DOI: http://dx.doi.org/10.22122/ijbmc.v10i1.467 Published by Vesnu Publications

International Journal of Body, Mind and Culture

Studying the Mediating Role of Psychological Flexibility and Self-Compassion in the Relationship between Traumatic Memories of Shame and Severity of Depression and Anxiety Symptoms

Mohsen Mohajeri[1], Aniseh Alfooneh[1], Mehdi Imani[2]

[1] MA, Department of Clinical Psychology, Faculty of Educational Science and Psychology, Shiraz University, Iran
[2] MA, Department of Clinical Psychology, Faculty of Educational Science and Psychology, Shiraz University, Iran
[3] Associate Professor, Department of Clinical Psychology, Faculty of Educational Science and Psychology, Shiraz University, Iran

Corresponding Author: Mehdi Imani***; Associate Professor, Department of Clinical Psychology, Faculty of Educational Science and Psychology, Shiraz University, Iran***
Email: dr.mahdiimanipsy@gmail.com

Quantitative Study

Abstract

Background: The objective of the current study was to further explore the mediating role of psychological flexibility and self-compassion in the relationship between traumatic memories of shame and the severity of depression and anxiety symptoms. The psychological processes that may have an impact on this connection make it difficult to understand.

Methods: The research method was structural equation modeling. A sample of 296 university students from Tehran, Iran, was chosen through random cluster sampling for online research. The study data collection tools included the Early Life Experiences Scale (ELES), Impact of Event Scale-Revised (IES-R), Depression Anxiety Stress Scales (DASS), Cognitive Fusion Questionnaire (CFQ), Acceptance and Action Questionnaire-II (AAQ-II), Self Experiences Questionnaire (SEQ), and Self-Compassion Scale (SCS). Based on the partial least squares (PLS) approach, structural equation modeling, SPSS, and SmartPLS software were used to evaluate the generated data. A statistical investigation revealed a clear correlation between the intensity of depression and anxiety symptoms and painful recollections of shame.

Results: The results showed that traumatic memories of shame had a significantly favorable impact on anxiety ($P < 0.001$; $\beta = 0.30$) and depression ($P < 0.001$; $\beta = 0.33$), and a significantly negative impact on self-compassion ($P < 0.001$; $\beta = 0.31$) and psychological flexibility ($P < 0.001$; $\beta = 0.47$). Self-compassion significantly decreased sadness and anxiety ($P < 0.001$; $= 0.25$), and psychological flexibility significantly decreased sadness ($P < 0.001$; $=0.54$) and anxiety ($P < 0.001$; $= 0.37$).

Conclusion: These results suggest that the effects of experiential avoidance, cognitive fusion, and self-conceptualization, which together make up the overall construct of psychological resilience and are linked to the aggravation of depression and anxiety symptoms in people with traumatic shame memories, may be significantly reduced by self-compassion.

Keywords: Anxiety; Depression; Psychological flexibility; Traumatic memory; Shame; Self-compassion

Citation: Mohajeri M, Alfooneh A, Imani M. **Studying the Mediating Role of Psychological Flexibility and Self-Compassion in the Relationship between Traumatic Memories of Shame and Severity of Depression and Anxiety Symptoms.** Int J Body Mind Culture 2023; 10(1): 41-50.

Received: 30 Oct. 2022
Accepted: 23 Dec. 2022

Introduction

The emotion of shame is a self-conscious emotion with a broad evolutionary history that is rooted in the social threat system and in which the self is viewed as a subject of negative evaluation, an expectation of rejection, or attack by others. Gilbert (2002) describes the emotion of shame as a self-conscious emotion (Gilbert, 2002; Gilbert & Miles, 2000). However, even though shame is a self-conscious feeling and an intrinsic capacity (Gilbert & Miles, 2000), several researchers have found a link between traumatic shame experiences and psychopathological symptoms (Averill, Diefenbach, Stanley, Breckenridge, & Lusby, 2002). Research suggests that early negative educational experiences with caregivers, such as shame with caregivers, can have a significant impact on our identity and feelings towards ourselves. Shame is associated with the perception that a person has personal characteristics or actions that are perceived as undesirable, worthless, defective, or incomplete (Gilbert & Miles, 2000).

