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Shame, self-criticism, self-stigma, and compassion in Acceptance and Commitment Therapy

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Within the past decade, empirical evidence has emerged supporting the use of Acceptance and Commitment Therapy (ACT) targeting shame and self-stigma. Little is known about the role of self-compassion in ACT, but evidence from other approaches indicates that self-compassion is a promising means of reducing shame and self-criticism. The ACT processes of defusion, acceptance, present moment, values, committed action, and self-as-context are to some degree inherently self-compassionate. However, it is not yet known whether the self-compassion inherent in the ACT approach explains ACT's effectiveness in reducing shame and stigma, and/or whether focused self-compassion work may improve ACT outcomes for highly self-critical, shame-prone people. We discuss how ACT for shame and stigma may be enhanced by existing approaches specifically targeting self-compassion.

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Introduction

Empirical evidence continues to mount demonstrating the effectiveness of Acceptance and Commitment Therapy (ACT) across a wide range of conditions [1–3]. In many head-to-head trials, ACT outcomes are comparable to those in more established gold-standard treatments for a particular difficulty, but only sometimes outperform those treatments [4,5•]. Thus, efforts need to shift from 'Is ACT effective?' to researching processes of change that may provide guidance for how to further improve outcomes. One way to improve outcomes would be to focus on new transdiagnostic processes, such as self-criticism and shame, which have been shown to play important roles in a variety of psychological disorders and issues, including depression [6], post-traumatic stress disorder [7], borderline personality disorder [8], eating disorders [9••], schizophrenia [10], addiction [11••], paranoid ideation and social anxiety, and [12] narcissistic personality disorder [13].

An important contributor to self-criticism and shame is the societal devaluation of stigmatized identities. Shame is the emotional core of the experience of stigma [11••] and tends to involve fusion with beliefs of being flawed or unlovable [14]. Self-stigma involves the internalization of a socially devalued status. Shame, the main emotional component of stigma, impedes social engagement [15], promotes interpersonal disconnection [16], and interferes with interpersonal problem solving [17]. The ashamed person's perspective is narrow, focused inward toward thoughts of a 'bad self' [14]. In contrast to the socially-distancing and isolating effects of shame, compassion tends to evoke more flexible ways of responding and includes behavioral repertoires around caring for and relating to self and others that are associated with affilliative emotions such as warmth, interest, sympathetic joy, and pride [18]. As such, clinical interventions targeting shame and self-criticism often focus on fostering self-compassion [19–21].

Self-compassion is fundamentally about self-to-self relating, wherein a person responds to their own behavior with the same sort of caregiving repertoire that one might apply to a friend, loved one, or other beloved person. This is a fairly complex cognitive task that requires the person to be able to observe their own behavior and respond to it in a manner that evokes these evolved caregiving repertoires. A central task of working with high self-critics is activating and cultivating these caretaking repertoires as they apply to oneself.

To date there have been a number of ACT studies looking at issues of self-criticism, shame, and self-stigma. However, with the exception of one pilot study [22••], none of this work has focused on self-compassion as a potential process variable. Below is a brief review of the existing research on ACT for shame and stigma, followed by considerations for the important role self-compassion may have in this work. Figure 1 also summarizes research examining ACT for shame and stigma, as well as research relevant to compassion in ACT.

Evidence supporting ACT for stigma and shame

In the past decade, several studies have examined ACT interventions for stigma and shame. Of particular relevance

Figure 1

Concepts Discussed

Concept Discussed	Supporting Evidence
Acceptance and Commitment Therapy appears to be effective in addressing shame and self-stigma	• Internalized shame decreased following a 6-hour ACT intervention supplementing treatment-as-usual in sample of people addicted to substances (open trial) [23]
	• Compared to control, a 6-hour ACT intervention led to decreased substance use, increased treatment attendance and less shame (randomized controlled trial) [11]
	• Compared to control, a daylong ACT intervention led to improved quality of life, and reduced self-stigma and body mass in a sample of people with obesity (randomized controlled trial) [24]
	• Following 6-10 ACT sessions, sexuality-related distress and internalized homophobia improved in individuals with concern about sexual orientation (multiple baseline design) [25]
	• HIV-related stigma and psychological distress decreased following combined ACT and Compassion-Focused Therapy intervention (pilot study) [22]
Self-compassion is a potential process variable in ACT	• Self-compassion was a robust mediator of improvement in chronic pain (open trial) [28]
Compassion-based techniques may enhance ACT for shame and self-stigma	• HIV-related stigma and psychological distress decreased following combined ACT and Compassion-Focused Therapy intervention (pilot study) [22]

