

Výzkumné studie

DIFFERENCES IN SELF-COMPASSION AND SHAME IN PATIENTS WITH ANXIETY DISORDERS, PATIENTS WITH DEPRESSIVE DISORDERS AND HEALTHY CONTROLS

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ABSTRACT

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Objectives. The aim of this study was to compare the levels of self-compassion, shame-proneness and internalized shame in samples of patients with anxiety/depressive disorders and in healthy controls.

Participants and setting. Patients with anxiety disorders ($N_1 = 58$), depressive disorders ($N_2 = 57$) and healthy controls ($N_0 = 180$) were administered scales measuring self-compassion, shame-proneness, internalized shame, anxiety and depressive symptoms.

Hypotheses. It was hypothesized that: 1) both clinical samples would demonstrate a lower level of self-compassion and a higher level of shame-proneness and internalized shame than the healthy controls; 2) there will be no significant differences between the anxiety and the depressed sample in study variables; 3) self-compassion would be correlated with shame-proneness and internalized shame in all samples; 4) self-compassion, shame-proneness and internalized shame would correlate with the severity of anxiety/depression among patients with anxiety/depressive disorders.

Statistical analysis. Data was analyzed using the IBM SPSS Statistics software, Version 23. Differences between samples were tested using Chi-square tests, one-way ANOVA and one-way

MANOVA with Bonferroni post-hoc tests. Associations between study variables were further determined by using correlation analysis and regression analyses.

Results. Both anxiety/depressed patients were found to have significantly lower self-compassion and significantly higher shame-proneness and internalized shame than healthy controls. There were no significant differences between the anxiety and the depressed sample in study variables. All correlations were in the expected directions.

Study limitations. The main limitations of this study are possible volunteer bias in healthy controls and conceptual overlap between measured constructs of self-compassion and shame.

key words:

self-compassion,
shame,
self-criticism,
transdiagnostic factors,
comparison

klíčová slova:

soucit se sebou,
stud,
sebekritika,
transdiagnostické faktory,
srovnání

INTRODUCTION

The frequent comorbidity of mental disorders indicates the possible presence of underlying transdiagnostic factors that can manifest differently on the outside (e.g. Caspi et al., 2014; Krueger, Eaton, 2015). Some researchers pointed in this con-

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This research was supported by the Grant Agency of the Charles University under research Grant No. 44317. The study was conducted at the Faculty of Arts, Charles University in Prague.

nection, for example, to the frequent presence of shame (e.g. Gilbert, 2009) or lack of self-compassion (e.g. Nehmy, Wade, 2012) in mental disorders. It is possible that the lack of self-compassion is one of the important factors causing the formation of a wide range of anxiety and depressive disorders. The identification of such factor could improve understanding of these disorders as well as their treatment. But first, let us shortly introduce the concepts of shame and self-compassion.

Shame has long been considered a marker of psychopathology (Gilbert, Andrews, 1998; Lewis, 1971; Tangney, Dearing, 2003 etc.). Research studies documenting the presence of shame in anxiety and depressive disorders, however, have emerged only in the last two decades (e.g. Fergus, 2010; Ghatavi et al., 2002; Gilbert, 2000; Kim, Thibodeau, Jorgensen, 2011; Valentiner, Smith, 2008). Shame is a self-conscious emotion associated with feelings of inadequacy, inferiority and worthlessness and with a desire to hide or conceal deficiencies. It is a “social” or “moral” emotion that can be seen as resulting from the comparison of the self’s action and experiences with the self’s standards. It is closely related to self-criticism and it is usually differentiated from guilt. According to Lewis, the fundamental difference between shame and guilt centers on the role of the self. Shame involves fairly global negative evaluations of the self (i.e., “Who I am”). Guilt involves a more articulated condemnation of a specific behavior (i.e., “What I did”, Lewis, cited in Tangney, Dearing, 2003). Shame is therefore a much more problematic emotion than guilt and, when internalized, it could become pathogenic (Cook, 2001; Tangney, Dearing, 2003).