The experience of being shamed, criticized, neglected, or undervalued by caregivers might result from this imbalance in the evolutionary systems of emotional regulation, which can have a substantial influence on the formation of the inner notion of oneself as weak, incomplete, and worthless. Due to their intense emotional nature and recurrence in autobiographical memory, these negative emotional memories can be placed at the center of a person's narrative about him/herself. They can be seen as an important component of a person's identity and life story, and serve as a focus for processing daily inferences in life. Finally, because of their impact on emotional and attentional functions, they may prolong stress-related conditions in daily life (Bluck & Habermas, 2000). Numerous studies have demonstrated the impact of these early experiences on how adults experience shame. These studies demonstrate that childhood experiences of abuse may have a traumatic component, and thus, may be a risk factor for the emergence of later psychopathologies, such as anxiety, depression, and stress (Weckerle, Ineichen, Huber, & Yang, 2009).

According to previous research, psychological flexibility is a variable that is linked with shame (Dozois & Rnic, 2015). Acceptance and commitment therapy (ACT) is based on the psychological flexibility model, and demonstrates that the capacity to adapt behavior flexibly in response to environmental opportunities results in actions based on personal values and is a necessary condition for psychological well-being (Hayes, Strosahl, & Wilson, 1999). According to the psychological flexibility model, the idea of the self as context also appears to be crucial in rigid responses to early feelings of shame and subsequent experiences of despair and anxiety (Dozois & Rnic, 2015).

Self-compassion appears to have a significant protective function in psychological well-being and to have a negative link with psychopathology symptoms. Self-compassion is an evolutionary-rooted self-regulatory mechanism that is triggered in times of psychological stress and threat (Terry & Leary, 2011). Self-blame and self-criticism are the antithesis of self-compassion and are a result of insecure attachment styles, threatening childhood traumas, and early shame memories (Swannell et al., 2012). One of the major effects of childhood trauma may be a lack of self-compassion, and it appears that this lack is what leads to the emergence of shameful sentiments. Children who endure trauma in their early years of life feel shame because they lack an internal framework for self-respect and self-compassion. It appears that self-compassion poses a threat to psychological survival, so the individual avoids it. As a result, he/she also avoids pleasant

experiences out of fear, which creates a vicious cycle that may make melancholy and anxiety worse (Swannell et al., 2012).

Methods

The method of research was structural equation modeling. The statistical population of the study included all students enrolled in universities in Tehran, Iran, during the 2021–22 academic year.. The sample size is equal to 5 times the sum of the number of routes, factor loadings, and mistakes. To boost the statistical power of the study, the researcher may use more samples. The study inclusion criteria included willingness and knowledge to agree to participate in the research, being a pupil, and not having physical disabilities or mental illnesses that require medicine. Some of the study exclusion criteria were Reluctance to continue taking part in the study, and failing to complete a questionnaire or failing to provide the requested demographic information. The approach used to select the study participants was a multi-stage cluster type. In this manner, several universities were initially chosen from among the universities in Tehran, and from the selected universities, several faculties were selected, and the participants were selected from among the students of these faculties. Finally, links to questionnaires were sent to the selected students to complete.

The study data collection tools included the Early Life Experiences Scale (ELES), Impact of Event Scale-Revised (IES-R), Depression Anxiety Stress Scales (DASS), Cognitive Fusion Questionnaire (CFQ), Acceptance and Action Questionnaire-II (AAQ-II), Self Experiences Questionnaire (SEQ), and Self-Compassion Scale (SCS).

Early Life Experiences Scale: The ELES) is a self-report tool created by Gilbert et al. (2003) to assess childhood recollection, threat, and perceived compliance. This scale includes 15 items, with the main focus on 6 items that recollect the feeling of being threatened and 9 items that recall the feeling of inferiority and acting submissively as children. The initial versions of the items, which were based on normal comments and experiences shared by patients in psychotherapy, were created in conjunction with clinical psychologists. Unofficial pilot research revealed that the participants had no issues in understanding any of the questions. The participants are asked to score the frequency and degree of truth of each assertion about their childhood on a 5-point Likert scale ranging from 1 (totally false) to 5 (absolutely true). Items 6 and 7 are reverse scored to reduce any response bias. This scale has strong internal consistency with a Cronbach's alpha of 0.84 for the entire scale (Gilbert & Irons, 2009).

