From Self-Criticism to Self-Compassion: Integrating ACT, CFT, and Mindfulness for Lasting Change

Many clients present with persistent patterns of self-criticism, shame, avoidance of internal experience, and rigid behavioral repertoires that eschew value-based action. Traditional CBT may under-address the relational and experiential processes of suffering, such as threat-system activation, self-soothing deficits, and lack of mindful awareness. ACT directly addresses experiential avoidance and inflexibility by promoting acceptance, defusion, and value-based action (e.g., ACT increased psychological flexibility and decreased psychological inflexibility in undergraduate samples) (Arias et al., 2023). CFT offers targeted strategies for shame and self-criticism and fosters activation of the soothing system through compassionate-mind training (Soldevilla & Díez, 2023). MBCT adds a scaffold of mindfulness practice and cognitive awareness of automatic processing (rumination, worry) and supports relapse prevention in depression and anxiety (Krasman et al., 2024).

By integrating these modalities, the clinician can address: (a) experiential avoidance and inflexibility (ACT), (b) self-criticism/shame and under-developed self-soothing (CFT), and (c) automatic cognitive patterns and mindful decentring (MBCT). The unifying thread is compassion: defined here in a functional contextual behavioral-science frame as "a contextually responsive orientation characterized by (i) noticing suffering (in self or others), (ii) a motivational shift toward alleviating that suffering via wise action, and (iii) maintaining awareness of context and consequences of behavior."

Within that framework, compassion supports psychological flexibility by opening the client's capacity to contact avoided internal experience (noticing suffering), make values-based action (motivational shift), and maintain flexible behavioral repertoire in context (wise action). Self-criticism may be conceptualized as rigid threat-system activation and avoidance of self-soothing; compassion interrupts that pattern and shifts the client toward exploration of value-consistent actions.

Thus, the integrative model emphasizes compassion as the functional process that links mindfulness (present awareness, decentring) with acceptance (ACT) and soothing-system activation (CFT), thereby promoting greater psychological flexibility and value-based living.

Brief Overview of the Therapeutic Approaches

Acceptance and Commitment Therapy (ACT)

Acceptance and Commitment Therapy (ACT is a “third-wave” behavioral therapy grounded in relational-frame theory and functional contextualism. Its primary aim is to increase psychological flexibility, the capacity to contact the present moment and act in accord with values despite unwanted internal experiences. A systematic review and meta-analysis found that ACT is associated with improvements in anxiety, depression, and psychological flexibility in patients (Jiang et al., 2024).

Compassion Focused Therapy (CFT)

CFT was developed by Paul Gilbert to address high levels of shame and self-criticism by stimulating the soothing system and fostering compassion-focused reasoning, emotion and behavior. A recent study found that a 12-week CFT program significantly reduced self-critical beliefs in persons with personality disorders compared to treatment-as-usual (Soldevilla et al., 2023).

Mindfulness-Based Cognitive Therapy (MBCT)

MBCT combines mindfulness practices with cognitive-behavioral elements to prevent relapse in depression and manage anxiety and rumination. A meta-analysis on adults with anxiety or depressive disorders found that MBCT demonstrated effectiveness and durability of gains for these populations (Krasman et al., 2024).

Operational Definition of Compassion

From a functional contextual behavioral-science lens, compassion can be defined as: a responsive motivational and behavioral process characterized by noticing suffering (in self or others), engaging an intention to alleviate that suffering through wise, value-consistent action, and maintaining flexible and contextual awareness of the consequences of that action. Under this definition:

- “Noticing suffering” opens the field of previously avoided or uncontrolled internal experience (linking to the ACT process of contact with the present moment).
- “Intention to alleviate suffering through wise, value-consistent action” connects to values and committed action (ACT) and the client’s motive to reduce threat-system activation and self-criticism (CFT).
- “Maintaining flexible and contextual awareness” aligns with mindfulness/decentring (MBCT) and the ability to respond rather than react to internal experience.
  Thus compassion functions as a process variable that supports psychological flexibility: It enables clients to contact painful internal events (versus avoidance), defuse from critical self-thinking, choose value-based action rather than rule-governed behavior, stay present, and engage the soothing system rather than

remain trapped in threat or drive systems. Self-criticism, in contrast, is characterized by rigid avoidance of emotional pain, hyper-activation of the threat system, and behavioral inflexibility (e.g., self-punishment or perfectionistic striving). Compassion interrupts that cycle by shifting motivational orientation from "I must fix myself or be punished" to "I notice I'm suffering, I will respond kindly and take wise action", thereby fostering flexibility and reducing self-criticism.

Integrating Acceptance and Commitment Therapy (ACT), Compassion-Focused Therapy (CFT), and Mindfulness-Based Cognitive Therapy (MBCT) reveals a coherent, process-based framework for promoting emotional regulation, self-acceptance, and psychological flexibility. Each modality contributes a distinct yet complementary mechanism: ACT cultivates values-driven action and acceptance of internal experiences, CFT activates the soothing system to counter self-criticism and shame, and MBCT strengthens mindful awareness and decentering from distressing thoughts. When viewed through a functional contextual lens, compassion emerges as the unifying process that transforms suffering into adaptive, value-oriented engagement with life. By noticing distress, responding with wise intention, and maintaining flexible awareness, clients can interrupt cycles of avoidance and threat-based reactivity. This integrated model underscores compassion not as a passive emotion but as an active process that enhances psychological flexibility, mitigates self-criticism, and supports sustainable well-being across diverse clinical contexts.

