *perception* of shamefulness and brokenness is the result of a process of fusion with a self-dialogue characterized by a particular manner of relating to themselves.

The case (re)conceptualization process is meant to be an experiential exercise for the client. As opposed to simply being a diagnostic or treatment planning tool to aid the therapist, a shared case conceptualization has important therapeutic functions in its own right. This includes beginning to build awareness of self-critical thinking and shame and thus beginning the process of dis-embedding them. Through the case conceptualization process, the client begins to develop more awareness of these forms of thinking and feeling as a process of thinking and feeling, rather than something “true” about themselves. Through this process of learning to observe shame and self-criticism as an experience in the body and mind, the client is less caught up in it and more open to other possible ways of relating to themselves.

In addition, through the case conceptualization process, the client learns to identify central relationships and situations that may be key in the development, maintenance, or cessation of shame and self-criticism. Relationships and situations that elicit shame will serve as the focus of future exposure and self-compassion exercises later in therapy. Alternatively, compassionate relationships and experiences will be used to help the client contact a more self-compassionate perspective in perspective taking exercises.

Finally, the shared conceptualization is the keystone of the therapy contract. This conceptualization is returned to throughout therapy and is used to remind the client of the shared understanding that shame and self-criticism have been ineffective. This helps create the possibility of a new way of relating to oneself--with more kindness, gentleness, and compassion.

The case conceptualization process can take several sessions. Few clients have much experience talking about their self-criticism and shame. Clients don't often come in to therapy saying that they want to work on their self-criticism and shame; rather, they frequently focus on what they view as some inherent flaw or “pathology” (e.g. anxiety, depression, etc.) to which they see their self-criticism and shame as a valid reaction, if they are even aware of their self-criticism and shame. Thus, even those who have been in extensive therapy will often not have spoken directly about these topics. Self-criticism often serves a self-protective function and the primary action tendency associated with shame is to hide. As such, it often takes persistent and gentle focus on the part of the therapist to begin to elicit the thoughts, feelings and other content associated with shame. The simple act of beginning to speak out loud about topics and thoughts that have never been said to anyone before is often healing on its own. If shame is like a festering wound, then talking about it is like bringing healing light and air to the wound.

In order for this case conceptualization to serve the various above mentioned functions, the shared reconceptualization can be broken down into three key components:

- 1) Assessing the function and form of shame and self-criticism in the person's life
- 2) Identification of key historical and current relationships and events that have contributed to the person's current sense of shame and self-criticism
- 3) Identification of key historical and current experiences and relationships associated with compassion, warmth, and kindness

1. Assessing the function and form of shame and self-criticism in the person's life

This component of the case conceptualization focuses on developing a shared functional analysis. Questions for the therapist to consider when conducting a functional analysis of

shame/self-criticism include: What are the client's core self-criticisms? When do these tend to occur? What are they in response to? Where do they lead in terms of outcome/behavior (paying particular attention to responses that unintentionally result in more shame)?

Places to look for self-criticism include:

- after a perceived failure or mistake
- after failing to control some behavior
- when trying something new
- when entering social situations
- when withdrawing from or avoiding others
- when isolated and alone

Often, key self-criticisms and shame do not happen during the events that the client is focusing on (for example panic attacks), but may happen either before or after those events. Thus, the therapist should look at the minutes immediately preceding or following a particular event as important factors that maintain problematic patterns. For example, during the functional analysis, explore the period after the event occurs to see if the person beats themselves up or keeps themselves in a state of heightened threat. Also, look before the event to see if the person is making fear-inducing and self-critical predictions about what is likely to happen in the upcoming situation that the person wishes to avoid. It can be helpful to chart this pattern out with the client on a whiteboard or something similar both to increase a sense of collaborative understanding and also clarification of the pattern.

