Received: 27 September 2019 | Revised: 18 November 2020 | Accepted: 13 January 2021

DOI: 10.1002/cpp.2560

RESEARCH ARTICLE

WILEY

The effects of self-compassion components on shame-proneness in individuals with depression: An exploratory study

Andreea-Alexandra Ceclan[1] | Diana-Mirela Nechita Ph.D.[2]

[1]Faculty of Psychology and Educational Sciences, Babeş-Bolyai University, Cluj-Napoca, Romania

[2]Department of Clinical Psychology and Psychotherapy, Babeş-Bolyai University, Cluj-Napoca, Romania

Correspondence
Diana-Mirela Nechita, Department of Clinical Psychology and Psychotherapy, Babeş-Bolyai University, 37 Republicii Street, Cluj-Napoca 400015, Romania.
Email: diananechita@psychology.ro

Abstract

To date, there is no evidence regarding how self-compassion's components, self-kindness, common humanity and mindfulness could work as distinct interventions. Thus, the main objective of the present study was exploring the effects that the three separate components of self-compassion would have on shame-proneness levels in individuals with clinical depression. All the participants (n = 122) with a diagnostic of Major Depressive Disorder were randomized in four experimental groups: the self-kindness exercises group, the mindfulness exercises group, the common humanity one and the control group. Results indicated that levels of depression and shame-proneness, as measured by BDI-II, TOSCA-3 and ESS decreased from baseline to post-intervention, but no significant differences were observed between groups. Therefore, we cannot conclude that one self-compassion component is more efficient than the others, but the present study does offer, though, a strong starting point for more complex, future studies.

KEYWORDS
common humanity, depression, mindfulness, self-compassion, self-kindness, shame

1 | INTRODUCTION

Shame is a self-conscious emotion, one that is evoked by negative, global self-evaluations and accompanied by a sense of powerlessness and worthlessness (Tangney & Tracy, 2012), in which the entire self feels exposed, judged as being inferior, undesirable or unattractive (Gilbert, 1998, 2003; Lewis, 1992; Tangney et al., 1992). Although it can be argued that under some circumstances, shame could prove to be a useful affect, as it serves social goals (Muris & Meesters, 2014), it is also a painful emotion due to its underlying emphasis on self-criticism. Literature so far differentiates between shame as a state emotion and shame-proneness, which is the tendency of individuals to experience shame across various situations (Tangney, 1996), with shame-proneness playing an essential role in psychopathology. Furthermore, different distinctions can be made between different types of shame, across two major dimensions: internal versus external shame (Gilbert, 1998) and behavioural, characterological and body shame (Andrews, 1998). Whereas internal shame refers to self-directed criticism and negative self-evaluations, external shame focuses on others' perceived negative assumptions about the self. In most cases, when we are ashamed, we feel both types of shame (Kim et al., 2011). On the other hand, characterological shame means that the individual will experience shame in relation with his or hers personal habits and abilities; behavioural shame refers to shame about inadequate behaviours, whereas body shame is associated with being ashamed of one's own body (Andrews et al., 2002).

There is a growing body of evidence showing that shame-proneness is associated with various forms of psychopathology, including social anxiety (Fergus et al., 2010; Gilbert & Miles, 2000; Lutwak & Ferrari, 1997), PTSD (Kubany et al., 1995, 1996; Leskela et al., 2002), eating disorders (Cândea & Szentagotai, 2014; Sanftner et al., 1995; Troop et al., 2008), and borderline personality disorder (Rüsch et al., 2007). Shame-proneness is also strongly associated with depression (Allan et al., 1994; Andrews, 1995; Andrews et al., 2002; Andrews & Hunter, 1997; Cheung et al., 2004; Fontaine et al., 2001; Harder et al., 1992; Stuewig & McCloskey, 2005;

Note. M = mean, SD = standard deviations

Tangney et al., 1992), even after controlling for rumination effects (Cheung et al., 2004). Different studies also demonstrated that shame plays a key role in the onset and course of depression symptoms (Andrews et al., 2002; Andrews & Hunter, 1997), whereas other studies pointed out that individuals with greater levels of depression also display higher levels of shame-proneness (Pinto-Gouveia & Matos, 2011; Robinaugh & McNally, 2010). It is argued that various mechanisms that generate and maintain depression are also seen in shame-prone individuals. Shame can signal different social problems, like conflicts or rejection, which are related to negative affect (Gruenewald et al., 2007). Furthermore, shame is characterized by causal attributions (stable, uncontrollable and global) related to a 'bad self', known to overlap with attributions that predict depressive symptoms as well (Kim et al., 2011). On the other hand, some authors have argued that the negative self-evaluation component of shame might only be indirectly associated with depression through the process of rumination. Also, these authors proposed that the withdrawal component might be more closely linked to depression (Cohen et al., 2011).

Nevertheless, given the enormous personal suffering and increased impairment in everyday functioning of individuals caused by both higher levels of shame and depressive symptoms, efficient strategies targeting them are still highly needed.

