Essay: Clinical Case Formulation Using a Shame-Informed Model

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Abstract

Because of the power of the emotion of shame to influence intra-personal emotional wellbeing and inter-personal behavior, the mental health profession should consider adopting a shame-informed model to assess emotional and behavioral problems, rather than the medical model of the Diagnostic and Statistical Manual (DSM) and International Classification of Diseases (ICD). While shame is often ignored by clinicians and clients, it is considered a trans-diagnostic influence on conditions labeled as mood disorders, personality disorders and even childhood behavioral disorders. Clinicians can easily learn to identify indicators of client negative self-image and beliefs of unworthiness by assessing for trauma history, attachment patterns, view of self and other, affect/presentation, and interpersonal functioning. Because compassion is the antidote to shame, compassion-focused therapy models provide evidence-based interventions that directly address the cause of emotional distress. A shame-informed case formulation would lead to simplified, but meaningful, case conceptualization and treatment planning for clinicians and — most importantly — improved outcomes for clients.

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Introduction

An increasing number of mental health professionals and those harmed by the profession are speaking out against the Diagnostic and Statistical Manual (DSM-5) and International Classification of Diseases (ICD), which inaccurately medicalizes emotional and behavioral patterns. Contrary to the direct-to-consumer advertising messages from pharmaceutical companies, research has failed to find any significant functional, genetic, or biochemical cause of conditions such as ADHD, anxiety, bi-polar disorder, personality disorders, or depression. Notably, a meta-analysis of 107,000 studies failed to find a biological marker for any psychological issues [1].

Reconsidering how "mental disorders" are defined and described would reduce this over-reliance on biologic etiologies and on prescription medications to alleviate supposed "symptoms" of "disease."

Increasing research indicates that shame is a major factor in the cause of mood disorders, personality disorders, and behavioral problems.

A scientifically based means of case assessment and formulation based on the involvement of shame as a trans-diagnostic cause of emotional distress would de-stigmatize mental health diagnosis for patients and provide a simple, yet powerful, case formulation model. Unlike the DSM, which provides no etiology or interventions for the disorders listed, this new model would inherently provide guidance toward effective therapeutic interventions. Because compassion-focused interventions are an antidote to shame, this trans-diagnostic and trans-theoretical approach would be more effective and beneficial for clients.

The Failures of the Medical Model of Mental Illness

Numerous authors have very capably presented the many faults of the DSM, including its lack of scientific rigor, poor reliability and validity, disregard for psychosocial and cultural models, arbitrary diagnostic criteria, and overly cozy relationship with pharmaceutical companies. [2-7]. Many mental health consumers have become anti-psychiatry activists, asserting that the DSM stigmatizes sufferers, limits treatment options to medication, and harms far more than it helps.

The DSM is based on two unproved assumptions: that "mental disorders" are caused by imbalances in brain chemistry or are passed along genetically.

If the false disease model is stripped away, there is nothing left of the DSM, leaving labels such as depression, bi-polar, and ADHD as arbitrary and meaningless.

Phillip Hickey, Ph.D., a leading anti-psychiatry advocate, writes: "(T)hose of us on the anti-psychiatry side of the issue have been saying for years that the various items listed in the DSM are nothing more than loose collections of vaguely defined problems with no explanatory or ontological significance." He has also called the disease model the "Great Psychiatric Hoax" and "a lie" [8]. Vanheule [3] states the DSM is essentially a "belief system."

We only have to look back in history to see that numerous diagnostic labels have fallen by the wayside with changing cultural norms. The profession no longer diagnoses monomania, masturbatory insanity, hysteria, homosexuality, and drapetomania. (In the 19th century this was considered the mental illness that would cause slaves to flee slavery.) Why should we be wedded to today's DSM, which is likely to be filled with similar ill-considered labels?

In 2019, the United Nations Special Rapporteur issued a report stating that effective mental health interventions have been hindered by narrow conceptions of causes of emotional distress and an over-reliance on biomedical explanations of mental health conditions [9]. The report advocates for a human rights approach and recommends considering social conditions, such as poverty, discrimination, and violence, as the root causes of mental distress.

Then, in 2021, after years of promoting the biomedical model, the World Health Organization changed course and released a report that concurred about the failure of biomedical mental health systems. In a 300-page document, WHO echoed the UN report and stated that mental health systems over-diagnose human distress and over-rely on psychotropic drugs to the detriment of psychosocial interventions. The report criticized "an entrenched overreliance on the biomedical model in which the predominant focus of care is on diagnosis, medication and symptom reduction while the full range of social determinants that impact people's mental health are overlooked, all of which hinder progress toward full realization of a human rights-based approach" [10, p. xvii].

The report concluded that what is needed is "a fundamental paradigm shift within the mental health field, which includes rethinking policies, laws, systems, services and practices across the different sectors which negatively impact people with mental health conditions and psychosocial disabilities [10, p. xviii].

In no less than the well-respected publication *JAMA Psychiatry,* Kendler [11] wrote that despite years of research there is little scientific evidence for DSM diagnostic labels because the pathophysiologies of major mental health disorders cannot be directly observed. As a result, current psychiatric diagnoses are merely working hypotheses, subject to change, and do not correspond to reality.

It is becoming clear that billions of dollars in research funding have been thrown at trying to prove a biological cause of emotional problems, with an almost frantic avoidance by psychiatrists and pharmaceutical companies to even consider other explanations.

The smokescreen of the disease model has distracted the profession from the fact that emotions and thoughts drive human behaviors, especially two of the most powerful emotions: shame and fear. The DSM completely ignores the entire construct of moral emotions, notably the self-conscious emotions of shame, regret, and disgust, and the resulting spectrum of anti-social and pro-social behaviors.

This gross absence is especially notable in that it completely ignores the connection between emotions and evolution. As a social species, humans relied on moral emotions to ensure acceptance. Shame and compassion are both strategies that arose through human evolution because they helped support survival and reproduction through pro-social mental states and behaviors. Immoral acts, such as greed or violence, led to expulsion from social groups, possible harm or death, and reduced reproduction opportunities.

Paul Gilbert, the originator of compassion-focused therapy, has written extensively about the role of evolutionary motivations and strategies. "Hence, rather than focusing on a clustering of 'symptoms' or suggested 'attributes,' the evolutionary approach seeks the origins of compassion in the evolution of caring motives and behaviors" [12, p. 2].

In addition, the DSM largely ignores issues of causation or psychosocial context, such as developmental trauma or attachment distress.

Yet most DSM diagnoses are descriptions of those who, because of adverse life experiences, are hyper-vigilant to being inter-personally harmed—shamed, victimized, or rejected. Many have learned to cope by adopting unhealthy shame management strategies and behaviors. Nearly all of the DSM diagnoses could be more concisely rendered under a case formulation model that categorizes most mental health diagnoses as "shame disorders" or poor shame tolerance.

To deal with the overwhelming emotion of shame, many adopt one of three maladaptive shame management strategies (to be discussed more fully later in this article):

1. Blame others or externalize shame
2. Blame self or internalize shame
3. Avoid blame and shame

Shame leads to the fear of being discovered as flawed and unworthy and then rejected by others or by oneself. Shame is so powerful because it triggers a survival-related dread of social exclusion. We can see the power of shame when we consider that essentially all interpersonal violence situations are caused by the shame-rage reaction. A perpetrator feels criticized, which he interprets as personal rejection, then this triggers feelings of shame and unworthiness that he finds unbearable. Often in an instant, his rage is triggered and abuse can be the result.

In essence, shame is the opposite of love, because disconnection is the opposite of the primal need for belonging. It is no surprise that shame is the foundational emotion that fosters so much dysfunctional human behavior—it drives us away from love. What is often missed is this important fact: Poorly tolerated shame also drives us away from loving ourselves, which is why it provokes levels of distress that become labeled as mental illness.

It is very unfortunate that the DSM not only ignores shame as a cause of emotional distress, but also worsens feelings of shame in millions of people. Because of the internet, anyone can search for "symptoms" of mental disorders and self-diagnose. Many then begin to over-analyze minute changes in mood, judging their experience as signs of being "mentally ill." This judgment and resulting feelings of shame trigger the amygdala into the threat response mode, actually worsening psychological functioning. The very presence of the medical model establishes a shame-based, blame-based way of thinking about human emotions and psychological experiences that then triggers judgment and fear, creating a negative spiral of shame and threat.