The case conceptualization should include some exploration of the function(s) of the self-criticism. Self-criticism can occur at two points in the conceptualization. On the one hand, it can be a learned reaction to identified threats. Often, people who are highly self-critical have a developmental history in which they learned to be highly vigilant of their own behavior in order to protect themselves from threat or neglect. Essentially, self-criticism is serving a self-protective function. In this situation, self-criticism serves to motivate the person to avoid feared outcomes. For example, the person who fears the shame of rejection may use self-criticism such as telling themselves "You're so ugly she'd never go out with you" or "No one could ever love you" to avoid taking the risk of asking someone out and thus exposing themselves to possible rejection and shame. In ACT terms, self-criticism is serving primarily as a form of experiential avoidance and is maintained by short-run avoidance of feared outcomes.

On the other hand, self-criticism can serve a self-punitive function. Typically, this takes the form of more intense self-hatred, self-loathing, or contempt toward the self. This often results from the person identifying with the viewpoint of an abusive other in seeing the self as a disgusting object that needs to be punished or controlled and that is deserving of contempt and hatred. In this form of self-criticism, it is as if one part of the self is telling another part of the self that she or he is disgusting, unlovable, or even a mistake for existing. Fear is a natural consequence of being attacked so harshly. The therapist would then analyze how the client responds when this self-punitive loathing occurs and the consequences of these responses. In ACT terms, this kind of self-criticism is primarily a form of fusion with self as content.

One way to distinguish these two forms of self-criticism is by having the client complete the [Functions of Self Criticizing/Attacking Scale \(FSCAS\)](#), a self-report measure focusing on these two functions of self-criticism. In addition to assessing the primary function a client's self-criticism serves, completing the FSCRS can also help a client develop more awareness of their self-criticism and when it occurs. During this tracking process, it can be helpful to record some of the core self-

criticisms the client reports, especially any that seem particularly poignant or painful. These core self-criticisms can then be used in later exercises to more rapidly get to the most painful criticisms.

Another useful assessment tool that can be completed during this functional analysis process is [Rizvi et al.'s \(2010\) Shame Inventory](#). This self-report measure can provide useful information about the situations in which the client is most likely to experience significant shame. Completion of the inventory can be followed by a more in-depth discussion of focusing on those specific situations where the person endorsed significant shame.

Finally, in addition to these self-report measures, homeworks can be used to help the client better understand the functions of their self-criticism and possible relationship between their shame and self-criticism. For example, simply having the client write about how/when/and with what result, they are critical with themselves versus self-compassionate can provide the client with useful insight that can then be further explored in session with the therapist. These types of homework assignments may also provide useful information for the next two components of the case conceptualization: identifying key relationships and events that have either contributed to the person's sense of shame/self-criticism or who have been associated with compassion or kindness.

2. Case Conceptualization: History related to shame and self-criticism

In this first part of the case conceptualization, the therapist explores for key relationships and events that contributed to the client's current self-criticism and shame. Some clients may find this history taking highly aversive, and so this process may take some time to unfold. Many clients have a relatively poor recall of events that may contribute to their shame and self-criticism. Some important relationships and key events may only come to light in the later stages of therapy. These specific events elicited in later phases of therapy can subsequently be added to the list of key relationships and events when they are discovered. In this way, it is important to recognize that case conceptualization process is a dynamic, ongoing process, rather than some static rubric that remains unchanged throughout therapy. Regardless of the speed with which the process unfolds, it is usually important to gently and compassionately elicit these events so that the therapist can play the role of the compassionate observer of the clients report, validating their experience of the events described. Through this process, the client has the opportunity to learn to re-view their own experiences with more compassion via seeing the experiences through the eyes of another who validates and verbally reflects a more compassionate perspective. Often, this will be the first time that the client has experienced someone listen to their hurts, hopes, losses, and pains with kindness and non-judgment.

Initially, the case conceptualization may focus mostly on identifying what these key historical events were and some limited amount of information about how these impacted the person. Often, it is only later in therapy that the groundwork has been laid to revisit these memories from a perspective that will allow for some new way of interacting with them, so that learning can occur.

