Building a Foundation for Working with Shame and Self-Criticism

The Preparation Phase of ACT with Compassion

Jason Luoma, Jenna LeJeune, and M. Kati Lear

Contents

Four Steps to Building a Foundation for Working with Shame and Self-Criticism 3
Step 1: Introducing Shame and Self-Criticism as a Possible Focus for Therapy 4
Step 2: Exploring the Function of Shame and Self-Criticism in the Person's Life 4
Step 3: Developing a Compassionate Perspective Through Exploring Contributing Events 4
Step 4: Identifying Key Social Safeness Resources 5
Cross Cutting Concepts for Foundation Building 5
Therapist empathy and validation 6
Empathic exploration and conjecture 6
Empathic validation 6
Navigating validation challenges 6
Creating emotional safeness 7
Therapist social signaling 7
Re-conceptualization 9
The Paradox of Validation and Change 9
Shifting from Fusion to Relationship 10
The Therapeutic Functions of Re-conceptualization 11
Integration with Larger Treatment Framework 11
The Experiential Process of Foundation Building 11
Step 1: Introducing Shame and Self-Criticism as a Possible Focus for Therapy 12
Step 2: Exploring the Function of Shame and Self-Criticism in the Person's Life 15
Beginning the Exploration: Review of Assessment Measures 15
Deepening Understanding Through Eliciting Examples 16
Working with Shame in the Session 17
Addressing Secrets 18
Helping Clients Build Awareness of Shame and Self-Criticism 18

© 2026 Jason Luoma, Jenna LeJeune, and M. Kati Lear · www.actwithcompassion.com

Developing a Therapeutic Focus on Shame and Self-Criticism 21
Step 3. Developing a Compassionate Perspective by Exploring Contributing Events 22
Therapeutic Value 22
Expected Outcomes 22
The Process: Compassionate Exploration 23
Areas to Explore: Understanding Contributing Events 24
Key Clinical Tool: Empathic Conjectures and Fit Questions 25
Examples of Using Empathic Conjectures and Checking Fit 26
Common Difficulties that Emerge During this Step 28
Moving on From This Step 33
Step 4. Identifying Key Social Safeness Resources: History of compassion and connection experiences 34
Exploring Resources for Social Safeness 34
When Social Safeness Resources Are Limited 36
Conclusion: Moving from Foundation Building to Intervention 37
Building Upon the Foundation: Key Intervention Components 37
The Therapist's Role Beyond Foundation Building 38
Measuring Progress 39
Conclusion 39
Homework Handouts for Preparation Phase 42
Experiences with Caregivers 45
Experiences with peers 46
Other experiences that might have contributed to shame and self-criticism 46
Wrapping up 47
We are social creatures 51
Your communities, and this relationship 51
It's a basic part of being human to fear being excluded 51
Rejection and exclusion trigger shame 51
What is shame and how does it work? 51
When shame gets stuck 52
Why do some people experience more shame and self-criticism? 52
A hopeful note 53
Questions to reflect on 53

© 2026 Jason Luoma, Jenna LeJeune, and M. Kati Lear · www.actwithcompassion.com

This document outlines how to build a foundation for the treatment of problematic shame and self-criticism. It is intended to be used to work with clients where shame and self-criticism cause significant problems in their lives and where focused work on those difficulties could be helpful. It provides guidance on how to form an initial alliance for working on these topics together and results in information that can be used to guide later intervention from many different theoretical perspectives. It builds on and replaces our earlier outline, *Developing a Shared Case Conceptualization When Working with Highly Self-Critical and Shame Prone Clients* (2020).

This document is the result of many years of research and clinical work with clients suffering from strong shame and self-criticism. It also pulls together a number of resources published at actwithcompassion.com for how to work with people who are highly shame prone and self-critical. Its foundation is Acceptance and Commitment Therapy (ACT) and contextual behavioral science, and it also draws on emotion-focused therapy, radically open dialectical behavior therapy, compassion-focused therapy, physiological research on threat responding, and affective science more broadly. The re-conceptualization that runs through all four steps is at heart an ACT process: helping clients step back from a self-critical story about who they are (defusion) and relate to themselves from a more flexible, compassionate perspective. Because the approach also integrates these other traditions, therapists who work from other models can use it as well.

About this document. It is written for mental health professionals and for trainees working under supervision. It is not a self-help guide, and it does not replace training, supervision, or clinical judgment. Pace the work to each client; for clients in acute crisis or at high risk of harming themselves or others, focus first on safety. Clinical examples are composites or are used with permission, with identifying details changed.

Four Steps to Building a Foundation for Working with Shame and Self-Criticism

When working with clients who experience problematic shame and self-criticism, establishing a proper foundation is essential before engaging in more targeted interventions. This preparatory phase provides both client and therapist with a shared understanding that serves as the cornerstone for subsequent therapeutic work. Rather than rushing into techniques that attempt to reduce shame or interrupt self-criticism, we have found that deliberately working through these foundational steps creates a more sustainable platform for change.

This foundation-building process involves four steps, each with distinct therapeutic functions. Together, they create a compassionate framework from which clients can begin to observe—rather than be embedded within—their shame and self-criticism.

© 2026 Jason Luoma, Jenna LeJeune, and M. Kati Lear · www.actwithcompassion.com

Step 1: Introducing Shame and Self-Criticism as a Possible Focus for Therapy

The first step involves determining whether shame and self-criticism are significant enough in the client's life to warrant focused therapeutic attention. Many clients enter therapy unaware that shame and self-criticism are central to their difficulties, often viewing their presenting problems (anxiety, depression, relationship issues) as separate from their harsh self-relationship. Through careful exploration, the therapist helps the client recognize how these painful inner experiences might be relevant treatment targets. This initial phase typically involves introducing the concepts in a way that resonates with the client's experience, whether they describe themselves as self-critical, feeling "not good enough," or perfectionist in their tendencies. Often, assessment measures are introduced to help clients reflect on these experiences between sessions and to provide a structured way to begin discussing these often hidden aspects of their experience.

Step 2: Exploring the Function of Shame and Self-Criticism in the Person's Life

The second step focuses on developing a clear understanding of how shame and self-criticism operate in the client's daily experience. Through reviewing assessment measures and engaging in deeper exploration, clients begin to recognize how these painful inner experiences function in their lives—both what they attempt to accomplish and what they cost. During this phase, the therapist assists clients in building awareness of their self-critical patterns and shame responses. This involves identifying triggers, clarifying the content of self-criticism, exploring associated bodily sensations, and mapping the behavioral consequences. Assessment measures like the Forms of Self-Criticism and Reassuring Scale or the Internalized Shame Scale often facilitate this process, helping clients articulate experiences that may have previously existed outside their awareness. Importantly, this step serves not merely as information gathering but as a therapeutic intervention in itself. By bringing previously unspoken experiences into the therapeutic conversation, clients begin the process of defusion from these patterns. The simple act of discussing shame and self-criticism in a validating environment begins to shift the client's relationship to these experiences, allowing them to be observed rather than fused with as absolute truth about the self.

Step 3: Developing a Compassionate Perspective Through Exploring Contributing Events

The third step focuses on building a more validating perspective by exploring key relationships and events that contributed to the client's current sense of shame and self-criticism. This involves examining formative experiences that shaped the client's self-concept, including experiences of criticism, rejection, abuse, neglect, or humiliation. Unlike traditional trauma work, the goal here is not primarily processing past wounds (though this may occur as a byproduct). Rather, this exploration helps the client construct a narrative that makes sense of their shame and self-criticism. Many clients blame themselves not only for their perceived inadequacies but also for their self-criticism itself—feeling ashamed of their shame and critical of their criticism. This phase disrupts this recursive pattern by helping clients understand how their patterns of self-relating were inevitable given their history.

© 2026 Jason Luoma, Jenna LeJeune, and M. Kati Lear · www.actwithcompassion.com

The therapist serves as a compassionate witness, offering conjectures about how particular events might have been interpreted in ways that contributed to shame and self-criticism. Through this process, clients begin to see their difficulties not as evidence of inherent defectiveness but as understandable responses to their unique life circumstances. This shift from self-blame to compassionate understanding provides the platform for a new relationship with oneself.

Step 4: Identifying Key Social Safeness Resources

The final foundational step involves identifying psychological resources that can be found in the client's history related to warmth and connection with others. Here, the therapist explores relationships and experiences where the client felt a sense of love, belonging, kindness, or compassion—even if these experiences were limited or fleeting. This exploration often reveals surprising sources of warmth: a supportive teacher, a cherished pet, moments in nature, or even characters from books or films who demonstrated compassion. For some clients with particularly harsh histories, this exploration may initially elicit grief over connections they never experienced. Even in these cases, the therapeutic relationship itself can serve as a novel experience of being seen with kindness and understanding. These identified resources serve multiple functions in subsequent therapy. They help build a contrasting experience to the threat-based states involved in self-criticism and shame, provide templates for more compassionate self-relating, and offer touchpoints the client can access when beginning to cultivate self-compassion. By mapping these experiences, the therapist and client collaboratively build a repository of resources that will become instrumental in later phases of treatment.

The foundation-building process is not merely preparatory work but therapeutically significant in its own right. Through these phases, clients begin to develop a new relationship with their shame and self-criticism—one characterized by understanding rather than judgment, context rather than condemnation. This phase often takes several sessions, as clients frequently have limited experience discussing these painful aspects of their experience and may initially struggle to find language for what has been hidden. By patiently working through these foundational steps, therapists create the conditions for subsequent interventions to take root. Rather than attempting to eliminate shame and self-criticism directly, this approach establishes a compassionate platform from which clients can begin to relate differently to these painful experiences—ultimately creating space for more flexible and values-consistent responding even when shame and self-criticism arise.

Cross Cutting Concepts for Foundation Building

Before we progress into the four steps, we first need to review two cross-cutting concepts that apply throughout this whole phase: 1. Therapist empathy and validation and 2. Re-conceptualization.

© 2026 Jason Luoma, Jenna LeJeune, and M. Kati Lear · www.actwithcompassion.com

Therapist empathy and validation

Empathy involves more than simply understanding the client's perspective—it requires an active process of attunement to the client's emotional experience, with the therapist tracking moment-to-moment shifts in the client's emotional states. Empathy also involves verbally reflecting that understanding back to the client in order for clients to experience it and provide feedback to maintain the understanding. When working with shame and self-criticism, this empathic attunement becomes particularly crucial, as clients are often disconnected from or overwhelmed by their emotional experience. The therapist's presence and empathy communicates that the therapist is willing to "be with" the client in difficult emotional states without becoming overwhelmed or pulling away. For shame-prone clients who often experience others as rejecting or judgmental, the therapist's steady, accepting presence provides a corrective emotional experience—one where their emotions can be witnessed without triggering rejection or further shame.

Empathic exploration and conjecture

A concept from emotion-focused therapy is particularly helpful here - empathic conjecture, which involves helping clients articulate and symbolize emotional experiences that are currently implicit or unnamed. This is particularly important when clients struggle to identify or express what they're feeling. For example, a therapist might say, "I'm wondering if underneath that self-criticism, there might be a feeling of sadness or disappointment?" These empathic conjectures help clients expand their emotional awareness and vocabulary, particularly around difficult emotions like shame that they may habitually avoid or suppress. When offering these conjectures, the therapist maintains a tentative stance, checking with the client about whether the reflection feels accurate to their experience.

Empathic validation

Validation 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 their perspective. This includes validating and empathizing with the emotions that are aroused as the client talks about what they are struggling with. 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. For example, research shows that therapists unintentionally show less warmth and positive regard to highly self-critical clients (Zuroff et al., 2016), which may adversely influence the alliance or lead to premature dropout. One explanation for this may be that self-critical clients often present in a state of defensive arousal, triggering the therapist's own threat system and affecting nonverbal behavior such as posture, vocal tone, and facial expressions in session.

Navigating validation challenges

Therapists must be mindful about how they validate clients with deep shame and self-criticism. When a client feels fundamentally broken or defective, well-intentioned statements like "You're not broken" or "There's nothing wrong with you" can paradoxically feel invalidating, even if they're meant to be supportive. These statements may inadvertently communicate that the therapist doesn't fully understand the depth of the client's experience or isn't willing to acknowledge their pain. Similarly, clients who feel profoundly different from others may experience attempts to normalize their experience ("Everyone feels this way sometimes") as dismissive of their unique suffering. Direct comparisons to others can feel invalidating when the client's lived experience is one of profound otherness or alienation. Rather than telling clients they are the same as others, validation might

© 2026 Jason Luoma, Jenna LeJeune, and M. Kati Lear · www.actwithcompassion.com

instead focus on meeting them in their experience of difference while gently exploring the universal aspects of human suffering when the client is ready to consider this perspective. More effective validation acknowledges the client's subjective experience without contradiction while simultaneously holding space for alternative perspectives to emerge organically. For example, "I hear how broken you feel right now, and that feeling is so painful and real for you. I'm here with you in that pain" honors the client's current reality while maintaining the therapeutic relationship that may eventually allow for new perspectives.

Creating emotional safeness

To promote an environment of openness and warmth, therapists should tend to their own emotional experience during the session and monitor for their own states of defensive arousal. This way, therapists can take steps to self-soothe and activate their own social safeness system, thereby allowing them to naturally signal safeness nonverbally to the client through cooperative displays including an open and relaxed posture, musical tone of voice, or smiling.

At the same time, exhibiting too much warmth or positive affect in therapy may trigger anxiety within the client and be perceived as invalidating, as high levels of overt praise or affirmation will likely be inconsistent with the client's experience of themselves, leaving the client feeling misunderstood or alone. Observing the client's nonverbal behavior is important in this context, as therapists will want to adapt their own interpersonal behavior to a level of warmth that is comfortable for the client. For instance, sustained eye contact may feel like an intensely intimate and uncomfortable experience for a client struggling with chronic shame. Although eye contact may facilitate warmth and connection in many relationships, the therapist shouldn't push the client to match their level of intimacy too quickly (e.g., by encouraging more eye contact) as the client may feel unsafe, disconnected, or even ashamed of their perceived inability to meet the therapist's expectations. Often, this foundation building process needs to include a focus on the therapeutic alliance and navigating barriers to developing a working relationship trusting enough to discuss delicate personal material involving shame. A validating, affirming, and empathic presence is key in forming this initial sense of trust and a "safe enough" environment.