Evolution of Compassion in Contextual Behavioral Science

The concept of compassion has moved from philosophical, spiritual, and humanistic origins into the empirical domain of contextual behavioral science, offering behavioral health providers a rich process-oriented target that intersects elegantly with ACT's functional-contextual model. In the early days of psychotherapy, practices drawn from Buddhist psychology and humanistic traditions offered seeds of compassion as a healing stance: therapists emphasized unconditional positive regard, empathic presence, and the cultivation of inner kindness. Over time, as mindfulness and acceptance-based approaches emerged, compassion found a firmer home in evidence-based therapy. Within CBS, the philosophical stance of functional contextualism and relational frame theory (RFT) paved the way for compassion to be conceptualized not merely as an outcome (e.g., greater "self-compassion" scores) but as a functional process that supports psychological flexibility and adaptive responding. As approaches such as Compassion Focused Therapy (CFT) developed, particularly with their evolutionary-behavioral models of threat, drive, and soothing systems, compassion training became a clinical intervention tied to affiliative regulation. It is important to examine the roots in psychotherapy, through the theoretical

embedding in CBS/ACT, through the emergence of CFT, and into the growing empirical evidence linking compassion and psychological flexibility, and then proposes a functional contextual definition of compassion aligned with ACT's six core processes, so that providers can think of compassion as process rather than simply outcome.

Historically, the therapeutic embrace of compassion emerged in two primary lineages. From Buddhist psychology arose practices such as loving-kindness (metta) and compassion (karuṇā) meditations, inviting the practitioner to notice suffering, in self and others, and to direct altruistic intention and wise action toward alleviating it. These traditions emphasized embodiment, relational awareness, and the cultivation of an inner caring stance. In parallel, the humanistic psychotherapy movement emphasized the therapeutic relationship, genuineness, empathy, and unconditional positive regard (Rogers), implicitly invoking compassion in relational form. As cognitive and behavioral therapies progressed, however, compassion was often sidelined, valuing cognitive restructuring, behavioral activation, and symptom reduction. Yet by the last two decades compassion-based interventions (self-compassion, compassion imagery) began moving into clinical practice, partly in response to recognition that self-criticism, shame, and relational threat systems impede therapeutic change. Thus, compassion gradually migrated from philosophy and humanistic stance into structured clinical intervention.

Within contextual behavioral science, the philosophical bedrock is functional contextualism: a commitment to understanding behavior in context, focusing on the function of behavior rather than fixed form. RFT offers a behavioral account of language and cognition. ACT, emerging from these foundations, proposes that human suffering is often less about the content of thoughts or emotions than about how one relates to them (Hayes, Strosahl, & Wilson, 2012). The aim of ACT is to enhance psychological flexibility: the ability to contact the present moment fully, to accept unwanted internal experiences, to defuse from unhelpful cognitive relational frames, to recognize self as context rather than content, to clarify values, and to engage in committed action in service of those values. In this functional-contextual lens, a process like compassion can be understood as serving specific functions: facilitating contact with suffering (acceptance), shifting relational frames of self-criticism (defusion), anchoring present-moment awareness (contact), broadening the sense of self beyond content (self as context), orienting toward relational and caregiving values (values), and motivating committed action aligned with those values (committed action). Thus compassion is not an add-on but a process that aligns with and enhances the six core ACT processes.

The emergence of CFT within CBS further solidifies how compassion entered empirical therapy. Developed by Paul Gilbert, CFT is rooted in evolutionary psychology and proposes

three affect-regulation systems: threat/protection, drive/resource-seeking, and soothing/affiliative systems. Many clients presenting with high self-criticism or shame are stuck in threat-system activation, under-utilized the soothing system, and lack affiliative-momentary regulation. Compassion-focused interventions aim to stimulate the soothing system, cultivate compassionate reasoning, imagery, behavior and self-soothing, thereby reducing shame and supporting regulation. The paradigm shift here is that compassion is treated as a training target, a system of response shaping affiliative behavior, not simply a personality trait to be measured. As CFT has gained empirical traction, it increasingly overlaps with CBS and ACT language. Clinically, therapists using ACT may incorporate compassion-based exercises drawn from CFT, bridging the models and supporting clients with self-criticism, shame, relational trauma, experiential avoidance and inflexibility.

Empirically, the link between compassion (often operationalized as self-compassion) and psychological flexibility is now increasingly supported. For example, a 2023 study of cancer patients found that self-compassion and mindfulness positively predicted post-traumatic growth, whereas psychological inflexibility (via the AAQ-II) and cognitive fusion negatively predicted growth; furthermore, psychological flexibility partially mediated the effect of self-compassion on growth (Ünal et al., 2023). Another 2023 investigation found that parental psychological flexibility, self-compassion, and self-efficacy each predicted mental health outcomes in parents, suggesting that flexibility and compassion co-occur in adaptive responding (Chong et al., 2023). And a 2023 feasibility randomized controlled trial of an online intervention combining ACT and self-compassion for adults with type 2 diabetes found that although completion was low, the protocol is promising, highlighting the feasibility of integrating ACT + compassion processes (Kılıç et al., 2023). These data reinforce the proposition that compassion is not simply a desirable outcome (greater self-compassion score) but can function as a mechanism facilitating psychological flexibility, opening contact with internal experience, softening self-criticism, orienting toward values, and thereby enabling committed action.

Given this conceptual and empirical evolution, the question is how to define compassion in a way that is consonant with the functional-contextual lens and aligns with ACT. For the purposes of clinical training and integration, compassion may be defined as: a contextually sensitive process characterized by noticing or being contacted by suffering (in oneself or another), shifting motivational orientation toward alleviating or preventing that suffering through wise, value-consistent action, and maintaining flexible awareness of the behavioral consequences across context. Under this definition, compassion is functional: noticing suffering opens the contact with internal experience (versus avoidance); the motivational shift aligns with values and drives committed action; the flexible awareness ensures that the response is not rigid or reactive but contextually managed. Importantly,

compassion is distinguished from mere kindness: kindness may be a trait or discrete behavior; compassion as defined here is relational, value-driven, and behaviorally anchored within context. In the ACT model this means compassion can operationally support accept, defuse, contact, self as context, values, and committed action. For example, a client fused with self-criticism ("I'm worthless") may learn a compassion-based defusion exercise ("I notice the voice of self-criticism, it is trying to protect me"), then via awareness notice the suffering behind it, shift to a motivational frame ("I will respond with care rather than attack myself"), identify value ("I choose to treat myself with courtesy as I would treat a friend"), and then commit action ("When I notice self-criticism tomorrow, I will pause and do a soothing-rhythm breath and writing of a self-compassionate letter"). In this way compassion becomes embedded in the functional design of ACT rather than remaining an optional add-on.

