Self-Criticism and Self-Compassion in Adolescents: Two forms of self-relating and their implications for psychopathology and treatment

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Abstract

Different ways of relating to oneself are linked with distinctive mental health outcomes: shame and self-criticism underpin a variety of psychological disorders, while self-compassion stands as a resource or protective factor related to psychological well-being, resilience and positive development. Despite the fact that compassion-based interventions have flourished over the last decade, holding promising results for adult populations, the integration of compassion in adolescent psychotherapy remains scarcely discussed. The present paper endorses an evolutionary model of human development and psychopathology for outlining our basic affect regulation systems, describing their functioning and development in the context of adolescence. The role of shame and self-criticism as transdiagnostic features is discussed for different forms of adolescent psychopathology, and the process of promoting self-compassion is summarized under specific compassion-based therapeutic models.

Keywords: Adolescence, self-criticism, self-compassion, Compassion Focused Therapy, Mindful Self-Compassion

Adolescence and growing abilities

Adolescence involves a multitude of neurophysiological and psychosocial transitions[1] that relate to developmental tasks that are typical of this period (e.g., to develop emotional independence and a sense of identity), accounting for the challenges and difficulties adolescents have to face and overcome. Social pressure (namely peer pressure) and family/school expectations further complicate these processes. The successful resolution of these tasks reflects on the adolescents' well-being and may prepare them to face the next developmental period – adulthood – or, in turn, may contribute to make them vulnerable to develop an emotional disorder, namely anxiety and/or depressive disorders[2]. Also, the emergence of new cognitive abilities – abstract thinking and metacognition[3] – are responsible for the complex nature of their relationship both with the external world as with themselves. In fact, from childhood to adolescence, the interaction of experience with critical neuroplasticity literally shapes the developing brain from the "reptilian brain" (i.e., brainstem) and the "old mammalian brain" (i.e., limbic region) – and their primitive functions, such as instinctive strong emotions, and breathing, digesting or regulating sleep cycles – to the more evolved cerebral cortex, which is responsible for more complex and sophisticated mental processes that enable sound decision making and planning, regulation of emotions and body, personal insight, flexibility and adaptability, empathy, and morality[4]. The growing importance of peers and the adolescents' cognitive development makes it possible and essential to see themselves through the eyes of others, therefore rendering themselves more vulnerable to experience shame more than ever before. Additionally, the increased ability to compare themselves with others, and the fear of rejection increases the possibility of disappointment with the self, thus leading to shame feelings and self-criticism[5].

Shame, self-criticism and psychopathology

Humans' survival depends on how they relate to others and how others relate to them. Therefore, one core social need is the need to create positive affect in the mind of others[5]. Self-knowledge that one is valued by others will create a sense of security and of personal worth[6, 7]. From childhood to adolescence humans develop cognitive abilities specifically focused on understanding what is going on in the mind of others[8], based on which they build complex models of the self and of the self in relation to others[5]. Shame emerges when the individual experiences the self as being unattractive, undesirable, worthless, inferior or defective in some way[9], especially if particular negative aspects of the self are exposed[10].

Gilbert[11, 12] proposes two types of shame: external shame, related to how the self exists in the mind of others, believing that others see the self as unattractive and will thus be rejected or excluded; and internal shame, related to the way the self judges one's own self, where the individual considers the self as undesirable and bad in some way. Since the development of basic self-conscious emotions (e.g., pride and embarrassment) is particularly noticeable from preschool years onwards[13], first shame experiences will probably happen in childhood, particularly in early experiences with attachment figures, if the child experiences the parents as dismissive or critical, sensing that s/he exists in their mind in a negative way. If this kind of experiences is repeated, it may lead to the development of negative self-evaluations and to internal shame. In later childhood and adolescence, when concerns about social competition and social acceptance become more salient, shame experiences may be even more prevalent, as adolescents are increasingly more sensitive to the image and feelings they generate in peers[5]. Taken altogether, if the child/adolescent experiences others as caring, loving and acceptant s/he will have memories of these emotional experiences, allowing the development of positive self-beliefs, such as "I am lovable"; however, if the child/adolescent memories include experiences of contempt, criticism, abuse, bullying, rejection, s/he will develop a negative view of her/himself, thus feeling unlovable and flawed. This perception of the self will lead to the engagement in defensive maneuvers and strategies to keep the self safe (e.g., submission, appeasing, avoidance, affiliative behaviours). Regardless of how damaging this link between other-evaluation and self-evaluation may seem, it may nevertheless serve an adaptive function: "if I judge myself according to how others judge me, I will be on the safe side, keeping on the track of devaluating myself and behaving submissively".