Therapist social signaling

Much of what tells a client whether they are safe is due to nonverbal social signals from the therapist. Facial expression, tone of voice, posture, gaze, and pacing all function as signals that shame-prone clients are especially attuned to. Because shame evolved to track threats to belonging, people prone to shame tend to read ambiguous social signals as disapproving. For example, neutral facial expressions are often interpreted as hostile or angry (Gutiérrez-García & Calvo, 2017). This means that the neutral, "professional" face many therapists were trained to maintain is not neutral to many of these clients. In the absence of clear signals of warmth, the client is likely to fill in the blank with judgment. In contrast, affiliative signals from others cue social safeness and can directly inhibit threat responding (Hornstein et al., 2022). For therapists trained in more technique-focused approaches, the idea that their own nonverbal behavior is an active ingredient in treatment is often new, so we make it explicit here. Several of the ideas below draw on the work on social signaling in Radically Open Dialectical Behavior Therapy (Lynch, 2018).

The pull toward coolness. Shame has a recognizable nonverbal display—slumped posture, averted gaze, and a downward tilt of the head (Keltner & Harker, 1998; Landers & Sznycer, 2022)—and highly self-critical clients often show some version of it in session, sometimes along with a flat expression or a smile that doesn't fit what they are describing. As discussed in Step 2, these signals tend to elicit less warmth and openness from others, which the client then experiences as confirmation

© 2026 Jason Luoma, Jenna LeJeune, and M. Kati Lear · www.actwithcompassion.com

that they are unlikeable or unwanted. Therapists are not immune to this pull. One way to understand the finding, noted above, that therapists show less warmth toward highly self-critical clients is that this same cycle is playing out in the therapy room. When therapists notice themselves becoming more distant, flat, or businesslike with a client, this can be treated as useful information about the client's social signaling rather than as a personal failing. Choosing not to follow that pull by working to remainwarm and engaged when the client's signals invite withdrawal offers a small but meaningful disconfirmation of the client's expectation of rejection. Later in treatment, this dynamic can become an explicit target, as clients learn to interact with the therapist in ways that invite affiliation and then practice carrying this into other relationships.

When the therapist isn't feeling warmth. It is normal for therapists to have stretches of a session in which they don't feel much warmth or connection with a client. The first step is to notice one's own state: Am I tired, preoccupied, frustrated, or bored? Is something in this interaction activating my own threat system? Rather than forcing expressions of warmth, which shame-prone clients are likely to detect as incongruent, the therapist can lean on curiosity, attentiveness, and empathic attunement, which communicate acceptance without requiring intense feeling. Therapists can also take deliberate steps to activate their own social safeness system, such as a slow breath or brief centering practice, recalling something they appreciate about the client or an earlier moment of connection with them, silently offering lovingkindness phrases, or reconnecting with their values as a therapist. Radically Open DBT offers a simple version of this meant to alter the therapist's physiology and outward signals at the same time: leaning back slightly in the chair, taking a slow, deep breath, and softening the face into a gentle closed-mouth smile, sometimes with a brief eyebrow raise when making eye contact (Lynch, 2018). If difficulty accessing warmth persists with a particular client, or comes up consistently around certain topics, this is a useful focus for supervision or consultation.

Reading the client's signals and adjusting. Signaling goes both ways, and part of the therapist's job is to track how their own signals are landing. Signs that the client is feeling some social safeness include a relaxed face, a softer gaze, slower and deeper breathing, spontaneous smiling, natural gestures, speaking at a natural pace, and curiosity or questions. Signs that more safeness may be needed include rapid scanning of the room, difficulty maintaining eye contact, shallow breathing, visible muscle tension, hesitant or rushed speech, and protective postures. When these signs appear, the therapist can turn the intensity down by slowing the pace, softening the voice, leaning back, or easing off eye contact, or can check in directly. With highly self-critical clients in particular, it helps to normalize difficulty with eye contact and make it clear that looking away is fine.

Matching words with signals. When therapists do feel warmth, tenderness, or appreciation toward a client, sharing it briefly can be powerful, especially right after the client has disclosed something they expected to be judged for. Much of the impact comes from congruence. Positive words accompanied by a warm tone, a genuine facial expression, and engaged posture are far more convincing to a shame-prone client than the same words delivered from a distant, professional stance. These disclosures work best when they are brief, specific, and focused on the here and now (e.g., "As you were telling me that, I noticed feeling a lot of tenderness toward you"), followed by a check-in such as, "What was it like to hear me say that?" Many shame-prone clients find warmth hard to take in, and their discomfort is something to explore with curiosity rather than push through. In the preparation phase, we keep this light. More deliberate practice in receiving warmth, such as inviting the client to look at the therapist's face while the therapist shares their reaction, is usually better suited to later phases, once more trust has been established.

Noticing and repairing ruptures. Even well-attuned therapists will sometimes send a signal that lands poorly. Signs of a rupture can be subtle: a sudden withdrawal, a shift toward more guarded or

© 2026 Jason Luoma, Jenna LeJeune, and M. Kati Lear · www.actwithcompassion.com

deferential behavior, or defensiveness. When this happens, the therapist should explore whether repair is needed, approaching what happened with curiosity rather than defensiveness: “I notice something shifted between us just now. What was that like for you?” or “I’m wondering if something I said didn’t land well.” For clients who expect disconnection to end in rejection, the experience of a therapist who notices, takes responsibility, and stays engaged can itself be a corrective experience.

Re-conceptualization

Re-conceptualization is the therapeutic process of helping clients develop a new understanding of their difficulties with shame and self-criticism by shifting from seeing themselves as inherently flawed objects that need "fixing" to recognizing they have a relationship with themselves that can be transformed. This process validates the client's experiences while simultaneously introducing the possibility of a more compassionate self-relationship. Re-conceptualization serves as both the foundation for therapeutic change and an intervention in its own right, as it helps clients begin to dis-embed from shame and self-criticism and see these experiences as learned processes rather than truths about themselves.

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. Instead of noticing that they have a critical view of themselves, they fuse with this view and simply see a flawed person.

The Paradox of Validation and Change

Re-conceptualization addresses a fundamental therapeutic paradox: the need to fully validate the client's current perspective while simultaneously helping them move beyond it. This paradox is particularly relevant when working with shame and self-criticism because the client's own narrative of what is "wrong" and what needs to be "fixed" is often itself part of the problem maintaining their suffering. Shame-prone and self-critical clients typically arrive at therapy having already exerted massive effort to improve themselves. They have suffered greatly in their struggle with what troubles them and have tried countless strategies to overcome their perceived deficiencies. However, it's often these very efforts to "fix" themselves that perpetuate their difficulties. This happens because:

- Their attempts at self-improvement are based on the premise that they themselves are fundamentally flawed
- Their strategies for change reinforce rather than challenge this core belief
- Their efforts to eliminate shame paradoxically intensify it
- Their self-criticism about being self-critical creates recursive cycles of judgment

The challenge for the therapist is to validate the client's suffering and acknowledge their genuine efforts to improve, while simultaneously helping them examine the workability of their "fixing" strategies. Simply agreeing with the client's view that they need to be fixed would reinforce their self-critical perspective. Conversely, challenging this view too directly risks invalidating their lived experience. Re-conceptualization resolves this paradox by creating a context in which painful

© 2026 Jason Luoma, Jenna LeJeune, and M. Kati Lear · www.actwithcompassion.com

memories and experiences can be shared and witnessed with understanding and compassion rather than harsh judgment. This new context allows the client to revisit familiar material but have a different experience with it. Instead of rehashing shaming events in ways that reinforce old patterns, the therapeutic relationship provides a new vantage point from which clients can view themselves and their difficulties with greater kindness and understanding. This shift in perspective doesn't happen through intellectual discussion alone but emerges from the lived experience of having one's pain witnessed and validated without judgment. The therapist models a different way of relating to the client's difficulties—one characterized by curiosity and compassion rather than criticism and correction. Through this experience, clients begin to glimpse the possibility of relating to themselves differently as well.

Shifting from Fusion to Relationship

In the process of re-conceptualization, one of the most profound shifts occurs when clients move from a state of fusion with a negative self-concept to recognizing that they have a (perhaps still unnoticed) relationship with themselves. This transformation represents a fundamental change in how clients understand their experience of shame and self-criticism.

When operating from a fused perspective, clients typically:

- Are completely merged with their self-critical thoughts and shame-based identity
- Believe there is something fundamentally wrong with them that must be "fixed" or "corrected"
- Experience shame not as an emotion but as an identity ("I am shameful" rather than "I experience shame")
- View self-criticism as merely "seeing the truth" about themselves
- Feel that their worth is contingent on somehow repairing these perceived defects

The relationship perspective, in contrast, opens new possibilities:

- Recognizes that one has a relationship with oneself that can be cultivated, much like a relationship with a friend
- Understands that self-criticism is a habitual pattern of internal dialogue, not an intrinsic quality of themselves
- Experience shame as an unfolding felt experience in the present
- Creates distance between the person and their experiences of shame and self-criticism
- Allows for choice in how one relates to oneself in difficult moments
- Makes space for relating to oneself with greater kindness and compassion

This shift doesn't happen through intellectual understanding alone. As clients begin to observe their self-critical thoughts and shame responses as experiences happening within them, rather than facts about them, they create psychological distance that allows for new perspectives. The therapist facilitates this shift through careful language that highlights the relational nature of self-criticism ("How do you speak to yourself when you make a mistake?") rather than reinforcing fusion ("We need to fix your negative thought patterns."). The recognition that one has a relationship with oneself—a relationship that can be transformed—is often revelatory for clients steeped in shame. This insight creates space for agency and choice where previously there seemed to be only the immutable fact of

© 2026 Jason Luoma, Jenna LeJeune, and M. Kati Lear · www.actwithcompassion.com

being "broken." When clients begin to experience themselves as having a relationship with themselves that can be cultivated differently, they gain access to new possibilities that transcend the limited options available when operating from a fused perspective. This shift also approaches self-compassion from a relational perspective that makes it more accessible. Rather than attempting to "fix" a "broken" self (which paradoxically reinforces fusion), clients can begin to develop a new, more compassionate way of relating to themselves during difficult experiences—much as they might relate to a valued friend in distress.

The Therapeutic Functions of Re-conceptualization

Re-conceptualization is not merely preparatory work but serves several crucial therapeutic functions throughout the treatment process:

1. **Creates a shared language and understanding**: Together, therapist and client develop a common framework for understanding the client's shame and self-criticism. This shared narrative becomes a touchstone they can return to when challenges arise.
2. **Reduces meta-shame and meta-criticism**: By understanding shame and self-criticism as learned responses to life experiences rather than personal defects, clients often experience relief from "shame about shame" and "criticism about criticism." Interruption of this pattern represents an important early therapeutic gain.
3. **Identifies key targets for intervention**: Through the re-conceptualization process, the therapist and client identify specific relationships, situations, and internal dialogues that become the focus of later therapeutic work.
4. **Serves as a therapeutic contract**: The new understanding that emerges contributes to a shared agreement about the focus and direction of therapy.
5. **Models compassionate perspective-taking**: Through the therapist's curious, nonjudgmental, and validating responses, clients experience firsthand what it feels like to have their struggles met with understanding rather than judgment.

Integration with Larger Treatment Framework

The re-conceptualization process weaves through all four steps of the foundation-building phase described earlier. During the exploration of how shame and self-criticism function in the client's life (Step 2), re-conceptualization begins as clients start to observe these patterns rather than be embedded within them. When developing an understanding of contributing events (Step 3), the re-conceptualization deepens as clients see how their shame and self-criticism emerged naturally from their experiences. And in identifying social safeness resources (Step 4), the re-conceptualization expands to include awareness of their capacity for more compassionate self-relating.

The Experiential Process of Foundation Building

Re-conceptualization doesn't happen through intellectual discussion alone—it is fundamentally an experiential process that unfolds over time. This initial preparation process is not primarily an information gathering exercise, although it does serve that function. More importantly, it is an experiential journey for the client and an opportunity for the therapist to develop a deep, empathic understanding of the client's history, current context, and struggles. Rather than serving simply as a

© 2026 Jason Luoma, Jenna LeJeune, and M. Kati Lear · www.actwithcompassion.com

diagnostic or treatment planning tool, this foundation-building phase has profound therapeutic value in its own right.

The process typically spans from two to several sessions, with the pace determined by the client's readiness and capacity. Few clients have extensive experience talking openly about their self-criticism and shame. Even those who have engaged in therapy previously often have limited experience articulating their most shameful thoughts, feelings, and experiences. When beginning to unpack these experiences, clients may become confused, dysregulated, shut down, or dissociated. This response may stem from activation of the threat-defense shutdown system or simply reflect the challenge of putting words to experiences that have never before been verbalized.

It's worth noting that clients rarely enter therapy explicitly requesting help with self-criticism and shame. Instead, they typically focus on what they view as inherent flaws or "pathologies"—anxiety, depression, addiction, or interpersonal problems—to which they see their self-criticism and shame as appropriate responses. Many aren't even fully aware of the role self-criticism and shame play in their difficulties. Since self-criticism often serves a self-protective function and the primary action tendency associated with shame is to hide, it frequently requires persistent and gentle focus from the therapist to elicit the thoughts, feelings, and other content associated with shame. The simple act of speaking aloud about topics and thoughts previously kept hidden can be profoundly healing. If shame is like a festering wound, then talking about it within a validating therapeutic relationship is like bringing healing light and air to that wound.