Self-compassion, according to Neff (2011b) represents an emotionally positive attitude toward the self in instances of perceived failure, inadequacy, or personal suffering. It can be considered as the opposite of excessive self-criticism, self-rejection or “self-coldness” and at the same time a supposed “antidote” to related feelings of shame (see Benda, 2016; Benda, Hamrová, 2016; Benda, Faltová, Dvorská, 2017; Boersma et al., 2015; Gilbert, 2009, 2010). Self-compassion has been the subject of a lot of research and inspired the development of many new psychotherapeutic procedures in the last ten years (see e.g. Desmond, 2016; Germer, 2009; Gilbert, 2010; Neff, 2011a). Existing research confirms that 1) self-compassion is most likely an important predictor of mental health and well-being (Neff, 2011a,b; Trompetter, 2016; Zessin, Dickhäuser, Garbade, 2015) and 2) the lack of self-compassion probably plays an important role in the etiopathogenesis of mental disorders, including anxiety and depressive disorders (Costa et al., 2015; Diedrich et al., 2014; Diedrich et al., 2016; Hoge et al., 2013; Krieger et al., 2013; MacBeth, Gumley, 2012; Van Dam et al., 2011; Werner et al., 2012).

We hypothesize that the lack of self-compassion leads to the formation of shame whenever one experiences something that is perceived to be “wrong” in comparison with one’s self-ideal. And since shame is a painful feeling, various defense mechanisms are then automatically activated, resulting in various surface-level psychopathological symptoms including anxiety or depression. Anxiety in agoraphobia, social phobia, panic disorder as well as in generalized anxiety disorder, for example, may be “shame-anxiety” (cf. Gilbert, 2000; Greenberg, Paivio, 2003) or shame-based unconscious fear of others’ negative evaluation, rejection or humiliation in the future. Also, depressed mood, self-critical rumination or social withdrawal in depression may be based on shame (cf. Greenberg, 2017; Kim, Thibodeau, & Jorgensen, 2011).

Up to this point there have only been a few studies focused simultaneously on both self-compassion and shame in clinical populations (e.g. Ferreira, Pinto-Gouveia, Duarte, 2013; Kelly, Carter, Borairi, 2014). To our knowledge, there is no study investigating both self-compassion and shame in patients with anxiety or depressive disorders.

Objectives and hypotheses

The aim of this study was to compare the levels of self-compassion, shame-proneness and internalized shame in samples of patients with anxiety disorders, depressive disorders and in a sample of healthy controls. The following hypotheses were tested: 1) patients with anxiety or depressive disorders would demonstrate a lower level of self-compassion and a higher level of shame-proneness and internalized shame than healthy controls; 2) there will be no significant differences between the anxiety and the depressed sample in study variables; 3) self-compassion would correlate with shame-proneness and internalized shame in all samples; 4) self-compassion, shame-proneness and internalized shame would correlate with the severity of anxiety among patients with anxiety disorders and with the severity of depression among patients with depressive disorders.

METHOD

Sample selection

All clinical participants were recruited from eleven psychiatric facilities¹ in the Czech Republic. They were all diagnosed by experienced psychiatrists according to ICD-10 diagnostic criteria (WHO, 1992). Patients with anxiety disorders (anxiety sample) were included if they met the following criteria: 1) they presented with a primary diagnosis of phobic anxiety disorders or other anxiety disorders (code F40-F41); 2) were aged at least 18 years old; and 3) had a rating of 10 or higher on the GAD-7 scale (this score indicates clinically significant anxiety, see Spitzer et al., 2006). Patients with depressive disorders (depressed sample) were included if they met the following criteria: 1) they presented with a primary diagnosis of a major depressive disorder, single episode or a major depressive disorder, recurrent (code F32-F33); 2) were aged at least 18 years old; and 3) had a rating of 10 or higher on the PHQ-9 scale (this score indicates clinically significant depression, see Kroenke, Spitzer, Williams, 2001). Participants were excluded from both clinical samples if they had a comorbid diagnosis of any psychotic disorder, personality disorder, substance use disorder, organic brain disorder or mental retardation.