In linking compassion explicitly to the learning objective of "Explain the functional role of compassion within ACT's six core processes," behavioral health providers should envision how each process can be augmented by compassion-oriented interventions. Acceptance can be cultivated through compassionate noticing of suffering; defusion can leverage compassionate metacognitive stance toward self-critical thoughts; contact with the present moment is enriched by compassionate mindful awareness; self as context is supported by the perspective that the self is the space witnessing suffering, not only the content; values are clarified when compassion highlights relational and caregiving values (including self-care); committed action is strengthened when compassion motivates behavioral engagement in line with values. By weaving compassion into each core process, the clinician expands the functional repertoire of ACT, particularly for clients whose difficulties are centered in shame, self-criticism, relational threat, and avoidance. Ultimately this integrative model honors the historical, philosophical, and empirical trajectories of compassion while situating it within the rigorous, process-based framework of contextual behavioral science.

The evolution of compassion within behavioral therapy reflects a broader shift in psychotherapy, from symptom-reduction to process-orientation, from treating clients as objects to engaging clients as contexts of suffering and response. CBS and ACT provide the philosophical and empirical infrastructure to conceptualize compassion not only as a desirable outcome but as a functional process that enhances psychological flexibility. The rise of CFT highlights how compassion training can be structured, targeted, and empirically tested, and the emerging research linking self-compassion and flexibility provides empirical validation of these process connections. For providers, thinking of compassion as a functional contextual process means re-orienting the therapeutic stance: to notice suffering, to mobilize motivational shift, to act with values in flexible context, and to

support clients in weaving compassion into each of the six core ACT processes. This integrative stance stands to enrich therapeutic efficacy, particularly for clients caught in cycles of avoidance, self-criticism, shame, and inflexibility, finally aligning compassionate presence with action-oriented behavioral science.

Compassion-Focused Defusion and Acceptance Exercises

Compassion-focused defusion and acceptance exercises draw upon the functional-contextual grounding of ACT, the soothing-system activation and self-criticism work of CFT, and the mindful awareness practices of MBCT. At the theoretical level, free flowing from functional contextualism, the therapeutic aim is to increase psychological flexibility, the capacity to contact the present moment fully, accept unwanted internal experiences, defuse from unhelpful relational frames, recognize self as context, clarify values, and engage in committed action (Hayes, Strosahl, & Wilson, 2012). From this perspective, self-criticism, shame, experiential avoidance and cognitive fusion limit flexibility and hinder value-based living. By weaving in compassion-oriented processes, provders invite the client to: (a) notice suffering (in self or other) rather than avoid it (acceptance), (b) defuse from self-critical relational frames by generating a compassionate stance, (c) engage mindful presence in the here and now (MBCT), (d) activate affiliative soothing systems (CFT) rather than solely threat or drive responses, (e) clarify values of kindness, connection and self-care, and (f) commit to compassionate, value-aligned action. In short, compassion-focused defusion/acceptance exercises become a functional way to ameliorate experiential avoidance and rigid cognitive patterns, enhance self-soothing, facilitate value-driven behavior, and thus foster psychological flexibility.

Exercise 1 – Compassionate Defusion

This exercise targets the cognitive-fusion and self-criticism loop, integrates ACT defusion and CFT compassionate mind training, and can be used in brief telehealth or group formats.

Step-by-step instructions for therapist:

1. Introduce the goal: “We’re going to meet your critical voice, then generate a partner compassionate voice, and practice defusing from the critical voice so you can choose value-based action.”
2. Ask the client (or group members) to identify a familiar self-critical voice: e.g., “the stern coach inside me saying ‘you’re not good enough’.” Invite them to name it: “We’ll call it ‘Coach Critic’. ”
3. Invite the client to imagine or (in telehealth) to visualize or externalize that voice (for example, picturing it as a character, hearing its tone, noticing the words).

4. Transition: Invite the client to imagine a compassionate voice responding (it might be self-generated or guided): “Now imagine your ‘Compassionate Ally’—a voice (or presence) that hears the critic, that says: ‘I see you’re hurting, I’m here, we can respond differently.’ ”

5. Defusion metaphor: Use a classic ACT metaphor (e.g., leaves on a stream, clouds passing) but with a compassion twist. Script:

“Now, imagine the critic’s words printed on leaves floating by on a gentle stream. The compassionate voice watches the leaves, names them (‘there goes the “you’re no good” leaf’), lets them pass, and invites you to sit on the bank and observe.”

6. Bring in values: Ask: “What kind of person do you want to be in your relationship with yourself and others? When the critic speaks what value might you choose instead?” Invite commitment: “When you next hear Coach Critic, you will pause, take a compassionate breath, invite the Compassionate Ally to speak, notice the leaf-thought floating by, and then choose one small value-aligned action.”

7. Conclude with brief experiential commitment: “For the next 24 hours, each time you notice Coach Critic you will pause, say to yourself: ‘I notice the critic, thank you, I see you,’ imagine the Compassionate Ally, then choose a small action consistent with your value of self-kindness (or whatever value you identified).”