Through this process, clients gain more than insight—they collect experiences and resources that will become instrumental in later therapy. The relationships and situations that elicit shame will serve as the focus of exposure and self-compassion exercises. Likewise, the compassionate relationships and experiences identified will help clients construct a more self-compassionate perspective and strengthen their ability to access a sense of social safeness. With this understanding of the cross-cutting concepts of therapist empathy/validation and re-conceptualization, we now turn to a detailed exploration of each of the four foundational steps: introducing shame and self-criticism as a possible focus for therapy, exploring the function of shame and self-criticism, developing a compassionate perspective through exploring contributing events, and identifying key social safeness resources.

Step 1: Introducing Shame and Self-Criticism as a Possible Focus for Therapy

This first step involves determining whether shame and self-criticism are significant enough in the client's life to warrant focused therapeutic attention. The approach varies depending on the client's existing awareness of these issues. For clients already cognizant of how self-criticism and shame affect them, this focus may emerge naturally from their initial session disclosures. Others may need guidance to recognize these patterns in their experience. In most cases, the most effective approach is to suggest exploring these difficulties—typically at the conclusion of the initial assessment or whenever these issues become apparent—and provide assessment forms for between-session reflection.

Below are examples of how this introduction might be framed, tailored to match the client's current understanding of their struggles:

© 2026 Jason Luoma, Jenna LeJeune, and M. Kati Lear · www.actwithcompassion.com

For clients aware of their self-criticism:

Based on what we've discussed, it seems like one of the things that really causes problems for you in your life is how hard you can be on yourself, the ways you really get down on yourself. It's almost like there's this bully or critic inside that is constantly commenting on what you do and how you do it. From where I sit, this voice seems pretty loud and disruptive in your life - you've talked about how it's hard to make decisions, relax and slow down with friends and family even when you want to, and feel like you've "done enough" - and it seems to me that this voice inside you could play a significant role in the ways you are feeling stuck right now.

For clients primarily experiencing shame:

It sounds like you've been carrying these feelings of "not good enough" and "feeling small and fragile" for a long time and they really weigh on you. Sometimes they're so heavy it's like you feel trapped by them and end up feeling really alone, believing you have no one who cares. Does that fit? [client agrees] *That place is so painful that over time you've learned not to approach situations that might trigger that feeling. For example, you shared feeling dread when you have to do something where you might be evaluated or fall short of expectations, so much so that it's hard to do things that might help you feel connected, like reach out to your friends, or take new opportunities at work. Am I getting this so far?*

For clients who frame their experience as perfectionism:

It *seems like you have extremely high standards for yourself, and maybe other people, that are really hard to meet. You've got this side of you that is constantly pushing you to do be better, to do more, like nothing is ever quite good enough. We might call this perfectionism. Does that seem to apply to you?* [client agrees] *While these high standards likely offer certain benefits, they may also create significant difficulties. What's your sense of this? Do your high standards ever seem to cause issues for you?*

These different approaches allow for matching the introduction to how clients currently conceptualize their difficulties. Some readily recognize their self-criticism and its negative impact, possibly because they successfully avoid overt shame through this criticism. Others may be frequently immersed in shame and connect more with the second framing. Still others might not identify with either self-criticism or shame directly, but recognize their perfectionism and high standards.

Once the client connects with one of these viewpoints, you might propose making it a therapeutic focus: "Would you be interested in exploring this further in our work together? If so, I'd suggest completing some questionnaires about these topics before our next session. We can then discuss your responses and determine whether this should be a focus of our therapy. How does that sound?"

© 2026 Jason Luoma, Jenna LeJeune, and M. Kati Lear · www.actwithcompassion.com

The examples provided are intended to demonstrate how you might incorporate the client's own language when introducing concepts of shame and self-criticism. The key is to begin where the client is and use terminology that resonates with their experience. Whether they're more aware of self-critical thoughts, feelings related to shame, or perfectionism, tailoring your approach to match their current understanding creates a stronger foundation for exploring these issues.

After this initial agreement, the next step is to give the client some self-report measures of self-criticism, shame, or self-compassion to complete and review at the next session. We've found that one of the most straightforward ways to begin this exploration process is by having the client fill out self-report measures related to their difficulties and then to discuss them. Some therapists have expressed concerns that clients may feel overly exposed in filling out measures like this, but our experience has been the opposite – that many clients actually feel highly validated that a therapist has selected a questionnaire that asks questions about things that they have never talked about with anyone. We've even had at least a couple clients say something along the lines of "I've never felt so understood by a therapist as when I filled out these measures."

A number of standardized assessments exist that may be useful in working with highly self-critical and shame prone clients. In addition to eliciting discussion, these measures also can be used to 1. see where the client falls in terms of overall intensity of self-criticism and shame by comparing their scores to published norms and 2. track change in therapy over time. Some of these measures may even help guide how you might structure therapy. For example, some data suggests 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 (Palacios et al., 2026), suggesting that highly self-loathing and self-hating clients may need more time in therapy to develop self-compassion.

Reviewing these measures together can help the client and clinician join together around a common understanding of difficulties and collaboratively identify treatment goals. Repeating the measures later in therapy, when combined with a discussion of results, can help with assessment of progress and revising treatment plan and case conceptualization. In our practice, we often give three measures to clients at this point 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 (scoring templates for all three are in our blog post on these measures):

- Forms of Self-Criticism and Reassuring Scale (FSCRS)
- Internalized Shame Scale (ISS) – last week version (now freely available; our blog post includes our last-week version and a scoring template)
- Self-Compassion Scale (SCS-short form)

Here are other self-report measures that can help with obtaining useful assessment information or be used to track progress:

- Fears of Compassion Scale
- Early Memories of Warmth Scale
- Compass of Shame Scale
- External and Internal Shame Scale
- Other As Shamer Scale – 2 (OAS-2)

© 2026 Jason Luoma, Jenna LeJeune, and M. Kati Lear · www.actwithcompassion.com

Self-report measures such as these provide useful information in terms of case conceptualization and treatment planning. *How* the client responds to the questionnaires when you discuss them can also provide important information about their struggles with shame and self-criticism. Other measures may be helpful in exploring specific clinical questions relevant to the conceptualization. For example, the Functions of Self Criticizing/Attacking Scale (FSCAS) can help you more quickly distinguish whether self-criticism functions primarily as a form of self-monitoring/self-correction or also includes a strong element of self-punishment. The Forms of Self-Criticism and Reassurance Scale (FSCRS) also distinguishes between these two kinds of self-criticism. The Other As Shamer Scale – 2 (OAS-2; Matos et al., 2015) assesses external shame, or the sense that others view one as inferior, inadequate, or flawed. Used alongside a measure of internal shame such as the ISS, it can help clarify whether a client's shame is organized more around their own self-judgment or around anticipated judgment from others, which is often central for socially anxious clients. At eight items, it is also brief enough for repeated administration. Another useful assessment tool is Rizvi's (2010) Shame Inventory. This self-report measure can serve as a quick way to identify typical situations in which the client is most likely to experience significant shame. An in-depth discussion of what the client wrote on the form can rapidly identify situations that you might focus on in therapy. We talk about how we use self-compassion scale here. Some other relevant scales are also available here.

Step 2: Exploring the Function of Shame and Self-Criticism in the Person's Life

The main goals of this session are to develop an initial, shared understanding of how shame and self-criticism function in the client's life, identify core self-critical themes, and begin shifting the client's relationship to shame and self-criticism through awareness-building. This exploration serves both assessment and intervention purposes, as the process of discussing these experiences begins to change the client's relationship to them.

Beginning the Exploration: Review of Assessment Measures

Prior to the session, the therapist should review and score the forms the client has completed, comparing scores to established norms when possible. This preparation involves identifying responses that warrant deeper discussion and noting patterns or themes across different measures. These highlighted items will serve as entry points for more meaningful conversation during the session.

The session begins with discussing the overall scores and the client's reactions to them, before moving to explore specific responses that stand out. The forms provide a structured way to discuss experiences that clients might otherwise find difficult to bring up spontaneously. Throughout this review, the therapist should pay attention to both verbal and non-verbal responses, as these often provide important information about the client's relationship with shame.

Normalizing and humanizing: People 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 that others may also 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

© 2026 Jason Luoma, Jenna LeJeune, and M. Kati Lear · www.actwithcompassion.com

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.

If the client expresses feeling understood or validated, therapists may consider encouraging the client to explore what these feelings are like in session, as these feelings inherently differ from the chronic sense of isolation and self-invalidation often experienced by highly shame-prone and self-critical people. Curious exploration can help enhance the memorability and accessibility of this experience while helping construct an experience of the therapist as a validating and compassionate other. Therapists should pay careful attention to client's body language during this process and titrate discussion to client's comfort and willingness in initial sessions, as feeling understood or "seen" by another may feel extremely vulnerable for clients with a shame-bound sense of self. However, slow and careful exploration during the debriefing process can help clients begin to experientially practice acceptance of feelings of vulnerability and exposure that will benefit future work.

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 critical 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 relating to shame, self-criticism, or self-compassion 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 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.

Deepening Understanding Through Eliciting Examples

When reviewing assessment measures, the therapist should focus on connecting the abstract items on questionnaires to concrete examples from the client's life. For instance, if a client endorses an item such as "I had a sense of disgust with myself," the therapist might say, "I noticed that you rated the item 'I had a sense of disgust with myself' as 'quite a bit like me.' Would you be open to telling me about a time where that sense of disgust showed up for you this week?" It's likely that this client may have never revealed to the therapist that they felt disgust toward themselves in the absence of it being revealed on the questionnaire, even though self-directed disgust is often a very important trigger of shame and self-criticism. Asking questions like, "where is the most difficult?" can help you to discover the places where shame and self-criticism cause the most problems and where it is the most painful. These specific examples help to identify when and where self-criticism or shame occurs most intensely, the specific language and content of self-critical thoughts, and their emotional and behavioral consequences. Writing down the specific self-critical statements that seem particularly poignant or painful can be helpful. These core self-criticisms can then be used in later sessions to elicit shame or

© 2026 Jason Luoma, Jenna LeJeune, and M. Kati Lear · www.actwithcompassion.com

self-criticism in order to work with it, while also helping the therapist develop a more nuanced sense of empathy for the client's struggles.

Through this exploration, the therapist begins to identify core self-critical themes—patterns in the content of self-criticism, common triggers and contexts, emotional and behavioral responses, and areas where shame and self-criticism cause the most distress. By the end of this process, the therapist should have a clearer sense of what the client's core self-criticisms are, when they tend to occur, what they're in response to, and how they impact the client emotionally and behaviorally. You should have initial answers to questions like:

- What are the client's core self-criticisms?
- When do these tend to occur? What are they in response to?
- What happens to the client when they engage in self-criticism? How does this impact them emotionally and what kind of behavior does it lead to?

Self-criticism and shame often appear in specific situations that are worth exploring: after a perceived failure or mistake; after failing to control some behavior; when trying something new; in reaction to social situations that involve some social threat; when withdrawing from or avoiding others; when isolated and alone; and in relation to devalued identity aspects (e.g., LGBTQIA+ identities, racial/ethnic identities in contexts of discrimination). The therapist should be attentive to these contexts while discussing the client's experiences. When exploring these contexts, the shame and self-criticism may sometimes be clearer in the minutes before or after the events, rather than during the event itself. For example, the client may beat themselves up after these events, keeping themselves in a state of heightened threat. Or they may be making fear-inducing and self-critical predictions about what is likely to happen in the upcoming situation that the person wishes to avoid.

Working with Shame in the Session

As the therapist and client discuss shame-inducing experiences, shame itself often emerges in the session. The therapist should be attentive to non-verbal cues such as averted gaze, slumped posture, or quieter voice, as well as shifts in the client's engagement, changes in affect, and self-invalidating statements. These signals offer an opportunity to work directly with shame as it arises.

When shame emerges in session, the therapist should slow down the conversation, gently name the emotion, and stay with the emotional experience rather than immediately following self-critical narratives. This provides an opportunity for experiential learning around this often neglected or avoided emotion. For example, the therapist might say in a soft and gentle tone of voice, "I'm noticing that it seems like it's hard to make eye contact right now. Is it possible shame is showing up right here as we talk?" This intervention validates the difficulty of discussing these experiences while helping the client begin to notice and label their shame rather than simply seeing themselves as flawed. Exploration of this emotion may also surface additional core self-critical themes that are worth noting.

It's important to note that the goal isn't to spend extensive time discussing shame as it shows up, as this could be too exposing early in therapy. Instead, the therapist should moderate this exposure based on the client's capacity and the strength of the therapeutic relationship, ensuring that the

© 2026 Jason Luoma, Jenna LeJeune, and M. Kati Lear · www.actwithcompassion.com

session remains within the client's window of tolerance. At times, the therapist might even need to direct the client away from more direct or detailed descriptions of shame inducing events.

One pattern to watch for is that self-criticism often follows closely on the heels of shame. A client may feel a flash of shame and then quickly launch into a self-critical narrative ("I'm such an idiot, I always do this…"). This self-critical narrative often functions to move away from the felt experience of shame, and following it tends to give the critic more air time rather than building awareness of the pain it causes. In these moments it is often helpful for the therapist to gently interrupt and redirect back to the experience itself, for example: "Can we back up for a moment. It looked liked something difficult came up there? Am I right? What was showing up for you in that moment?" The goal at this stage is not to analyze or track the content of the self-criticism, but to help the client notice the shame underneath it and the distress the inner critic causes.

Addressing Secrets

This step also involves an initial discussion of secrets. Giving the message that secrets are expected and normal helps set the stage for more open communication between client and therapist in later sessions and can reduce dropout related to fear and shame over unrevealed secrets. A study we conducted (Lear, Luoma, & Chwyl, 2021) found that 69% of high-shame clients were keeping important, therapeutically relevant secrets from their therapists after an average of nine sessions. The therapist should address secrets directly such as by saying:

> "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. How does this sound to you?"

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. Therapists may want to return to the topic of secrets later in treatment when the alliance has strengthened to see if they might be revealed then as clients also report they are more likely to reveal secrets if directly asked about them (Love & Farber, 2017).