Key events to look for during the exploration process include experiences of sexual, physical or verbal abuse, trauma, neglect, or bullying. These may be one-time events that had a powerful impact on the person, or they may instead be repeated, in which case they may be more nested inside a relationship context. Often times, single events that involve some violation of the person's sense of self or extreme forms of humiliation can have profound effects over time,

particularly if they were not discussed or otherwise processed in a supportive context. For example, survivors of a single sexual assault may become particularly shame prone if they are in some way made to believe that it is not okay to talk about the event, or if disclosure is met with disbelief, retaliation, or invalidation of one's emotional reactions. A single non-traumatic event involving feelings of exposure may also contribute to shame proneness and self-criticism. An example is being called a name and laughed at by peers, especially if such an event is also linked with social disconnection and isolation and inability to repair a more positive sense of self.

In addition to some of these formative events, an exploration of the individual's key attachment relationships can also provide critical information for understanding how the person developed their current patterns of relating to self and other. In particular, it can be important to explore whether the person felt that key attachment figures expressed warmth and caring to them. One need not have a history of extreme levels of abuse or verbal criticism from others in order to develop a shame prone and self-critical tendency. Our mind's basic tendency towards negativity will result in tendency toward high levels of self-criticism merely because of the absence of warm and loving communications and physical contact from attachment figures. Questions such as "How did this person respond to you when you were distressed? Did they soothe you or validate your experiences?" can help to draw out relevant experiences.

It is important to note whether their primary caregiver(s) were consistent and predictable in their warmth, criticism, or detachment, or whether they were hard to predict. Caregivers who were predictably cold may lead to the development of predictable styles of self-to-self relating (e.g., consistently self-criticizing). On the other hand, caregivers who were sometimes warm, and other times harsh and attacking are more likely to lead to more varied and dissociative self-to-self (to self to self) relating. In addition to questions about the warmth and caring an individual felt, it is also important to explore how differences between a child and her or his attachment figures' emotions, wants, needs, and interests were addressed. When they were sad would their caregiver recognize, "Hey, you are sad right now. It's okay. I'm here," and give them a big hug? Would they ignore their sadness? Would they punish it by mocking them or saying, "Stop crying!" Did their caregiver confuse their own emotions for the client's emotions? Were certain emotions more or less acceptable or discouraged compared to others?

People who experience significant amounts of shame often frame relationships in terms of hierarchy. Interpersonal interactions are understood in terms of one person being in the dominant role and the other in the submissive role. This is in contrast to more egalitarian and affiliative ways of viewing relationships. Thus in interpersonal contexts, shame prone clients often tend to relate in ways that are either attempts to dominate, submit, or may alternate between these two ways of relating. In understanding these struggles for a sense of control and agency in relationships as an adult, it can be important to explore whether, as a child, differences in what he or she wanted or was interested in and the wants and interests of his or her attachment figures were met with a warm and accepting stance from the attachment figure or whether the attachment figure tended to make their desires dominant and be dismissive of the child's needs or wants. Some questions to assess this are, "What happened when you wanted something that your parent didn't want you to have?" "Did your parents show enthusiasm and excitement for the things that you were inherently interested in? Or did you feel like they had expectations of what you should want and who should be that you need to live up to?"

A core part of this process is developing a coherent, non-shamed-based narrative for why the person responds in the way that they do, and why they feel so inadequate and/or self-hating. A key message is that the client is not responsible for having these thoughts about themselves and

that this negative view of themselves is the understandable learned response from a particular learning history. The therapist's job is to validate that it is understandable, and in fact inevitable, that the client has this view of herself or himself given the events and relationships described. Thus, while the therapist does not agree with the evaluations of the self-critical mind that the person is damaged, broken, or somehow shameful, the therapist does take the position that it is completely understandable that the individual's mind would be programmed to produce such thinking. The therapist's job is communicate this viewpoint during the case conceptualization process.