Self-compassion is one of the strategies that has proven to be particularly effective in reducing depressive symptoms (Braehler et al., 2012; Gilbert & Procter, 2006; Kuyken et al., 2010; Lucre & Corten, 2013; Mayhew & Gilbert, 2008; Neff & Germer, 2013; Shapira & Mongrain, 2010). Moreover, shame is also negatively associated with self-compassion (Barnard & Curry, 2012), and various self-compassion based interventions have proven to be effective in reducing shame levels, negative affect and self-criticism (Arimitsu & Hofmann, 2015; Gilbert & Procter, 2006; Kelly et al., 2009). Past research also showed that self-compassion strategies reduced shame-proneness levels in a student sample with depressive symptoms (Johnson & O'Brien, 2013). Self-compassion is viewed as compassion directed inward (Neff & Germer, 2017), meaning that we accurately recognize our shortcomings and our mistakes, but even in the light of negative life events, we consider ourselves just as worthy of compassion as others, so we react with kindness rather than with self-criticism and harshness (Leary et al., 2007). The three main components of self-compassion, as defined by Neff (2003a), are self-kindness, common humanity and mindfulness. Self-kindness means being caring, understanding and accepting of one's own suffering, trying to alleviate this pain, whereas common humanity refers to recognizing that failure and suffering are all part of a shared human experience (Neff, 2003a). Finally, the mindfulness component entails acknowledging and accepting painful thoughts and emotions in a non-judgmental manner.

Little is known, however, about how self-compassion's components interact with various psychopathology mechanisms. As mentioned before, some key elements of shame, like negative self-evaluations and self-criticism, are, among others, mechanisms that contribute to the onset and course of depression but are, in the same time, opposed to the self-kindness dimension (Gilbert & Procter, 2006). Mindfulness and common humanity are also opposed to a sense of social isolation and the constantly self-blaming and over-identification with one's Thoughts and suffering, also important factors that maintain depression and higher levels of shame-proneness. To our best knowledge, self-compassion has only been studied in empirical settings in its unified manner, one that views all three dimensions working together. On one hand, Neff (2003b) claimed that self-kindness, common humanity and mindfulness dimensions are not only conceptually speaking different but are also experienced as distinct elements. On the other hand, Barnard and Curry (2011) argued that it is not clear whether Neff (2003b) views the three components as being completely related or if they are just different elements that positively correlate and produce a cumulative effect. From another point of view, Brito-Pons et al. (2018) suggested Through their studies that self-compassion and mindfulness could be rather related constructs, both in a theoretical and empirical way, so a complementary look at the mindfulness and compassion-based trainings could also be of interest for future studies. Moreover, various authors pointed out the need for empirical research to be conducted for a detailed examination of self-compassion's components (Adams & Leary, 2007; Barnard & Curry, 2011; Blackie & Kocovski, 2018; Geller et al., 2015; Krieger et al., 2013), with Muris and Petrocchi (2017) even advancing the idea that maybe not all of the three components are equally relevant in therapeutic approaches based on self-compassion (e.g., self-kindness or mindfulness to be more relevant than common humanity).

The main purpose of our study was to test the effects that self-compassion's components would have when applied as distinct interventions upon shame-proneness levels in a clinically depressed

Key Practitioner Message

- Shame-proneness is an extremely important factor that contributes to the onset and course of various forms of psychopathology and needs to be targeted directly in therapy sessions through efficient strategies.
- Self-compassion is a new strategy being used for addressing both shame and depression, and in the present study, self-compassion's components (self-kindness and common humanity and mindfulness) were successfully studied separately as distinct interventions and were applied in online-based exercises.
- The main significant effect observed was time, interventions based on self-compassion's components successfully reduced shame-proneness and depressive symptoms from pre- to post-intervention in a clinical sample.
- There is still need for studies to empirically test different Hypotheses in this direction, and being still in its early ages, self-compassion alongside its components can be further studied.

sample. Literature so far lacks solid arguments for favouring one self-compassion component over the other two but emphasize the need for exploring them. Thus, we conducted an exploratory research, without formulating any a priori hypothesis but aiming to examine whether the tendency to experience shame could be reduced when distinct interventions, based on self-kindness, common humanity and mindfulness components are to be applied on a clinical sample. We also compared the effects of self-kindness, common humanity and mindfulness interventions with a control group and tested the effects not only on shame-proneness, but also on behavioural, characterological and body shame.

2 | METHOD

2.1 | Participants and recruitment

Volunteer applicants were screened for the study (n = 534), with participants being recruited via social media networks. Eligibility criteria were (a) being over 18 years old; (b) exceeding a score of 14 on *Beck Depression Inventory-II* (BDI-II); (c) fulfilling The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5; American Psychiatric Association, 2013 *BDI-II*) and (f) not currently receiving other forms of treatment for mental disorders (no psychological treatments or medication). After two selection stages, 122 participants meeting DSM-5 and The Structured Clinical Interview (SCID) criteria for MDD were randomly assigned to a self-kindness exercises group (n = 31), a common humanity exercises group (n = 30), a mindfulness exercises group (n = 30) and a control group (n = 31; see Figure 1 for patient flow). All these participants were blinded to treatment randomization. Twenty-one participants dropped prior to completing the pre-treatment assessment, and another 16 dropped between sessions. All participants who completed pre-assessment and the first set of exercises were included in the intent-to-treat (ITT) analysis with the last observation carried forward.

Participants' age ranged between 18 and 34 years, with a mean age of 21.14 (SD = 2.69). The sample included 100 females and 22 males, most of which were students, but there were also employed people or persons that finished their studies or were not taking any courses at the time of enrollment in our study.