Helping Clients Build Awareness of Shame and Self-Criticism

A critical foundation for effective work with shame and self-criticism is helping clients develop awareness of these processes. This awareness-building is both therapeutic in itself and necessary for further intervention. Without awareness, clients cannot engage with these patterns in a way that allows for change—you cannot change your relationship with something you cannot see.

Many clients do not come into therapy expressing desire to work on their self-criticism or shame and many highly self-critical clients don't even see themselves as self-critical. This may be for several reasons. Some have experienced these patterns for so long that they've become background noise—as familiar and unnoticed as breathing. Others actively avoid acknowledging shame due to its painful nature, while some are so identified with their self-critical thoughts that they experience them as simple truth rather than as a process of self-relating. As one client put it, "I didn't realize I was being

© 2026 Jason Luoma, Jenna LeJeune, and M. Kati Lear · www.actwithcompassion.com

self-critical... I thought I was just being realistic about how awful I am." They may seem themselves as "having high standards" or just see themselves as a failure, inadequate, or broken, without any awareness that this perception is the result of a process of fusion with thinking. From this vantage point there seems to be little to report; the critical thinking itself is not even noticed but instead they just see a damaged, bad, inadequate, or flawed person with no awareness. This is the result of seeing themselves from the vantage point of critical thoughts.

For these clients, rather than immediately challenging the content of self-criticism, first help them notice its presence and impact. You might say something like, "I'm wondering if we could get curious together about this voice that seems to be commenting on your actions—where it shows up, what it tends to say, and how it affects you." This framing introduces the possibility that self-criticism is a process occurring within them rather than a fundamental truth about them.

Clients who are not aware that shame is an issue for them

Oftentimes clients have a hard time identifying shame as shame. They may not notice when shame is present or have language to label it when it occurs. Shame often operates in the background, driving particular action tendencies, thoughts, bodily sensations, social signaling, and memories. When someone is experiencing shame from the inside, it can be sort of like being trapped inside of a dark room without a flashlight. This is especially true in the case of overwhelming shame that may be accompanied by dissociation and disorientation. The client may believe there is something wrong with them or that they have done something terribly wrong while they are stuck in shame. This can happen during early sessions when triggers come up as relevant topics and life experiences are explored.

This experience of being in the dark with shame matters for a couple of reasons. First, it's hard to take effective action when you don't know what you are experiencing. When the lights are switched on, the client can see, "Oh this is shame!" With that information they are then in a stronger position to decide what to do, rather than letting the action tendencies of shame decide on autopilot. Second, when the client is experiencing shame in the presence of another person or people but isn't aware that that is what they are experiencing, they may be unaware of their shame-driven social signaling and the effect that has on other people. For example, a client experiencing shame might have the thought, "Nobody likes me," and as a result be interacting with others in a collapsed posture, averted gaze, or flat expression. Others may respond to these social signals with decreased warmth and openness, which the person experiencing shame interprets as verification of, "Nobody likes me." Therefore, turning the lights on around shame is empowering and allows people to engage in new behaviors.

We have found it helpful to give clients a worksheet (the Learning about Shame Worksheet) that they can use to initially explore feelings of shame on their own before discussing them with the therapist. This worksheet can be completed either during the episode of shame or soon after and then discussed with the therapist in session. The worksheet helps the client disembed from the shame experience by helping them identify trigger(s), interpretations of the other person/people involved, physiological sensations, urges and desires, social signals, and thoughts. This process of exploring shame involves turning toward, rather than away from, this powerfully painful emotional experience. Because of this, the worksheet also suggests some helpful/soothing behaviors that clients can try *before* deciding what actions to take next. Ultimately, the idea is for clients to become familiar enough

© 2026 Jason Luoma, Jenna LeJeune, and M. Kati Lear · www.actwithcompassion.com

with shame that they can catch it, engage their social safety system through responding in caring or soothing manner, and then respond flexibly as directed by their values. But at this starting point, our main goal is to help the client simply see shame as shame, not as who they are.

More tools for building awareness

For clients deeply fused with their shame-based self-concept, a gradual approach works best. Begin by helping them distinguish between events, their interpretations of those events, and their emotional responses. For example, "You made a mistake on the report (event), then had the thought that this means you're incompetent (interpretation), which led to feeling shame and withdrawing from colleagues (response)." This simple distinction can be revolutionary for clients who have never separated these elements of their experience.

The therapeutic relationship itself provides a crucial context for awareness-building. When clients experience your non-judgmental curiosity about their shame and self-criticism, they can begin to adopt a similar stance. Your validation of their experience ("It makes sense you would feel this way given what you've been through") creates safety for exploring painful patterns that have previously remained hidden or unquestioned.

Timing is essential in awareness-building. Introducing too much awareness too quickly can overwhelm clients or activate defensive responses. Notice signs of emotional dysregulation or disconnection and adjust accordingly. Sometimes, simply noticing when shame or self-criticism is active in the present moment of therapy can be powerful: "I'm wondering if your critic might be showing up right now as we're talking about this?"

It sometimes takes a few sessions of psychoeducation, exploration, and homework to build enough awareness of self-criticism and shame that people are motivated to work with them. Here are some handouts and homeworks that can help you with different client presentations:

- For clients who are unaware they experience shame, explaining what shame is and its common manifestations can help them recognize it in their lives. The Shame Psychoeducation Handout provides a structured way to explore these experiences, while the Learning about Shame Worksheet guides clients in noticing and documenting shame as it arises between sessions.
- For clients who feel ashamed about experiencing shame (meta-shame), normalizing shame as an evolved, prosocial emotion can be particularly helpful. The Shame, Belonging, and Connection Handout (see Appendix) explains how shame evolved to help humans maintain social bonds and repair relationships after transgressions, while acknowledging that chronic or overwhelming shame becomes problematic and no longer serves its adaptive function.
- For clients who don't recognize their self-criticism, exploring how they speak to themselves compared to how they would speak to others they care about can create powerful insights. The Writing about Self-Criticism exercise asks clients to document their inner dialogue and compare it to how they would respond to a friend in similar circumstances, often revealing stark disparities in tone and content.
- For clients who believe their self-criticism is necessary and helpful, experiential learning is often more effective than intellectual discussion. The Building Awareness of Self-Criticism monitoring

form has clients track both the immediate and longer-term consequences of self-criticism, allowing them to discover for themselves whether it actually produces their desired outcomes.

Throughout this awareness-building process, maintain a stance of collaborative curiosity rather than expert correction. Questions like "What do you notice happens in your body when that critical voice shows up?" or "How does criticizing yourself this way affect what you do next?" invite clients to become interested in their own experience without judgment. As awareness develops, clients often experience a mix of relief ("I'm not actually broken—I just have these patterns") and grief ("I've been speaking to myself this way for so long"). Both responses provide openings for deeper therapeutic work and indicate growing capacity to relate to shame and self-criticism rather be fused with them.

This awareness-building phase creates the necessary foundation for later interventions by helping clients develop the observer perspective needed for all subsequent therapeutic work. When clients can notice "I'm having the thought that I'm worthless" rather than simply experiencing "I am worthless," they've taken the first crucial step toward a new relationship with themselves.

Developing a Therapeutic Focus on Shame and Self-Criticism

Once awareness is established, the therapist should develop an explicit agreement to focus on these patterns in therapy. This helps ensure shared goals and reduces the potential for alliance ruptures or premature dropout. A sample intervention might sound like:

> "Now that we've started to get a sense of how shame and self-criticism cause problems in your life, I'm wondering whether this seems like something that might be worth focusing on in therapy for a while. How are you feeling about the idea of focusing on these problems?
>
> The next step I'd suggest is trying to understand where this stuff came from. Then we'll spend some time identifying psychological resources that we can call on as we start to work more intensively with your shame and self-criticism. The goal is to make sure we have a good understanding of how this works for you and how it came to be before we move into seeing what we want to try to change.
>
> This initial phase focuses on building the foundation for future work on shame and self-criticism. Ultimately, the goal is to help you feel empowered to choose how you want to be with yourself when the going gets tough. Who knows, maybe even relating to yourself, perhaps, a bit more kindly? (therapist smiles) [alternately: so that you can choose how you want to take care of yourself when you're in this vulnerable, painful place. Perhaps more like a friend might?] Would that be work you'd be interested in pursuing together?"

By the end of this step, the client should have increased awareness of their shame and self-criticism patterns, recognize these as processes rather than truths about themselves, begin to observe their impact rather than being fully embedded in them, have a preliminary understanding of key triggers and contexts, be motivated to explore the origins of these patterns, and feel validated in their experience without reinforcement of self-criticism.

© 2026 Jason Luoma, Jenna LeJeune, and M. Kati Lear · www.actwithcompassion.com

When the therapist gets to the end of this phase they provide the client with the History Related to Shame and Self-criticism Handout (see Appendix below) to complete in preparation for the next session. This sets the stage for Step 3: exploring the developmental origins of shame and self-criticism and Step 4: identifying social safeness resources.

Step 3. Developing a Compassionate Perspective by Exploring Contributing Events

In this third step of the preparation phase, therapist and client work together to explore key relationships and formative events that have contributed to the client's current experience of shame and self-criticism. The primary goal is to build a more validating perspective through which the client can understand their present struggles.

Most clients begin therapy with an invalidating perspective on their shame and self-criticism. They often view their shame as excessive, unwarranted, or a sign of personal weakness rather than an understandable response to life events. The core aim of this step is to help clients recognize how their shame and self-judgment make sense given their unique history—how these painful patterns couldn't have developed any other way given their specific life experiences.

This exploration focuses on helping the client develop a coherent narrative for why they feel badly about themselves. The implicit message throughout this process is that the client is not responsible for developing these negative views. Their shame and self-criticism are understandable learned responses to their experiences, not accurate reflections of personal defects or flaws. We help clients see that their struggles resulted from events that produced feelings of shame and then led to internalizing a flawed sense of self, rather than them feeling shame because they actually were or are fundamentally flawed.

Therapeutic Value

This stage of therapy serves several crucial functions:

1. **Reduces meta-emotions**: By understanding the origins of their shame and self-criticism, clients experience relief from "meta-shame" (shame about feeling shame) and "meta-criticism" (self-criticism about being self-critical).
2. **Forms the core of a new self-narrative**: The exploration provides the foundation for a more compassionate and contextual understanding of the client's difficulties.
3. **Deepens the therapeutic relationship**: Through compassionate witnessing of painful past events, the therapeutic alliance strengthens as clients experience being seen and understood without judgment.
4. **Provides crucial assessment information**: The therapist gains valuable insights about formative experiences that will inform later interventions.

Expected Outcomes

By the conclusion of this step, clients should:

- Begin to view their shame and self-criticism as learned responses rather than personal defects

© 2026 Jason Luoma, Jenna LeJeune, and M. Kati Lear · www.actwithcompassion.com

- Develop a preliminary narrative that makes sense of their current struggles in light of past experiences
- Experience decreased shame about their shame and decreased self-criticism about their self-criticism
- Start to feel the emotional impact of having their experiences validated rather than merely understanding it intellectually
- Recognize the link between specific past events and their current patterns of self-relating

This step typically spans one to three sessions, depending on the client's history, readiness to explore painful memories, and ability to articulate these experiences. While proceeding at the client's pace is essential, the therapist actively guides this exploration using specific clinical tools discussed in subsequent sections.

The Process: Compassionate Exploration

This exploration involves taking the role of compassionate witness as the client reviews the events outlined on their worksheet. Rather than merely gathering information, the therapist actively offers a new perspective on how the experiences discussed naturally led to shame and self-criticism. Through discussing painful past events with a therapist who validates how these events could have contributed to a shame-prone and self-critical self-concept, the client begins to develop a more compassionate view of their own experience. Often, this is the first time the client has experienced someone listening to their hurts, hopes, losses, and pains with kindness and non-judgment. This experience itself becomes a corrective emotional experience that begins to shift how the client views their own history.

Crucially, this process aims to engage the client not just intellectually but emotionally. While clients can often cognitively understand how past events contributed to their shame and self-criticism, true therapeutic change requires visceral, felt experience of this connection. The therapist should pace the exploration to allow for emotional processing, using gentle prompts like 'What are you feeling right now as you describe this?' or What’s it like inside as you share this?' These interventions help clients move beyond simply talking about their experiences to actually feeling the impact of these events, creating the emotional foundation necessary for developing genuine self-compassion. (For more detailed guidance on addressing challenges with emotional engagement, see the 'Common Difficulties' section later in this document.)

Some clients may find this process of discussing painful past events highly aversive, which makes sense as these events often include rejection, ostracism, abuse, neglect, betrayal, and humiliation. Some clients have a poor recall of events that may contribute to their shame and self-criticism. Sometimes important relationships and key events are only revealed later in therapy when there is more trust in the relationship. For these reasons, it’s important that this process of building a validating narrative be dynamic and ongoing rather than simply a static assessment completed solely at the beginning of therapy. The therapist should approach this exploration with patience, recognizing that building a validating perspective is a process that unfolds over time. Through discussing past painful events that contributed to shame and self-criticism, 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 that makes sense of their experiences.

© 2026 Jason Luoma, Jenna LeJeune, and M. Kati Lear · www.actwithcompassion.com

Areas to Explore: Understanding Contributing Events

Early Experiences of Criticism, Ostracism, Neglect, Betrayal, Bullying, and Abuse

Key events to explore include experiences of sexual, physical or verbal abuse, trauma, neglect, ostracism, criticism, betrayal, or bullying. These may be one-time events with powerful impact or repeated occurrences within a relational context. Single events that involve violation of the person's self or extreme forms of humiliation or degradation 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're made to believe it's not okay to talk about the event, or if disclosure is met with disbelief or invalidation. Even less intense events involving feeling exposed or humiliated should be explored as potential contributors to shame—such as being called a name and laughed at by peers, especially in contexts of social disconnection where the person couldn't repair their sense of self or belonging.