Healthy controls were recruited through an advertisement inviting participants with an interest in self-knowledge to participate in a study concerning the attitude toward the self (shame versus self-compassion). The advertisement was posted on Facebook. All Facebook users residing in the Czech Republic were targeted. Respondents were eligible: 1) if they were 18 years of age or older and 2) if they had a rating of 9 or less on the GAD-7 scale and the PHQ-9 scale. Participants were excluded from this sample if they reported a history of any mental disorder or if they had a score ≥ 10 on the GAD-7 scale or the PHQ-9 scale.

All samples were collected between May and September 2017. All participants were informed about the aim of the study, that participation was voluntary and that personal data would remain confidential. The study was approved by the Ethical Committee of the Faculty of Arts of Charles University in Prague (reference number: 2016UKFF08913).

¹ We would like to thank the medical staff of Psychiatric Hospitals in Prague-Bohnice, Kosmonosy, Havlíčkův Brod and Opava, the Psychotherapeutic and Psychosomatic Clinic ESET in Prague, Fokus Praha and the Departments of Psychiatry at the General University Hospital in Prague, the Military University Hospital Prague, the Institute for Clinical and Experimental Medicine in Prague, the Military Hospital Olomouc and the Regional Hospital Jičín for their kind cooperation.

Measures

Self-compassion. The first scale used in the questionnaire was the Czech version of the Self-Compassion Scale (SCS-CZ, Neff, 2003; Czech version Benda, Reichová, 2016). The original English version is a 26-item, self-report inventory measuring six facets of self-compassion and the overall self-compassion score. In the Czech version, six items were removed from the original scale (items 3, 9, 15, 21, 22 and 23) to achieve the same factor structure as in the original scale (see Benda, Reichová, 2016). Respondents rated each self-statement on a five-point Likert-type scale (from 1 = almost never to 5 = almost always). The sum of scores of all twenty items was used for the statistical analysis.

Shame-proneness. Shame-proneness was assessed using the short form of the Test of Self-Conscious Affect-3 (TOSCA-3S, Tangney, Dearing, 2003; Czech version Dvořáková, 2013). Respondents were presented with a series of 11 situations (scenarios) they may encounter in daily life. Each scenario was followed by 4 possible responses to the situation. Respondents rated the likelihood of each response on a five-point Likert-type scale (from 1 = not likely to 5 = very likely). The measure assesses the four personality traits: 1) shame-proneness, 2) guilt-proneness, 3) externalization (blaming others and circumstances) and 4) detachment/unconcern. For the purposes of the present study, only the shame-proneness subscale of the TOSCA-3S was used.

Internalized shame. Internalized shame was measured using the Internalized Shame Scale (ISS; Cook, 2001 Czech version Hamrová, 2016). It is a self-report inventory designed to measure trait shame. It is composed of two subscales: self-esteem (6 items) and internalized shame (24 items). Respondents rated each self-statement on a five-point Likert-type scale (from 0 = never to 4 = almost always). For the purposes of the present study, only the internalized shame subscale of the ISS was used.

Anxiety symptoms. To assess anxiety symptoms in patients with anxiety disorders and in healthy controls, the Generalized Anxiety Disorder-7 was used (GAD-7; Spitzer et al., 2006, Kroenke et al., 2010; Czech version Daňsová, 2015). GAD-7 has seven items describing the severity of the patient's anxiety over the past 2 weeks. Respondents rated each statement on a four-point Likert-type scale (from 0 = not at all to 3 = nearly every day). GAD-7 scores can range from 0 to 21, and a cutpoint of ≥ 10 denotes a screening cutpoint for clinically significant anxiety. In this study, respondents with a score of < 10 were excluded from the sample of anxiety patients. Respondents with a score of ≥ 10 were excluded from the sample of healthy controls. The sum of scores of the GAD-7 items was used for the statistical analysis.

Depressive symptoms. To assess depressive symptomatology in patients with depressive disorders and in healthy controls, the Patient Health Questionnaire-9 was used (PHQ-9; Kroenke, Spitzer, Williams, 2001, Kroenke et al., 2010; Czech version Daňsová et al., 2016). PHQ-9 has nine items describing the severity of the patient's depression over the past 2 weeks. Respondents rated each statement on a four-point Likert-type scale (from 0 = not at all to 3 = nearly every day). PHQ-9 scores can range from 0 to 27, and a cutpoint of ≥ 10 denotes a screening cutpoint for clinically significant depression. In this study, respondents with a score of < 10 were excluded from the sample of depressed patients. Respondents with a score of ≥ 10 were excluded from the sample of healthy controls. The sum of scores of the PHQ-9 items was used for the statistical analysis.