Closely related to internal shame is self-criticism, regarding how people relate to themselves when they fail or make mistakes. This process is considered an internal shaming process[5]. If being criticized by others triggers external shame, self-criticism triggers internal shame feelings. Therefore, self-criticism can be conceptualized as an inner social relationship, a dominant-subordinate self-to-self-relationship, in which one part of the self accuses, condemns and puts down another part of the self, which feels beaten down and submits[14]. This self-to-self relationship derives from the fact that humans have evolved specific abilities to understand and enact social roles with others (e.g., dominant-subordinate). Thus, these competencies and behaviours to relate with others can be recruited to relate with the self[14].

Additionally, individuals with high shame and self-criticism tend to hold negative beliefs about compassion, which will reflect in fears of compassion – fear of giving compassion to others, receiving compassion from the others, and giving compassion to oneself[15] and studies have demonstrated that self-criticism and psychopathology are especially related to fear of receiving compassion from others and from the self[16, 17]. This may further complicate the activation of the soothing system in difficult life situations and within a therapy context.

As for the origins of shame and self-criticism, some factors related to the absence of warmth, social put-down, dysfunctional modelling and/or inadequate responses to emotional needs have been put forward, including insecure attachment[6], sexual abuse[18], harsh, critical and abusive parenting (like being shout at and being called names)[19, 20, 21] or school/peer bullying[22, 5]. In such environments, shame, self-criticism and a submissive style can be considered helpful defensive strategies and survival tools, especially if the child cannot escape from – blaming powerful others is too risky[23]. After all, in unsafe contexts, the defense system is tuned to a "better safe than sorry" processing, i.e., it is better to assume a threat and behave accordingly (take defensive action, namely a submissive behaviour) than to miss a threat[24]. Later on, when this process is internalized, self-criticism acts as self-monitoring system constantly looking for internal threats – weaknesses and flaws – and condemning the self[23], in an almost non-stopping process of "internal bullying".

According to Gilbert and colleagues[14], self-criticism may have different forms and different functions. In the first case, in face of mistakes, the self is viewed as inadequate and feels defeated or angry for having made the mistakes ("Inadequate Self"); in these instances, usually, self-criticism is aimed at correcting behaviour (people believe that self-criticism will help to prevent future mistakes). However, in another form of self-criticism ("Hated Self"), the self is viewed as bad, defective, disgusting and worthless, and self-criticism is aimed at harming, attacking, persecuting destroying/eradicating (parts of) the self. This latter function of self-criticism is considered to be more pathogenic[25, 26, 27] and relates to toxic and pervasive mental problems[17].

Despite the fact that shame can help to regulate social behaviour – it acts as a warning signal that one is not creating positive feelings in the minds of others, being at risk of rejection and leading to defensive behaviours to cope with that[28] - the dysregulation of shame has consistently been found to be associated with psychopathology, both in adults (e.g., depression, post-traumatic stress disorder, anxiety disorders, eating disorders, personality pathology, suicidal and self-injury behaviour and substance abuse) and in adolescents (e.g., anxiety disorders, depression, non-suicidal behaviours, risky and illegal behaviour)[29]. Similarly, self-criticism has been identified as a trans-diagnostic feature underlying psychopathology, including anxiety, depression, interpersonal difficulties, self-harm, eating disorders, PTSD, substance use[16, 17], and in adolescence it predicts latter difficulties with adjustment[30]. Globally, these results highlight the importance of shame and self-criticism as trans-diagnostic features, while suggesting that different ways of coping with shame may result in distinctive clinical manifestations, such as internalizing and/or externalizing problems.