This is the very opposite of that advocated by a compassion-based approach. A healthier approach would be to help individuals connect to feelings and thoughts without judgment, so that the nervous system will not label them as threats to survival, therefore reducing the automatic instigation of the threat response system.

Benefits of a Shame-Informed Case Formulation

A shame-informed case formulation model brings numerous benefits, including:

1. It provides a simple, coherent, usable conceptual framework to describe, understand, and intervene in the hundreds of psychologically based diagnoses in the DSM.

2. Explanations are based on facts, common sense, and scientific findings from many fields.

3. It describes causes of behavior, not just symptoms.

4. It addresses interpersonal factors, not just intra-psychic factors.

5. It normalizes behaviors and reduces stigma.

6. Compassion-focused interventions are based on actual causes of emotional distress, such as shame and fear, not spurious assumptions or no given etiology.

7. Compassion-focused interventions lead to permanent change for a lifetime of emotional health and are not temporary solutions, such as psychoactive medication, which harm the client's brain and body.

7. It promotes client accountability and agency and decreases helplessness.

8. It provides a description of a healthy, emotionally functional person—one with self-acceptance who can tolerate shame in non-reactive ways—something the DSM fails to do.

It seems obvious that the mental health profession should reconsider the traditional ways of defining mental disorders based on common sense and scientific evidence about what is known of the emotion of shame and the power of self-compassion to heal shame.

Five Causative Factors of Shame Intolerance

The DSM and ICD ignore many of the most well-accepted psychological constructs and well-researched facts about human emotions. In contrast, a shame-informed case formulation model would consider five causative factors that interact to trigger poor shame tolerance and therefore lead to most human emotional and behavioral dysfunctions.

Five Causative Factors of Shame Intolerance

Factor 1. Threat Response

Factor 2. Fear of Social Exclusion

Factor 3. Shame as an Attempt to Prevent Social Exclusion

Factor 4. Acute Trauma

Factor 5. Attachment Status or Chronic/Developmental Trauma

The first three of these factors are naturally occurring, while factors 4 and 5 are affected by a person's life experiences.

When considered together, these five factors provide a useful paradigm to understand emotional and behavioral struggles and directly provide guidance regarding a case formulation or diagnostic model.

Because these five factors are extensively researched and described in numerous other texts, the following descriptions are brief.

Factor 1 - Threat Response

All humans respond to threatening situations with activating or inhibitory responses. The fear responses are generally considered: pre-emptive avoidance of the threat (if possible), freeze or shut down (to avoid detection), flight, fight, and fold (appeasement, submission or helplessness to elicit caregiving).

We can view most DSM diagnoses as variations in the threat response. Anxiety, mania, and ADHD are chronic elevations of the activation aspect (fight-or-flight), with hyper-vigilance and over-reactivity to threat. The inhibitory aspect of the threat response is labeled as diagnoses such as post-traumatic stress disorder, which may occur when trauma triggers the freeze response. Depression is also a chronic activation of the fold response, with hypo-reactivity to threat and behaviors of helplessness, hopelessness, and low motivation.

Fearful responses occur with physical threat, but also to real or perceived social or emotional threat. Humans are social animals with an innate desire to be accepted by others. When victimized, rejected, judged, or shamed, people may feel their connection to others is at risk and react with the threat response. When they perceive interpersonal invalidation, humans use the limbic system, not the higher, more objective and reflective regions of the brain to appraise the situation [13].

Fear interferes with the ability to be compassionate and nurturing—toward others or *toward oneself*. Survival threat decreases the ability to be empathic to our own emotional states and needs. Perhaps we may even turn away from ourselves in dissociation, emotional numbness, "schizoaffective" behaviors, and "depression."

It is important to recognize that the threat response can be triggered by self-critical thoughts: It is not possible to feel safe with yourself if you loathe yourself. Compassion-based interventions are effective because they decouple shame and fear by providing a warm, non-judgmental response to experiences of inadequacy or failure. Shameful acts can then be experienced more matter-of-factly with healthy shame tolerance, rather than triggering the threat response, with its accompanying emotional dysregulation, cognitive shutdown, and poor coping.

Despite volumes of research on the threat response and its tremendous primal influence on human emotions, cognitions, and physiology, the DSM largely dismisses this fact when describing human behavior. A shame-informed case formulation would consider the very obvious fact that mental disorders are often responses to fear-provoking situations. It makes one wonder: If fear is to be considered a mental disorder, why is joy not considered a mental disorder? It is time to reframe mistaken beliefs about emotions: Fear is not a mental disorder.

Factor 2 - Fear of Social Exclusion

Evolution favors groups of animals that can cooperate and share. Resource gathering, protection, and caregiving are much easier as a community. The resulting benefits of safety, procreation, and communal resources promote survival.

Human ancestors with an urge to get along with others were less likely to excluded from the tribe, which increased their survival odds. As a result, prosocial "tend-and-befriend" behaviors, such as nurturance, protection, emotional support, altruism, reciprocity, conformity, and obedience, are deeply engrained in human behavior because they brought evolutionary benefits.

The urge for social affiliation plays out in a strong desire to avoid feeling shamed, rejected and cast out. As a result, when we believe we may be ostracized, those with healthy shame tolerance generally have predictable reactions, including fear, humility, submission, and compliance.

This urge is so elemental that when we feel victimized, rejected, or shamed by our social group, it can trigger the threat response. When anticipating social disconnection, our primal brain believes our survival is at stake and responds, perhaps in an exaggerated manner. Neuroscientists now know that the same parts of the brain that evaluate physical pain are used to judge the emotional pain of social rejection [14].

The neurobiological connection is clear with studies that show that feeling alone and excluded triggers feelings of fear, hostility, and shame that may result in physical symptoms, such as high blood pressure and heart disease [15].

Most psychotherapy clients have feelings of unworthiness that make them hyper-vigilant to being judged as inadequate and rejected. This rejection sensitivity is the tendency to "anxiously expect, readily perceive, and overreact" to social rejection [16].

Considerable research has been done on the power of social affiliation or rejection sensitivity and its links to mood disorders [17-18]. However, the DSM never mentions this major influence on human behavior or uses it in its diagnostic criteria. By not acknowledging the importance of social affiliation needs, the DSM is based on an insurmountable deficit that limits its usefulness in explaining human behavior.

Fear of social exclusion is a natural human condition. Therefore, loneliness and the need for human relationship should never be considered a mental disorder. Is this evidence completely excluded from the DSM because there are no drugs to sell to treat fear of social disaffiliation? Could it be because it would confirm that the medical model was wrong all along?

Factor 3 - Shame as an Attempt to Prevent Social Exclusion

To be a trusted and accepted part of a tribe, a person's reputation becomes an important asset to survival. Social affiliation needs underlie the prosocial behaviors of honesty, cooperation, reciprocity, obedience, trust, and altruism. "Humans have evolved to want to create positive feelings about the self in the mind of others" [19, p. 83].

Shame, guilt, embarrassment, humiliation, and regret are self-conscious emotions characterized by fears of negative evaluation by others. This fear serves a purpose: To help prevent or control inappropriate behavior and encourage moral conduct. Anthropologists studying hunter-gatherers have identified the use of teasing as a form of reverse dominance which teaches humility and ensures continuation of the egalitarian ethos of the tribe.

By feeling guilty when we do something wrong, we are primed to apologize and choose different behavior in the future, helping to ensure compliance with moral norms, repair of social relationships, and social acceptance.

The neurobiology of shame has also been proven. Shame signals the adrenal gland to release cortisol, the primary stress hormone, leading to increased heart rate and the flooding of major muscles with glucose [20].

The conundrum of shame is that it is designed to improve social relationships. However, when poorly tolerated it can block human connection, as the threat response and "fight-or-flight" stress hormones overwhelm a person's ability to function.