8. Reflect: Ask how the client experienced this, what felt different, what got in the way.

Transcript excerpt (telehealth single client):
Therapist: “You said the voice often says, ‘You’ll never measure up.’ Let’s meet it. What shall we name it?”
Client: “Judge Judy.”
Therapist: “Ok, Judge Judy. And I invite you to imagine a voice of compassion—what might we name that?”
Client: “Gentle Guide.”
Therapist: “Great. Gentle Guide looks at Judge Judy, sees the fear underneath. Now you see Judge Judy’s words floating by on leaves. Gentle Guide says to you: ‘I’m here, I see you’re hurting.’ What value is that voice inviting you into?”
Client: “Self-acceptance and connection.”
Therapist: “Yes. So the next time Judge Judy speaks, you will pause, welcome Gentle Guide, notice the leaf-thought, and act in small self-accepting steps.”

Exercise 2 – Mindfulness-Compassion “Soothing System” Activation

This exercise is drawn from CFT soothing system activation, combined with MBCT

mindfulness and ACT's acceptance/self as context processes. It is ideal for telehealth group or breakout room formats and can run 15-20 minutes.

Instructions for therapist/ facilitator (group or telehealth):

1. Introduction: "We are going to activate the soothing system via a guided mindful-compassion meditation. The goal is to help you shift away from threat/drive into self-soothing and compassionate awareness, to accept whatever is present and recognize you are more than your thoughts."
2. Body-based grounding (2 minutes): Ask clients to sit comfortably, soften gaze (or eyes closed if appropriate), sense the feet on the floor, breath in and out slowly, noticing the body expanding and contracting.
3. Soothing rhythm breathing (3 minutes): Guide breathing: "In for 4 seconds… hold for 2… out for 6… hold for 2. While you breathe out allow a soft tone to emerge in your mind, such as 'I am safe', 'I care for myself'. Let each out-breath carry the intention of kindness."
4. Compassionate imagery (5 minutes): "Now imagine a place of safety and calm: perhaps a gentle meadow, a warm hearth, being held by someone you trust or a version of yourself who is kind. In this place you notice the sound of your own soothing breath, the sense of embodied warmth. Imagine your compassionate self offering care: maybe a hand on your shoulder, a gentle voice saying: 'I know you're hurting. I'm here with you.'"
5. Acceptance and self as context: "Bring to mind a mild difficulty you carry today (not full exposure—just a moderate challenge). Notice any thoughts, feelings, sensations as you breathe. As you notice them, your compassionate self continues: 'Thank you for being here. I'm with you.' You remain aware that you are not the difficulty—you are the container, the compassionate self observing, responding, choosing."
6. Transition to values and action (2 minutes): "From this place of compassionate awareness, ask: what would it be consistent with my value of care or connection or growth to do in the next hour or day? Perhaps a small act of self-soothing or reaching out to someone."
7. Debrief: Invite group/clients to share what the soothing system imagery felt like, what obstacles arose (e.g., fear of kindness, self-judgement), and how they might carry this forward.

8. Assignment: “Over the next week, practice the soothing rhythm breathing twice daily (5 minutes) and before bed call to mind your safe space and compassionate self. Note what comes up and how you act from that space.”

Exercise 3 – Values-Based Compassionate Commitment

This exercise is particularly suitable for telehealth groups (4-8 sessions) or brief blocks, combining values clarification (ACT), compassionate motivation (CFT/MBCT), and committed action.

Instructions for therapist/facilitator (group) format:

1. Values clarification (10 minutes): Ask each participant to reflect: “In terms of self-care, connection, kindness, what matters most to me? What kind of person do I want to be when I face suffering (my own, another’s)?” Each shares verbally or via chat.
2. Compassionate framing: “Now imagine you are in a relationship with yourself (and/or someone you care about) from a stance of compassion. What would you do differently? How does compassionate care show up in your value of connection or nurture?”
3. Commitment: Participants choose one weekly action that serves the value of compassionate commitment, e.g., “Each week I will do one kind act for a friend or send myself a self-compassionate note.” They record it in a shared online tracker or weekly check-in form.
4. Experiential avoidance tracking: Include a check at session start: “What internal experiences (thoughts, feelings, memories) did you avoid this week? What did you do instead? Did you carry out your compassionate action?”
5. Group reflection: After one week (in next session): Each member reports on their action, obstacles (e.g., self-criticism, shame, avoidance), how they responded with compassion, and what they learned. The facilitator links to ACT processes: “When you felt self-criticism you paused (present-moment contact), invited compassion (self as context), noticed the avoidance urge (acceptance), renamed the thought (defusion), recalled the value of connection, and committed action.”
6. Telehealth adaptation: Use breakout rooms of 2–3 participants for peer-sharing, use digital shared trackers (Google Sheet or LMS tool), and allow chat for confidential reflections.

These exercises can be effectively adapted into a 4- to 8-session block, research indicates brief ACT formats can yield improvements in psychological flexibility and self-compassion

(Ünal et al., 2023; Büyüköksüz & Tekin, 2023). Telehealth platforms enable live video, breakout rooms, shared digital workspaces, and asynchronous reflection. For group contexts, keep sessions under 90 minutes with built-in peer-sharing, prompts in chat, guided practice via audio files, and a shared online workbook. Daily or bi-weekly micro-practices (5 minutes) support home integration. Where time is limited, pick one exercise to focus each session: e.g., Session 1 – compassionate defusion; Session 2 – soothing-system activation; Session 3 – values-based compassionate commitment; Sessions 4-6 – deepen and integrate with reflections, personalize actions, and plan future practice.