2.2 | Procedure

At the beginning of the enrolment process, informed consent was obtained from all individuals. Participants with a minimum score of 14 on BDI-II (mild depressive symptoms), with no suicidal ideation and under no treatments, were contacted for a face-to-face interview based on the DSM-5 criteria for MDD and SCID. All clinical interviews were conducted by the first author of this paper, master-level assessor. Following these assessments stages and being randomly assigned to one of the four groups, participants filled in the baseline measures evaluating shame-proneness levels, but also behavioural, characterological and body shame. These, alongside all the exercises, were sent and completed online, with participants receiving an e-mail providing a hyperlink internet address that allowed them to access the exercises. Each participant received three sets of exercises that

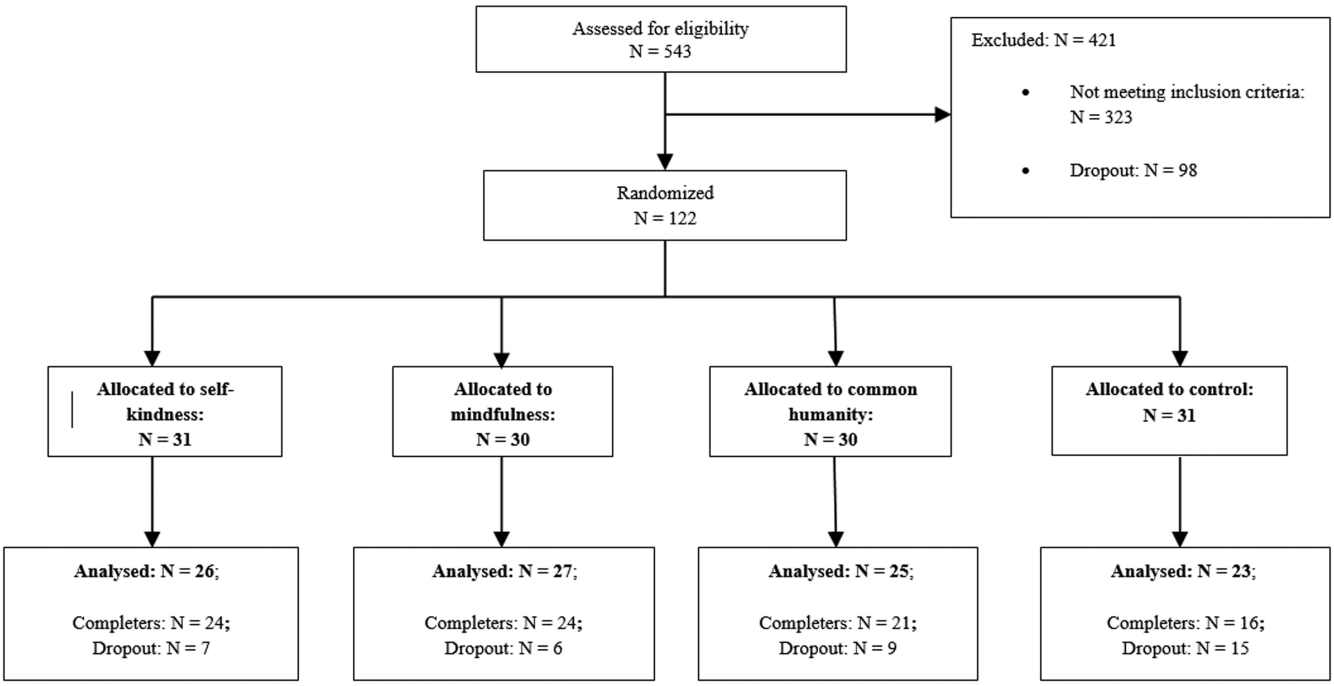

FIGURE 1 Flowchart of study participants

were adapted from Neff's (2011) self-compassion practices and Germer's (2009) book, *The Mindful Path to Self-Compassion*. At the beginning of each set of exercises, participants were asked to think about past, recent or future situations in which they felt or are likely to feel ashamed and to describe them as accurately as they can. Next, participants received instructions for completing various exercises, adapted for each self-compassion component and for the control group. For the self-kindness group, the first exercise stated, 'Thinking about the situation described earlier, write yourself some kind, understanding, words of comfort. Let yourself know that you care about yourself, adopting a gentle, reassuring tone. Read the paragraph a couple of times'. The mindfulness group had different meditations to practice (Mindfulness of Emotion in the Body, Light Meditation, Here and Now Stone), whereas participants in the common humanity group were asked to write about how they think the situation they detailed earlier could be connected to a larger human experience. The control group, on the other hand, had simple writing exercises, without any elements of self-compassion included, like describing objectively what were the circumstances that lead to the negative event mentioned before. The next two sets of exercises were similar to the ones illustrated earlier for each of the four groups; participants received the second one a week after the first sets, and the final ones after another 7 days.

To control for the level of task involvement, we asked participants to take a maximum of 3 min for describing the negative situations and maximum 10 min for completing the exercises. Furthermore, because the self-kindness, common humanity and control groups' exercises were easily accessible for verifying, in order to assure that participants in the mindfulness group also complied with our exercises, we created several items that asked them what emotions they centred on when doing the meditations or what thoughts they had during it.

After the last set of exercises, participants filled in the baseline measures for shame-proneness and BDI-II. In the following days, they were also debriefed via e-mail.

3 | MEASURES

3.1 | Depressive symptoms

BDI-II (Beck et al., 1996) was used to assess the severity depressive symptoms. It consists of 21 items that ask respondents to assess how they have been feeling throughout the past 2 weeks. Items are evaluated on a 5-point Likert scale, with higher scores indicating higher levels of depression. The scale has good psychometric proprieties (Beck et al., 1996), and it demonstrated adequate internal consistency in this study (α = .82).