Attachment Relationships and Emotional Climate

Exploring key attachment relationships provides crucial information for understanding how the client developed their current patterns of relating to self and others. Beyond obvious contributors like abuse, neglect, or harsh criticism, explore whether the client felt warmth and caring from attachment figures. One need not have a history of extreme levels of abuse or verbal criticism from caregivers in order to develop a shame-prone and self-critical tendency. A relative lack of loving communications and physical contact from attachment figures is likely to result in high self-criticism due to our mind's basic tendency towards negativity. Questions that reveal important patterns about caregivers' emotional responsiveness include: "How did this person respond when you were distressed? Did they soothe you or validate your experiences?" and "Did you feel comfortable seeking comfort from your caregivers when distressed?" These can indicate whether caregivers showed that the client was valuable by protecting and soothing them.

It's also important to note whether primary caregiver(s) were consistent and predicable in their warmth, criticism, or detachment, or whether they were erratic. Caregivers who were predictably cold may lead to the development of consistent self-criticism, while those who were sometimes warm and other times harsh may lead to more varied and compartmentalized self-to-self relating. Explore how caregivers addressed emotional experiences: When the client was sad, would their caregiver recognize and validate those feelings, ignore them, or punish emotional expression? Were certain emotions more or less acceptable than others? Questions like "How did your caregivers respond when you shared your thoughts or feelings?" and "Did your caregivers demonstrate an understanding of your perspective, even when it differed from theirs?" can illuminate whether the client learned that their feelings and preferences were valid versus unimportant.

Dominance and Submission in Relationships

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, explore whether differences in the child's wants and interests were met with acceptance or whether the attachment figure made their desires dominant and dismissed the child's needs. Key questions include: "What happened when you wanted something that your parent didn't want

© 2026 Jason Luoma, Jenna LeJeune, and M. Kati Lear · www.actwithcompassion.com

you to have?" and "Did your parents show enthusiasm for your interests, or did you feel they had expectations of what you should want and who you should be?" This hierarchical framing may also emerge within the therapeutic relationship itself, with clients potentially perceiving the therapist as either dominant (to be feared or challenged) or as someone they need to please or impress. Being aware of these dynamics can help therapists recognize when shame is being activated in the therapeutic relationship and address it directly.

Key Clinical Tool: Empathic Conjectures and Fit Questions

The session involves reviewing each area on the handout completed for homework and attempting to construct a narrative that makes sense of how the experiences may have contributed to the client's shame or self-criticism. The therapist's primary intervention in this process is providing empathic conjectures about how the client might have interpreted events as indicating something was wrong or bad about them. After offering a conjecture, the therapist checks if it fits the client's experience. This approach differs from simply asking clients what they concluded about themselves because clients' understanding of events is typically self-blaming and invalidating—which is precisely why this work is needed. By offering alternative interpretations, the therapist provides new possibilities for understanding past experiences.

In general, when you make a conjecture, it's important to make sure to follow that up with asking the client a fit question to see if it lands, such as "*Does that seem like how you might have interpreted that as a kid?", "Does that fit with your experience?", or "Do you think that could have happened in your case?"*

The basic flow follows three steps:

1. Client describes an event from their history
2. Therapist offers a conjecture about how such an event might lead someone to feel something was wrong with them
3. Therapist checks whether this conjecture resonates with the client

The therapist repeats this basic pattern with each event, building a larger narrative of how these events cumulatively formed client's view of themselves as bad/wrong/defective in some way. Repetition is key. You want to go through multiple examples of events that could have led to a sense of a flawed/bad self. The idea is to build a pattern where the client can stand back and see enough examples that it starts to make sense that they would feel the way they do.

The reason for the therapist to conjecture versus asking the client what they concluded about themselves is that the client's understanding of the events is typically invalidating and shaming (thus why you are doing this work with them). While more basic empathic responses are important as well (e.g. "That must have been really hard" or "I'm so sorry that happened to you") the main emphasis should be on offering conjectures that *tie the events they are discussing to their sense of shame and/or negative self-concept*.

Here's an example of how one exchange might go:

> **Client:** "My mom was really critical of me and just always all over me about stuff. It felt like I could never do enough. This is a little thing, but one example is that if I wanted to go to a

© 2026 Jason Luoma, Jenna LeJeune, and M. Kati Lear · www.actwithcompassion.com

friend's house, it seemed like she would always be grilling me about my chores, expecting me to not have done my chores or not having done them to her satisfaction."

Therapist: "It's like no matter how hard you tried you could never meet her standards?" (conjecture)

Client: "Yeah that's right."

Therapist: "Often when people are criticized repeatedly they start to believe it. I could imagine that over time that would lead you to a sense that you're not good enough. Maybe you're lazy or you're selfish, or something like that. (conjecture) Does that resonate at all?" (fit question)

The message conveyed through these conjectures is that the client's responses were normal and understandable reactions to their experiences. Not "normal" in the sense that everyone feels this way (which clients often experience as invalidating), but normal *given their specific history*. Here's an example, "We're so vulnerable as kids. Anyone who had a mom who constantly delivered a message that you're not good enough would develop a sense of themselves as inadequate or bad."

Examples of Using Empathic Conjectures and Checking Fit

Peer Rejection and Social Ostracism

Ostracism often feeds shame as signals that you are unworthy of inclusion in the social group. It communicates lower social status to both the person being ostracized and the observers. The demotion is social status is inherently shame-inducing. Especially if repeated or prolonged, ostracism can be internalized as being unworthy of connection or belonging.

Client: "I got a sense pretty early on that most of the other kids thought I was weird. I started making myself smaller in reaction to that. I was deemed too loud, too enthusiastic, too weird in general. People looking at me like, 'what are you doing?'"

Therapist: "It seems like you learned early on that you were weird in some way. Too loud, too much energy. Just too much. (conjecture) Does that still linger today, that sense that you are weird in some way or that you're too much? (checking fit) Do you ever say things like that to yourself, like 'You're too much' or 'stop being a weirdo?'"

Here's an example of a client who reports being ostracized by other kids and the therapist conjectures about how this might have contributed to a sense of self as different or weird.

Client: By middle school I was trying to make myself smaller, so they would stop looking at me like that. By high school, I passed through like a ghost, totally ignored. Before that I could tell I wasn't jiving with other kids. I got this core group of cool friends. I found my core group of people who were all weird together.

Therapist: You felt different. It was nice to have your friends, but it also felt like you were different and outside. Maybe strange or weird? (conjecture, phrased as question to check for fit)

© 2026 Jason Luoma, Jenna LeJeune, and M. Kati Lear · www.actwithcompassion.com

Client: Yeah. I got a sense pretty early on that most of the other kids thought I was weird. I started making myself smaller in reaction to that. I was deemed too loud, too enthusiastic, too weird in general. People looking at me like, "what are you doing?"
Therapist: It seems like you learned early on that you were weird in some way. Too loud, too much energy. Just too much. Does that still linger today, that sense that you are weird in some way or that you're too much? Do you ever say things like that to yourself, like "You're too much" or "stop being a weirdo?"

Caregiver Neglect or Distance

A shame-bound sense of self can result from neglectful or uninvolved caregiving, which gets internalized as the idea that you aren't valued or not important (with the implication that there must be something wrong with you that makes people not care about you).

Client: When I was distressed it was always my mom.
Therapist: You'd go to her.
Client: Yeah, so I guess it's good that she was mostly understanding in those situations. But, you know, there's a whole missing half with my dad, you know?
Therapist: Okay, so what does that bring up for you? That idea that you feel like your dad was missing? What does that make you think about?
Client: I think it's kind of hard because I know when I look back at being a young kid, I always wanted my dad's acceptance. I wanted to be just like him. And I just felt like he was always tied up with other things and it wouldn't be a good idea for me to approach him with some kind of problem that I was having, cause whatever he was dealing with would probably be bigger or more important in some way.
Therapist: So, it felt like you weren't important to him at some basic level. Like those other problems were a bit more important than you or something. (conjecture) Does that sound right? (fit question)
Client: Yeah, I feel like I was important to him, but it was just not as important as these bigger problems – like not having money, working a shitty job, and being tired all the time. I don't know if that had some effect on me or not, or if it still does. But just a realization I had as I was going through it.
Therapist: It makes sense to me that what you're describing could have contributed to some shame. There's a way in which it felt like you weren't valuable to him, or at least not valuable enough to listen to. That's a pretty important person in your life to not feel valued by.

Bullying

Bullying can lead to shame through a variety of pathways. Insults or negative messages can get internalized as part of a person's self concept. In addition, the person being bullied may attribute the cause of the bullying to something being wrong with them versus the other person doing something wrong. Bullying also interferes with a sense of belonging and safeness with others that can promote shame. In the example below, the client has shared how he was bullied for about 6 years by someone he thought was his best friend and also felt like he didn't really fit into expectations for his gender identity.

Client: I didn't really have a lot of physical bullying growing up. It was mostly him and his other friend. They would gang up on me and both beat me up at the same time.
Therapist: Wow, did you talk to anybody about it? Did your parents know about it? Did any adults know about it?

© 2026 Jason Luoma, Jenna LeJeune, and M. Kati Lear · www.actwithcompassion.com

Client: I don't remember. We would mostly hang out during the day when both of our parents would be at work. So it was something would happen during the middle of the day, and I'd run home and I don't remember anyone being there to talk to about it at that time. And I don't know if we ever addressed it later that day or ever past the point of it happening.
Therapist: So, it really just never got addressed by anybody. You were totally alone in it.
Client: Yeah, I think so. And if it did get addressed, it was probably just, "It's kids being kids," kind of explanation.
Therapist: Yeah, nobody really took it seriously. It's almost like you got the message that what you felt didn't matter. (conjecture with a hesitant tone)
Client: Yeah, it's like no one cared enough.
Therapist: Yeah, like you weren't important enough to protect you.
Client: Yeah.
Therapist: That's a long time to be bullied that seriously. That's four years, or three years, or whatever it was. That's a really long time. That's going to affect you a lot.
Client: Probably true. I always thought it was because he was physically bigger than me and I was super scrawny and a pretty nerdy kid. (attributes cause to self) I had glasses since I was in second grade. I was just kind of perceived as a person you could beat up and not really have any push back.
Therapist: Was that true in general at school?
Client: Yeah, I just felt like I never fit in. I was this sensitive kid who liked art and that just wasn't OK where I grew up. There were lots of fights at school so I was always scared.
Therapist: It's like you always felt different at school. On the outside. The culture of the area was not really you, and you eventually found this skater crowd and kind of felt like you fit in with them at least. But, even then, you were still seen by everyone else as not good. (conjecture)
Client: Right.
Therapist: Shame is very much about feeling like you don't belong in one way or another. You had plenty of experiences of feeling like you weren't valued and didn't belong. At school, you weren't tough enough, a nerd, or versions of that. You didn't really fit the mold of what a boy was supposed to be, or a man is supposed to be in that world. And then you even got bullied by a friend. That's gonna make any kid feel bad about themselves and likely scar them for a long time. How does it feel to look back on these events in this light? (checking fit)

The examples above are not meant to be exhaustive of the kinds of things that clients might relate, but instead examples of how you might use conjectures and fit questions to help draw links between how past events could have lead to the client's current difficulties with shame and self-criticism. Now let's turn our attention to some common therapeutic difficulties or impasses that can occur at this step.

Common Difficulties that Emerge During this Step

During this step of exploring events contributing to shame and self-criticism, several common challenges often emerge. These difficulties involve ongoing fusion with self-critical narratives, defensive strategies for managing shame, and the emotional vulnerability inherent in revisiting painful

© 2026 Jason Luoma, Jenna LeJeune, and M. Kati Lear · www.actwithcompassion.com

experiences. Recognizing these challenges as they arise—rather than viewing them as resistance or therapeutic obstacles—allows therapists to respond with validation and compassion, using these moments as opportunities to deepen the therapeutic work.

Client Downplays the Impact of Events

Clients often downplay or minimize the impact of the events they are discussing. Common forms include comparing ("Other people had it so much worse"), protecting caregivers ("They did their best"), dismissing ("It wasn't that big a deal"), and not noticing an absence—focusing on what did not happen ("They never hit me") rather than on what was missing, such as warmth, attunement, or someone to turn to. Minimizing is often motivated by loyalty or a wish to protect caregivers, and that wish deserves to be validated rather than argued with.

A helpful guiding principle here is both/and: caregivers can be loving and well-intentioned, and the child can still have learned something painful about themselves. The goal of these conjectures is not to assign blame but to understand impact—to see how even unintentional or good-natured patterns of caregiver behavior can contribute to a sense that certain parts of ourselves are bad, unimportant, or need to be hidden. Framing it this way lets clients keep their loyalty while still looking honestly at what happened.

In the example below, the client protects their father while describing a subtle form of emotional unavailability. The therapist validates the loyalty, offers a both/and conjecture, checks fit, and then links what the client learned to their current self-criticism.

> Client: My parents were good people. They fed me, they came to my games. My dad just wasn't someone you talked to about feelings. He grew up in the '50s. I don't blame him.
> Therapist: It sounds like you really care about your dad, and you don't want this to turn into blaming him. I don't want that either. I'm wondering if two things can be true: he did his best, and there were times you were left on your own with some pretty big feelings. (both/and) Does that fit at all? (checks fit)
> Client: Yeah. When I was getting bullied, I never told them. It just didn't feel like something I could bring home.
> Therapist: That sounds really lonely for a kid. I'm wondering whether, when there's nowhere to take your hurt, a kid might start to conclude that their feelings are too much, or not important. (conjecture) Does any of that ring true? (checks fit)
> Client: I still think that. I hate bringing my problems to anyone.
> Therapist: So maybe that's one of the places where your critic learned its lines. Not because anyone meant to teach it, but because of what was missing. (link to current self-criticism)

When clients minimize by comparing themselves to others who "had it worse," the therapist can gently note that pain is not a competition: "Someone else having it worse doesn't mean this didn't affect you." Whatever form the minimizing takes, the therapist's role is to stay curious and to offer conjectures about how these kinds of experiences would lead many people toward shame or a self-critical view of themselves.