Rumination about past mistakes is a way for the brain to try to learn from social errors and feel safe. For many people, this overthinking can lead to repeated self-criticism, resulting in anxiety or depression. This tendency to be hyper-vigilant for rejection and fearful of shaming experiences is especially prevalent in those who have been exposed to trauma (factor 4) or lack secure attachment (factor 5).

While the need for social belonging has its roots in an instinctual drive to survive, too many people today have been raised to rely on social approval far too heavily for a sense of their self-worth. When they define themselves by the approval of others they are at the mercy of others for their self-worth. These emotionally dependent people have a nearly insatiable

need for acceptance and approval, which could be labeled insecure anxious attachment (factor 5).

Shame, trauma, and childhood sexual abuse have even been considered a cause of "hearing voices," or auditory hallucinations [21]. Those diagnosed with schizophrenia often hear voices with messages that are self-evaluative, which may also provide a window into the impact of shame.

The topic of shame is essential to understand as it relates to self-acceptance. Consider that the typical social behaviors associated with shame are avoidance, abject slinking away, downcast eyes, and submissive postures. When we are embarrassed we tend to remove ourselves from contact with others. However, when the source of shame is the self it is impossible to escape. The self is attacker and attacked and there is no safe haven. Feeling "never good enough" creates an untenable situation that provokes chronic fear. What the DSM labels as depression, anxiety, and other mood disorders are directly related to the experience of self-shaming.

Why is shame completely ignored in the DSM as a cause of emotional distress? Could it be because there are no drugs to sell to treat shame? Could it be because it would confirm that the biomedical model was wrong all along?

Factor 4 - Trauma

Trauma is one of the most widely recognized external causes of psychological suffering, especially following the Adverse Childhood Experiences Study (ACES) in the mid-1990s [22]. This landmark study found that childhood experiences, such as abuse, neglect, witnessing domestic violence, household substance abuse, parental mental illness, or parental abandonment, predicted emotional, behavioral, and physical health consequences throughout life. Fearful experiences in childhood are especially impactful because they couple terror with helplessness. This sense of powerlessness and lack of control can continue into adulthood, resulting in depression, anxiety, OCD, and panic attacks.

Notably, most ACES traumas are relational, not random external events, such as experiencing war or crime. In fact, one of the ten original ACES assessment questions asks about chronic shame in childhood: "Did a parent or other adult in the household often or very often… Swear at you, insult you, put you down, or humiliate you?"

Relational trauma is more devastating for a child than an acute trauma, because it typically interferes with the formation of a secure attachment bond between child and caregiver (see factor 5). Victims conclude that caregivers are not willing or able to protect and that the world and relationships are frightening.

This attachment injury may cause a confusing psychological experience: distrust alternating with increased need for reassurance and safety through connection to others. The DSM would label these disorganized attachment patterns of both anxious pursuing and avoidant withdrawing as diagnoses such as borderline personality disorder or bipolar disorders.

Even psychosis, long considered a "pure mental illness" of unknown origin, is being proven to have connections with trauma. A 2017 study found that childhood emotional abuse, physical neglect, and high perceived stress were significantly associated with "ultra-high-risk" for psychosis in adulthood [22].

Acute trauma (factor 4) and attachment trauma (factor 5) combine to heighten the sensitivity of our primal alarm system that signals social exclusion (factor 2). Stolorow and Atwood posit that the recollection of "nobody there" is more traumatic than the memory of the actual event. "Pain is not pathology. It is the absence of adequate attunement and responsiveness to the child's painful emotional reactions that renders them unendurable and thus a source of traumatic states and psychopathology" [24].

Those who have been harmed, neglected, or rejected by others will be especially attuned for that rejection in the future. They may also develop self-rejecting strategies of excessive guilt and blame in an attempt to "fix" the self.

Childhood trauma sensitizes the threat system and causes physical changes in the body and brain that affect the ability to manage mood, cognitive comprehension, and social behaviors. Children who have experienced significant trauma show significantly reduced grey matter in the cortex, an area related to decision-making and self-regulatory skills, and in the amygdala, or fear-processing center [25].

Jeong et al [26] reported that: "In sum, consistent with prior research showing an association between childhood maltreatment and structural brain changes, the present findings suggest that exposure to trauma during childhood is associated with differences in cortical thickness and volume in key regions associated with attention/executive functioning, emotion regulation, and self-referential processing. Thus, childhood trauma exposure may be a risk factor for structural aberrations in the developing brain, which may have implications for the manifestation of psychopathology symptoms later in life" [26, p. 11].

Cook et al [27] also conclude that exposure to chronic, prolonged traumatic experiences has the potential to alter children's brains in areas such as:

1. Attachment: Trouble with relationships, boundaries, empathy, and social isolation
2. Physical Health: Impaired sensorimotor development, coordination problems, increased medical problems, and somatic symptoms
3. Emotional Regulation: Difficulty identifying or labeling feelings and communicating needs
4. Dissociation: Altered states of consciousness, amnesia, impaired memory
5. Cognitive Ability: Problems with focus, learning, processing new information, language development, planning and orientation to time and space
6. Self-Concept: Lack of consistent sense of self, body image issues, low self-esteem, shame and guilt
7. Behavioral Control: Difficulty controlling impulses, oppositional behavior, aggression, disrupted sleep and eating patterns, trauma re-enactment

Given the wide range of impacts on behaviors, emotions, thinking, memory, and social relationships, is it any wonder that people might develop issues with hyperactivity, impulsivity, inability to follow directions and focus, difficulty with relationships, poor decision making, and inappropriate social behaviors—behaviors that look like ADHD, ODD, autism, social anxiety, or mania?

Based on significant evidence, trauma cannot be ignored as a cause of psychological suffering. And yet the DSM makes essentially no accommodation for the effect of trauma.

Why does the DSM completely disregard the impact of childhood trauma? Could it be because there are no drugs to sell to treat trauma? Could it be because it would confirm that the biomedical model was wrong all along?

Factor 5 - Attachment Status

Attachment theory is an extensively researched concept that explains that humans learn relationship patterns starting at birth based on the emotional attunement, responsiveness, and warmth of primary caregivers. When optimal parenting practices are used, optimal child development occurs, resulting in the child's secure attachment relationship or bond with her parents [28].

In contrast, if a parent is emotionally or physically unavailable, a child learns that if she cries no one will come to comfort. Being cut off from others and lacking safety is the ultimate danger signal to a helpless child. Worse: If a caregiver is overtly abusive, the child learns to link caring with threat. Through relational trauma, a child learns she is peripheral, unwanted, inadequate and unlovable, priming a victim to conclude she is shameful: "I feel rejected, and that feels bad, so my intrinsic self must be unworthy and bad."

As DeYoung [29] writes: "In everyday language, family members will feel shame when what they need to feel human is withheld and there's absolutely nothing they can do about it" [29, p. 65].

Researchers believe that rejection sensitivity stems from early attachment relationships and parental rejection [30]. "To lay down (non-warm) feeling memories of being undesirable or only an object for the other creates considerable (implicit) uncertainty as to the ability to form (subsequent) safe relationships based on liking/being liked" [31, p. 31].

Psychologists now know that attachment is the origin of emotional wellbeing and directly affects cognitive, emotional, social, and physical development. A secure attachment pattern teaches a child a positive model of how another person feels about him, allowing him to accept care from others, and then from the self, permitting healthy, loving relationships with others and with himself.

Those who experience secure attachment are better able to develop secure self-attachment or self-acceptance. Those who believe that other people are a source of comfort and caring, not just rejection and pain, can hear criticism and can tolerate conflict in relationships without over-reacting with emotionality and unhealthy shame management strategies. Research has linked insecure attachment patterns to lower measures of self-compassion [26 & 32] and fear of compassion from others [33].

Insecure attachment in childhood can also lead to emotional reactivity later in life when a person perceives he will be rejected. What is more shaming and fear-provoking than feeling unloved and unwanted by one's key social group — the family?

Adding insult to injury, when terrified at times of rejection, the child's stress is not co-regulated by the parent, who is unavailable. This teaches a child to become easily aroused to fear, and yet he is not helped to develop the skills to self-soothe or turn to others for soothing.