3. Case conceptualization: History of compassion and connection experiences

In this part of the conceptualization, the therapist is probing for relationships and experiences in which the person felt a sense of love, connection, kindness, compassion, or warmth. Common relationships to probe for include:

1. Excellent teachers or mentors who cared about the person and strove for them to do well
2. Family members or attachment figures (parents, relatives, siblings) that were non-abusive and/or expressed warmth
3. Friends that were warm and caring and non-competitive
4. Periods of life where the person felt like they fit in or were valued, such as at a summer camp or on particular vacations or during particular activities
5. Religious/spiritual experiences with a warm or loving God
6. Pets and other animals that the person loved or felt loved by
7. People (and animals) that they are able to feel kindness, compassion, and warmth toward, at least at times

Sometimes clients find it difficult to identify memories of warmth from others in their life. This may particularly be the case if they have experienced severe or chronic abuse or neglect by people close to the. If they are unable to come up with any such people or experiences, here are some other avenues to explore with the client that might have elicited feelings of warmth at some point in their lives – even for a moment.

1. Spending time in nature
2. Imaginary friends that kept the person company growing up when it was hard to find warmth elsewhere
3. Characters in books, movies, or on TV who demonstrated warmth for others or who elicited warmth in the person
4. Particular stuffed animals or special toys

Other areas to explore for people with very few memories of warmth are sensory experiences of physical warmth like drinking tea or eating soup by a fire, or of being in a warm bath. Through careful exploration, most people are able to identify at least some relationships and situations in which they experienced compassion and kindness. For those who are not able to identify experiencing of compassion and kindness, they may be able to identify experiences of emotional warmth through imaginary or sensory experiences of physical warmth.

For people who are highly self-critical and shame-prone, contacting and describing moments and relationships containing warmth and love can be just as difficult and scary as reporting on experiences of being criticized, shamed, abused, or bullied. These memories and experiences are often associated with intense vulnerability. People who are self-critical and shame prone have often learned to not allow themselves to experience the openness, emotional

vulnerability, and letting go of defense associated with feeling warm and loving emotions. Paradoxically, discussing experiences with compassion and kindness can elicit a threat response and the person's characteristic ways of responding to feeling threatened. People might have been abused in the past when they let their guard down, they may have learned that compassion is something to mock or ridicule, or they may have simply lacked experiences of warmth in their life. Present day attention to compassion may evoke shame, grief and other painful emotions for these types of reasons.

The ability to identify several touch points for compassion and kindness is an important strength that not all clients will have. Sometimes, the person's history is so deprived of love and warmth that they have never been able to develop the ability to identify, or even experience affiliation, safety, and contentment-based emotions. If, through this exploration, the client comes to an awareness that they have never experienced these sorts of emotions with another person, this can lead to a grieving process for the love that was never experienced and the relationships that were hoped for. If this kind of an experience is elicited, it is the therapist's job to serve as a kind and compassionate observer and empathic listener so that the client can begin to develop a perspective of a loving and kind other who cares about their welfare. Sometimes, it is through the relationship with the therapist that the individual is able to really experience this type of kind and compassionate relationship for the first time in their lives. This is not to say that the client has never had people around them who were kind and caring, but rather that the client has not been sufficiently able to *see and experience* the perspective of a kind and caring other in relation to themselves. This is a fairly complex cognitive task but an extremely important one. Therefore, it is imperative that the therapist is able to be warm and loving with their clients. It is also important for the therapist to be able to coach the client in explicitly taking the perspective of the therapist in order to develop this new, gentler perspective. For example, while conducting a perspective taking exercise with a particular client, I (JBL) asked the client to move into my chair and observe herself from that perspective. I asked her whether she had ever known someone who was kind to her in moments like this. For a moment, the client paused, appeared sad, and said, "only you." Based on this, the client was asked to imagine what I might be feeling and thinking about her as I observed her feeling upset and overwhelmed. It was apparent that the client had a poor understanding of my emotional experience and sense of empathy towards her. I was able to empathically share my emotions and thoughts that I had been feeling. She was then asked to imagine what it would be like to feel and think those things towards herself. Through this process, the client hopefully strengthened her ability to imagine the perspective of a more compassionate other viewing herself in difficult moments.