3.2 | Shame-proneness

The tendency to experience shame was measured with two distinct scales. *The Test of Self-Conscious Affect–3* (TOSCA-3; Tangney et al., 2000) has 16 scenarios which measure proneness to shame, guilt, pride, detachment and externalization. For each scenario, respondents evaluate on a 5-point Likert scale the probability to follow the described affective tendency. In this study, only the shame subscale was used. The scale has good psychometric proprieties (Tangney & Dearing, 2002), and the shame subscale demonstrated high internal consistency in our study (α = .81).

The second scale used was *Experience of Shame Scale* (ESS; Andrews et al., 2002), which allowed us to assess tendencies for experiencing behavioural, characterological and body shame. ESS consists of 25 items, asking respondents to evaluate them on a 4-point Likert scale when thinking about the experiences from the past year as a timeframe. The scale has good test–retest reliability (r = .83; Andrews et al., 2002), and we obtained an excellent internal consistency in the present study (α = .93). Considering ESS subscales, we obtained internal consistencies of α = .92 for characterological shame items, α = .86 for behavioural shame and α = .86 for body shame.

4 | RESULTS

4.1 | Data analysis and descriptive statistics

To assess the effects of self-kindness, common humanity and mindfulness components on shame-proneness and depressive symptoms, separate mixed within-between analyses of variance (ANOVAs) were conducted, with time of assessment as the within-subjects factor and group as the between-subjects one. All the results were computed using the IBM SPSS software, and an Intent-To-Treat analysis (ITT) with last observation carried forward was applied for the missing data due to its conservative nature.

Furthermore, a statistical power analysis was performed a priori for sample size estimation, using the GPower software. With an α = .05, effect size of .20 and a power = 0.95, the projected sample size needed was approximately N = 112 for the within-between ANOVA.

Table 1 presents the descriptive statistics for the studied variables. There were no significant differences between groups at baseline as determined by one-way ANOVA for BDI-II ($F(3, 97) = 2.19$, $p = .094$), nor for TOSCA 3 ($F(3, 97) = .098$, $p = .961$) or for ESS ($F(3, 97) = .112$, $p = .953$).

4.2 | Effects on depressive symptoms

The analysis indicated a significant main effect of time $F(1, 97) = 79.56$, $p < .001$, $\eta_p^2 = .45$ but no significant effects of group $F(3, 97) = 2.34$, $p = .077$, nor time × group interaction $F(3, 97) = .64$, $p = .586$. Within-subject pairwise comparisons (Sidak adjustment) pointed significant decreases in depressive symptoms for all the participants, including ones in the control group ($p < .001$ for self-kindness, d = 0.950, mindfulness, d = 1.238 and common humanity ones, d = 0.908, and $p = .002$ for control group, d = 0.642).

TABLE 1 Descriptive statistics and between groups effect sizes

	Condition								Between groups effect sizes (Cohen's *d*)				
	Self-kindness (N = 26) (1)		Mindfulness (N = 27) (2)		Common humanity (N = 25) (3)		Control (N = 23) (4)		1 versus 4	2 versus 4	3 versus 4	1 versus 2	1 versus 3	2 versus 3
	M	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*						
Baseline														
BDI-II	27.34	9.38	21.88	4.90	26.92	10.39	24.82	9.17	0.271	−0.399	0.214	0.729	0.042	−0.48
TOSCA	52.53	9.63	53.51	10.50	54.12	10.10	53.34	11.83	−0.075	0.015	0.070	−0.097	−0.161	−0.059
ESS	68.96	17.00	71.18	14.95	71.20	16.05	70.69	16.63	−0.102	0.030	0.031	−0.138	−0.135	−0.001
Post-treatment														
BDI-II	18.42	9.33	13.92	7.25	17.64	9.96	18.86	9.32	−0.047	−0.591	−0.126	0.538	0.080	−0.427
TOSCA	48.11	12.82	53.22	9.94	50.96	12.73	51.82	11.24	−0.307	0.131	−0.071	−0.445	−0.223	0.197
ESS	62.03	13.94	69.33	16.21	67.96	16.14	70.30	15.76	−0.555	−0.060	−0.146	−0.482	−0.393	0.084

4.3 | Effects on shame-proneness

To test for the effect of self-kindness, common humanity, mindfulness and control group on shame-proneness, two separate mixed within-between ANOVAs for TOSCA-3 and ESS were conducted. For TOSCA-3, results indicated a significant main effect of time $F(1, 97) = 8.60$, $p = .004$, $\eta_p^2 = .08$, but no significant effects of group $F(3, 97) = .41$, $p = .742$ and time × group interaction $F(3, 97) = 1.33$, $p = .269$. Within-subject pairwise comparisons (Sidak adjustment) showed that only in the self-kindness group, scores on TOSCA-3 significantly decreased from pre- to post-assessment ($p = .006$, $d = 0.512$), whereas in the common humanity group ($p = .052$, d = 0.039), mindfulness ($p = .849$, d = 0.367) and control group ($p = .366$, d = 0.182) unchanged.