Statistical analysis

Data was analyzed using the IBM SPSS Statistics software, Version 23. Shapiro–Wilk tests were used to test the normality of distribution of continuous variables. Demo-

graphic differences between samples were tested using one-way ANOVA and Chi-square tests, as appropriate. T-tests were conducted to show gender differences in key study variables in all samples. Associations between study variables were determined by using correlation analyses. Differences in self-compassion, shame-proneness and internalized shame were analyzed using a multivariate analysis of variance (MANOVA) with Bonferroni post-hoc tests. The effect sizes of differences between groups were then calculated in terms of Cohen's *d*. Finally, multivariate regression analyses were performed using self-compassion, shame-proneness, internalized shame, gender and age as predictors of the severity of anxiety or depression.

RESULTS

Demographic characteristics

The final sample consisted of 58 patients with anxiety disorders (69% females; mean age 41.26 years; SD = 13.02 years; mean score on the GAD-7 14.52; SD = 3.59)², 57 patients with depressive disorders (66.7% females; mean age 43.46 years; SD 13.68 years; mean score on the PHQ-9 16.44; SD = 4.18)³ and 180 healthy controls (65.6 % females; mean age 40.55 years; SD 8.43 years; mean score on the GAD-7 3.62; SD = 2.44; mean score on the PHQ-9 3.99; SD = 2.60). Demographic characteristics of each sample are shown in Table 1. Data was analyzed by means of one-way analysis of variance for continuous variable (age) and the chi-square test for categorical variables. Samples did not differ regarding age ($F(2, 292) = 1.625, p = .199$), gender distribution ($\chi^2(2, N = 295) = .230, p = .891$) or educational level ($\chi^2(6, N = 295) = 10.208, p = .116$).

Table 1 Demographic characteristics of study participants

	anxiety sample	depressed sample	healthy controls
Age – mean (SD)	41.26 (13.02)	43.46 (13.68)	40.55 (8.43)
Gender			
Male	18 (31%)	19 (33.3%)	62 (34.4%)
Female	40 (69%)	38 (66.7%)	118 (65.6%)
Educational level			
Primary education (1st–9th class)	5 (8.6%)	5 (8.8%)	4 (2.2%)
Secondary education (apprenticeship certificate)	15 (25.9%)	13 (22.8%)	31 (17.2%)
Secondary education (school-leaving exam)	21 (36.2%)	19 (33.3%)	73 (40.6%)
Tertiary education (college, university, etc.)	17 (29.3%)	20 (35.1%)	72 (40%)

Gender differences in key study variables in all samples

Results of t-tests (see Table 2) indicated significant gender differences in self-compassion ($d = .63$), shame-proneness ($d = 1.07$) and internalized shame ($d = 0.58$) in anxiety sample. Women reported more shame-proneness than men did also in healthy

² 52 were inpatients and 6 were outpatients. 9 patients (16%) had phobic anxiety disorder and 49 patients (84%) had other anxiety disorder. There were no significant differences in the three key study variables between the F40 and F41 subgroups (all t-tests were non-significant).

³ 44 were inpatients and 13 were outpatients. 33 patients (58%) had depressive episode and 24 patients (42%) had recurrent depressive disorder. There were no significant differences in the three key study variables between the F32 and F33 subgroups (all t-tests were non-significant).

controls ($d = .32$). There were no gender differences in key study variables in depressed sample.