One possible prompt for discussion is the [Early Memories of Warmth Scale](#).

4. Using and Debriefing Self-Report Measures of Shame, Self-Criticism, and Self-Compassion with Clients

A number of standardized assessments exist that may be useful in working with highly self-critical and shame prone clients. These measures can be used for obtaining initial normative assessments as well as tracking change in therapy over time. Some of these measures may even have predictive utility. For example, the hated-self subscale from the [Forms of Self-Criticism and Reassuring Scale](#) seems to respond more slowly to interventions aimed at reducing self-criticism, suggesting that highly self-loathing and self-hating clients may need more time in therapy to

develop self-compassion. In our practice, we often give three measures to clients at intake and periodically throughout therapy. We typically discuss the results in some detail as part of their ongoing conceptualization. These are the three we give to clients:

- [Forms of Self-Criticism and Reassuring Scale \(FSCRS\) – last week version](#)
- [Internalized Shame Scale \(ISS\) – last week version](#)
- [Self-Compassion Scale \(SCS-short form\)](#)

In addition, there are several other measures that can help with obtaining useful assessment information or be used to track progress:

- [Functions of Self-Criticism/Attacking Scale](#)
- [Fears of Compassion Scale](#)
- [Early Memories of Warmth Scale](#)
- [Rizvi's \(2010\) Shame Inventory](#)
- [Compass of Shame Scale](#)

Other relevant measures can be found here:

<http://www.compassionatemind.co.uk/resources/scales.htm> and
<http://www.actwithcompassion.com/measures>

Self-report measures such as these provide useful information in terms of case conceptualization and treatment planning. How the client responds to the questionnaires informs functional analysis and helps identify important treatment targets. A client's responses to these measures can be used at the onset of therapy to help the client and clinician join together around a common understanding of difficulties and collaboratively identify treatment goals. As therapy progresses, these measures can be used to track progress towards goals. Alternatively, if therapy seems to not be progressing as desired, using one or more of the above measures may help identify new treatment targets and/or inform a revised treatment plan or case conceptualization.

Debriefing self-report measures

While a client's responses to self-report measures may provide useful information in and of themselves, how the client and provider debrief these measures together often elicits further information about the client's struggles with self-criticism, shame, and self-compassion. Thus, the debriefing process can be seen not only as a way to give feedback to the client, but also as a therapeutic intervention. The following are some things to consider as you debrief any self-report measure with clients in this context.

Normalizing and humanizing: Individuals who are highly self-critical and shame-prone often feel incredibly isolated in their experiences of shame and self-hatred. They may walk around the world hearing their own mind's self-attack but see others who appear very confident or self-assured. In essence, they are comparing their insides to others' outsides. This is only made worse by the fact that a primary action tendency in shame is to hide and so they are not likely to have a lot of opportunity to learn from others that they too may struggle with self-criticism and shame. The very fact that self-report measures of shame and self-criticism exist communicates that they are not the only ones who experience these things. It can be very helpful for the client and therapist to be able to sit down together and look at the client's responses in order to bring some of what has been hidden into the light. Through this process, clients can see that while not

everyone struggles to the same extent they do (which itself can feel validating for clients who do struggle a great deal), they are not alone.

Deblaming: While debriefing a client's responses to self-report measures can be helpful in terms of decreasing a sense of isolation, the therapist must take care so as to not minimize the unique struggle the individual is having in these areas. Clients who struggle with profound shame and self-criticism often also feel ashamed of their own shame and ashamed of their self-criticism. The debriefing process can help the client gain some understanding of their own experience. This can be especially true when the client and therapist are able to explore together both the more quantitative self-report measures such as the ISS, FSCRS or SCS in conjunction with the more qualitative information gained from assessments such as the "Understanding Your History Related to Shame and Self Criticism" questionnaire. Using this combination of self-report scores (e.g. ISS, FSCRS, SCS) within the historical context that the more qualitative questionnaires can provide can help client and therapist together understand how the client's self-criticism and shame-proneness makes sense given the client's unique history.