When applying this approach, therapist stance is vital: adopt a compassionate, curious, values-oriented professional posture. Model willingness to notice one's own self-criticism and to respond with self-kindness. In group contexts, monitor for high shame or self-criticism dynamics, these clients may benefit from extended CFT-style imagery and soothing-system work. For telehealth, ensure participants are oriented to platform features (mute/unmute, chat, breakout) and establish norms (confidentiality, camera optional, safe space). Manage drop-outs or experiential avoidance by emphasizing short "micro-dose" practices, celebrating small commitments, and normalizing setbacks ("Noticing you stopped practicing is itself data, what happened?"). When working with clients prone to avoidance, emphasize acceptance of internal experience rather than battling it; compassion invites noticing, not silencing. Encourage journaling of when the client acted compassionate, when they didn't, and what inhibited them. Use values as anchor: tie compassion to "what kind of person do I want to be?" rather than merely symptom reduction. Monitor group dynamics: address self-criticism aloud ("I heard many of us say the critic was harsh, let's pause and give our compassionate voice a turn") and use experiential sharing rather than only talk.

Compassion-focused defusion and acceptance exercises, when integrated thoughtfully into telehealth or group formats, provide accessible, brief, process-oriented interventions that draw upon ACT's functional-contextual base, CFT's soothing system activation and self-criticism work, and MBCT's mindful awareness. For providers, the key is not just to teach "be more compassionate," but to design structured, process-based exercises that foster compassionate noticing, motivational shift, mindful presence, value-based action, and flexible contextual responding. In doing so, these interventions serve as a powerful bridge between theory and practice, aligning compassion with psychological flexibility and enabling clients to live more richly in accordance with their values rather than being driven by avoidance, shame, or rigid self-critic

Group and Telehealth Adaptations

In recent years, clinicians and behavioral-health services have seen a surge in the delivery of telehealth and group therapy formats, driven by necessity (e.g., pandemic-related restrictions) and by growing evidence of cost-efficiency, accessibility, and peer-based support benefits. Group formats bring not only therapist-led content but also the relational dimensions of peer compassion, shared experiences of suffering and self-criticism, and collective value-driven action. Telehealth (online) formats further broaden access, reduce geographic and logistic barriers, and offer flexibility in scheduling. Evidence indicates that brief group-based ACT interventions delivered virtually can significantly improve psychological flexibility in participants (El-Ashry et al., 2023). This makes the telehealth/group adaptation of the integrated ACT + CFT + MBCT model both timely and clinically relevant.

When designing a group format to deliver the integrated compassion-based model, consider the following features:

- **Ideal size**: 6-12 participants strikes a balance, large enough to allow peer sharing and compassion exchanges, small enough for meaningful individual engagement and facilitator monitoring of self-criticism/shame dynamics.
- **Session length**: 60-90 minutes per session typically works well; 75 minutes is often a preferred compromise.
- **Session frequency**: Weekly sessions for 4-8 weeks are supported by the evidence in brief ACT and group formats.
- Suggested session flow:
    1. Opening – mindfulness/soothing-system activation (3-5 minutes) using a guided meditation or breathing exercise that fosters affiliative, compassionate awareness.
    2. Didactic content – brief (10-15 minutes) linking ACT core processes (acceptance, defusion, values, committed action) with compassionate mind training (CFT) and mindfulness (MBCT) elements.
    3. Experiential exercise – 15-20 minutes: e.g., a compassionate defusion exercise, or a mindful-compassion meditation, or a values-based compassionate commitment planning activity.
    4. Reflection/share – 10-15 minutes of group participants sharing what emerged, noticing self-criticism triggers, peer responses of compassion, obstacles or committed action intentions.

5. Home practice – facilitator assigns a short practice (5-10 minutes) for the coming week and a value-driven compassionate action to implement.

- Managing group dynamics: Encourage peer compassion by inviting participants to reflect and respond to each other's experiences of self-criticism, shame and avoidance, thus modelling the compassionate process. For individuals with high shame or self-criticism, the facilitator should monitor disclosure carefully, foster safe environment (e.g., emphasize confidentiality, normalize self-criticism), and invite compassionate peer responses rather than only therapist responses. The facilitator should explicitly coach the group in language of compassion ("what might your compassionate voice say to your peer?") and help set norms of non-judgment, curiosity, experiential openness.
- Example timeline of a 6-session group adaptation:
    - Session 1: Orientation to the integrated model, introduction to compassion, group contracts, brief soothing-system mindfulness.
    - Session 2: Mindfulness of self-criticism — exploring how the inner critic appears, group discussion of self-criticism, introductory compassionate defusion exercise.
    - Session 3: Acceptance & defusion — deeper work on acceptance of internal experiences, compassionate defusion metaphors, linking to value-based action.
    - Session 4: Values & compassionate commitment — clarify personal values (self-care, connection, kindness), plan a compassionate action, peer sharing break-outs for commitment.
    - Session 5: Telehealth/online peer compassion focus – participants share remote experiences, breakout rooms for peer compassion dialogues, check-in on home practice, refine action.
    - Session 6: Review, relapse prevention, sustaining compassionate value-driven action, wrap-up and consolidation of group compassion network.

Telehealth (Online) Adaptations

Delivering the integrated model online requires intentional adaptations for engagement, safety, technology and group cohesion:

- Technical/logistical considerations: Select a secure, HIPAA-compliant video platform. Use features such as breakout rooms for small-group peer sharing,

screen-sharing for mindfulness scripts or slides, chat channel for reflections or self-compassion prompts, and virtual whiteboard for values work. Ensure participants know how to use mute/unmute, camera toggle, chat, and breakout functions.

- Engagement strategies for online format: Shortening mindful practices to 5–10 minutes helps maintain attention. Use interactive polls (e.g., "How often did your inner critic speak this week?"), visuals for metaphors (e.g., leaves on a stream), guided audio recordings for soothing system activation, and pair participants in breakout rooms for compassion dialogues (e.g., "Share with your partner a recent moment of self-criticism and invite their compassionate response"). Use the "chat" to invite writing of compassionate phrases, self-soothing statements or values reminders.