For ESS, a similar pattern occurred: a significant main effect of time was observed, $F(1, 97) = 9.68$, $p = .002$, $\eta_p^2 = .09$, but no significant effects of group $F(3, 97) = 8.60$, $p = .604$), nor time × group interaction $F(3, 97) = .620$, $p = .124$). Within-subject pairwise comparisons (Sidak adjustment) showed that shame-proneness significantly decreased from pre- to post-assessment only in the self-kindness group ($p = .001$, $d = 0.670$), with the changes in the other groups the others not reaching a significant level ($p = .338$, $d = 0.184$ for mindfulness group, $p = .108$, $d = 0.314$ in the common humanity group, respectively, $p = .852$, $d = 0.037$ for control one).

For characterological and body shame, significant main effects of time were observed, $F(1, 97) = 7.35$, $p = .008$, $\eta_p^2 = .07$ and $F(1, 97) = 8.00$, $p = .006$, $\eta_p^2 = .07$, respectively, but no significant effects of group $F(3, 97) = 1.03$, $p = .381$ and $F(3, 97) = .24$, $p = .886$ for body shame. No time × group interactions were observed either, with $F(3, 97) = .88$, $p = .451$ for characterological shame and $F(3, 97) = 2.52$, $p = .062$ for body shame. Within-subject pairwise comparisons (Sidak adjustment) showed that characterological shame significantly decreased from pre- to post-assessment only in the self-kindness group ($p = .006$, $d = 0.571$), with the changes in the other groups the others not reaching a significant level ($p = .389$, $d = 0.180$ for mindfulness group, $p = .431$, $d = 0.143$ in the common humanity group, respectively, $p = .314$, $d = 0.205$ for control one). For body shame, within-subject pairwise comparisons (Sidak adjustment) showed that body shame significantly decreased from pre- to post-assessment only in the self-kindness group ($p = .000$, $d = 0.705$), with the changes in the other groups the others not reaching a significant level ($p = .554$, $d = 0.116$ for mindfulness group, $p = .189$, $d = 0.226$ in the common humanity group, respectively, $p = .927$, $d = 0.018$ for control one).

Interestingly, for behavioural shame, none of the effects were significant (with $F(1, 97) = 3.66$, $p = .059$ for time effect, $F(3, 97) = .29$, $p = .829$ for group and $F(3, 97) = 2.06$, $p = .110$ for time × group interaction). Within-subject pairwise comparisons (Sidak adjustment) showed that behavioural shame significantly decreased from pre- to post-assessment only in the self-kindness group ($p = .011$, $d = 0.482$), while the other changes did not reach a significant level ($p = .432$, $d = 0.136$ for mindfulness group, $p = .148$, $d = 0.339$ in the common humanity group, respectively, $p = .369$, $d = 0.176$ for control one).

5 | DISCUSSION

The present study explored the efficacy of self-kindness, common humanity and mindfulness components of self-compassion in reducing shame-proneness and depressive symptoms in clinically depressed individuals. Results demonstrated that in time, from baseline to post-intervention, both shame-proneness and depression levels decreased, with main effect of time being the only significant one observed. When analysing depressive symptoms, results indicated reductions even in the control group. Whereas no participant was enrolled in other forms of psychotherapies, nor were they treated with medication for mental disorders, reductions in depressive symptoms could have been observed due to spontaneous remission, the normal passing of time process or due to various positive events or coping mechanisms that participants had and could not be controlled for. With group effect and time × group interaction yielding no significant changes, we cannot state that one self-compassion component is more efficient than the others.

Using ESS allowed us to examine the effects that exercises for each self-compassion component had upon three distinct forms of shame, namely, characterological, body and behavioural shame. Data revealed similar effects: although main effect of time was significant for characterological and body shame, it did not reach a significant point for behavioural shame, and in all three cases, groups did not differ between them at baseline, nor at the end of the intervention.

The present study responds to numerous past statements that underlined the need for self-compassion's components to be studied separately (Adams & Leary, 2007; Barnard & Curry, 2011; Blackie & Kocovski, 2018; Geller et al., 2015; Krieger et al., 2013). Even though there were some speculations in this direction (Muris & Petrocchi, 2017), in our study, none of the components produced significantly different changes compared to the other two. Thus, the present results seem to indicate that self-kindness, common humanity and mindfulness components are not efficient in reducing shame-proneness and depression levels in a clinical sample. On the other hand, the exploratory nature of the study does not allow us to draw any specific conclusion but rather suggest that future studies should test the hypothesis that no differences in self-compassion's components will be observed.

Through our research, we tried to overcome several limits of earlier studies and to test new paths for using self-compassion-based interventions. Most of self-compassion literature relies on correlational studies and student-based samples; thus, we selected clinically depressed participants and empirically tested the effects of the intervention in order to extend previous findings. Furthermore, participants completed online all three sets of exercises for each group, adding to a growing number of contexts in which self-compassion interventions can be successfully applied and being an extremely useful asset in nowadays or even future pandemic contexts.

However, the study has some inevitable limitations that should be considered. First, our sample was mostly composed of students and female participants, so future studies should include more individuals from the larger community. Second, severity of recalled events at the beginning of each exercise was not controlled for. Although these strategies ensure ecological validity, differences in the recalled experiences can influence how participants applied and experienced the exercises that followed. A third limitation is the fact that we did not include measures for other related constructs, such as mindfulness or self-compassion scales. Future studies should include such measures in order to test whether the three components might have a different impact. Another limitation could be the fact that we had only one session of assessment after the intervention was finalized; thus, we cannot state anything about our data stability in time. Future research should also include follow-up meetings and assessments to clarify the durability of observed effects. Moreover, given the fact that self-compassion is still a relatively new strategy being used in emotional regulation, our 3 weeks, online-based intervention might have been too short for participants to fully understand and feel the effects on a more profound level, which could explain the lack of significant differences between groups. Because we tested the intervention on individuals with clinical levels of depression, only three sets of exercises per each group might have been less than what our participants needed in order to report significant changes in their symptoms and shame levels. Both shame and depression rely on similar mechanisms (Gruenewald et al., 2007; Kim et al., 2011) and intensify one another, so longer interventions are required in clinical samples.