Eliciting information that might not otherwise get reported: As noted above, there is often a self-perpetuating relationship between shame and self-criticism, with clients often being ashamed of their self-criticism and shame-proneness. As a result, people who are shame prone are often inclined to gloss over their tendencies to be self-critical or may not talk about what they feel shame around in any detail, or even at all. Alternately, clients may be so fused with their shame-based self-concept that they are unable to observe this pattern of thinking and feeling at all, instead simply seeing themselves as flawed, bad, weak, damaged, or inadequate. Thus, there seems to be little to report, except the consequences of this fusion with self-concept; the critical thinking itself is not even noticed. Reviewing responses to self-reports measures and, in particular, inquiring more deeply into the situations that elicit their responses can accomplish two goals: 1. To help the client step back and see shame and self-criticism as an ongoing pattern of thinking and feeling, rather than what it says it is – an immutable quality of themselves, and 2. Revealing additional detail about the contexts that elicit shame and self-criticism and the function of this behavior within those contexts. For example, a client might endorse items on self-reports such as, "I had a sense of disgust with myself" or "I thought that others are able to see my defects" but might never have brought those up spontaneously in session. Inquiring as to when and where these thoughts occur can reveal a great deal of useful information that might otherwise never be revealed. Functional analyses of when and where these shaming and self-critical thoughts occur can also help clients to gain a healthy distance from this type of thinking.

Assuming there are secrets and making space for them: Debriefing a client's responses to self-report measures can also be a good time to talk about the important issue of "secrets" with the client. Given the action tendency to hide that is associated with shame, we recommend that the therapist discuss directly the likelihood that the client has aspects of themselves or their history they feel are so shameful they must hide them even from the therapist. In addition to past events of abuse or being humiliated, clients may also feel ashamed of times they were a perpetrator of abuse or engaged in mean or vengeful behavior. Alternately, they may harbor secret jealousy, envy, or bitterness that they are reluctant to discuss. An acknowledgment early in therapy that secrets are expected can set the stage for more open communication between client and therapist in later sessions and also help reduce dropout related to fear and shame over unrevealed secrets. For example, the therapist might say "Research shows that people who are shame prone and self-critical often have secrets they don't talk about with anyone. Sometimes people may have hurt another person, engaged in sexual behavior they feel shame around, or acted jealous or bitter.

Alternatively, there may be things that were done to them that they keep secret. Secrets are expected in therapy and you don't need to talk about any you may have now, but it's often important that they are discussed at some point in therapy. Does this make sense or you have anything you'd want to say in response to this?" This both normalizes the experience of hiding and secrecy while encouraging the client to begin to consider the possibility that at some point he or she may find it helpful to talk about even those things with the therapist.

Homework handouts for case conceptualization

When to use:

After tracking self-critical thoughts exercises

This and the “History of Warmth and Compassion” exercise are the beginning of the functional analysis

Materials needed:

Handout: Understanding your history related to shame and self criticism

Example Instructions to Relate in Session:

As children and adolescents, we develop our views of ourselves through the way we believe we are seen by others. Another way to say this is that we “internalize” the views of those around us. For example, if we’re surrounded by a culture that devalues an attribute we have, then we may experience shame. Or if we believe that important person to us saw us negatively, then we are likely to develop a negative view of ourselves, at least in part. This means that an important source of self-criticism can be found in the way that we were treated by our early caregivers. Keep in mind that it doesn’t necessarily take a lot of abuse or criticism as a child for a person to develop into a self-critical adult. A lack of warmth, expressions of love, or affectionate physical contact from others can leave a void that the mind can on to fill with self-criticism and shame. It also doesn’t mean that people who hurt us were “evil” or all bad. It’s very likely they didn’t know how to treat *themselves* with kindness and care either.