Impact of Event Scale-Revised: The IES-R was created by Weiss and Marmar (1997). This scale is a self-report tool created to assess present psychological suffering for any life experience connected to recollections of shame with peers, coworkers, teachers, strangers, or others, as well as to assess shame with attachment faces. There are 22 items on this scale, and 7 items have been added (Zatzick et al, 1997). The IES-R consists of 3 subscales, which measure 3 crucial aspects of the primary traits of traumatic memories, including avoidance, hyperarousal, and disturbance in 3 dimensions aligned with the DSM criteria for post-traumatic stress disorder (PTSD). The items of the IES-R are scored on a 5-point Likert scale ranging from 0 to 4. In the main research, the Cronbach's alpha of the subscales of annoyance, avoidance, and hyperarousal was estimated to be 0.87-0.92(Zatzick et.al, 1997), 0.84-0.86, and 0.79-0.90, respectively.

Depression Anxiety Stress Scales: The DASS is a self-report questionnaire designed by

Lovibond and Lovibond (1995) to assess 3 aspects of the symptoms of psychopathology, namely stress, anxiety, and depression. The components of the DASS cover the subscales of depression, anxiety, and stress, and ask respondents to express their negative emotional symptoms on a 4-point scale ranging from 0 to 3. The points on each scale are added together to determine the final score. The more psychological symptoms, such as sadness, anxiety, and stress, a person experiences, the higher his/her score will be. The subscales in the original edition of the scale have a high level of internal dependability. The anxiety, stress, and depression subscales have a Cronbach's alpha of 0.84, 0.90, and 0.91, respectively (Lovibond & Lovibond, 1995).

Cognitive Fusion Questionnaire: The CFQ is intended to evaluate cognitive fusion. This questionnaire consists of 14 questions that are scored on a 7-point Likert scale ranging from 1 to 7. The total score of the CFQ ranges between 7 and 49. In a student population with a sample size of 1040 individuals, Gillanders et al. (2014) reported a Cronbach's alpha value of 0.93 and a test-retest reliability coefficient of 0.80 after 4 weeks. Higher scores on this scale are representative of more cognitive fusion. According to Gillanders et al. (2014), the CFQ is uni-factorial, and its item scores have strong internal consistency ranging from 0.88 to 0.93.

Acceptance and Action Questionnaire-II: The AAQ-II, which consists of 7 items, was created by Bond et al. (2011) to assess psychological flexibility and experiential avoidance. The items are scored on a 7-point Likert scale ranging from 1 (never true) to 7 (always true), and the total score is calculated by adding the individual scores. Higher scores show a greater avoidance of experiential learning. The internal consistency of the original version the AAQ-II is 0.84, and it has strong psychometric qualities (Bond et al., 2011). This scale has demonstrated strong psychometric qualities in previous investigations, including an internal consistency value of 0.84 (Hayes et al., 1999).

Self-Related Experiences Questionnaire: The Self-Related Experiences Scale (Yu, McCracken, & Norton, 2016) is a 15-item questionnaire and the items are scored on a 7-point Likert scale ranging from 0 (never true) to 6 (always true). This scale is meant to help you assess your abilities as an observer or context. The ability to recognize oneself as a distinct and independent whole that encompasses ideas, feelings, and bodily sensations manifests as the ability to see oneself and distinguish oneself from these experiences. Higher overall scores on this scale suggest higher degrees of both self-as-observer and self-as-context. This scale was reported to have a strong internal consistency with a Cronbach's alpha of 0.90 for the entire scale, 0.88 for itself as a distinction, and 0.87 for its subscale of self-as-observer in the study by Yu, McCracken, & Norton, 2016).