Table 2 Means and standard deviations for key study variables related to gender within each sample

a) Anxiety sample				
	Males (N = 18)	Females (N = 40)	t (df)	p
Self-compassion (SCS-CZ)	52.39 (11.32)	45.33 (11.03)	2.238 (56)	.029
Shame-proneness (TOSCA-3S-S)	30.56 (8.21)	39.20 (7.91)	-3.807 (56)	< .001
Internalized shame (ISS-S)	51.89 (18.30)	61.53 (14.83)	-2.127 (56)	.038
b) Depressed sample				
	Males (N = 19)	Females (N = 38)	t (df)	p
Self-compassion (SCS-CZ)	47.37 (6.02)	48.87 (9.47)	-.628 (55)	.533
Shame-proneness (TOSCA-3S-S)	35.11 (7.29)	33.82 (6.97)	.649 (55)	.519
Internalized shame (ISS-S)	55.00 (9.78)	59.13 (15.37)	-1.232 (55)	.224
c) Healthy controls				
	Males (N = 62)	Females (N = 118)	t (df)	p
Self-compassion (SCS-CZ)	63.63 (10.90)	64.67 (11.25)	-.596 (178)	.552
Shame-proneness (TOSCA-3S-S)	26.60 (7.47)	29.14 (8.18)	-2.037 (178)	.043
Internalized shame (ISS-S)	29.94 (14.96)	29.62 (12.36)	.152 (178)	.880

Correlations between study variables in all samples

Bivariate correlations among all study variables in all samples are presented in Table 3. As expected, self-compassion was significantly negatively correlated with shame-proneness and internalized shame in all samples. Particularly high negative correlations between the SCS-CZ and the ISS-S (ranging from $|.509|$ to $|.731|$, $p < 0,01$)

Table 3 Correlation matrix for anxiety sample, depressed sample and for healthy controls

a) Anxiety sample ($N_1 = 58$)				
	SCS-CZ	TOSCA-3S-S	ISS-S	GAD-7
Shame-proneness (TOSCA-3S-S)	-.532**			
Internalized shame (ISS-S)	-.731**	.578**		
Anxiety (GAD-7)	-.452**	.289*	.385**	
b) Depressed sample ($N_2 = 57$)				
	SCS-CZ	TOSCA-3S-S	ISS-S	GAD-7
Shame-proneness (TOSCA-3S-S)	-.401**			
Internalized shame (ISS-S)	-.509**	.280*		
Depression (PHQ-9)	-.263*	.261*	.491**	
c) Healthy controls ($N_0 = 180$)				
	SCS-CZ	TOSCA-3S-S	ISS-S	GAD-7
Shame-proneness (TOSCA-3S-S)	-.433**			
Internalized shame (ISS-S)	-.660**	.550**		
Anxiety (GAD-7)	-.434**	.372**	.514**	
Depression (PHQ-9)	-.384**	.415**	.502**	.611**

** $p < 0,01$; * $p < 0,05$

support the hypothesized link between the lack of self-compassion and the experience of shame. Further to this, in both clinical samples, as well as in healthy controls, self-compassion, shame-proneness and internalized shame were significantly correlated with the severity of anxiety/depression (correlations ranging from $|.261|$ to $|.514|$, $p < 0.05$).

Between-group differences in self-compassion, shame-proneness and internalized shame

Means and standard deviations for key study variables within each sample are presented in Table 4. To confirm differences between clinical samples and healthy controls, a one-way multivariate analysis of variance (MANOVA) was performed, comparing the groups on measures of self-compassion, shame-proneness and internalized shame. A statistically significant MANOVA effect was obtained, $F(6, 580.000) = 41.116$, $p < .001$. Wilk's Λ was .492, indicating that almost 51% of the variance in the dependent variables was explained by the differences between groups (partial η^2 was .298). A series of one-way ANOVA's on each of the three dependent variables was then conducted as a follow-up tests to the MANOVA. As can be seen in Table 4, all of the ANOVA's were statistically significant, with effect sizes ranging from .165 to .496 (i.e. 17 to 50% of the corresponding total variance can be explained by group membership).