Those who lack secure attachment patterns in childhood may later attempt to find what are called substitute attachments, usually addictive behaviors. These attachments to depersonalized rewards, such as drugs, objects, sex, or work/achievement, are an attempt by the brain to avoid shame, to create a sense of connection, to gain approval, or feel emotional

satisfaction. Yet the DSM has spread the widely accepted myth that addictions are a genetically linked disease.

For those who have childhood relational traumas and subsequent adult patterns of insecure attachment, there is hope. Self-compassion counteracts shame and feelings of isolation and provides a sense of emotional safeness and connection when distressed, which is exactly the functional purpose of human attachment in childhood. Mackintosh [32] found that self-compassion mediates attachment avoidance and emotional distress or anxiety.

Compassion-focused therapies can repair negative attachment experiences and directly build earned secure attachment by developing an inner sense of self as a secure base and safe haven.

Connecting the Five Causative Factors

The power of a shame-informed model of assessment is that it considers the five causative factors in combination as influences on psychological functioning. While there is increasing emphasis on trauma and attachment in clinical settings, it is extremely rare to find a clinician aware of, much less trained in fear of social exclusion (factor 2) and shame (factor 3). Compassion-based interventions are increasingly well-known in a few countries, but essentially unknown in large swaths of the United States and other countries. An understanding of the use of the five factors in assessment, followed by compassion-based interventions, would significantly advance clinical practice, providing improved outcomes.

While an awareness of the impacts of trauma and attachment are important advances, the five causative factors must all be considered as cumulative in creating sensitivity to shame. Factors 1, 2, and 3 are naturally occurring tendencies. A childhood filled with love, safety, and acceptance predisposes a person to have resilient responses to these experiences. However, trauma (factor 4) and insecure attachment (factor 5) are variables that can increase maladaptive behaviors, including hyper-vigilance to social threat and rejection, elevated shame sensitivity, lack of emotional resilience and coping skills, and blame-shifting behaviors to manage shame. An ability to respond with self-soothing and the contentment system may be underdeveloped. Because of a trauma bond, “tend-and-befriend” urges may even be experienced as a danger, making it difficult to regulate emotions and blocking self-compassion.

Most DSM diagnoses are actually descriptions of hyper-vigilance to being shamed, victimized, betrayed, or rejected by others, combined with an inability to self-soothe, which results in maladaptive shame management strategies.

Lack of self-compassion is fundamentally also a self-betrayal, which leads to ongoing shaming experiences at one’s own hands and an experience of threat merely due to the rejecting relationship one has with oneself. If one is self-rejecting, a world filled with possible failure looks frightening. Relationships that may lead to social rejection create fear. Even one’s intrinsic self looks unlikeable, unworthy, and threatening.

The DSM completely ignores research in the self-compassion field and fails to mention the significance of self-acceptance even once in its hundreds of pages.

The Impact of Shame on Interpersonal Relationships

The vast majority of people who have been adversely affected by the five causative factors respond to feelings of shame and fear with what in Emotion-Focused Therapy (EFT) is called “primary maladaptive shame.”

"This shame was once a useful response to interpersonal danger, but now a sense of being worthless or unlovable turns up in response even to minor interpersonal trouble. Maladaptive shame leads to withdrawal and avoidance and to treating self and others badly" [29, p. 58].

Three predictable behavioral responses to poor shame tolerance in interpersonal relationships can be easily identified via the behavior of blame shifting. A simple, but powerful assessment for shame intolerance is to consider: How does the person handle criticism or being held accountable? Do they:

1. Blame others (externalize, deflect or deny shame)
2. Blame self (internalize shame or feel excessive guilt)
3. Avoid blame and shame with social withdrawal, conflict avoidance, or emotional dissociation

In contrast, those with healthy self-acceptance manage embarrassment or failure with equanimity — a balanced ability to tolerate experiences of shame. They have healthy levels of guilt, accurate perceptions of critical messages from others, and appropriate emotional and behavioral reactions. They can self-soothe when they do make mistakes and, as a result, can hold themselves accountable for those mistakes and learn. This improves the relationship with others and with oneself, and reduces symptoms commonly labeled as mental disorders, especially personality disorders.

While the blame-shifting strategies are coping mechanisms intended to protect the emotional status and reputation of the individual, they cause difficulties in relationships. Most significantly, other-blaming is at the root of many relationship problems because of the reluctance to admit fault or be accountable, leading to defensive anger and lack of reciprocity. Other-blaming personalities may engage in coercion and exploitation, emotional and physical abuse, high-conflict arguing, and dominance, as well as narcissistic, authoritarian or anti-social behaviors. Many people come to therapy with trauma-induced anxiety and depression as a result of experiencing this type of narcissistic abuse in child and/or adult relationships.

Shame intolerance is clinically relevant, because nearly all DSM disorders could be re-characterized as blame-shifting strategies.

Self-blamers tend to have mood disorders, perfectionism, OCD, illness anxiety disorder, body dysmorphic disorder, dependent personality disorder, and submissive behaviors in abusive relationships. They are often the victims of abusive or other-blamer personalities, resulting in chronic trauma and worsening self-blame.

Other-blamers may be merely subclinical "difficult" personalities, but behaviors may extend toward narcissistic, anti-social, or borderline personality traits. They may have issues with defiance and anger, dominating and abusive behaviors, entitlement, grandiosity, under-functioning, addictions, and criminality.

Blame avoiders may be diagnosed as schizoid personality disorder, schizotypal personality disorder, schizoaffective disorder, avoidant personality disorder, paranoid personality disorder, or autism spectrum disorder.

Bipolar disorders and borderline personality disorder indicate behaviors alternating between self-blaming, with hypo-arousal or "depressive" symptoms, and other-blaming, with hyper-arousal or "manic" behaviors.

Clinicians must be careful to avoid using a pejorative lens when considering the blame-shifting strategies, but should adopt a compassionate therapeutic approach. These behaviors are learned, self-protective, adaptive traits that arose out of a person's exposure to the five causative factors, especially adverse childhood experiences and emotional neglect.

Clinicians should especially assess for attachment history, because it informs how a client internalized the acceptance or rejection of caregivers, which then mediates adult shame management strategies. A narcissistic parent fails to relate to the child with warmth and acceptance and does not model accountability and healthy shame tolerance, directly teaching a child that admitting fault is unacceptable. A non-warm, unavailable, addicted, or abandoning parent may lead a child to fear further rejection in the form of interpersonal criticism, failure, or disappointment. The result may be one or both of the main insecure attachment patterns:

1. avoidant attachment pattern with guarded withdrawal and avoidance of intimacy
2. anxious attachment pattern with over-compliance and a tendency to appease and please others to gain approval

Attachment style is linked to shame and self-compassion in this way: "[A]voidant attachment style is associated with a greater tendency to disengage from the threat of self-criticism, whereas secure attachment is associated with the ability to tolerate the threat of self-criticism. This may explain why an avoidant attachment style is associated with criticizing others rather than criticizing self (Mikulincer & Shaver, 2016)." (12, p.12]

An understanding of the shame management strategies brings significant benefits to the clinical setting. Blame-shifting is easy to observe and assess. It is highly indicative of the person's inner world and predictive of difficulties in interpersonal behaviors. Relationship problems, usually caused by these shame management strategies, are a major reason for seeking therapy. Yet the DSM ignores the harm caused by blame-shifting strategies on interpersonal relationships and does not even address emotional or physical abuse as a possible reason for psychological distress.

Case Assessment and Formulation

Unlike the DSM, a shame-informed model directly and logically links etiology, assessment, case formulation, and interventions. Assessment naturally arises from the five causative factors, which are the roots of human emotional and behavioral problems.

Under a shame-informed model, case formulation must involve a paradigm shift in the clinician's mind from viewing a patient's behaviors as symptoms of disease to viewing behaviors as adaptive and self-protective.

Instead of the arbitrary classifications of the DSM, clinicians could assess using the following chart. The chart summarizes the five factors and provides a way to conceptualize and plan interventions. Most notably, interventions would be very different for a client with high levels of other-blaming or narcissistic traits compared with a client with more self-blaming traits.