Affect regulation systems

Shame and self-criticism are thought to be related to the threat system, one of the three emotion regulation systems that research in neurophysiology of emotion has been hypothesizing[31, 32] the threat and protection system; the drive, resource-seeking system; and the soothing and safeness system.

The threat and protection system operates through the motto "better safe than sorry"[24], is quickly activated by potential threats, and activates feelings, like anxiety or anger that will urge us to take action to protect from threat. In this system, serotonin may play a crucial role[33]. The drive resource-acquisition system is a motivational system of "seeking out" that guides us in the direction of important goals (e.g., performance goals, friendships). It activates positive feelings, like excitement or pleasure and may be related to the dopaminergic system[34]. Both systems are shared with the other species (to survive and seek out resources) but, in humans, they interact in complex ways, aiming to avoid negative events - for instance, a person may want to achieve a high status (drive system) to avoid feelings of rejection (threat system). Finally, the soothing and safeness system is activated when animals (namely mammals) do not have to deal with threats or seek resources. It provides a calm positive affect, feelings of peacefulness and well-being that are different from the positive feelings elicited by the drive system. This system is thought to be linked to oxytocin and to attachment behaviour, where caring and kindness from parents have a soothing effect on the child, providing a sense of "social safeness"[31, 32]. There is evidence that, since birth, the brain has specialized systems that are highly sensitive and responsive to social cues (voice tone, touch, facial expressions), and that these social signals regulate emotions and physiological processes[35]. Therefore, the soothing system, associated to positive affect in social relationships, will help people to feel safe and allow sharing and caring[31].

Early experiences of abuse, neglect and criticism may overstimulate the threat system, therefore accounting for shame and self-criticism when things go wrong, that will later characterize the individual[9]. On the contrary, being cared for, loved, protected, supported and valued will stimulate the soothing system, providing memories that will be recruited in the future both to relate to the others and to the self. These memories will provide a valuable tool to deactivate the threat system, enabling an alternative response of self-support, self-reassurance and self-compassion to deal with failure, and helping the individual to self-regulate when facing adversity and stressful situations[36, 37, 38].

These three emotion regulation systems are interactive and mutually affect each other, in a way that when one is activated, the other two deactivate. Gilbert[32] argues that these systems can be unbalanced and that this would relate to psychopathology. The overactivity of the threat system and/or of the drive system is found in individuals with high shame and self-criticism, who find it hard to self-regulate through the soothing system, therefore rarely feeling safe or content. Taken to therapy, this information means that even if individuals are helped in reducing self-criticism, this does not mean that they will be able to active self-soothing abilities[23]. In line with this, the strengthening of the soothing system should be the aim of therapy.

Activation of the soothing system: promoting self-compassion

If signals that are perceived as threatening, either located in the outside or in the inside (i.e., coming from the self) activate the safety-seeking threat protection system, an attitude of care, empathy and warmth, (also either coming from the outside or from the inside) will activate the soothing system.

According to Gilbert and Irons[23], this last kind of an attitude represents some of the attributes of compassion. These authors, conceptualized compassion in evolutionary terms as a multi-dimensional response to suffering, sadness and distress that includes several core components, embedded in a global attitude of warmth: care for well-being, non-judgment, sensitivity, sympathy, empathy, and distress tolerance. Self-compassion is directing all these components to the self.

Neff[39, 40] talks of self-compassion as a healthy attitude and relationship with oneself, especially in times of difficulty, and defines self-compassion as "being touched by and open to one's own suffering, not avoiding or disconnecting from it, generating the desire to alleviate one's suffering and to heal oneself with kindness"[40, p.87], considering it an effective emotional regulation strategy in times of suffering[41]. Furthermore, Neff[40, 42] operationalized self-compassion as consisting in three main elements: kindness – being self-supportive and understanding to ourselves, instead of self-critical and harsh; common humanity – recognizing that everyone fails and everyone suffers, instead of feeling abnormal and isolated from the others; and mindfulness – being aware of painful thoughts and feelings, taking them as just that, instead of becoming overidentified with them.