Thus, if interest for studying self-compassion components is maintained, researchers could aim to test specific hypotheses regarding the efficacy of self-kindness, common humanity and mindfulness as distinct interventions. Moreover, we strongly suggest considering the above-mentioned limitations when designing future studies. Participants could benefit more from long-term interventions based on the distinct dimensions of self-compassion and maybe with constant feedback from clinicians, results might reveal different patterns and significant effects. Furthermore, given the issues raised by Cohen et al. (2011) regarding the measurement of shame, that withdrawal component of shame is related to depression, but negative self-evaluation might only indirectly be so, further investigation might also be required using scales that separate the measurement of the two facets of shame, and not incorporate them. Finally, we nevertheless encourage researchers to continue testing different, more innovative strategies for decreasing shame-proneness levels and helping individuals regulating their emotions.

CONFLICT OF INTEREST

The authors declare that they have no conflict of interest.

COMPLIANCE WITH ETHICAL STANDARDS

Ethical approval: all procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards. The research study was approved by the Institutional Review Board at Babes-Bolyai University. Informed consent was obtained from all individual participants prior to their inclusion in the study.

ORCID

Andreea-Alexandra Ceclan https://orcid.org/0000-0002-6892-1899

Diana-Mirela Nechita https://orcid.org/0000-0002-0750-8953

REFERENCES

Adams, C. E., & Leary, M. R. (2007). Promoting self-compassionate attitudes toward eating among restrictive and guilty eaters. *Journal of Social and Clinical Psychology*, *26*(10), 1120–1144. https://doi.org/10.1521/jscp.2007.26.10.1120

Allan, S., Gilbert, P., & Goss, K. (1994). An exploration of shame measures—II: Psychopathology. *Personality and Individual Differences*, *17*(5), 719–722. https://doi.org/10.1016/0191-8869(94)90150-3

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: American Psychiatric Association.

Andrews, B. (1995). Bodily shame as a mediator between abusive experiences and depression. *Journal of Abnormal Psychology*, *104*(2), 277–285. https://doi.org/10.1037/0021-843X.104.2.277

Andrews, B. (1998). Methodological and definitional issues in shame research. In P. Gilbert & B. Andrews (Eds.), *Shame: Interpersonal behavior, psychopathology, and culture* (pp. 39–54). New York: Oxford University Press.

Andrews, B., & Hunter, E. (1997). Shame, early abuse, and course of depression in a clinical sample: A preliminary study. *Cognition & Emotion*, *11*(4), 373–381. https://doi.org/10.1080/026999397379845

Andrews, B., Qian, M., & Valentine, J. D. (2002). Predicting depressive symptoms with a new measure of shame: The experience of shame scale. *British Journal of Clinical Psychology*, *41*(1), 29–42. https://doi.org/10.1348/014466502163778

Arimitsu, K., & Hofmann, S. G. (2015). Cognitions as mediators in the relationship between self-compassion and affect. *Personality and Individual Differences*, *74*, 41–48. https://doi.org/10.1016/j.paid.2014.10.008

Barnard, L. K., & Curry, J. F. (2011). Self-compassion: Conceptualizations, correlates, & interventions. *Review of General Psychology*, *15*(4), 289–303. https://doi.org/10.1037/a0025754

Barnard, L. K., & Curry, J. F. (2012). The Relationship of Clergy Burnout to Self-Compassion and Other Personality Dimensions. *Pastoral Psychology*, *61*(2), 149–163. https://doi.org/10.1007/s11089-011-0377-0

Beck, A. T., Steer, R. A., & Brown, G. K. (1996). *Manual for the Beck depression inventory—II*. San Antonio, TX: Psychological Corporation.

Blackie, R. A., & Kocovski, N. L. (2018). Examining the relationships among self-compassion, social anxiety, and post-event processing. *Psychological Reports*, *131*(4), 669–689. https://doi.org/10.1177/0033294117740138

Braehler, C., Gumley, A., Harper, J., Wallace, S., Norrie, J., & Gilbert, P. (2012). Exploring change processes in compassion focused therapy in psychosis: Results of a feasibility randomized controlled trial. *British Journal of Clinical Psychology*, *52*(2), 199–214. https://doi.org/10.1111/bjc.12009

Brito-Pons, G., Campos, D., & Cebolla, A. (2018). Implicit or explicit compassion? Effects of compassion cultivation training and comparison with mindfulness-based stress reduction. *Mindfulness*, *9*, 1494–1508. https://doi.org/10.1007/s12671-018-0898-z

Cândea, D. M., & Szentagotai, A. (2014). Shame, body image and eating disorders: a conceptual and empirical map. In K. G. Lockhart (Ed.), *Psychology of shame: New research* (pp. 121–140). New York: Nova Science Publishers.