Clinicians should rely on observation, client verbal self-report, and clinical judgment. Assessment tools, such as the ACES questionnaire, may be used as an aid, but should be used judiciously, with clear patient education about their limitations, and are best given as a clinician interview, rather than in written format. Overuse of written self-report assessments may cause patients to infer that these are a formal and scientific way to measure a "disease." Clinicians

who regularly use written assessments of “symptoms” or check-ins about a client’s levels of anxiety or depression train patients to over-focus on their emotional functioning in judgmental, comparative, and stigmatizing ways that is in opposition to a compassion-based approach.

Shame-Informed Model Assessment and Case Formulation Matrix	Rank from 1-10, with 1 being healthiest functioning and 10 being unhealthiest level of behavior
ASSESSMENT PEARL:	How does shame show up in this person's life?
Factor 1: Fear/Threat System 1. Vigilance to Threat NOTES:	____Hyper-vigilance: overly sensitive to threat cues from relationships and environment; irrational and overblown fears and phobias of situations and objects; anxious; fearful; disrupted sleep; sensory sensitivity; suspicion and distrust, hearing voices; hallucinations _____Hypo-vigilance: under-assesses threats, especially from dominant others in relationships; undervalues self-care and self-protection under relational or physical threat; dissociation; limited perception of emotions in self and others; tolerance of abusive or authoritarian (other-blaming) behavior; lack of awareness of boundary violations; passiveness; submissiveness _____Balanced and Flexible Threat Vigilance or Assessment
2. Reactivity to Threat NOTES:	___Hyper-reactive: under-regulation of cognitions, emotions and behaviors. Behaviors include anxiety, irritability, impulsivity, exaggerated startle response, sensory sensitivity, difficulty concentrating, "mood swings", "mania," aggression, poor anger control, emotional volatility, insomnia, hyperactivity, fidgeting, distractibility, pressured speech and thought. ___Hypo-reactive: over-regulation of affect, emotions and behaviors. Behaviors include limited affect or emotional expression, emotionally "numb," "depressed"; under-responsive to the emotional needs of self and others, withdrawal from relationships and emotional connection, slowed or limited response to threats, lack of assertiveness and self-protection. ___Balanced and Flexible Threat Responsiveness

Factor 2: Fear of Social Exclusion NOTES:	Approval Seeking ____Approval seeking: high need for reassurance, achievement oriented, over-functioning to gain approval, narcissistic self-aggrandizing, "people pleasing," appeasing at the expense of personal boundaries, self-aggrandizing, vanity, boasting ____Disapproval avoidance: OCD, perfectionism, over-achieving, social fears and avoidance, few or superficial relationships, fear of failure, avoidance of risk, procrastination, under-functioning, fear of dependence, cannot ask for help, fear of vulnerability. Specific fears of disapproval may include: fear of failure at work, fear of being an ineffective parent, fear of being unpopular, fears of judgment about appearance, etc. ____Balanced Fears of Social Exclusion
1. Assess for social mentality/ hierarchy preference in relationships ("view of other") and flexible or inflexible responding (10/ higher scores = inflexible responding) NOTES:	Social Mentality/Hierarchy ____Dominance toward others, intrusive boundaries, coercive or abusive in relationships, pre-emptive blaming of others, and lack of reciprocity ____Submission toward others, permeable boundaries, tolerance of coercive/abusive relationships, pre-emptive self-shaming and blaming ____Avoidant toward others, guardedness ____Balanced Hierarchy Preference (view of other is non-threatening), flexible responding with assertiveness and submission in appropriate ways, times, and levels.
Factor 3: Shame: Assess for how a person handles relationships when feeling shamed, rejected, or excluded NOTES:	Blame-shifting Strategies (Assess for predominant behavior or mixed behaviors, frequency of responses, intensity of responses.) ____Other-blaming ____Self-blaming ____Blame Avoiding ____Self-Accepting/Healthy Shame Tolerance
	Conduct Fears of Compassion Scale (P. Gilbert) ____Fear of compassion from other ____Fear of compassion for other ____Fear of compassion for self

Additional assessment for shame intolerance: NOTES:	1. Observe affect and body language for sensitivity to shame (poor eye contact, downcast face, blushing, stammering, placating crying, nervous laughter, incongruent emotions, pressured speech, slumped posture, muted affect, passivity, lack of assertiveness). 2. Listen for themes of unworthiness, self-deprecation, self-blaming, or self-judgment. 3. Frequency and severity of self-critical messages (May range from minor thoughts of self-doubt to active suicidality due to extreme self-loathing) 4. Body image issues, eating disorders 5. Evidence of blame avoidance: Isolation, lack of or limited intimate or close relationships, limited social skills, lack of long-term relationships 6. Narcissistic or antisocial behaviors of avoidance of blame and accountability, inability to tolerate criticism, vengeance when shamed, victimhood, self-righteousness, abusive relationships, criminality, exploitative behaviors, self-aggrandizement, vanity. 7. Addictions and lack of accountability for personal choices, irresponsibility, low functioning in life, inability to hold a steady job, frequent relationship changes, financial failures, obesity, poor decision making.
Factor 4: Trauma NOTES:	Assess for significant physically or emotionally threatening life experiences ACES SCORE _____ out of 10 and ____discrimination via race, gender, sexual orientation, immigrant status. class, income level/poverty ____ narcissistic parent or sibling
Factor 5: Attachment Style NOTES:	Complete Adult Attachment Interview (AAI) or similar assessment Attachment patterns of: ____Insecure: Avoidant ____Insecure: Anxious ____Insecure: Disorganized ____Secure or Self-attached/Self-accepting

Factor 5: Attachment Style (cont) NOTES:	Conduct family of origin history, especially for attachment-related trauma, including: ___Parenting style: ___ Authoritarian ___ Permissive ___ Authoritative / Democratic / Balanced ___ Parent(s) warm, loving, close, dependable ___ Child could turn to the parent for emotional support, connection, comfort ___ Parent(s) emotionally neglectful or emotionally withholding ___ Parent(s) harsh, dismissive, rejecting, critical, non-warm, shaming, behaviorally focused or punitive ___ Parent(s) inconsistent in attention or control ___ Parent(s) abandoned through addictions, over-focus on partner relationships, divorce, jail, scapegoating or favoritism ___ Child feared parental neglect, rejection, or abuse ___Parents separated or divorced. Did both parents maintain relationship with the child? ___ Parent had an affair, addiction or other attachment-based issue ___ Chaotic home life, instability, poverty, cultural/racial factors, frequent moves ___ Relationship between parents/stepparents: Modeled warm, affectionate, loving, mutually reciprocal relationships ___ Parent had a personality disorder, depression, anxiety, post-partum depression, etc, even if not formally diagnosed ___Narcissistic sibling, bullying or abuse by sibling ___ Parentification of child or over-protection of siblings against an abusive, narcissistic or neglectful parent

NOTES:	**View of Self and Other** View of other and relationship as: ___ "bad," threatening, rejecting or unsafe (emotionally or physically) ___ "good," accepting, comforting, and safe ___ flexible view of other ___ inflexible (idealized or devalued) View of self as: ___ "bad," rejecting, unworthy and shameful ___ "good," accepting, comforting, and safe ___ flexible view of self ___ inflexible (idealized or devalued)

Interventions in a Shame-Informed Model

A major downfall of the disease model of mental health is that the only cause proffered for "mental disorders" is a biological failure of the brain. This leaves only one path forward in formulating a way to conceptualize treatment and intervention: a "broken brain" requires medications to manage "symptoms." Psychotherapy is only conceptualized as a way to provide coping mechanisms to manage "symptoms" that are expected to persist for a lifetime.

In sharp contrast, a shame-informed model would provide a logical link straight through from causation to case formulation to interventions. Most significant for outcomes and patient outlook is the fact that interventions can actually change psychological functioning.

The five causative factors combine to create an expectable emotional outcome (poor shame tolerance) and resulting behaviors (shame management strategies). Interventions focus on helping clients learn to identify and manage the emotion of shame in adaptive ways with self-compassion.

Therapy must focus on down-regulating the threat system through self-calming and mindfulness meditation, but also focus on re-engaging an underperforming soothing system. Interventions can include those in Paul Gilbert's Compassion-Focused Therapy model and Kristen Neff and Christopher Germer's Mindful Self-Compassion model.