Table 4 Means and standard deviations for key study variables within each sample

	anxiety sample	depressed sample	healthy controls	F	p	η^2
SCS-CZ	47.52 (11.50)	48.37 (8.45)	64.31 (11.11)	81.700	< .001	.359
TOSCA-3S-S	36.52 (8.90)	34.25 (7.04)	28.26 (8.02)	28.869	< .001	.165
ISS-S	58.53 (16.45)	57.75 (13.81)	29.73 (13.27)	143.605	< .001	.496

Post-hoc tests (using Bonferroni correction for multiple comparisons) indicated that both anxiety and depressed samples showed significantly lower scores on the SCS-CZ and significantly higher scores on the TOSCA-3S-S and ISS-S compared to healthy controls (all p 's < .001). The magnitudes of difference (Cohen's d values) between both clinical groups and healthy controls were all large ($d = .79$ – 2.07 , see Table 5). As expected, there were no statistically significant differences between anxiety and depressed groups (all p 's > .05). Also, the magnitudes of difference between anxiety and depressed samples were all small ($d = .05$ – $.28$).

Table 5 Magnitudes of difference (Cohen's d values) between samples

	SCS-CZ	TOSCA-3S-S	ISS-S
anxiety sample vs. healthy controls	1.48	.98	1.93
depressed sample vs. healthy controls	1.61	.79	2.07
anxiety sample vs. depressed sample	.08	.28	.05

Self-compassion, shame-proneness, internalized shame, gender and age as predictors of the severity of anxiety and depression

As a last step, two multivariate linear regression analyses were performed in order to determine to what extent, if at all, the three key study variables, gender and age statistically predict the severity of anxiety or depression. Because healthy controls

were only included to our study, if they had a rating < 10 on the GAD-7 scale and the PHQ-9 scale and clinical samples were only included, if they had a rating \geq 10 on the GAD-7 scale (anxiety sample) or the PHQ-9 scale (depressed sample), two combined samples were created for the purposes of this analyses. For the analyses of the severity of anxiety healthy controls and the anxiety sample were combined (A+H sample, $N_{0+1} = 238$). For the analyses of the severity of depression healthy controls and depressed sample were combined (D+H sample, $N_{0+2} = 237$).

When entering all three key study variables, gender and age simultaneously into a multiple regression in the A+H sample, only internalized shame, self-compassion and age but not shame-proneness or gender were significantly associated with the severity of anxiety ($F(5, 232) = 65.890, P < .001, R^2 = .587$, see details in Table 6). Similarly, in the D+H sample, only internalized shame and age but not self-compassion, shame-proneness or gender were significantly associated with the severity of depression ($F(5, 231) = 66.588, P < .001, R^2 = .590$, see Table 6).

Table 6 Results of multivariate regression analyses for three key study variables, gender and age predicting the severity of anxiety or depression

a) A+H sample, $N_{0+1} = 238$							
	F	B	SE	Beta	p	R ²	VIF
(Constant)	65.890	1.915	2.564		.456	.587	
Self-compassion (SCS-CZ)		-.083	.028	-.203	.004		2.723
Shame-proneness (TOSCA-3S-S)		-.016	.035	-.026	.655		1.881
Internalized shame (ISS-S)		.177	.022	.610	< .001		3.096
Gender		.642	.500	.056	.201		1.064
Age		.071	.024	.127	.004		1.041
b) D+H sample, $N_{0+2} = 237$							
	F	B	SE	Beta	p	R ²	VIF
(Constant)	66.588	-1.174	2.962		.692	.590	
Self-compassion (SCS-CZ)		-.051	.032	-.104	.114		2.435
Shame-proneness (TOSCA-3S-S)		.010	.039	.013	.805		1.510
Internalized shame (ISS-S)		.231	.023	.675	< .001		2.567
Gender		.344	.552	.027	.533		1.028
Age		.056	.026	.091	.033		1.020

DISCUSSION

This study, in accordance with previous reports, found that both patients with anxiety and depressive disorders reported significantly lower self-compassion and significantly higher shame-proneness and internalized shame than healthy controls (cf. e.g. Fergus, 2010; Ghatavi et al., 2002; Gilbert, 2000; Hoge et al., 2013; Werner et al., 2012). Results further showed, that the magnitudes of difference in self-compassion, shame-proneness and internalized shame, between both clinical groups and healthy controls, were all large (in most cases bigger than one standard deviation of the given variable, Cohen's d 's ranging from .79 to 2.07) while the magnitudes of difference between the anxiety and the depressed sample were all small (Cohen's d 's ranging from .05 to .28). It was also demonstrated that self-compassion, shame-proneness and internalized shame were significantly correlated with the severity of anxiety among patients with anxiety disorders and with the severity of depression among patients

with depressive disorders. Multivariate linear regression analyses then proved that internalized shame together with age are the best predictors of observed symptoms severity in A+H and D+H samples. Moderate to high correlations of self-compassion with shame-proneness and internalized shame in both clinical samples, as well as in healthy controls, further documented that self-compassion and shame are closely related.