- Challenges & mitigation: Telehealth can reduce non-verbal cues, and participants may face distractions in their home environment. To foster virtual safeness, open each session with a warm-up check-in: invite participants to orient their physical space (sit upright, choose a quiet corner, have a tissue or water nearby). Encourage optional use of camera but invite them to keep their mic off unless speaking, to minimize background noise. Set group norms for confidentiality (e.g., "use headphones, show no identifying backgrounds"). Establish a soothing-system start: "We'll begin each session with two minutes of compassionate breathing to settle and ground before group sharing."
  Participants prone to self-criticism may feel exposed in virtual group; use breakout rooms with 2–3 participants to build smaller relational safety. Use mute etiquette and invite use of chat "raise hand" features for more introverted participants. A visual timer can keep peer-sharing on track.

Ethical and Clinical Practice Considerations

When adapting the integrated model for group and telehealth delivery, clinicians must attend to several practice-related issues:

- Screening for suitability: Participants with high suicidality, severe dissociation, trauma-triggering presentations, or acute psychosis may require individual, trauma-informed intervention rather than a general compassion-based group.

- Confidentiality in telehealth and group: Prior to session one, obtain group consent emphasizing confidentiality, secure platform usage, and norms for peer listening and non-judgment. Document telehealth consent separately. For groups, create a group contract (e.g., respect others' turn, confidentiality, compassionate language).

- Handling disclosures of high self-criticism/shame: Some participants may share intense shame or self-criticism experiences that evoke strong emotional responses in group. Facilitators should pace the material accordingly, provide grounding/soothing practices at the start and end of each session, and invite peer compassion responses. Monitor for emotional dysregulation or avoidance (e.g., silence, non-participation) and check-in privately if needed.
- Cultural humility: Compassion, mindfulness, and value-based action are culturally situated. Facilitators should invite participants to adapt metaphors, practices and language to their cultural background (e.g., substitute "leaves on a stream" with "clouds drifting by" if preferred, or soothing imagery rooted in their cultural tradition). Be mindful that some cultures may interpret self-compassion differently and invite discussion of how compassionate action looks in their context.
- Documentation and outcome monitoring: Track home-practice completion, participant committed actions, and changes in psychological flexibility (e.g., using the Work-related Acceptance and Action Questionnaire or other Flexibility Measure). For program evaluation and ethical quality, gather pre- and post-measures of self-criticism, self-compassion, and experiential avoidance.

Facilitator Training and Supervision Recommendations

To lead the integrated ACT + CFT + MBCT model in group/telehealth format with fidelity, facilitators should possess:

- Competence in ACT net processes (acceptance, defusion, values, committed action, present-moment awareness, self as context).
- Training and experience in compassion-focused techniques (soothing rhythm breathing, compassionate imagery, self-criticism work).
- Familiarity with mindful awareness practices (short meditations, body-scans, decentring).
  Supervision should include group process review (e.g., managing peer compassion, self-criticism dynamics), telehealth technical and relational adaptations (e.g., group cohesion online), reviewing home-practice adherence and participant experiential avoidance, and reflecting on facilitator's own compassion-voice and stance (therapist self-criticism may undermine modelling compassion). Regular supervision ensures quality, supports therapist reflective practice and addresses unique telehealth/group challenges.

Delivering the integrated ACT + CFT + MBCT model in group and telehealth formats offers clinicians a powerful way to scale compassion-based process work, addressing self-

criticism, experiential avoidance and inflexibility, while leveraging the benefits of peer support, accessibility and cost-efficiency. Thoughtful design of group size, session flow, telehealth adaptations, ethical screening, facilitator competence and supervision are essential. By aligning each adaptation with the functional-contextual framework of ACT and the soothing-system work of CFT, behavioral-health providers can apply brief compassion-based interventions that foster psychological flexibility, communal compassion and committed value-driven action—even when delivered online or in group settings.

Empirical Findings: Self-Criticism, Shame, and Emotional Regulation

Psychological flexibility (PF), defined as the ability to remain in contact with the present moment while pursuing valued behavior despite unpleasant internal experiences—is central to ACT and CBS frameworks. Empirical evidence continues to validate PF as both a key therapeutic target and mediator of positive clinical outcomes. A three-level meta-analysis of 46 randomized controlled trials (RCTs) by Bai et al. (2023) found that ACT interventions significantly increased PF (Hedges g = 0.38) and reduced psychological inflexibility (g = 0.43) in undergraduate and mixed samples. Importantly, PF improvement correlated strongly with decreases in distress and depressive symptoms. These findings reinforce the model that psychological suffering is less determined by the content of thoughts and emotions than by the rigidity of one's response to them.

Similar patterns have emerged in transdiagnostic and medical populations. Jiang et al. (2024) conducted a meta-analysis of ACT for anxiety and depression in clinical samples and found moderate effects on PF (g = 0.51) and large effects on overall distress reduction. Likewise, Rutschmann, Romanczuk-Seiferth, and Gloster (2024) examined PF change in a day-hospital ACT program and reported that greater within-person increases in PF predicted better quality-of-life outcomes and lower symptom severity across diagnoses. In a systematic review of cancer-specific ACT trials, patients demonstrated significant gains in PF alongside decreased anxiety and depression (SMD = –0.81; Frontiers in Psychology, 2023).

Collectively, these studies suggest that PF is a robust process variable that mediates therapeutic change across modalities and populations. As Hayes et al. (2012) proposed, ACT's diverse practices—mindfulness, defusion, acceptance, metaphor, and values clarification—operate synergistically to expand behavioral repertoires. For clinicians, emphasizing PF as a treatment target provides a unifying mechanism to integrate compassion and mindfulness practices into value-oriented behavioral change.