In early therapy sessions, clinicians should organically and briefly weave in psycho-education content on the five causative factors and their impact on the development of unhealthy shame strategies.

Because being a victim of coercive, abusive, or exploitative relationships can activate the threat response, exacerbate self-blaming, and weaken self-confidence, clinicians must actively inquire about a client's history of involvement in this type of relationship.

Other-blamers who have anti-social or narcissistic traits do not easily tolerate direct challenge of their behaviors due to their shame defensiveness. Clinicians must work slowly and patiently to build a therapeutic alliance and trust, then gradually explore deeply hidden issues of self-doubt or insecurity.

Many patients come to therapy already self-diagnosed via website searches, priming them to feel ashamed and stigmatized for having a "brain malfunction" or "genetic condition."

Clinicians should listen for expressions of shame around an assumed "diagnosis" or directly ask about a patient's beliefs about this topic, then educate about the failures of the DSM/ICD model. Clinicians should also be very circumspect about sharing diagnostic labels and should work to de-stigmatize by normalizing the common human experience of emotional suffering.

At initial sessions it can also be helpful to use direct, orienting language that acknowledges the experience of embarrassment. Clinicians may consider addressing this forthrightly and give clients agency to manage their shame: "Most people are very nervous coming to therapy, so I imagine that you are too and so that is perfectly normal. Please let me know if anything I say or ask you makes you especially uncomfortable. We may have to address difficult topics, but I want to do it only in a way that is helpful to you."

In the clinical examples that follow, signs of shame, low self-worth, and blame-shifting strategies are noted to educate clinicians on entry points into compassion-based interventions.

Clinicians can observe shame-based affect or body language and explore these embodied experiences with the patient by engaging in brief embodiment or mindfulness exercises, emotional heightening and exploration, or psycho-education.

Because of the trans-diagnostic nature of shame, compassion-based interventions can be applied to nearly all clinical presentations from major depressive disorder to generalized anxiety disorder to relationship problems. In contrast, the biomedical model encourages disorder-specific treatment protocols, leading to a piecemeal cognitive-behavioral therapy approach for each specific diagnosis of OCD, social phobia, panic disorder, etc. Clinicians must undergo expensive, time-consuming training in each "disorder." Patients with less-specific symptoms, or co-morbid presentations (e.g., mild depression and anxiety), often confuse clinicians who are only trained to approach a single diagnosis with a single intervention protocol.

Of course, the main benefit of compassion-based interventions is not just a temporary reduction in DSM "symptoms," but the permanent modification of maladaptive psychological processes.

Given that the focus of this article is on assessment and case formulation, readers are directed to the numerous books and articles on compassion-focused interventions.

Conclusion

Mental health professionals are ethically bound to protect and help clients. It could be considered unethical to unthinkingly adhere to the DSM with all its harmful effects and lack of efficacy and to ignore other solutions that reduce harm.

The DSM's core construct is that normal human emotional responses are a sign we are broken and need fixing. In contrast, compassion-based therapies provide a hopeful counter narrative. They normalize our human need for love, connection, and worthiness and provide the tools to build inner resources toward self-acceptance.

The good news is that self-compassion is a skill humans already possess. We are not born to live chronically with shame, anxiety, and insecurity. By uncovering inherent self-attachment, one can have improved relationships with others and with the self.

Clinical Examples

Following are clinical examples to further explain how a shame-informed model can be used to assess, develop case formulation, and guide interventions in psychotherapy. Clinical examples have been modified to protect privacy.

Client Presentation and History	Case Formulation
Traditional Diagnosis: Major Depressive Disorder, Recurrent, Severe Robert is a 30-year-old single male whose physical appearance is very slight, even anorexic. He has a stooped posture and seems to try to take up as little space as possible. He was an only child.	His entire physical presence signals shame, deference, and submission. He does not use expansive gestures, posture, or body language. This placating behavior signals he does not want to threaten or burden others and he feels he is not worthy of expressing himself in an authentic, enthusiastic, spontaneous way.
Robert's father was a hoarder with high levels of anxiety. Robert has no positive memories of time spent with his father. He reports feeling his father did not like him and he was unimportant to his father; his father valued "things" more than relationships. He describes his father as "oblivious" and "checked out of parenting."	Robert's parents were preoccupied with their own emotional and behavioral issues. His father had avoidant relationship patterns as evidenced by his hoarding; he chose to be addicted to objects, rather than enjoy positive, nurturing relationships with people, which Robert experienced as rejection. Statements of not feeling important to another, especially a key attachment figure, are a significant marker of unfulfilled attachment need.
His mother was highly critical and rejecting. She told him on a daily basis that she was ashamed of and disappointed in him. His parents inconsistently ignored him or yelled at him for no reason. He remembers crying alone in his room. Parents would never comfort him.	While his father's silent rejection was painful, so was his mother's outright criticism and shaming. Both parents communicated that Robert was not good enough. He learned that his parents were unavailable to console and support him and that criticism came only in the form of heavy-handed shame with no opportunity for repair.
As a child, Robert largely isolated in his room because he did not feel safe around his parents. Robert did poorly in school and was rebellious in his teen years. His mother gave up on him, let him "run wild" and he would leave for days at a time. He began to drink and take painkillers in his teens; drug use continued through his 20s.	He turned inward for solace, but lacked the emotional resilience to provide it for himself because he had not experienced secure attachment. His parents did not set safe boundaries and rules, leading him to believe he was not worthy of feeling cared for and protected. He learned to distrust his own emotions and to self-soothe with drugs, indicators of insecure attachment and avoidance of shame.
His father would feel "attacked" by any type of conflict or criticism, and would "go into silent mode." His father lacked accountability to address his hoarding behaviors, endangering Robert with the lack of cleanliness in the home and the financial stress of spending on hoarded objects.	Robert's father was an other-blamer. Clinicians must assess for narcissistic or emotionally abusive parents, because children raised by other-blaming parents may learn to self-blame and/or may replicate other-blaming. Conflict with other-blamers may range from emotional abuse to rejecting and freezing the child out, both provoking a fearful response. Robert learned that relationships are either about distancing to avoid conflict or about being attacked. He now fears relationships, as they may involve conflict or rejection.
He attempted suicide multiple times starting as a young child and continuing into his 20s. He repeatedly expresses that he feels he is a burden, he does not want others to see his many flaws, and that even his "depression" is a flaw he does not want others to see. He feels hopeless about changing anything in his life.	Suicide is the ultimate signal of low self-worth. If you believe you are deeply unworthy of any human connection, you will isolate from others to avoid being seen as flawed and shameful. A natural response is to try to end this painful realization and isolation. Depression symptoms and suicide are signs of the "fold" response, with individuals giving up in helplessness and a low drive system.

Client Presentation and History	Case Formulation
Robert had several inpatient admissions for depression and suicide attempts. Outpatient therapy focused on the use of cognitive-behavioral therapy, medications, and DSM labeling of his behaviors as “disordered.”	Robert's existing low self-worth from his childhood was exacerbated by the shaming and stigmatizing experience of being in the psychiatric system. Being diagnosed and told he needed lifelong treatment with drugs cemented beliefs about the supposed permanence of his condition and his beliefs of helplessness to change his experiences. CBT is a fundamentally shaming experience because it involves an authority figure correcting the patient’s errant behaviors. CBT also does not address the underlying emotions of fear and shame, or provide compassion-based interventions as an antidote to shame.
Robert is socially avoidant, has no friends, and is highly anxious during even the briefest social interaction. He feels he does not belong anywhere.	His upbringing taught him that relationships were non-comforting at best and threatening at worst. He turns inward for comfort, but then feels isolated and lonely, which increases his sense of shame (“I have no friends, so I must be a loser.”) He over-perceives threat from others in social situations, indicative of hyper-vigilance to rejection.
He reports feeling he will not live up to his potential, assumes others will reject him, and feels unworthy. He feels “the blame always comes back to me.” He is overly responsible, with panic attacks over fears of minor possible failures, such as not waking up in time for work. He cannot ask for assistance, has difficulty being vulnerable, and cannot give or accept compliments.	Self-blamers learn they cannot be angry at parents, so they internalize anger. Robert uses self-blame to fix himself so he will not be criticized and rejected —something he was trained to do by critical and rejecting parents. Clinicians can use a client’s inability to ask for help or receive compliments as doorways to work with shame. Fears of asking for help are indicative of fear of dependency and vulnerability, fear of appearing inadequate, and beliefs that he is unworthy of someone coming to his rescue.