© 2026 Jason Luoma, Jenna LeJeune, and M. Kati Lear · www.actwithcompassion.com

Client Can't See How Mistreatment from Others Leads to Shame

Some clients can see clearly that a caregiver treated them badly but cannot see why that would leave them feeling defective ("Yes, my mom was cruel, but that's her problem. It doesn't explain why I feel broken."). From an adult perspective, the responsibility seems to lie squarely with the caregiver, so the client's own shame can seem unrelated, or even like further evidence that something is wrong with them. (Clients who blame themselves for their shame are addressed in the next section.)

It helps for the therapist to have several ways that children commonly make sense of mistreatment in mind, so they can offer the conjecture that best fits the client:

- Safety: It is less frightening for a child to believe "I'm bad" than to believe that the people they depend on are dangerous or unreliable.
- Control and hope: If it is my fault, I can fix it by being better, quieter, or more perfect.
- Developmental limits: Young children cannot step back and see a parent's stress, illness, or history; they see only how they are treated.
- Shame as a social signal: Repeated rejection or criticism teaches that "something about me makes people pull away." This is shame doing its evolved job of tracking our social standing.

Rather than only explaining these ideas, it is often more powerful to invite the client to take the perspective of a child in a similar situation. Clients frequently reach the insight themselves more readily than they accept it when the therapist offers it:

> Therapist: Imagine a seven-year-old whose mom yells at him and then won't talk to him for days. Not you, just some kid. What do you think that kid would start to believe about himself? (perspective taking)
> Client: That he did something wrong. That he's annoying.
> Therapist: Right. Not because it's true, but because that's how kids make sense of it. Do you think something like that might have happened for you? (checks fit)

If it seems useful, the therapist can follow with a brief explanation, for example: "That's how kids make sense of things. When kids have a problem with their parents, they often internalize it or blame themselves in some way. It's safer to blame yourself when you're a kid than to think there's something wrong with the bigger, more powerful people taking care of you. It's not something kids choose to do; it just tends to happen naturally. Does that make sense for you?"

Client Becomes Self-Critical While Reflecting on an Event

When exploring past experiences, clients often begin criticizing themselves in the moment, presenting a valuable therapeutic opportunity. Rather than simply redirecting this self-criticism, the therapist can use this real-time experience to help the client notice the effects of their invalidating self-dialogue.

Consider this example where a client begins invalidating their own emotional experience:

© 2026 Jason Luoma, Jenna LeJeune, and M. Kati Lear · www.actwithcompassion.com

Client: It feels like it doesn't add up. It doesn't add up. It doesn't make sense. I can kinda see how this started, but the intensity of how broken I feel just feels so disproportional from what I experienced. It just doesn't feel like enough, pointing into the past.

Therapist: Yeah, this is how most people who are really self-critical are. They often have a hard time seeing how much the painful events of their past have impacted them, how hard it actually was, and how they didn't really get what they needed in some important ways. This is your self-critic talking right now. What's it feel like to say to yourself, "what you are feeling is disproportional. What you're feeling doesn't make sense. You don't have any real reason to be feeling the way you are." What shows up when I say back to you the message your critic was just saying to you?

In this interaction, the therapist first normalizes the client's difficulty in recognizing the impact of past experiences—a common pattern for highly self-critical individuals. Then, instead of simply countering the criticism, the therapist helps the client viscerally feel its impact by repeating the critical messages back to them. This approach serves multiple purposes: it helps the client recognize their self-criticism as it happens, provides firsthand experience of how painful these messages feel when heard from another person, and moves beyond intellectual understanding to an embodied awareness of how these patterns affect them. By engaging with the client's self-criticism in the moment, the therapist creates an experiential learning opportunity that deepens the client's understanding of their own internal processes and advances the therapeutic goal of helping them develop a more compassionate relationship with themselves.

Client Blames Themselves for Their Shame or Self-Hatred

A central goal of this process is developing a coherent narrative that explains why clients feel so inadequate or self-hating. Paradoxically, many clients blame themselves for their self-hatred (e.g., "I feel disgusted with myself because I used to cut myself"). This creates a recursive pattern where they feel shame about feeling shame, further entrenching their suffering. While clients may identify behaviors they've engaged in as causes of their current shame, it's important to look for earlier experiences that preceded these behaviors. The therapist's role is to help clients recognize that their negative self-view isn't their fault but rather an understandable response to earlier life experiences.

Client: "I think a big part of this is that I didn't ask for help. There were people around me, like teachers, who I think would have done something. I could have stopped it if I had just told someone about what was happening. But I didn't even do that and so it just went on and on."

Therapist: "It sounds like you were really isolated and didn't have anyone you trusted with such a big secret. Does that seem right?"

Client: "I guess, but I'm pretty sure there were people who would have done something. I just needed to say something."

Therapist: "Maybe that's true, maybe there were people who could have been trusted. But what I'm wondering, how do you think you learned not to trust them? Was there anything in your childhood that taught you that? Perhaps that you were weak or bad in some way for asking for help? Or perhaps you learned you wouldn't get what you needed even if you asked for it? (conjectures) That kind of learning can be really powerful. It might even leave you developing a sense that you weren't important enough for people to help you. Does that fit for you?" (checks fit)

In this exchange, the therapist redirects from the client's self-blame about not seeking help to exploring what earlier experiences might have taught them not to trust others or seek assistance.

© 2026 Jason Luoma, Jenna LeJeune, and M. Kati Lear · www.actwithcompassion.com

Rather than engaging in an extended analysis of every contributing factor, the therapist aims to build the foundation for a more validating and compassionate understanding of how the client's shame and self-criticism developed. The implicit message throughout is that the client's negative self-perception is an understandable learned response to their experiences—not a personal failing or accurate reflection of who they are. By consistently conveying this perspective, therapists help clients begin to separate from their shame-based identity and develop a more compassionate relationship with themselves.

Getting Drawn into Other Topics

During this exploration process, clients often reveal significant personal experiences that can easily lead the conversation in multiple directions. While these tangential topics may be important to address eventually, they can distract from the immediate goal of building a validating narrative about the origins of shame and self-criticism. For example, clients may:

- Shift to discussing current life stressors
- Describe past events unrelated to their shame development
- Focus on interpersonal conflicts that don't directly connect to their self-criticism
- Begin problem-solving practical issues rather than exploring emotional patterns

When this happens, gently redirect the conversation while acknowledging the importance of what they've shared: "That sounds like something important for us to explore later. For now, I'd suggest we continue to focus on understanding how these early experiences shaped your view of yourself. Is that OK with you?" The most productive threads to follow are those involving events where the client experienced criticism, humiliation, ostracism, devaluation, rejection, abuse, or neglect. These experiences most directly contribute to the development of shame and self-criticism. You might say, "I notice when you mentioned your teacher embarrassing you in front of the class, your posture changed. Could we spend a little more time with that memory?"

You might make brief notes about important tangential topics or behaviors that arise so you can return to them in future sessions. This demonstrates that you value everything the client shares while maintaining the therapeutic focus necessary for this foundation-building phase. By keeping the exploration targeted, you'll develop a more coherent and useful narrative about how the client's shame and self-criticism developed—creating the groundwork for more effective intervention later.

Client Gets it Intellectually, but not Viscerally

Perhaps the most common challenge in this process is when clients engage with their history at a purely intellectual level rather than connecting emotionally with their experiences. They may quickly summarize painful events without accessing the associated feelings, resulting in a conceptual understanding that lacks emotional depth. This intellectual processing misses a crucial therapeutic opportunity—clients need to *feel*, not just understand, how their experiences shaped them to develop genuine self-compassion. The goal is to have an *embodied* understanding of the impact of these past events.

The primary strategy is to deliberately slow the conversation pace and direct attention to the client's in-the-moment emotional experience. When clients describe painful events, gently prompt them to notice what they're feeling: "As you talk about that memory, what are you noticing in your body right now?" Pay particular attention to emerging emotions of shame, loneliness, or sadness, as these often provide emotional doorways to deeper work.

© 2026 Jason Luoma, Jenna LeJeune, and M. Kati Lear · www.actwithcompassion.com

Client: When I was getting bullied, my parents were like, “Oh, don’t worry about them. Who cares about them.” They weren’t trying to be dismissive. They were just like “don’t worry about it.”

Therapist: That little kid didn’t get the support they needed. What would you have wanted for that kid that was being bullied?

Client: (pauses) I guess I would have wanted to have had someone to talk to, to help me understand what was going on and help me figure out what to do.

Therapist: That must have been lonely. (conjecture) Is that right? (checks fit)

Client: Yeah, I did feel lonely a lot.

Therapist: When kids don’t get the attention they need, they often turn it on themselves and feel like they must not be important enough to get support and protection.[pause] What’s it feel like now to think about this? [has client notice emotions that are coming up]

Here’s another example where the therapist conjectures about how a father’s response might have led the client to feel bad about themselves. They then ask the client what it feels like.

Client: Yeah, and the other thing with my parents, and this is not something my dad has ever said, but I’ve always gotten the sense from him that I wasn’t what he wanted as a son. I think this has contributed to feelings of inadequacy. He’s never said it directly, but I think I know him well enough to know that he’s disappointed. Disappointed that I wasn’t high achieving, into sports, hunting, you know, a “manly man.”

Therapist: That really makes sense. I could see how feeling like your dad was disappointed in you could make you feel like you were a bad son, or something like that. [conjecture] What is it like right now to think about having disappointed your dad? [feeling the impact]

By inviting the client to connect with the felt, visceral impact of their experiences, the therapist helps them develop an embodied understanding of how their past shaped their current patterns of self-relating. This emotional processing lays the groundwork for authentic self-compassion that goes beyond intellectual acknowledgment to genuine self-empathy.

Moving on From This Step

This step typically closes with the therapist offering a summary that weaves together the client's experiences into a coherent, validating narrative about how past events shaped their current self-view. This empathic formulation—to use EFT terminology—describes the client's difficulties in conceptually relevant terms while remaining closely connected to their lived experience. The goal is to articulate a new, more compassionate understanding that resonates emotionally with the client.

Therapist: One thing that can be helpful is if you can kind of look at your history and see, “Oh, it makes sense why I feel this way. There’s some stuff that happened to me in my life that made me feel like this. There’s some serious stuff that happened to you. You’ve described a number of difficult, traumatic, stressful events as a kid that were prolonged and repeated. And also a lack in support in how to deal with those. You felt like your mother was supportive when you went to her much of the time but even she wasn’t there in relation to the bullying. You were *completely alone* in that. You didn’t get what you needed. Given the events you experience, it really makes sense that you would develop this sense of not feeling good enough or like a failure that you have described. That’s what happens when you’ve had these kind of things happen in your life. (pauses) What is this like to hear?

Client: Yeah, that feels right. It makes me feel kinda sad to think about that.

Therapist: Yeah, sad. That makes sense. You lost out on a lot. Maybe with this new perspective, from here we’ll see a bit more of, “This makes sense. This makes sense that I have these struggles.” And maybe that will help a bit with criticism about your criticism, or the shame you feel about your shame.

© 2026 Jason Luoma, Jenna LeJeune, and M. Kati Lear · www.actwithcompassion.com

This closing summary serves multiple functions: it validates the client's experience, normalizes their emotional responses, reduces self-blame, and creates a foundation for developing greater self-compassion. The therapist emphasizes that the client's shame and self-criticism are understandable responses to their experiences rather than personal defects.

As with previous steps, this phase concludes by giving the client a handout to complete before the next session—in this case, the "History of Compassion and Connection Experiences Worksheet"—which prepares them for Step 4: Identifying Key Social Safeness Resources.

Step 4. Identifying Key Social Safeness Resources: History of compassion and connection experiences

From an affective science perspective, shame reflects the activation of the threat/defensive system, which evolved to detect and respond to potential social rejection or status threats. This system prepares the body for protection through fight, flight, or freeze responses and narrows attention toward perceived dangers. For clients with chronic shame, this threat system is frequently activated, creating physiological states that inhibit psychological flexibility and reinforce avoidant behaviors, including self-criticism.

The social safeness system serves as a crucial counterbalance to threat activation. This parasympathetic-dominant system, when engaged, promotes relaxation, openness to experience, flexible attention, and prosocial behavior. Importantly, research shows that social safeness cues can directly inhibit threat responses, creating physiological conditions conducive to psychological flexibility and self-compassion. This occurs through two primary routes: interpersonally through affiliative signals from others, and intrapersonally through self-reassuring or compassionate responding to oneself.

This step focuses on identifying and mapping the client's historical experiences of social safeness, warmth, and compassion. These experiences represent psychological resources that can be leveraged throughout therapy to:

- Provide access points to activate the social safeness system when clients experience shame
- Serve as templates for developing more compassionate self-relating
- Create experiential contrast to threat-based states associated with shame and self-criticism
- Build repertoires for cultivating safeness through both interpersonal and intrapersonal routes

Even for clients with limited experiences of social safeness, identifying even small moments of connection, warmth, or compassion provides crucial resources for later therapeutic work. For those with extensive trauma histories who struggle to identify any such experiences, the therapeutic relationship itself can serve as a novel experience of felt safeness.

Exploring Resources for Social Safeness

When transitioning to this phase of the work, it's helpful to explicitly frame the shift in focus for the client. The therapist might introduce this exploration with language like:

> "So up until now we've been spending most of our time exploring the places you struggle, the places you experience shame, and get down on yourself or are harsh on yourself. We've also begun exploring how you're impacted by that, and have some sense of where it came from - at least somewhat – we'll never know all of it.
>
> For today, I thought we could spend some time reviewing your responses describing warm and compassionate relationships in your life. We'll explore what comes up for you when

© 2026 Jason Luoma, Jenna LeJeune, and M. Kati Lear · www.actwithcompassion.com

you reflect on those relationships in the here and now. Another aim will be to get a sense of your past experiences, people, relationships that might be resources for you that we'll be able to incorporate into therapy as we go along to draw on as potential sources of strength, resilience, support for you.

It's likely we won't get to everything on the form, and that's okay. If we need another session we can always take more time on it we can, but my sense is we'll spend a good chunk of today on it. Do you have any questions?"