According to our results, females in anxiety sample reported significantly lower self-compassion and significantly higher shame-proneness and internalized shame than males did (Cohen's d 's ranging from .63 to 1.07). And similar gender difference was found also in shame-proneness in healthy controls ($d = .32$). We suppose that these differences may be interpreted as a possible consequence of gender role socialization and gender stereotyping. It seems that females generally tend to be more self-critical and to have more of ruminative coping style than males (cf. Neff, 2003; Neff & Vonk, 2009; Raes, 2010). Another explanation might be that men are generally not willing to disclose such sensitive information as the experience of shame (cf. Else-Quest et al., 2012). But even if highlighting gender differences in self-compassion and shame could be an important target for future research, it was not our focus in this study. And because the differences in means between men in anxiety sample and men in healthy controls were still big enough in all key study variables (see Table 2), we further reported results of unseparated samples.

As was mentioned in the introduction, we assume that the lack of self-compassion and maladaptive shame are perhaps playing important roles in the etiology of a wide range of mental disorders. And although the identification of basically preverbal and often unconscious experiences of self-compassion and shame by the means of questionnaires can be difficult, it seems, that the results of this study are, more or less in accordance with this assumption regarding anxiety and depressive disorders. According to our results, we can at least presume that adding therapeutic techniques designed for developing self-compassion or for shame management to treatments for patients with anxiety or depressive disorders may improve their treatment outcome. Furthermore, there is a possibility that the development of self-compassion could be shown to be an important common factor in almost any successful psychotherapy in the future. Of course, much more research is needed at this stage before a conclusive statement can be made in that regard.

Limitations and future directions

Several limitations should be considered in the interpretation of our results. Firstly, objections could be raised concerning the sampling of healthy controls via Facebook. Although the control sample was comparable with both clinical samples regarding age, gender and education of respondents, results may have been affected by volunteer bias. It is possible that the control sample may be biased e.g. by having a higher proportion of participants with higher motivation levels, more interested in self-knowledge, etc. The sample may thus not be representative of the general healthy population. And therefore, our results need to be confirmed in a controlled study.

Secondly, the present study relied mostly on self-report measures. This leads to concerns about shared method variance as well as concerns about the general validity of the presented data. To further confirm our findings, qualitative research methodologies may be used, evaluating, for example, data from clinical interviews with patients. Additionally, neuroscience research may highlight relevant neurobiological processes

underlying self-compassion and shame in the future. Especially studies focused on neural networks responsible for caring, affiliation, altruism, as well as “threat system”, “soothing system”, “oxytocin system” or vagal pathways might be beneficial in this regard (see e.g. Cozolino, 2016; Eisenberger, Cole, 2012; Klimecki, Singer, 2017; Porges, 2011, 2017; Saturn, 2017).

Thirdly, concerning the Self-Compassion Scale, it needs to be mentioned that three of six subscales of the SCS-CZ (namely self-judgement, isolation, and over-identification subscales) may overlap with the construct of shame and the high correlations between these two variables may therefore be partly a consequence of this conceptual overlap. Also, correlations between (a lack of) self-compassion and anxiety and depressive symptoms may be somewhat inflated by the negative components of the SCS-CZ. Fortunately, this should not have any influence on the group differences, which are the most important findings of the present study. It can be added here that there is an ongoing debate over the factor structure of the Self-Compassion Scale (see e.g. Muris, Petrocchi, 2017) as well as over the definition of compassion and self-compassion (for alternative definitions, see e.g. Jazaieri et al., 2014; Strauss et al., 2016) and it can be hoped that, sooner or later, a new scale measuring self-compassion will be developed with no possible overlap with shame. Up until now, the only self-report instrument available for measuring self-compassion was the Self-Compassion Scale.