Client Presentation and History	**Case Formulation**
Traditional Diagnosis: Attention-Deficit/Hyperactivity Disorder (ADHD) and Oppositional Defiant Disorder (ODD) Connor is a 9-year-old male who has hyperactivity and attentional issues, along with disobedience and disrespect. He becomes angry when disciplined, but also clings to his mother. He texts or calls incessantly when she leaves and does not calm down until she returns. Rages began as a toddler and he now punches holes in the wall and slams doors hundreds of times.	Connor is overly attentive to and solicitous of his mother, a clear sign of anxious attachment. Many clinicians might miss the clinging behaviors by focusing on more obvious oppositional behaviors. They are related. Children who feel emotionally safe are less likely to become fearful and then self-protectively angry. Connor is alternating between various responses to find a solution that helps him feel safe and calm. He is seeking emotional connection that is not inherently present in his family.
Behaviors include fidgeting, lack of focus, hyperactivity, difficulty doing homework, and homework refusal.	“ADHD symptoms” are merely hyper-reactivity to threat. Many children report being distracted by thoughts of unworthiness or fears of failure while they are doing homework (“I can’t do this,” “I am a slow learner,” “I don’t want to make a mistake,” “What if I get a bad grade,” etc). Internal self-shaming messages trigger the threat response, leading to worry, distracted thinking, poor memory, low self-motivation, and poor performance.

Client Presentation and History	Case Formulation
His father is an alcoholic, has frequent rages, and blames others extensively for his problems. Father gets angry, then leaves the home for days, and did this throughout Connor's childhood. Connor's parents have consistently modeled anger and are highly anxious, so he does not feel calm. They do not provide emotional attunement and responsiveness to help him learn to regulate emotions in a safe environment.	Connor mimics his father's emotional dysregulation and poor shame tolerance with oppositional other-blaming. Connor has learned that relationships are not about mutual caring, trust, and safety. Connor experienced being abandoned physically and emotionally by adults who are unable to manage their own emotional needs and distress. Alcohol abuse is a sign of the father's insecure attachment pattern and likely high levels of anxiety and shame that he is self-medicating. Addictions are a sign of poor bonding in the addict's childhood. His father may lack the experience of being compassionately cared for, making it unlikely that he will know how to bond with his children.
Connor rages to the point of blackout and reports enjoying feeling exhausted and calmer after his rages.	Connor has learned an unhealthy way to regulate his threat-based emotions by becoming enraged, which leads to eventual feelings of calm.
Connor used to get good grades in school, but now gives up easily and has low motivation.	Homework resistance and low drive are indicative of avoidance of shame, as well as the "fold" response of the threat system. Those who do not have self-compassion lack the skill of responding with warmth when they fail. Many parents and clinicians may focus on behavioral changes, such as helping the student remember to turn in homework, not realizing that shame intolerance is creating an emotional block that will resist behavioral changes. If a person has not learned to meet themselves with kindness when they fail, they will resist risks and failures for fear of facing a judgmental self in the future.
When he was a toddler, Connor's parents used timeouts and consequences to enforce behavior.	Timeouts isolate a child during emotional distress, signal parental rejection, and teach a child that normal emotions and behaviors are shameful. The child does not get a parent to co-regulate and comfort, which helps the child learn to manage emotions. When parents lecture at length about logical consequences to an embarrassed child, it provokes additional shame, possibly leading to more tantrums. The original behavior was "bad," but if children fail to calm down, it leads to further parental negative reactions, followed by a child's self-criticism: "Why can't I control myself?"
Mother is highly anxious in presentation, has extremely pressured speech, fidgets excessively, and cries easily in Connor's presence.	Children are very attuned to a parent's emotional state even at young ages. An anxious or depressed parent triggers hyper-vigilance in a child: "If my parent is worried, perhaps we are in danger." Anxious or depressed parents are also less likely to be attuned to a child's needs because they are focused on getting their own emotional needs met.
Connor bangs his head on walls. He says he will kill himself or "Why don't you just kill me?" Connor states he feels he is "stupid, crazy, a psychopath, and everything is wrong with me."	Suicidality and self-loathing are clearly indicative of self-blaming behaviors. Not all children are this explicit, but his statements are obvious commentary about shame, self-judgment, and low self-worth. Children may alternate between the three blame-shifting strategies, trying to find a solution to handle difficult emotions and thoughts.

Client Presentation and History	Case Formulation
Both parents denigrate each other, telling Connor that the other parent is a "bad parent." His father told Connor his mother did not want him.	When parents engage in parental alienation and vindictiveness toward a partner, this clearly models other-blaming behaviors. It also may trigger an attachment fear, as the child learns that parents cannot be relied on for a sense of dependable connection. This may eventually cause him to be distrustful of relationships and emotional closeness. Children have difficulty blaming parents for inappropriate adult behaviors, instead defaulting to self-blaming strategies.
Connor becomes enraged when corrected, especially when his mother is getting ready to leave the home. He lashes out at siblings, says "no" to everything his parents suggest, and tenaciously argues with parents, even about minor topics.	A child who becomes oppositional when disciplined cannot tolerate shame and has other-blamer traits. Most parents and therapists try behavioral approaches and medications, both of which trigger additional shaming messages to the child: "You are defective and 'crazy.' You need drugs to fix your broken brain. You are unable to control yourself without drugs." Therapists should instead normalize anger as shame and fear driven and emphasize education to reduce shame-based parenting. Children naturally want to please parents. If they are highly oppositional it is because they have given up on pleasing the parents. A child's lack of prosocial emotions is a sign the child has not been treated with care and empathy and may indicate a lack of self-compassion.
Like many parents, Connor's parents are mostly concerned that he comply and act a certain way. The reasons for his oppositional behaviors are not really of concern to them. When he misbehaves, which may be a normal childhood expression, his parents overreact with criticism and blame.	When parents are concerned about good behavior, a child learns he only gets approval with compliance. Parents should first attune to a child's emotional state, then address behavioral compliance ("Connect then correct."). Lack of emotional connection leads to insecure attachment, reinforcing messages of unworthiness, and triggering a shame/anger loop.
When his father calls on the phone and asks "How was your day?" Connor becomes irritated because "Dad asks too many questions."	Clinicians should be on the lookout for signs of perfectionism or fear of failure as clues to shame intolerance. When questioned further, Connor added that when his father asked questions it "makes me afraid I'll give the wrong answer."

Client Presentation and History	Case Formulation
Traditional Diagnosis: 1) Autism Spectrum Disorder 2) Generalized Anxiety Disorder 3) Attention Deficit/ Hyperactivity Disorder - Inattentive Olivia, 12, presents as much younger in appearance and behavior, yet is also overly serious in thoughts and actions. She wears brands of clothing favored by much younger girls, despite the teasing of peers. She has quirky affect, poor eye contact, and perseverates on unusual topics. She can play video games and read for long periods of time, is a good student, is an accomplished artist, and can sit in therapy compliantly. She is currently on Zoloft and has been on many ADHD medications.	While many clinicians had diagnosed Olivia with attentional and autism spectrum disorders, her behaviors actually largely stem from the emotions of shame and fear.