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Concepts discussed.

to treatment are several studies focused on self-stigma, or the devaluation of oneself and related fears of being stigmatized due to identification with a stigmatized group. Two studies provide support for the application of ACT for self-stigma and shame related to substance addiction. The first study [23] was an open trial that supplemented treatment as usual with a six-hour group focused on mindfulness, acceptance, and values. Internalized shame significantly decreased following the ACT intervention. A subsequent Randomized Control Trial (RCT) [11••] compared treatment as usual plus the six hour shame intervention developed in the open trial to treatment as usual. In this study, the brief ACT intervention appeared to be successful in increasing treatment attendance and reducing alcohol and drug use, with the result being greater reduction in shame at follow up compared to treatment as usual. Another RCT targeted self-stigma related to obesity [24]. Participants who had completed an intensive weight loss program were randomized to a one-day ACT workshop focusing on self-stigma or a waitlist control. At three month follow up, the self-stigma intervention resulted in larger improvements in quality of life, greater reductions in weight self-stigma, and greater decreases in body mass than the weight list condition. Yadavaia and Hayes [25•] used an ACT intervention to target self-stigma related to sexuality. The authors used a multiple-baseline design to examine the effects of 6–10 sessions of ACT on sexuality-related self-stigma in five individuals who expressed concern regarding sexual orientation. Although the sample size was very small, results showed large improvements in distress related to sexuality, decreases in internalized homophobia, and decreases in believability of judgment thoughts about same-sex attraction. Finally, Skinta et al. [22••] applied a combination of ACT and Compassion-Focused Therapy (CFT) [26] to address self-stigma related to HIV status in a pilot study of five HIV-positive men. Results suggest that the treatment was effective in increasing psychological flexibility and reducing HIV-related stigma.

Taken together, these findings suggest that ACT is an effective approach for reducing self-stigma and shame related to a variety of issues, and generally support the idea that these results occur through weakening the influence of self-disparaging thoughts, decreasing avoidance, and increasing psychological flexibility. The pilot study by Skinta and colleagues [22••] was the first to incorporate explicit compassion-focused work with some promising results, though larger and more rigorous studies are needed. Below we discuss why an increased focus on compassion and self-compassion may be helpful in increasing the effect sizes of ACT interventions targeting shame, self-criticism, and self-stigma.

ACT and self-compassion

While there is growing discussion of the role of self-compassion in ACT [22••,27] only one published study of ACT has examined compassion as a mediator of outcomes, to our knowledge. Vowles and colleagues [28••] found self-compassion to be a robust mediator of outcomes in an open trial of ACT for chronic pain. This finding is particularly interesting because the treatment did not emphasize self-compassion, raising the possibility that self-compassion may be an under-recognized mechanism of change in ACT, and that an increased focus on self-compassion in ACT might result in even greater effect sizes, particularly among populations with high shame and self-criticism.

To a certain extent, self-compassion is implicit in the processes targeted by ACT. Acceptance includes self-acceptance, or embracing a person's experience as it is. Defusion includes gaining distance from and building awareness of self-critical thinking and reducing attachment to a conceptualized self. Self as context involves contact with a transcendent sense of self that is larger than the constricting self-stories of shame and self-stigma. Additionally, self as context interventions often focus on increasing more flexible, empathic ways of relating to oneself and encouraging empathy and a sense of interconnection with others. Contact with the present moment includes awareness of and sensitivity to emotional experience in the moment and flexible responding to those experiences, rather than rigidly ignoring or judging ones' emotions. Values work often includes a focus on relationship values, including identifying values one might choose to have in their relationship with themselves, such as caring and warmth. Those values then inform effective actions that would be consistent with those relationship values, such as self-kindness and self-care.

While self-compassion can be seen as implicitly involved in all ACT work, that implicit self-compassion may need to become a more explicit focus of therapy when working with highly self-critical and shame prone clients. We might gain clues on how to more effectively cultivate these caregiving repertoires as applied to the self by looking to other theories and approaches that featured the concept of compassion more prominently.