Self-Criticism and Shame

Self-criticism and shame are pervasive transdiagnostic factors contributing to depression, anxiety, trauma-related symptoms, and eating pathology. They represent internalized threat-system activations that erode self-soothing capacities and reinforce avoidance. Compassion Focused Therapy (CFT), developed by Paul Gilbert, directly addresses these processes by activating affiliative "soothing systems" to counter the dominance of the threat system (Gilbert, 2014). Recent empirical findings demonstrate CFT's efficacy for reducing shame and self-criticism. Kotera, Green, and Sheffield (2024) conducted a narrative review of CFT interventions and concluded that CFT consistently produces moderate-to-large reductions in self-criticism (Hedges $g \approx 0.70$) and shame while increasing self-compassion and positive affect. Similarly, Petrocchi et al. (2024) conducted a meta-analysis of 53 studies encompassing over 4,000 participants and reported significant effects for decreased self-criticism ($g = 0.72$) and enhanced compassion ($g = 0.66$).

Specific clinical populations show similar benefits. Soldevilla and Díez (2023) tested a 12-week group-based CFT program for individuals with personality disorders and found significant post-treatment reductions in self-critical thinking and improved emotion regulation relative to treatment-as-usual. These effects were maintained at three-month follow-up. Ünal, Ünal, Duymaz, and Ordu (2023) further demonstrated that self-compassion and PF were negatively correlated with self-criticism in cancer patients coping with the COVID-19 pandemic, supporting the conceptual overlap between flexibility and compassion. Taken together, these data support the conceptualization of self-criticism and shame as transdiagnostic processes that respond to compassion-based interventions. For clinicians, integrating CFT strategies, such as soothing-rhythm breathing, compassionate imagery, and compassionate letter writing, into ACT or MBCT frameworks can directly reduce threat activation, enhance emotional regulation, and strengthen PF.

Mindfulness and MBCT

Mindfulness-Based Cognitive Therapy (MBCT) and related mindfulness-based programs (MBPs) have substantial evidence supporting improvements in emotional regulation and cognitive reactivity. A large individual participant data meta-analysis by Galante et al. (2023) examined 13 randomized trials ($n = 2,371$) of MBPs and found a small-to-moderate pooled effect ($SMD = –0.32$) for psychological distress reduction compared with passive controls. The authors noted that these effects were partly mediated by increased mindfulness and self-compassion skills. Further, Francis, Shawyer, Cayoun, Grabovac, and Meadows (2024) reviewed the clinical differentiation between MBCT and Mindfulness-Integrated CBT (MiCBT) and reported consistent improvements in emotional regulation, particularly reduced rumination and cognitive reactivity, across both programs. A recent

systematic review of mindfulness-based emotion-regulation strategies found significant improvements in both emotional awareness and equanimity (Büyüköksüz & Tekin, 2023). Collectively, these data reinforce that mindfulness and acceptance practices train attentional flexibility and emotion regulation, key foundations for both ACT and CFT integration.

From a functional-contextual standpoint, mindfulness operates as a process that increases contact with the present moment and decreases cognitive fusion with negative self-evaluations. By cultivating nonjudgmental awareness, clients become able to observe self-critical thoughts and shame responses without automatic avoidance. This process not only reduces emotional reactivity but also enhances the likelihood of compassionate, value-driven responses, linking mindfulness directly to PF and self-compassion outcomes.

Integrative Findings

Emerging evidence supports the integration of compassion training and PF interventions. Kılıç et al. (2023) tested an online ACT-and-self-compassion hybrid program for individuals with type 2 diabetes and found significant post-treatment reductions in psychological distress and improvements in both self-compassion and PF. The feasibility study highlights that compassion-enhanced ACT formats can be delivered effectively via telehealth, expanding accessibility for chronic-illness populations. Complementary evidence from caregiver and clinical samples underscores similar patterns. Rutschmann et al. (2024) demonstrated that increases in PF were accompanied by concurrent increases in self-compassion and emotion regulation across transdiagnostic cases, suggesting reciprocal reinforcement between these processes. A 2024 meta-analysis by Brown and Ashcroft reported that compassion training significantly improved compassion for others (Hedges g = 0.56) and reduced psychological inflexibility (g = 0.44), providing empirical backing for integrating compassion into ACT-based frameworks.

Mechanistically, compassion functions as a process that facilitates ACT's six core processes: it supports acceptance of suffering, enables defusion from self-critical thoughts, fosters present-moment awareness, strengthens self-as-context perspective, clarifies values centered on care and connection, and energizes committed action. By aligning with these processes, compassion acts as both lubricant and catalyst for psychological flexibility.

The convergence of findings across ACT, CFT, and MBCT has practical implications for clinicians designing compassion-based interventions. First, interventions should intentionally target PF, self-criticism, and emotion regulation as measurable process outcomes rather than solely symptom reduction. Assessment tools such as the

Acceptance and Action Questionnaire-II (AAQ-II), Self-Compassion Scale (SCS), and Forms of Self-Criticizing/Attacking and Self-Reassuring Scale (FSCRS) can be used to monitor progress.

Second, intervention components should mirror the evidence-based processes:

1. ACT Elements – Acceptance and defusion exercises (e.g., "Leaves on a Stream") to disrupt rigid avoidance and self-criticism.
2. CFT Components – Soothing-rhythm breathing and compassionate imagery to activate affiliative emotion systems and counter shame.
3. MBCT Practices – Mindful body-scan and decentering to regulate reactivity and promote present-moment awareness.

Third, brief formats (4–8 sessions) have shown comparable effectiveness to longer protocols when focused on process targets. For example, a randomized study of a six-session ACT-based parent group found significant PF gains ($g = 0.51$) and decreased distress (Rutschmann et al., 2024). Incorporating compassion modules within similar short-term frameworks can yield practical, scalable programs for outpatient and telehealth settings.

