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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.