Compassion focused therapy [26], for example, involves an explicit cultivation of a felt sense of kindness toward oneself and suggests methods to enhance the embodied experience of affiliative emotion that is an essential part of caregiving repertoires as applied to oneself. While cultivating a value of self-compassion or self-kindness would fit inside most ACT protocols, it would often not be given particular weight unless identified as important to that client. However, it may be the case that clients who are highly self-critical and shame prone would benefit from a more explicit focus on values relating to one's relationship to oneself. High self-critics typically think their self-criticism is needed and essential to keep in check a self that is perceived as weak, out of control, or even evil. As such, kindness and compassion do not seem to be a tenable option. A greater focus on self-compassion might entail emphasizing the construction of a new, potentially more workable relationship with the self based on self-kindness and compassion.

Neff's [29,30] model of self-compassion includes a concept called common humanity, wherein the person realizes that their suffering and personal inadequacies are a normal part of human experience, and that they are not alone in their suffering and self-judgment. This concept highlights the importance of addressing the objectification, otherness, and sense of isolation that is part of shame and self-stigma. It also highlights the importance of developing a more flexible sense of self that is more than the content of one's experience, one that is imbedded in a fundamentally interpersonal context. The idea of common humanity appears to overlap to a great extent with concepts from Relational Frame Theory (RFT) relating to deictic, or perspective taking, frames [31]. RFT suggests that I and you are intimately interconnected in that there cannot be an 'I/Here/Now' without a 'You/There/Then.' In other words, 'I don't get to show up as a conscious human being until you show up as a conscious human being' [32]. From this viewpoint, rather than being fused with an 'I' who is not good enough, a person can notice 'I am not good enough' as a thought and also be aware that others have their own private thoughts and experiences. A host of ACT exercises related to flexible perspective taking could be utilized to develop a more interconnected and less rigidly defined sense of self.

Neff [29,30] also highlights the importance of self-kindness, which includes an expressed and felt sense of warmth directed toward oneself as well as other potentially affiliative emotions. From an RFT perspective, this ability to feel warmth and express warmth toward oneself depends strongly on perspective taking frames being under effective contextual control. Put another way, this

repertoire depends upon a recognition that a part of the self is suffering, followed by a response of another part of the self emerging from a caregiving repertoire: 'From the perspective of the I-Here-Nowness of being, I can view my own suffering as I might view the suffering of another and be touched by the pain in that experience, without the dominant interference of my verbal learning history, with its potential for shaming self-evaluations' [33, p. 96].

Many people have had learning histories that have led to adequate caregiving repertoires. Indeed, even many highly self-critical individuals can engage in these caregiving repertoires with others and experience warmth toward them. However, fusion with self-critical thinking can be a barrier as the highly self-critical person attempts to apply these same caregiving behaviors to themselves. In these cases, treatment may need to focus explicitly on identifying and overcoming barriers to applying affilliative repertoires to the self as they would to another. Processes such as those listed above may help facilitate the kinds of defusion and perspective taking needed to generalize existing caretaking repertoires and their related affilliative emotions to oneself.

On the other hand, some people have had learning experiences that have led to weak or absent caregiving repertoires toward both others and self. For these people, caregiving repertoires, with their associated emotions, may need to be learned more generally. Often these people have experienced abuse, neglect, or betrayal from important others or have a history that was simply lacking in warm, supportive connection. As a result, they may have a tendency to construct a verbal view of others as neglectful, hurtful, or even malevolent. For these people, the relationship with the therapist and direct experience with therapist warmth may be particularly important. In addition, perspective taking interventions may be needed that allow these clients to observe their tendency to automatically construct an abusive or neglectful conceptualized other. Some healthy distance from this conceptualized other may be important in allowing the possibility of actually *experiencing* the warmth expressed by the therapist. Unfortunately, to our knowledge, there have not been any studies directly examining the effect of receiving compassionate warmth from others. More work is needed to determine the role of therapist warmth in enhancing clients' ability to cultivate warmth toward themselves.

Conclusion

Acceptance and commitment therapy successfully improves lives in a wide variety of ways. One fruitful domain for the application of ACT is in addressing self-criticism, self-stigma and shame, which are issues relevant to many people seeking treatment across a range of diagnostic categories. While self-compassion is inherent in the ACT model, there may be important ways to strengthen this process, a process which appears to be particularly important to highly self-critical and shame prone individuals. The rapidly growing body of research on compassion and self-compassion should be attended to by contextual behavioral science treatment developers.

Conflict of interest

None declared.

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