Self-compassion is not the same as self-esteem, self-pity, self-indulgency, passivity, and it does not undermine motivation[40]. Moreover, it has systematically been related to adaptive functioning in adults and in adolescents, being negatively associated with shame, self-criticism, stress, fear of failure, anxiety, depression, self-injury behaviours, trauma, problematic alcohol use, psychological distress, aggression, narcissism, and positively associated with mental health, happiness, curiosity, optimism, life satisfaction, emotional intelligence, adaptive coping with difficult conditions (e.g., divorce, trauma), emotional and interpersonal connectedness, and compassion for others[42]. In the already existing research that has been conducted with adolescent populations[43, 44, 45, 46, 47, 48, 49, 50, 51, 52], results also showed that self-compassion may be an important protective factor against psychological suffering and psychopathology.

A number of interventions aim to help people develop inner compassion and self-soothing abilities[53]. This paper will particularly focus on two of them: the Compassion Focused Therapy (CFT[37]) and Mindful Self-Compassion (MSC[54]).

Compassion Focused Therapy

Developed by Paul Gilbert and colleagues[23, 55], Compassion Focused Therapy is a form of cognitive behavioral therapy aimed at helping people with mental health problems related to shame and self-directed hostility. It is defined as "an integrated therapy that draws from social, developmental, evolutionary and Buddhist psychology, and neuroscience (…), that seeks to build a science of psychotherapy based on research and understanding how our mind works"[32, p. 206]. CFT is based on Gilbert's social mentality theory[36, 6], which describes social mentalities as conditioned patterns of relating to the others and to oneself, developed through the neurobiological activation of affect regulation systems in the brain, influenced by the patterns of relationships the child/adolescent has had with family and peers. Gilbert, revisited the three system theory from Depue and Morrone-Strupinsky[31], and developed a theory and a therapy aiming to help people regulate their emotions by developing the soothing centers of the brain. The main goal of CFT is to change the ways individuals relate to themselves through processes that generate warmth, understanding, nonjudgment, and kindness towards the self. This will be generally achieved by the kind compassionate qualities experienced in the therapeutic relationship, and specifically, through Compassionate Mind Training (CMT).

In therapy, the role of the therapist will be to demonstrate an attitude of compassion, to model such an attitude and to help the patient experience safeness in therapy, with the aim of replacing a self-critical attitude by a self-kind and self-compassionate one[32]. By demonstrating the attributes of compassion – care for well-being, sensitivity, sympathy, empathy, distress tolerance and non-judgement – the main goal of the therapist is to build a warm and safe therapeutic context in which the patient can also develop the same compassion qualities.

At the same time, CMT refers to training compassionate attributes and skills, to influence self-regulation[32, 55]. CMT begins with the construction of a shared case formulation, preferably drawn in a diagram, identifying background experiences (e.g., bullying), basic fears (e.g., being ridiculed), basic safety strategies/behaviours/beliefs (e.g., submissive behaviour) and unintended consequences (e.g., being easily manipulated by others). This is done within a framework of compassion and de-shaming, emphasizing that we all do the best we can to cope with our evolved brain and to deal with suffering. Although some strategies may be aimed at helping the patient to experience the power of the self-critical part in putting him/her down (e.g., the two chairs exercise), self-criticism is nevertheless positively conceptualized – despite the negative result, its intention is usually good. Then, the therapist investigates possible (negative) beliefs about compassion and begins to set the path to work on developing self-compassion. CMT (and the CFT therapist) aims to use the skills of compassion (through the therapeutic relationship and specific exercises) to help the patient develop self-compassion[32]: compassionate attention (e.g., focusing attention on personal strengths and on positive experiences; mindfulness exercises); compassionate reasoning (e.g., generating alternative self-compassionate thoughts); compassionate behaviour (e.g., exposure work within a compassionate spirit); compassionate imagery (e.g., building an image of an ideal compassionate other, which incorporates qualities like, warmth, wisdom, strength, care and non-judgment); compassionate feeling (e.g., experiencing compassion from the therapist); and compassionate sensation (e.g., focusing on body sensations when experiencing self-compassion) (for a more thorough review of Compassion Focused Therapy with children and adolescents, see[56]).