Cheung, M. S. P., Gilbert, P., & Irons, C. (2004). An exploration of shame, social rank and rumination in relation to depression. *Personality and Individual Differences*, *36*, 1143–1153. https://doi.org/10.1016/S0191-8869(03)00206-X

Cohen, T. R., Wolf, S. T., Panter, A. T., & Insko, C. A. (2011). Introducing the GASP scale: A new measure of guilt and shame proneness. *Journal of Personality and Social Psychology*, *100*(5), 947–966. https://doi.org/10.1037/a0022641

Fergus, T. A., Valentiner, D. P., McGrath, P. B., & Jencius, S. (2010). Shame- and guilt proneness: Relationships with anxiety disorder symptoms in a clinical sample. *Journal of Anxiety Disorders*, *24*, 811–815. https://doi.org/10.1016/j.janxdis.2010.06.002

Fontaine, J. R. J., Luyten, P., De Boeck, P., & Corveleyn, J. (2001). The test of self-conscious affect: Internal structure, differential scales and relationships with longterm affects. *European Journal of Personality*, *15*, 449–463. https://doi.org/10.1002/per.428

Geller, J., Srikameswaran, S., & Zelichowska, J. (2015). Resilience to shape and weight concerns and disordered eating: The role of self-compassion. *Advances in Eating Disorders*, *3*(1), 4–12. https://doi.org/10.1080/21662630.2014.945604

Germer, C. (2009). *The mindful path to self-compassion: Freeing yourself from destructive thoughts and emotions*. Guilford Press.

Gilbert, P. (1998). What is shame? Some core issues and controversies. In P. Gilbert & B. Andrews (Eds.), *Shame: Interpersonal behavior, psychopathology, and culture* (pp. 3–38). New York, NY: Oxford University Press.

Gilbert, P. (2003). Evolution, social roles, and the differences in shame and guilt. *Social Research: An International Quarterly*, *70*(4), 1205–1230.

Gilbert, P., & Miles, J. N. V. (2000). Sensitivity to social put-down: Its relationship to perceptions of social rank, shame, social anxiety, depression, anger and self-other blame. *Personality and Individual Differences*, *29*, 757–774. https://doi.org/10.1016/S0191-8869(99)00230-5

Gilbert, P., & Procter, S. (2006). Compassion mind training for people with high shame and self-criticism: Overview and pilot study of a group therapy approach. *Clinical Psychology and Psychotherapy*, *13*, 353–379. https://doi.org/10.1002/cpp.507

Gruenewald, T. L., Dickerson, S. S., & Kemeny, M. E. (2007). A social function for self-conscious emotions. *The Self-Conscious Emotions: Theory and Research*, 68–87.

Harder, D. W., Cutler, L., & Rockart, L. (1992). Assessment of shame and guilt and their relationships to psychopathology. *Journal of Personality Assessment*, *59*(3), 584–604. https://doi.org/10.1207/s15327752jpa5903_12

Johnson, E. A., & O'Brien, K. A. (2013). Self-compassion soothes the savage ego-threat system: Effects on negative affect, shame, rumination, and depressive symptoms. *Journal of Social and Clinical Psychology*, *32*(9), 939–963. https://doi.org/10.1521/jscp.2013.32.9.939

Kelly, A. C., Zuroff, D. C., & Shapira, L. B. (2009). Soothing oneself and resisting self-attacks: The treatment of two intrapersonal deficits in depression vulnerability. *Cognitive Therapy and Research*, *33*(3), 301–313. https://doi.org/10.1007/s10608-008-9202-1

Kim, S., Thibodeau, R., & Jorgensen, R. S. (2011). Shame, guilt, and depressive symptoms: A meta-analytic review. *Psychological Bulletin*, *137*(1), 68–96. https://doi.org/10.1037/a0021466

Krieger, T., Altenstein, D., Baettig, I., Doerig, N., & Holtforth, M. G. (2013). Self- compassion in depression: Associations with depressive symptoms, rumination, and avoidance in depressed outpatients. *Behavior Therapy*, *44*(3), 501–513. https://doi.org/10.1016/j.beth.2013.04.004

Kubany, E. S., Abueg, F. R., Owens, J. A., Brennan, J. M., Kaplan, A. S., & Watson, S. B. (1995). Initial examination of a multidimensional model of trauma-related guilt: Applications to combat veterans and battered women. *Journal of Psychopathology and Behavioral Assessment*, *17*(4), 353–376. https://doi.org/10.1007/BF02229056

Kubany, E. S., Haynes, S. N., Abueg, F. R., Manke, F. P., Brennan, J. M., & Stahura, C. (1996). Development and validation of the trauma-related guilt inventory (TRGI). *Psychological Assessment*, *8*(4), 428–444. https://doi.org/10.1037/1040-3590.8.4.428

Kuyken, W., Watkins, E., Holden, E., White, K., Taylor, R. S., Byford, S., … Dalgleish, T. (2010). How does mindfulness-based cognitive therapy

work? *Behaviour Research and Therapy*, *48*(11), 1105–1112. https://doi.org/10.1037/1040-3590.8.4.428

Leary, M. R., Tate, E. B., Adams, C. E., Allen, A. B., & Hancock, J. (2007). Self-compassion and reactions to unpleasant self-relevant events: The implications of treating oneself kindly. *Journal of Personality and Social Psychology*, *92*(5), 887–904. https://doi.org/10.1037/0022-3514.92.5.887

Leskela, J., Dieperink, M., & Thuras, P. (2002). Shame and posttraumatic stress disorder. *Journal of Traumatic Stress: Official Publication of the International Society for Traumatic Stress Studies*, *15*(3), 223–226. https://doi.org/10.1023/A:1015255311837

Lewis, M. (1992). *Shame: The exposed self*. New York: The Free Press.