This framing helps clients understand why we're shifting focus from painful experiences to positive ones, validates that exploring positive experiences is also meaningful therapeutic work, and sets realistic expectations for the session.

In this phase, we identify relationships and contexts where the client has experienced love, belonging, kindness, warmth, or compassion—no matter how fleeting or limited. These touchpoints become valuable resources for perspective-taking exercises and compassion practices that help clients develop more flexible responses to shame.

Common sources of social safeness to explore include:

1. Supportive mentors – Teachers, coaches, or other adults who showed genuine care and support
2. Nurturing family members – Relatives who consistently expressed warmth and acceptance
3. Affirming friendships – Relationships characterized by warmth, care, and non-judgment
4. Belonging experiences – Times when the client felt valued and included, such as during camps, retreats, or special events
5. Spiritual connections – Experiences of divine love, unconditional acceptance, or meaningful belonging
6. Animal bonds – Pets or other animals that provided unconditional love and acceptance
7. Caregiving experiences – People or beings toward whom the client felt warmth or fondness as social safeness can also be activated when we care for others

Finding the Most Effective Social Safeness Resources

When exploring these potential sources of safeness, our key focus is identifying relationships and experiences most likely to produce clear, uncomplicated, and strong activation of the social safeness system. Not all warm memories will serve equally well as resources. For instance, relationships with significant attachment figures who have been lost, if not fully grieved, may trigger sadness rather than safeness. Similarly, relationships that were inconsistent or contained both nurturing and harmful elements may produce mixed emotional responses. To identify the most effective resources, we can ask questions like: "Is there a specific memory or place that comes to mind with this person that feels particularly safe, connected, fun, or something like that?" This helps clients locate concrete, specific memories rather than general impressions of relationships.

These identified resources aren't simply historical artifacts—they become active therapeutic tools. We may need to test them empirically in later meditations or exercises to determine which ones most reliably activate social safeness for a particular client. The most effective resource may vary by context; for example, a client might find memories of a supportive teacher most helpful when facing achievement-related shame, while memories of a nurturing grandparent work better for interpersonal shame. Interestingly, clients are often surprised by which resources most effectively activate their social safeness system. A seemingly minor relationship or brief experience might produce stronger

© 2026 Jason Luoma, Jenna LeJeune, and M. Kati Lear · www.actwithcompassion.com

safeness responses than relationships they intellectually believe should be more impactful. This experimental approach helps bypass cognitive assumptions about what "should" work and instead identifies what actually creates embodied feelings of safeness for each unique client.

Alternative Pathways to Social Safeness: Finding Warmth in Unexpected Places

For clients with histories of severe or prolonged abuse, neglect, or ostracism, identifying social safeness resources may be challenging. In these cases, we can explore alternative sources of warmth:

1. Nature connections – Peaceful, grounding experiences in natural settings
2. Imaginary companions – Supportive figures conjured during childhood
3. Media characters – Fictional beings who modeled compassion or evoked warmth
4. Comfort objects – Special toys, blankets, or items that provided security

For clients with minimal experiences of emotional warmth, we can explore sensory experiences that activate similar physiological states—drinking tea beside a fire, soaking in a warm bath, or feeling sunshine on their face. Through careful exploration, most clients can identify at least some experiences of social safeness. For those who cannot, the therapeutic relationship itself becomes a novel experience of feeling seen with kindness and understanding.

For highly self-critical and shame-prone clients, exploring experiences of warmth and connection can be as emotionally challenging as discussing past traumas. This paradox—that accessing potentially healing memories can trigger threat responses—reflects the complex relationship many clients have with vulnerability. Many clients have developed protective strategies that guard against the vulnerability inherent in feeling cared for. Their defensive patterns may have developed for valid reasons: perhaps experiencing betrayal after opening up, having their emotional needs mocked or dismissed, or finding that moments of connection were unpredictable or fleeting. Some learned that compassion signaled weakness or naivety in their family or cultural context.

This defensive posture toward warmth serves important protective functions but also maintains isolation and impedes self-compassion. When invited to recall experiences of connection, clients may experience surprising levels of distress—manifesting as anxiety, emotional numbing, intellectualization, or shame. Some may feel grief over what they never fully received, while others may feel undeserving of the care they did experience. The therapist should approach this exploration with sensitivity and patience, normalizing these responses and titrating exposure to these experiences based on the client's capacity. By gently helping clients access even small moments of felt safety and connection, we begin building their tolerance for the vulnerability inherent in compassionate experiences—both receiving and giving care to themselves and others.

When Social Safeness Resources Are Limited

Some clients struggle to identify even a single experience of compassion or kindness in their history. This absence represents not merely a lack of positive memories, but potentially indicates an underdeveloped capacity to recognize, receive, and internalize experiences of social safeness. For clients with severely deprived attachment histories or with extensive interpersonal trauma, the very neural pathways that process the kinds of emotions that develop in safe interpersonal contexts -- love, warmth, or contentment -- may be underdeveloped. When clients realize they cannot recall experiencing genuine warmth from others, this often triggers grief for connections they never experienced. This recognition can be profoundly painful but also therapeutically valuable—it acknowledges the legitimacy of their emotional deprivation and honors the impact of what was missing. In these situations, the therapeutic relationship itself becomes a crucial resource. Through consistent empathic attunement and compassionate presence, the therapist offers what may be the

© 2026 Jason Luoma, Jenna LeJeune, and M. Kati Lear · www.actwithcompassion.com

client's first experience of being truly seen and accepted. The therapist's role is not merely to provide this experience, but to help the client consciously recognize and internalize it.

Therapists should be attentive to their own emotional responses, as research indicates clinicians tend to show less warmth toward highly self-critical clients. This unconscious withdrawal can recapitulate the client's earlier experiences of emotional deprivation. Instead, therapists must deliberately cultivate and express warmth while helping clients develop the capacity to receive it. Sometimes, it is through the relationship with the therapist that the client 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. Perspective-taking exercises can be particularly valuable. For example, in one case, I (JBL) asked a client to sit in my chair and observe herself from my perspective. When asked if she'd ever known someone who was kind to her in difficult moments, she paused, appeared sad, and whispered, "only you." I then guided her to imagine what I might be feeling and thinking as I witnessed her distress. As she did this, it was apparent that the client had a poor understanding of my emotional experience and sense of empathy towards her. In response, I shared my genuine care and concern, and invited her to practice thinking those same compassionate thoughts toward herself and imagine what it might be like to feel those compassionate feelings toward herself. Through this process, the client began developing a sense for how a caring other might view her in moments of vulnerability—an essential foundation for self-compassion and for being able to receive the care of others.

Conclusion: Moving from Foundation Building to Intervention

The four-step foundation-building process described in this document serves as the critical groundwork for the subsequent phases of therapy targeting shame and self-criticism. Once this foundation is established—typically over 3-5 sessions—clients and therapists have created a shared understanding, identified key patterns, developed a compassionate perspective on contributing events, and mapped social safeness resources that can be leveraged in the next phase of treatment. This forms a solid foundation for subsequent work on shame and self-criticism, whatever approach you use. Below we outline the key components of how we suggest working with shame and self-criticism, based on our work at actwithcompassion.com. Here’s a brief overview of how this foundation enables the targeted interventions that form the heart of the therapeutic work.

Building Upon the Foundation: Key Intervention Components

With the preparatory groundwork in place, therapy typically transitions to more active interventions focused on several core processes:

1. Fostering Psychological Distance from Self-Criticism

Using the awareness developed in the preparation phase, therapists help clients create psychological distance from their self-criticism. Rather than being embedded within self-critical thoughts, clients learn to observe these patterns with curiosity and without immediate reactivity. This defusion work often includes perspective-taking exercises, metaphors, mindfulness practices, and

© 2026 Jason Luoma, Jenna LeJeune, and M. Kati Lear · www.actwithcompassion.com

experiential techniques such as two-chair dialogues that externalize the critical voice. As clients develop the ability to notice their self-criticism as it happens, they gain the crucial capacity to choose how they respond rather than automatically reacting from within their critical narrative.

2. Cultivating Social Safeness and Self-Compassion

Building on the social safeness resources identified in Step 4 of the preparation phase, therapy now focuses on actively strengthening the client's capacity to access their social safeness system. This work often begins with lovingkindness meditation directed toward easy-to-love others before gradually extending toward the self. The perspective-taking abilities developed during the preparation phase are leveraged to help clients view themselves through the eyes of a compassionate other—whether that's a supportive figure from their past, their therapist, or their future self. When practiced repeatedly, these exercises help clients develop new neural pathways for accessing social safeness in the presence of shame, creating physiological conditions more conducive to flexibility and compassion.

3. Exposure to Shame Triggers with Flexible Responding

Perhaps the most potent intervention involves deliberately evoking shame in session, then practicing new, more flexible responses. Building on the patterns identified in Step 2, therapists work with clients to systematically engage with shame-inducing situations or memories, helping them remain present with the emotion rather than engaging in habitual avoidance patterns. These exposure exercises might involve sharing past secrets, revisiting painful memories, role-playing feared scenarios, or intentionally making mistakes in session. The crucial therapeutic element is not the exposure to the cue itself, but practicing new responses to shame that align with the client's values—whether that's self-compassion, authentic self-expression, or reaching out for connection rather than withdrawing in isolation.

4. Building New Relational Patterns

With increased flexibility and self-compassion, clients become ready to engage differently in relationships with others. This might involve practicing greater vulnerability and self-disclosure, setting boundaries that honor their needs, or expressing emotions that were previously hidden from others due to shame. By extending what they've learned about self-compassion into interpersonal contexts, clients create opportunities for corrective emotional experiences that further challenge their shame-based beliefs and build their social safeness system through connection with others.

The Therapist's Role Beyond Foundation Building

As therapy progresses from foundation building to active intervention, the therapist's role evolves while maintaining the foundational elements of validation and compassionate witnessing. The therapist now becomes:

- A coach who guides the client through experiential exercises and supports their practice of new skills
- A compassionate observer who helps clients notice their habitual shame responses as they happen in real-time

© 2026 Jason Luoma, Jenna LeJeune, and M. Kati Lear · www.actwithcompassion.com

- A co-regulator who models and facilitates access to the social safeness system
- A cheerleader who celebrates small victories and helps clients recognize progress
- A collaborator who continually refines interventions based on the client's unique response patterns

Measuring Progress

While standardized measures of shame, self-criticism, and self-compassion provide objective indicators of progress, equally important are qualitative changes in how clients relate to themselves and navigate relationships. Signs of successful intervention include:

- Increased ability to notice shame and self-criticism without immediate fusion or avoidance
- Faster recovery from shame episodes with less rumination and self-blame
- Greater willingness to take interpersonal risks despite the possibility of triggering shame
- More flexible behavioral responses in previously shame-inducing situations
- Integration of self-compassion practices into daily life
- Increased capacity to seek support rather than isolate when experiencing painful emotions

Conclusion

The foundation-building process described in this document is not merely preparation for the "real work" of therapy—it is a profoundly therapeutic intervention in its own right. By helping clients develop awareness of their shame patterns, understand the origins of these responses, and identify resources for a more compassionate self-relationship, the preparation phase creates the conditions necessary for deeper transformation. The subsequent interventions, built upon this foundation, enable clients to develop a fundamentally different relationship with shame and self-criticism—one characterized by flexibility, compassion, and values-aligned choice rather than avoidance and self-punishment.

Through this process, clients don't simply learn techniques to manage shame when it arises; they develop a new way of being with themselves in those moments when they feel most vulnerable. This shift represents the essence of what we mean by psychological flexibility in the face of shame—the ability to remain present, open, and engaged with life even when shame is present, holding one's fallible humanity with the same compassion one might offer to a dear friend.

© 2026 Jason Luoma, Jenna LeJeune, and M. Kati Lear · www.actwithcompassion.com

Acknowledgements

We would like to thank all our clients who have taken the risk to open their hearts to us and thereby helped us learn how to work more effectively with shame and self-criticism. We'd also like to thank all the trainees and students who have learned these skills and provided us with feedback that shaped this protocol. Finally, we'd like to thank Dr. Melissa Platt for her contributions to early drafts of this work.

References

Gutiérrez-García, A., & Calvo, M. G. (2017). Social anxiety and threat-related interpretation of dynamic facial expressions: Sensitivity and response bias. *Personality and Individual Differences, 107*, 10–16. https://doi.org/10.1016/j.paid.2016.11.025

Hornstein, E. A., Craske, M. G., Fanselow, M. S., & Eisenberger, N. I. (2022). Reclassifying the unique inhibitory properties of social support figures: A roadmap for exploring prepared fear suppression. *Biological Psychiatry, 91*(9), 778–785. https://doi.org/10.1016/j.biopsych.2021.11.017

Keltner, D., & Harker, L. A. (1998). The forms and functions of the nonverbal signal of shame. In P. Gilbert & B. Andrews (Eds.), *Shame: Interpersonal behavior, psychopathology, and culture* (pp. 78–98). Oxford University Press.

Landers, M., & Sznycer, D. (2022). The evolution of shame and its display. *Evolutionary Human Sciences, 4*, e45.

Lear, M. K., Luoma, J. B., & Chwyl, C. (2021). Psychological inflexibility prospectively predicts client non-disclosure in outpatient psychotherapy. *Journal of Contextual Behavioral Science, 19*, 36–41. https://doi.org/10.1016/j.jcbs.2020.11.004

Love, M., & Farber, B. A. (2017). Let's not talk about sex. *Journal of Clinical Psychology: In Session, 73*(11), 1489–1498.

Lynch, T. R. (2018). *Radically open dialectical behavior therapy: Theory and practice for treating disorders of overcontrol*. New Harbinger.