So for this exercise, I’d like to have you take a closer look at some of the relationships and events that may have contributed to your feelings of shame and your self-criticism.

As you do this exercise, please keep in mind that it can be very painful to recall these past events. You may find yourself feeling sad, angry, or confused. You may also notice getting caught up in your own self-criticism and shame as you review these events. All of this is completely understandable and very common. As best as you can, try to be kind with yourself as you approach this exercise and maybe see it as a part of starting to develop a more compassionate way of relating to yourself.

It’s common that people have a hard time recalling events that contributed to your current sense of self-criticism, being flawed, or inadequate. That’s quite alright. If you are not able to answer all of the questions on this handout or you are not ready to write the answers to these questions out on paper, feel free to just consider the questions for a while in your own mind and we can discuss them in our next session if you’re willing.

Do you have any questions?

Debrief at next session:

1. What was it like to do this homework? What did you notice?
2. Did you learn anything new here about what might have contributed to you developing the level of shame and self-criticism that you have?
3. How does it feel when you spend time thinking about and reflecting on these relationships and experiences that may have caused you pain?

Handout: Understanding Your History Related to Shame and Self-Criticism

Please use this form so that we can get a better understanding of some of the relationships and events that may have contributed to your tendency toward self-criticism.

- Looking back on your childhood and while you were growing up, who you would say were the people you most depended upon as to take care of your emotional and physical needs? These might include parents, grandparents, other family members, or others who helped care for you. For the purpose of this exercise, we are going to call these people your “caregivers.” Please list up to three of these people below and rate your relationship with them as indicated.

	Person 1	Person 2	Person 3
Person’s name			
How were you related to this person?			
Warmth/Care On a scale of 1-5 person how much warmth and caring did you feel from this person? <i>1 = not at all warm/caring</i> <i>2= rarely warm/caring</i> <i>3= moderately warm/caring</i> <i>4= frequent or somewhat strong warmth/caring</i> <i>5 = consistently or intensely warm/caring</i>			
Criticism/Shame/Abuse On a scale of 1-5 how critical would you say this person was of you (e.g. would say mean things to you, was abusive or neglectful, would shame or humiliate you in some way)? <i>1 = not at all critical/shaming</i> <i>2= rarely critical/shaming</i> <i>3= moderately critical/shaming</i> <i>4= frequently critical/shaming</i> <i>5 = consistently or intensely critical/shaming</i>			
Emotional/physical neglect On a scale of 1-5 how rate how well this person did at meeting your emotional and physical needs as a child <i>1 = Very consistent and reliable in meeting my needs</i> <i>2= Fairly consistent and reliable in meeting my needs</i> <i>3= Somewhat reliable in meeting my needs</i> <i>4= Usually unreliable and unable to meet my needs</i> <i>5 = consistently unreliable and neglectful</i>			
Importance On a scale of 1-5 how important was this person to you in terms of their impact on you? <i>1 = not at important</i> <i>2= slightly important</i> <i>3= moderately important</i> <i>4= quite important</i> <i>5 = extremely important</i>			

Of the relationships you've listed on the previous page, please identify the one you feel had the biggest impact on your own development of shame and self-criticism. If you are unsure, you might ask yourself who your self-critic sounds most like. Please answer questions 2-5 with that person in mind.