Lucre, K. M., & Corten, N. (2013). An exploration of group compassion-focused therapy for personality disorder. *Psychology and Psychotherapy: Theory, Research and Practice*, *86*(4), 387–400. https://doi.org/10.1111/j.2044-8341.2012.02068.x

Lutwak, N., & Ferrari, J. (1997). Shame-related social anxiety: Replicating a link with various social interaction measures. *Anxiety, Stress & Coping: An International Journal*, *10*, 335–340. https://doi.org/10.1080/10615809708249307

Mayhew, S. L., & Gilbert, P. (2008). Compassionate mind training with people who hear malevolent voices: A case series report. *Clinical Psychology & Psychotherapy: An International Journal of Theory & Practice*, *15*(2), 113–138. https://doi.org/10.1002/cpp.566

Muris, P., & Meesters, C. (2014). Small or big in the eyes of the other: On the developmental psychopathology of self-conscious emotions as shame, guilt, and pride. *Clinical Child and Family Psychology Review*, *17*(1), 19–40. https://doi.org/10.1007/s10567-013-0137-z

Muris, P., & Petrocchi, N. (2017). Protection or vulnerability? A meta-analysis of the relations between the positive and negative components of self-compassion and psychopathology. *Clinical Psychology and Psychotherapy*, *24*(2), 373–383. https://doi.org/10.1002/cpp.2005

Neff, K. (2011). *Self-Compassion: The Proven Power of Being Kind to Yourself*. Harper Collins.

Neff, K. D. (2003a). The development and validation of a scale to measure self-compassion. *Self and Identity*, *2*(3), 223–250. https://doi.org/10.1080/15298860309027

Neff, K. D. (2003b). Self-compassion: An alternative conceptualization of a healthy attitude toward oneself. *Self and Identity*2 August 2002, 85–101. https://doi.org/10.1080/15298860390129863

Neff, K. D., & Germer, C. (2017). Self-compassion and psychological wellbeing. *Oxford Handbook of Compassion Science*, 1–42.

Neff, K. D., & Germer, C. K. (2013). A pilot study and randomized controlled trial of the mindful self-compassion program. *Journal of Clinical Psychology*, *69*(1), 28–44. https://doi.org/10.1002/jclp.21923

Pinto-Gouveia, J., & Matos, M. (2011). Can shame memories become a key to identity? The centrality of shame memories predicts psychopathology. *Applied Cognitive Psychology*, *25*, 281–290. https://doi.org/10.1002/acp.1689

Robinaugh, D. J., & McNally, R. J. (2010). Autobiographical memory for shame or guilt provoking events: Association with psychological symptoms. *Behaviour Research and Therapy*, *48*, 646–652. https://doi.org/10.1016/j.brat.2010.03.017

Rüsch, N., Lieb, K., Göttler, I., Hermann, C., Schramm, E., Richter, H., & Bohus, M. (2007). Shame and implicit self-concept in women with borderline personality disorder. *American Journal of Psychiatry*, *164*(3), 500–508. https://doi.org/10.1176/ajp.2007.164.3.500

Sanftner, J. L., Barlow, D. H., Marschall, D. E., & Tangney, J. P. (1995). The relation of shame and guilt to eating disorder symptomatology. *Journal of Social and Clinical Psychology*, *14*(4), 315–324. https://doi.org/10.1521/jscp.1995.14.4.315

Shapira, L. B., & Mongrain, M. (2010). The benefits of self-compassion and optimism exercises for individuals vulnerable to depression. *Journal of Positive Psychology*, *5*(5), 377–389. https://doi.org/10.1080/17439760.2010.516763

Stuewig, J., & McCloskey, L. A. (2005). The relation of child maltreatment to shame and guilt among adolescents: Psychological routes to depression and delinquency. *Child Maltreatment*, *10*(4), 324–336. https://doi.org/10.1177/1077559505279308

Tangney, J., & Tracy, J. (2012). Self-conscious emotions. In M. Leary & J. Tangney (Eds.), *Handbook of self and identity* (pp. 446–478). New York: Guilford Press.

Tangney, J., Wagner, P., & Gramzow, R. (1992). Proneness to shame, proneness to guilt and psychopathology. *Journal of Abnormal Psychology*, *101*, 469–478. https://doi.org/10.1037/0021-843X.101.4.738

Tangney, J. P. (1996). Conceptual and methodological issues in the assessment of shame and guilt. *Behaviour Research and Therapy*, *34*(9), 741–754. https://doi.org/10.1016/0005-7967(96)00034-4

Tangney, J. P., & Dearing, R. L. (2002). *Shame and guilt*. New York, NY: Guilford Press. https://doi.org/10.4135/9781412950664.n388

Tangney, J. P., Dearing, R. L., Wagner, P. E., & Gramzow, R. (2000). *The Test of self-Conscious Affect–3 (TOSCA-3)*. Fairfax, VA: George Mason University.

Troop, N. A., Allan, S., Serpell, L., & Treasure, J. L. (2008). Shame in women with a history of eating disorders. *European Eating Disorders Review*, *16*(6), 480–488. https://doi.org/10.1002/erv.858

How to cite this article: Ceclan, A.-A., & Nechita, D.-M. (2021). The effects of self-compassion components on shame-proneness in individuals with depression: An exploratory study. *Clinical Psychology & Psychotherapy*, *28*(5), 1103–1110. https://doi.org/10.1002/cpp.2560