Despite these limitations, the current study is among the first to simultaneously investigate both self-compassion and shame in patients with anxiety or depressive disorders and, hopefully, it will inspire further research and discussion in this area. Because we assume the lack of self-compassion and resulting maladaptive shame to be important transdiagnostic factors, future work should confirm the presence of low self-compassion and high shame in other mental disorders as well, particularly, for example, in personality disorders, eating disorders and/or addictions. Also, it would be desirable to closely compare findings of transdiagnostic research, research on self-compassion and research on shame. We believe, that these so far rather independent research streams have much to offer each other. The same can probably be said for therapies focused on the treatment of shame and on the development of compassion or self-compassion (Boersma et al., 2015; Desmond, 2016; Germer, 2009; Gilbert, 2010; Jazaieri et al., 2014; Neff, 2011a; Reddy et al., 2013; Schoenleber, Gratz, 2017). Another interesting comparison could then be made between existing knowledge of self-compassion, shame and some relevant new findings of neuroscience research (see e.g. Cozolino, 2016; Porges, 2011, 2017).

CONCLUSION

The present study showed that both anxiety and depressed patients have significantly lower self-compassion and significantly higher shame-proneness and internalized shame than healthy controls. The lack of self-compassion and the presence of maladaptive shame thus proved to be transdiagnostic factors in these two diagnostic categories. In addition, results of this study indicated that the lack of self-compassion is essentially associated with shame. Both these observations suggested that clients suffering from anxiety and depression may benefit from treatments or particular interventions that facilitate the development of self-compassion or shame management. The possibly important roles of self-compassion and shame in the etiology of anxiety, depressive as well as other mental disorders, needs to be further explored.

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SOUHRN

Rozdíly v soucitu se sebou a ve studu u pacientů s úzkostnými poruchami, pacientů s depresivními poruchami a u zdravých kontrol

Cíle. Cílem studie bylo porovnat úroveň soucitu se sebou, tendence k prožívání studu a internalizovaného studu u vzorků pacientů s úzkostnými/depresivními poruchami a u vzorku zdravých kontrol.

Soubor a procedura. Pacientům s úzkostnými poruchami ($N_1=58$), depresivními poruchami ($N_2=57$) a zdravým kontrolám ($N_3=180$) byly administrovány škály měřící soucit se sebou, tendence k prožívání studu, internalizovaný stud, úzkost a depresivní symptomy.

Hypotézy. Autoři předpokládali, že: 1) oba klinické vzorky budou vykazovat nižší míru soucitu se sebou a vyšší míru tendence k prožívání studu a internalizovaného studu než zdravé kontroly; 2) mezi vzorkem úzkostných a vzorkem depresivních nebude ve sledovaných proměnných významný rozdíl; 3) soucit se sebou bude u všech vzorků korelovat s tendencí k prožívání studu a s internalizovaným studem; 4) soucit se sebou, tendence k prožívání studu a internalizovaný stud budou u pacientů s úzkostnými/depresivními poruchami korelovat se závažností úzkosti/deprese.

Statistická analýza. Data byla analyzována s využitím programu IBM SPSS Statistics, verze 23. Rozdíly mezi vzorky byly testovány pomocí testů chí kvadrát, jednocestná ANOVA a jednocestná MANOVA s Bonferroniho post-hoc testy. Vztahy mezi jednotlivými proměnnými studie byly dále prověřeny provedením korelačních a regresních analýz.

Výsledky. U pacientů s úzkostnými i depresivními poruchami byla zjištěna signifikantně nižší míra soucitu se sebou a signifikantně vyšší míra tendence k prožívání studu a internalizovaného studu než u zdravých kontrol. Mezi vzorkem úzkostných a vzorkem depresivních nebyl ve sledovaných proměnných významný rozdíl. Všechny korelace byly v předpokládaném směru.

Ómezení studie. Hlavními omezeními studie jsou možné zkresení způsobené účastí dobrovolníků u zdravých kontrol a pojmový překryv mezi měřenými konstrukty – soucitem se sebou a studem.