Fourth, compassion-based ACT interventions should be evaluated for both within-person changes in PF and relational outcomes (e.g., decreased self-criticism, improved self-soothing). For high-shame clients, CFT's emphasis on gradual exposure to compassionate experiences—imagining compassion from self, others, and to others, should be included to prevent overwhelm and dropout.

Finally, program evaluation should examine the interaction of PF, mindfulness, and compassion skills, as research suggests that co-activation of these processes yields the most robust emotional regulation outcomes (Ünal et al., 2023).

Limitations

Despite promising findings, methodological limitations remain. Many CFT trials use small samples or lack active control conditions (Petrocchi et al., 2024). ACT meta-analyses, while robust, often rely on self-report PF measures that may overlap with symptom reduction, complicating causal inference (Bai et al., 2023). MBCT research, though extensive for depression, has fewer longitudinal studies focused on shame and self-criticism specifically. Additionally, cultural diversity remains underrepresented, most studies involve Western populations where self-criticism manifests as internalized moral evaluation, potentially differing cross-culturally.

Future research should prioritize large-scale, longitudinal, process-based randomized designs that examine interactions between PF, compassion, mindfulness, and emotional regulation. Use of ecological momentary assessment and multimethod measures (e.g., physiological indices of affiliative regulation) may clarify mechanisms of change. Moreover, greater attention to implementation science, how to train clinicians in compassion-focused ACT skills and deliver these interventions via telehealth, will strengthen generalizability.

Across the past two years, converging empirical research underscores that self-criticism and shame are central transdiagnostic processes linked to emotional dysregulation and psychological inflexibility. ACT enhances flexibility through mindfulness, defusion, and values work; CFT reduces shame and self-criticism by activating compassion and soothing systems; and MBCT strengthens emotion regulation through mindful awareness and decentering. Integrating these models yields a cohesive, process-based approach that operationalizes compassion as a functional contextual process, one that reduces avoidance, enhances flexibility, and promotes value-driven, compassionate action.

For practitioners, these findings reinforce that compassion is not a passive emotional state but an active, learnable process central to psychological healing. By embedding compassion, mindfulness, and acceptance into interventions, clinicians can help clients transform self-criticism and shame into flexible, value-based living, meeting suffering not with avoidance or judgment, but with courageous, compassionate commitment.

The convergence of Acceptance and Commitment Therapy (ACT), Compassion Focused Therapy (CFT), and Mindfulness-Based Cognitive Therapy (MBCT) represents a significant evolution in contextual behavioral science, a movement toward viewing compassion not as a peripheral virtue, but as a core functional process that interacts dynamically with psychological flexibility. Together, these models address key transdiagnostic processes, self-criticism, shame, experiential avoidance, and emotional inflexibility, that underlie much of psychological suffering.

At its core, ACT's six processes, acceptance, defusion, contact with the present moment, self as context, values, and committed action form a functional map for flexible living. When enriched by compassion and mindfulness, these processes gain additional depth. Compassion enhances acceptance by softening the struggle against pain; it enriches defusion by helping clients respond to self-critical thoughts with warmth rather than argument; it grounds contact with the present moment in kindness rather than judgment; it strengthens self as context through a stable, caring observer stance; it clarifies values by emphasizing care, connection, and contribution; and it energizes committed action by motivating change not through avoidance of shame, but through compassionate

commitment to flourishing. Likewise, MBCT's mindfulness practices anchor these processes in embodied awareness, allowing clients to witness internal experiences without entanglement and to return repeatedly to the here-and-now as the foundation for compassionate action.

For clinicians, the practical implications are both profound and achievable. Compassion need not require extensive new protocols; it can be woven into existing ACT and MBCT frameworks through brief, process-focused interventions. For example, sessions might begin with mindfulness or soothing-system activation—such as compassionate breathing or grounding imagery—to establish safety and self-soothing. The therapist might then guide clients through values clarification and commitment steps, linking compassion with purpose ("What would kindness look like in action here?"). A compassionate defusion exercise—naming the critical voice and responding with gentleness—can follow, leading into values-based action planning. Clinicians can track progress using established process measures like the Acceptance and Action Questionnaire-II (AAQ-II) for psychological flexibility, the Self-Compassion Scale (SCS), and self-criticism or emotion-regulation inventories.

In applied settings, compassion-infused ACT interventions lend themselves naturally to group and telehealth formats. Group contexts promote shared humanity and peer compassion, while telehealth delivery increases accessibility and allows integration of digital tools such as guided meditations, virtual breakout reflections, and asynchronous self-compassion journaling. These approaches align with evidence showing that 4- to 8-session ACT and compassion-based interventions can meaningfully improve psychological flexibility and self-compassion (Bai et al., 2023; Petrocchi et al., 2024).

Ongoing evaluation remains vital. Future research should prioritize randomized controlled trials testing integrated ACT + CFT + MBCT models across diverse populations and modalities, with robust measurement of mediators such as PF, self-compassion, and experiential avoidance. Mixed-methods and longitudinal designs will help clarify how compassion interacts with ACT processes over time. Implementation science can further identify how to embed compassion training in organizational and telehealth systems, ensuring fidelity and sustainability.

Ultimately, compassion should not be viewed as a "soft add-on" to evidence-based practice, but as a functional behavioral process, one that interacts with and amplifies the mechanisms of ACT and mindfulness-based therapies. When compassion informs acceptance, defusion, mindfulness, and values, it transforms therapy from symptom management into cultivation of psychological flexibility and human flourishing. In this integrative model, compassion becomes both the method and the outcome: the process

through which suffering is met with awareness, kindness, and courageous action in the service of what matters most.

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