In adults, CMT efficacy was first demonstrated in a pilot study using CFT in a group format[55]. CMT significantly reduced depression, anxiety, self-criticism, shame, inferiority and submissive behaviour and increased participants' ability to self-sooth, and focus on feelings of warmth and self-reassurance. Two recent studies also reviewed research on CFT effectiveness, concluding that it had a significant effect in reducing distress and improving quality of life[53] and that CFT was a promising intervention, particularly for those high in self-criticism, reducing self-criticism, depression, anxiety and disordered eating behaviour, and improving happiness and self-compassion[57].

As a therapeutic approach that attempts to encourage self-soothing behaviors, foster self-acceptance, and help people feel connected to others, CFT may be particularly well-suited to address the most common mental problems and difficulties of adolescents. However, only a few studies on the application of CFT to adolescents have been reported yet. An example is the application of a CFT intervention to young offenders aiming to test the effects of such a treatment over the changeability of psychopathic traits in adolescents[58].

New developments and studies in adolescents will probably arise in the coming years.

Mindful Self-Compassion

Neff and Germer[54] developed an 8-week program for general population, aimed at increasing self-compassion and enhancing well-being, based on Mindfulness Based Stress Reduction (MBSR[59]) but integrating mindulfness and self-compassion exercises. The program includes several meditation practices, both formal (e.g., loving kindness for ourselves) and informal (e.g., self-compassion break), experiential exercises (e.g., motivating ourselves with compassion), and discussion topics (e.g., what is self-compassion and what it is not). It also includes interpersonal exercises to help generate feelings of common humanity. Home practices are also assigned (e.g., writing a compassionate letter), and daily practice up to 30 minutes is highly recommend combining formal and informal practices.

Neff and Germer[54] found that MSC significantly reduced depression, anxiety and stress, and significantly increased self-compassion, mindfulness, social connectedness, life satisfaction, happiness, and well-being. Also, Kirby[53] examined the studies on MSC effectiveness, and concluded that, as CFT it had a significant effect in reducing distress and improving quality of life.

The MSC program for adults was adapted to better fit adolescent characteristics, resulting in the program Making Friends with Yourself (MFY), the adolescent version of the MSC, that teaches the self-compassion components of self-kindness, common humanity and mindfulness in an age-appropriate way[60]. MFY aims to help adolescents cope more effectively with life challenges and emotional distress. A preliminary study[60] found the program feasible and acceptable for adolescents. Furthermore, compared to a waitlist control group, adolescents from the intervention group showed significantly higher mindfulness, self-compassion and life satisfaction, and significantly less depression, anxiety, stress, and negative affect. These effects were predicted both by mindfulness and self-compassion. The authors argue that MFY is a promising program to increase adolescents psychological well-being.

Conclusion

Adolescence is a particularly crucial time to experience different types of difficulties. Major developmental tasks during adolescence may increase adolescents' vulnerability to suffering and psychopathology. Nevertheless, adolescence is also an important period where important skills may be developed, working as protective factors against present and future negative experiences. Self-criticism as a relevant correlate of psychopathology and self-compassion as a health related competency have been proposed as relevant variables to be addressed in clinical interventions with adolescents.

In line with MacBeth and Gumley[61], meta-analysis concluding that self-compassion was an important variable in understanding mental health and resilience, we argue that self-compassion may have a buffering effect protecting adolescents from emotional distress. Enhancement of self-compassion may have benefits for both clinical and non-clinical adolescents, and should be included in adolescent prevention efforts and intervention programs to foster

resilience and well-being. Further research on the efficacy of such kind of interventions with adolescents is clearly warranted.

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