2. How did this person respond to you when you were distressed? Did they soothe you and express empathy for your experiences? Did you feel that they understood what you were feeling and expressed that it was ok to be feeling that? Or did they try to get you to change what you were feeling or tell you shouldn't be feeling that? Did they ignore what you were feeling or humiliate you further? Was this person predictably warm or predictably shaming, or was it hard to know what to expect from them? Please describe how this person responded to you when you were distressed:

3. What happened when your wants/needs conflicted with what that person wanted? Did this person show enthusiasm and excitement for the things that you were inherently interested in? Or did you feel like they had expectations of what you should want and who should be that you needed to live up to? Please write about this below:

4. Did this person neglect, bully, or abuse you? If so, in what ways?

5. Do you remember this person ever humiliating you making you feel ashamed? If so, how did this occur?

6. **Other experiences:** Sometimes events with other people or at other times can be significant contributors to self-criticism and shame. These can include times in which you may have been humiliated, experiences with bullying, or sexual or physical assaults. It can also include experiences of prejudice, stigma, or feeling like you were judged or devalued because of some attribute you have. Have you ever experienced any other events that have made you feel degraded, humiliated, worthless, or helpless? If so, record those below.

History of compassion and connection experiences handout

When to use:

Along with exercises to track self-critical thinking
As part of case conceptualization

Materials needed:

Handout: Your Experience of Warm and Supportive Relationships form

Instructions:

While we have talked about some of your past experiences that may have contributed to your history with shame and self-criticism, I think it's also really important to get a sense of any experiences you might have had with relationships that were characterized by kindness, caring, or warmth. People's experiences with caring and kind relationships are incredibly varied. Some people have had lots of relationships in their life with others who have treated them with kindness, caring, or compassion. For others, there may have been one or two of those relationships, but maybe those relationships were incredibly important. Still others may not be able to recall anyone who has treated them with kindness and compassion.

While this might be surprising, it's fairly common for people to feel sad or upset when thinking about past experiences of loving and caring. This may be the case whether you are unable to recall any at all or whether you are able to recall quite a few. Remembering past experiences of love and warmth can bring us into contact with what we are lacking in our current lives. That's normal and part of the process of developing greater self-compassion.

Just as we did with taking a look at your history with criticism and shaming experiences, I'd like us to just gather some data about your relationship, both in the past and currently that you'd say were characterized by feelings of kindness, care, or compassion.

Would you be willing to do that?

[Assuming client is willing]. Great. So this week, I will ask you to spend some time writing about those experiences you may or may not have had. If you're willing to answer the questions here on this handout [Your Experience with Warm and Supportive Relationships form] and bring it back to our next session. We can talk about it more then.

Do you have any questions or concerns?

Debrief at next session:

1. What was it like to do this homework? What did you notice?
2. Did you learn anything new in doing this homework?
3. After doing this exercise, did you have anything you might wish would have been different for you?

Handout: Your Experience of Warm and Supportive Relationships

Please use this form so that we can get a better understanding of some of the warm and supportive relationships you may have had in the past and currently.

1. Who, if anyone, in your family (parents, siblings, grandparents, aunts, uncles, etc.), would you say treated you with warmth, kindness, or affection as you were growing up? How would you describe those people to someone who had never met them? How did they show you they cared about you?

2. As you grew up, did you ever have any excellent teachers, mentors, or coaches who really cared about you and wanted you to do well? If so, please write some about who those people were and the way they treated you.

3. Did you ever have friends or other people such as neighbors or acquaintances that were warm, caring, or supportive to you? If so, please describe those relationships.

4. Have you had pets or other animals that you loved and that you felt cared for you in return? What did it feel like to be cared for by that animal?

5. Did you have religious or spiritual experiences with a warm or loving God or other spiritual experiences where you felt loved, connected, or part of something larger than yourself? If so, describe these experiences.
6. Did you ever have periods of life or situations where you felt you felt like they fit in or were valued, for example, as a summer camp, on particular vacations, at church, in a social group, or during particular activities (e.g., sports)? If so, please describe those experiences and how it felt to be a part of that experience.
7. Were there any other ways that you received feelings of warmth, comfort, love, or safety when you needed them?
8. Finally, how does it feel when you spend time thinking about and reflecting on these experiences you may have had or not had in the past? As you reflect on these experiences, what do you wish might have been different for you if anything?