Client Presentation and History	Case Formulation
For years, Olivia has picked at the skin on her fingers and hands incessantly to the point of bleeding.	Olivia admitted that the skin-picking was calming to her and put her in a "trance," a common reaction of those who self-harm in various ways. While these behaviors can be part of her underlying anxiety, tics and obsessive behaviors are also evident in 50% of children who have been medicated with stimulants. Zoloft and other anti-depressants are known to cause a stimulant effect. When taken off Zoloft, Olivia's tics ceased.
She is intolerant of change and uncertainty, has black-and-white thinking, becomes easily dysregulated with transitions, and needs reassurance about change and uncertainty.	The "friend-or-foe" mindset is an ancient survival skill to help instantly assess danger. Concrete or "black-and-white" thinking is a coping skill to speed decision making and reduce uncertainty. In addition, fears of new situations may be caused by Olivia's fear of making social errors, then experiencing the shame of self-criticism or the disapproval of others.
She has panic attacks in crowds.	Olivia has sensory sensitivity, indicating chronic heightened threat vigilance. She also stated that during her first panic attack she thought she heard someone call her name and began to worry that she had done something wrong.
Olivia has difficulty making and keeping friends. She regularly "snitches" on other students and lectures them on their behavior. However, she is also highly suspicious of peers whispering behind her back.	Other-blaming behaviors include "black-and-white" thinking and being highly judgmental or moralistic about others. Clinicians should watch for clients who are very opinionated, critical of others, and intolerant of others' failings. Other-blaming behaviors often occur in conjunction with self-blaming behaviors, especially in children who have not yet consolidated behavioral patterns. Olivia is hypersensitive to noise and distractions because she feels that if peers are talking in class she will miss what the teacher is saying and she will be less prepared for schoolwork (fear of failure). This makes her lash out at peers and correct them.
When asked how she feels when she is corrected, Olivia stated that she feels "like a five-year-old, retarded, and not a good person."	Being criticized triggers unworthiness, indicative of poor shame tolerance and lack of self-compassion.
She tends to lecture and pontificate on subjects in an overly dramatic manner, rather than relate reciprocally. She has difficulty attending to her emotions or physical sensations. Her voice is loud and intense, and she frequently interrupts adults.	Those who have not had the experience of parental attachment and attunement often over-focus on facts and information, and under-focus on emotional interaction with others. They have not learned the value of emotional connection, with its sensations of safety, comfort, and kindness, making it difficult for them to attend to their own emotional needs or the needs of others. Conversations with them may feel superficial or unsatisfying.

Client Presentation and History	Case Formulation
For years Olivia has resisted brushing her teeth.	This is a good example of how even minor behavioral problems can indicate deeper emotional issues. At first this symptom did not seem to be related to shame, but Olivia finally acknowledged that she had once eaten toothpaste and experienced a stomach ache. So she irrationally connected this experience with her fears of school failure. She developed a fear of getting a stomach ache in school from the toothpaste, which would interfere with her school performance. Her high levels of shame led to her fear failure, which led to what appears to be an irrational "oppositional" behavior.
Olivia was looking at a magazine article on dolphins in the waiting room. She volunteered: "I don't like dolphins and whales or mammals because they are social animals. I like fish because they are solitary animals and don't depend on anyone else. Depending on others is bad. I like animals that can function on their own. They are not a burden to others or waste resources."	In this unexpected and forthright statement we get a significant window into her avoidant attachment patterns. Insecure attachment can lead to a fear of dependency. Clinicians should look for what appear to be inconsequential comments as an opening to fears of dependency or vulnerability that indicate insecure attachment.
As therapy progressed, Olivia was able to note fears that "everybody hates me." She stated she had given up on getting others to like her. As a result, she over-focuses on school success.	Inside the child who appears to be intolerant of others, ("autistic" and lacking in social skills) may be someone who is highly sensitive to rejection. Fear of disapproval makes her both self-blaming and avoidant of social interactions. She has determined that success in school is one avenue to approval—and perhaps self-acceptance.
She is judgmental about others who lack her level of "self-control."	Her fear of failure makes her judge herself harshly, which leads to racing thoughts and obsessive perfectionism. She cannot understand the behavior of others who are not as self-critical. Her intolerance of imperfection in others is a sign that she does not tolerate imperfection in herself.
Reports insomnia symptoms.	Olivia reported an anxiety cycle based on her beliefs of inadequacy and fear of failure: She worries about her homework not getting done and fears she will stay up too late in order to complete it. Lack of sleep will cause her to be sleepy in school. She fears she will fall behind and then also be too tired to study after school, which will make her stay up too late, etc. Clinicians who focus only on cognitive or behavioral interventions to manage insomnia will miss the underlying fear of failure.
Is socially awkward, is accident prone, fears strangers, and prefers to avoid social situations.	Olivia noted her social anxiety and awkwardness come from her fear of "saying or doing the wrong thing." Those who fear disapproval often overthink to avoid making social errors, making them tense and accident prone.

Client Presentation and History	Case Formulation
Traditional Diagnosis: 1) Generalized Anxiety Disorder, 2) Major Depressive Disorder, Mild, 3) Body Dysmorphia Disorder Ashley is a 25-year-old female reporting anxiety alternating with mild depression that has continued since about age 12. She is intelligent and has performed well academically and is accountable in many areas of her life, but has concerns that she is procrastinating on studying for an important licensing examination for her profession.	Self-blamers may present as perfectionistic and set impossibly high standards for themselves. Often they may have early academic or athletic success, but then reach a point where they begin to struggle. Their parents and schools may not have taught them how to tolerate failure and shame with equanimity. When they fail, they engaged in self-criticism, and either strive excessively or abandon efforts they cannot complete perfectly. Clinicians can help this type of person develop a "compassionate coach" mindset that is encouraging, but also holds them accountable.
Ashley reports comparing her body and appearance to others, especially on social media. Feels others are constantly judging her looks, weight, clothing, and what she says. Is exhausted most evenings after work or after social events.	Many clinicians will use behavioral interventions, such as encouraging healthy eating, restricting social media use, etc. However, until the internal dialog of criticism is met with more acceptance and compassion, these behavioral changes will not persist. Those with body image issues crave the approval and fear the disapproval of others because of a lack of self-acceptance. Building self-compassion "fills the tank" so that they no longer have an addictive need for external validation.
Ashley initially reports a "normal" childhood, but further investigation reveals her father worked a lot, drank a bit too much, and was loud and authoritarian. Her mother was passive in the face of the father's dominance and while she worried about the children and acted over-protective, she was generally not assertive or competent.	Indicators of non-warm and non-protective parents signal that Ashley may not have experienced a compassionate, attuned, and responsive attachment figure. This may make it difficult for her to provide compassion to herself or accept it from others. An authoritarian parent may have meant Ashley experienced regular harsh criticism focused on behavioral compliance, so this is how she currently relates to herself — with high expectations and harsh self-judgment when she fails. Anxious, ineffective, or passive parents exhibit a lack of competence and an inability to protect children. Ashley reacted to this under-functioning by over-functioning with perfectionism and over-achievement. She also internalized a view of self as lacking in agency, which contributes to anxiety as she over-estimates danger and under-estimates personal resources.
Ashley failed the licensing exam once before. Since then she has rationalized and "tricks" herself into procrastinating on studying.	Ashley procrastinates because she has experienced shame and failure, but without the resource of self-compassion to deal with it. Now she fears a future failure because she knows it will be followed by self-blame and guilt. Many clinicians working with procrastination may focus on her lack of accountability and use behavioral interventions to increase study time. A compassion-focused approach would recognize that shame and fear of failure are blocks that cause her procrastination. Clinicians should help clients develop compassion skills to retrain brain and body to trust that failures will be met with compassion, which makes risk taking less threat-inducing and increases motivation and accountability.

Client Presentation and History	Case Formulation
Is obsessed with “transforming” herself, but also reports indecisiveness, low motivation, and feeling “stuck” in her life. Has rigid patterns of thinking and behaving. She believes every decision is important because it must bear the weight of transforming her completely, leading her to fear making any decision.	Those who feel very unworthy may be driven to transform themselves in an attempt to pull themselves out of their state of self-rejection. They may attach major importance to a decision, because it is viewed as a way to "fix everything that is wrong with me” and heal their shame. Paradoxically, they also fear decisions because the results may not work out well and they will engage in self-criticism about the decision. They toggle between fearful drivenness to recreate themselves as worthy humans and a hopelessness (“fold” response) because of the fear of failing at this task. Rather than label this as “bi-polar” or “depression,” clinicians should frame this as lack of self-compassion. Therapy should focus on helping a client recognize they need to accept their authentic personality, rather than transform it via self-rejection.

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