Matos, M., Pinto-Gouveia, J., Gilbert, P., Duarte, C., & Figueiredo, C. (2015). The Other As Shamer Scale – 2: Development and validation of a short version of a measure of external shame. *Personality and Individual Differences, 74*, 6–11. https://doi.org/10.1016/j.paid.2014.09.037

Palacios, A., Colombo, D., Fernández-Castilla, B., Wrzesien, M., & Cebolla, A. (2026). Self-criticism as a mechanism of change in compassion-based interventions: A meta-analytic structural equation modelling approach and systematic review. *Clinical Psychology & Psychotherapy, 33*(5), e70347. https://doi.org/10.1002/cpp.70347

© 2026 Jason Luoma, Jenna LeJeune, and M. Kati Lear · www.actwithcompassion.com

Rizvi, S. L. (2010). Development and preliminary validation of a new measure to assess shame: The Shame Inventory. *Journal of Psychopathology and Behavioral Assessment, 32*(3), 438–447. https://doi.org/10.1007/s10862-009-9172-y

Zuroff, D. C., Shahar, G., Blatt, S. J., Kelly, A. C., & Leybman, M. J. (2016). Predictors and moderators of between-therapists and within-therapist differences in depressed outpatients' experiences of the Rogerian conditions. *Journal of Counseling Psychology, 63*(2), 162–172. https://doi.org/10.1037/cou0000139

© 2026 Jason Luoma, Jenna LeJeune, and M. Kati Lear · www.actwithcompassion.com

Homework Handouts for Preparation Phase

Clinicians may copy these handouts for use with their own clients.

© 2026 Jason Luoma, Jenna LeJeune, and M. Kati Lear · www.actwithcompassion.com

Using the Understanding Your History Related to Shame and Self-Criticism Worksheet

When to use:

- Along with exercises to track self-critical thinking
- As part of preparation phase

Materials needed:

- Handout: Understanding your history related to shame and self-criticism

Instructions to use with the client:

As children, 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 believe that someone important around us saw us negatively, then we are likely to develop a negative view of ourselves, at least in part. Thus, 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 go on to fill with self-criticism and shame. It also doesn't mean that these people 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 kinder way of relating to yourself.

You also may 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?

© 2026 Jason Luoma, Jenna LeJeune, and M. Kati Lear · www.actwithcompassion.com

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

Because shame and self-criticism are so painful, people develop ways to keep these feelings at bay. Often this focuses on trying to fix yourself – figure out what you are doing wrong, what you need to improve, and what you can change about yourself so that you can prevent painful experiences from happening again. While it's logical to focus on what you can fix, this also tends to reinforce the sense that something is wrong with you. Paradoxically, this can actually intensify feelings of being inferior, not good enough, or flawed.

Rather than being about fixing you, this worksheet takes a different approach: looking at how these feelings developed in the first place.

As children, 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 believe that someone important around us saw us negatively, then we are likely to develop a negative view of ourselves, at least in part. Furthermore, if someone mistreats, neglects, or rejects us, we're likely to infer that they must not care about us very much and that we must not be very valuable. Thus, an important source of shame and 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 go on to fill with self-criticism and shame. It also doesn't mean that these people were "evil" or all bad. It's very likely they didn't know how to treat *themselves* with kindness and care either.

In addition, experiences with peers often play a large role in teaching us which parts of ourselves to keep hidden or try to improve. Experiences with trauma, abuse, and stigma or discrimination can also be big contributors. The events that contribute to shame and self-criticism are different for everyone, and everyone has them to some degree.

We believe it's important for us to have a shared sense of what led to your shame and self-criticism in order to work with it effectively. To begin that process, we'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 that you carry around today.

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. You also may have a hard time recalling events that contributed to your current sense of self-criticism, being flawed, or inadequate. 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 kinder way of relating to yourself.

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.

Feel free to write your responses in the spaces below or in a journal. You won't be turning in what you write. Instead, we'll discuss it together, so please bring it with you to your next session.

© 2026 Jason Luoma, Jenna LeJeune, and M. Kati Lear · www.actwithcompassion.com

Experiences with Caregivers

1. Looking back on your childhood and while you were growing up, who would you say were the people you most depended upon 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 identify those people below and indicate how warm/caring and how critical/abusive/shaming they were. Also indicate how important you feel each of these people were in your life in terms of their impact on you. Just list as many as you feel are important.

Name	Relationship	Warmth/Care	Criticism/Shame/Abuse	Importance
Person's name	How were you related to this person?	On a scale of 1-5 person how much warmth and caring did you feel from this person? ***1*** *= not at all warm/caring* ***2****= rarely warm/caring* ***3****= moderately warm/caring* ***4****= frequent or somewhat strong warmth/caring* ***5*** *= consistently or intensely warm/caring*	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)? ***1*** *= not at all critical/shaming* ***2****= rarely critical/shaming* ***3****= moderately critical/shaming* ***4****= frequently critical/shaming* ***5*** *= consistently or intensely critical/shaming*	On a scale of 1-5 how important was this person to you in terms of their impact on you? ***1*** *= not at all important* ***2****= slightly important* ***3****= moderately important* ***4****= quite important* ***5*** *= extremely important*
1.				
2.				
3.				

Of the relationships you've listed above, please consider which 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 2-4 with that person in mind.

2. How did this person respond to you when you were distressed? Did they soothe you, try to understand your experiences, and express empathy? 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 you should be that you needed to live up to? Please write about this below:

© 2026 Jason Luoma, Jenna LeJeune, and M. Kati Lear · www.actwithcompassion.com

4. Did this person neglect, bully, or abuse you? If so, in what ways? Do you remember this person ever humiliating you or making you feel ashamed? If so, how did this occur?

5. Do you have any other thoughts about how your relationships with *any* of your caregivers may have contributed to your current sense of shame or self-criticism?

Experiences with peers

Relationships with friends and other similar-aged peers also shape how we come to see ourselves. These relationships can play a big role in the development of our tendency to feel shame or get critical of ourselves. Think back to your important relationships in childhood and teenage years and consider these questions.

6. Bullying, humiliation, ridicule, and repeated unwanted teasing (either in-person or on the internet), or prolonged exclusions by friends or peers can increase shame and self-criticism. If you think back to your childhood and teen years, how much did these happen to you? Did you have formative experiences where you felt intentionally left out or ostracized? Did you experience bullying? Did you feel humiliated by peers or were you in a situation where there was a constant threat of possible humiliation? If you had these types of experiences and others found out, how did they react? Did you have friends, peers or adults who stood up for you or comforted you? Or did they stand by and not intervene?

Please write about any formative experiences with bullying, humiliation, ostracism, ridicule, or repeated unwanted teasing and any thoughts about how it may have contributed to your sense of shame and self-criticism.

Other experiences that might have contributed to shame and self-criticism

7. Other pivotal events in childhood or adulthood can also contribute to self-criticism and shame. These often include times when you may have been shamed or humiliated, deliberately left out or excluded, bullied, or victimized by sexual, verbal, or physical assaults. Have you ever experienced any other events that have made you feel degraded, humiliated, worthless, or helpless that you have not written about yet? If so, write about this below in as much detail as seems helpful to you.

© 2026 Jason Luoma, Jenna LeJeune, and M. Kati Lear · www.actwithcompassion.com

8. Sometimes people are criticized or shamed when aspects of their identities do not conform with the norms or expectations of their family, culture, or larger society. These may include subtle comments, being treated differently than siblings or peers, or experiencing more overt shaming or violence based on one's identity. Over time, these messages can get internalized as a sense of feeling different, inferior, or less than. Have you experienced stigma, prejudice, criticism, or shaming for any aspect of your identity (e.g., gender or sexuality, race or ethnicity, socioeconomic status)? If so, please write about this below.

Wrapping up

As you reflect on the experience of completing this worksheet, what was it like for you? You might consider the following prompts. What feelings were present? Did they stay the same or shift and change over time? Did you learn anything new about factors that might have contributed to the shame you feel or how you talk to yourself now? Please write any observations you have about the process of completing this worksheet and any new or interesting takeaways below.

Again, we want to emphasize that thinking about these things can be hard. Take a few minutes to acknowledge your efforts in doing this. You really showed up for it! Having done this hard thing, we encourage you to consider how you might build some ease or kindness into the next part of your day. Maybe ask yourself: if a dear friend was picking my next activity, what would they choose for me?

© 2026 Jason Luoma, Jenna LeJeune, and M. Kati Lear · www.actwithcompassion.com

Using the History of Compassion and Connection Experiences Worksheet

When to use:

- Along with exercises to track self-critical thinking
- As part of preparation phase

Materials needed:

- Handout: Your Experience of Warm and Supportive Relationships form

Instructions to use with the client:

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?

© 2026 Jason Luoma, Jenna LeJeune, and M. Kati Lear · www.actwithcompassion.com

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?

© 2026 Jason Luoma, Jenna LeJeune, and M. Kati Lear · www.actwithcompassion.com

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?

© 2026 Jason Luoma, Jenna LeJeune, and M. Kati Lear · www.actwithcompassion.com

Handout: Shame, Belonging, and Connection

We are social creatures

- We are a fundamentally cooperative species, and we do better together than alone.
- Humans do not function well without a group to belong to.
- A group we belong to can be as small as two people. Most of us belong to more than one community (for example, family, friends, or work colleagues).
- Close bonds and intimate relationships are built through shared:
    - Vulnerability
    - Warmth and kindness
    - Openness

Your communities, and this relationship

Most of us belong to several groups, such as family, friends, coworkers, or communities. The same three ingredients build closeness in all of them: shared vulnerability, warmth and kindness, and openness. Therapy can be a place to practice these too. As we work together, you'll be invited to share some vulnerable things, and you can expect to be met with warmth and respect, not judgment. Being open here means sharing your experiences as best you can, and also noticing how it feels when someone responds to you with care. Openness also works both ways: being receptive to others' views signals that we are trustworthy and that they are safe with us.

It's a basic part of being human to fear being excluded

- For our ancient ancestors living in very harsh environments, being part of the group was essential for survival. People who were cast out of their group were much less likely to survive. Our brains still respond as if we were living in those times, so they treat social exclusion as a potentially life-threatening event.
- We are extremely sensitive to potential signs of social exclusion, and we are constantly scanning for signs that others may disapprove of us.
- We are biologically "hard-wired" to feel anxious in social situations and to perceive others' social signals as disapproving or threatening, especially when those signals are ambiguous. For example, neutral facial expressions are often read as hostile or angry.

Rejection and exclusion trigger shame

- Being rejected is painful! Research suggests that rejection activates some of the same brain systems involved in physical pain. We also know that being accepted and feeling like we belong feels good.
- When we feel rejected, it triggers self-conscious emotions such as shame, humiliation, embarrassment, and guilt.
- Of all the self-conscious emotions, shame is probably the most powerful and painful. Shame can involve painful feelings and thoughts of being broken, inferior, abnormal, disgusting, or irredeemably damaged. When we feel ashamed, we also feel disconnected from others, and our sense of belonging is ruptured.

What is shame and how does it work?

Shame originally evolved to serve two survival-related functions:

© 2026 Jason Luoma, Jenna LeJeune, and M. Kati Lear · www.actwithcompassion.com

1. Shame evolved to discourage behavior that could disrupt the group and put its safety at risk. For example, shame might arise for a member who tries to upset the social order, steals something important from another member, or deliberately creates conflict for personal gain. These kinds of behaviors threaten the cohesion and functioning of the group as a whole. Shame did not evolve for minor social slip-ups, such as saying something silly or passing gas in public.

2. Shame triggers appeasement displays, such as an averted or lowered gaze, a collapsed posture, slumped shoulders, and covering the face or turning it away from others. These signals reduce potential aggression, draw sympathy from others, and help a person regain their place in the group.

When shame gets stuck

When shame works the way it evolved to, it switches on, the appeasement signals happen, others respond in ways that welcome the person back, and the feeling fades quickly once the person feels accepted again. For people who struggle with a lot of shame and self-criticism, shame rarely works this way. Instead, they tend to get stuck in it.

Why do some people experience more shame and self-criticism?

For people who struggle with a lot of shame and self-criticism, these feelings are often linked to past experiences of abuse, exclusion, or ostracism, or to being treated in ways that are the opposite of what builds a sense of belonging (shared vulnerability, warmth, and openness). The kinds of experiences that tend to lead to more chronic shame and self-criticism include:

1. Being treated with coldness, harshness, or rejection (ostracism)

2. Being treated as if your viewpoints or ideas don't matter (invalidation)

3. Having your vulnerability exploited rather than protected or respected (abuse)

It doesn't take many experiences like these to have a profound effect. And because human minds have a well-documented tendency to focus on the negative, even a simple lack of shared vulnerability, warmth, and openness can lead to high levels of shame and self-criticism.

These experiences can leave two lasting sensitivities:

1. Reminders of past rejection, invalidation, or abuse can trigger shame in situations where it serves no useful purpose.

2. The normal tendency to look for signs of rejection or disapproval can become heightened, making us even more sensitive to potential criticism. This can show up in two ways:

- We may read ambiguous social signals as hostile, for example, a blank facial expression, someone interrupting us, a slight turn of the body away, a frown, furrowed brows, or someone yawning while we are talking.
- We may react to small signs of criticism or rejection as if they were strong ones, responding with a lot of self-criticism, self-hatred, anger, or intense shame. We may take criticism to heart very easily, get stuck in self-blame, or automatically react to criticism with anger or argument.

© 2026 Jason Luoma, Jenna LeJeune, and M. Kati Lear · www.actwithcompassion.com

A hopeful note

If you recognize yourself in some of this, it makes sense given what you've experienced. These sensitivities were learned, and they can change, especially through new experiences of warmth and acceptance, from others and from yourself.

Questions to reflect on

Take some time with these questions. You can write your answers in the spaces below or in a journal, and bring them with you to your next session.

1. Who are the people you feel you belong with right now? With whom do you feel most able to be vulnerable, warm, or open?

2. When do you notice shame showing up? What were the signs that you might be judged or left out?

3. Which ambiguous signals are you most likely to read as rejection (for example, a blank face, someone being quiet, or a delayed reply)?

4. Did anything in this handout fit your experience? What would you like to talk about together?

© 2026 Jason Luoma, Jenna LeJeune, and M. Kati Lear · www.actwithcompassion.com