Self-Compassion Scale): The SCS was developed by Neff in 2003, and consists of 26 items and features 6 dichotomous components, including self-kindness versus self-judgment (reverse), human connection versus isolation, and mindfulness versus overidentification (reverse). The statements are answered on a 5-point Likert scale ranging from 1 (nearly never) to 5 (almost usually). The results demonstrated that the Cronbach's alpha coefficients of the subscales ranged from 0.68 to 0.77, the Cronbach's alpha coefficient of the whole scale was 0.90, its test-retest coefficients ranged from 0.56 to 0.71, and the correlation range between items was 0.54-0.78, indicating the scale's desirable reliability (Neff, 2003).

In the first stage, descriptive statistical indicators, such as the mean and standard deviation of the study variables, were analyzed to assess the research data. The approach of structural equation modeling based on partial least squares (PLS) was

employed with SmartPLS software (version 3; SmartPLS GmbH, Germany) in the second stage to investigate the conceptual models of the investigation. Additionally, the internal homogeneity of the variables was examined using Cronbach's alpha, and the correlation matrix between the study variables was examined using Pearson's correlation coefficient.

Results

The present study was conducted on 296 university students in Tehran who were 18-52 years of age with an average age of 25.88 ± 8.96 years during the academic year 2021–22. In terms of gender, 88.97% of participants were women and 11.1% were men. Moreover, 22.3% of the respondents had a diploma, 24.7% an associate degree, 25.7% a bachelor's degree, 10.1% a master's degree, and 17.2% a doctorate. Furthermore, 65.5% of the respondents were unmarried and 34.5% were married. The mean (standard deviation) of the research variables is presented in table 1.

As can be seen in table 2, there is a significant and positive relationship between the initial experiences of shame and the traumatic memory of shame, anxiety, and depression, but a significant and negative relationship between self-compassion and the psychological flexibility components. Self-compassion and psychological flexibility factors were negatively and significantly correlated with anxiety and sadness.

4-5- Fit of the conceptual model

The structural model of the study, which was conducted among university students in Tehran using PLS software, is depicted in figure 1.

Multiple non-collinearities were checked using the VIF index, and all values (1.964 to 4.241) were less than 5. Multiple collinearities were therefore not considered. Table 3 presents the findings of the direct and indirect impacts of the research model.

According to findings presented in table 3, traumatic memories of shame had a significantly favorable impact on anxiety ($P < 0.001$; $\beta = 0.30$) and depression ($P < 0.001$; $\beta = 0.33$), and a significantly negative impact on self-compassion ($P < 0.001$; $\beta = 0.31$) and psychological flexibility ($P < 0.001$; $\beta = 0.47$).

According to the findings, anxiety and sadness among students increase by 0.30 and 0.33 units, respectively, as do psychological flexibility and self-compassion, which decreased by 0.47 and 0.31 units, respectively, with the presence of more traumatic memories of shame. Additionally, the findings presented in table 3 demonstrate that self-compassion significantly reduces sadness and anxiety

Table 1. Descriptive indices of research variables in the studied sample (number: 296)

	Mean	SD	Minimum-maximum	Skewness	Kurtosis
Early experiences of shame	45.32	7.13	29-59	0.079	-0.437
traumatic memory of shame	62.83	9.88	36-79	-0.063	-0.052
Self-compassion	77.85	2.93	70-83	-0350	-0.218
Self-kindness	17.13	4.89	10-24	-0.206	-1.420
Self-judgment	14.24	3.81	7-24	0.715	0.140
Human commonalities	13.22	3.52	5-19	-0.126	-0.907
Depression	10.09	3.56	5-16	0.218	-1.300
Mindfulness	12.26	3.55	6-17	-0.161	-1.129
Extreme assimilation	10.56	3.41	5-16	0.279	-1.159
Cognitive fusion	196.18	21.55	163-232	+1.410	1.601
Experiential avoidance	26.57	8.83	12.41	-0.141	-1.371
Self-as-context	41.28	8.72	20.57	-0.486	-0.307
Anxiety	26.46	3.75	18-33	-0.320	-0.668
Depression	25.01	3.47	18-33	-0.054	-0.708

SD: Standard deviation

Table 2. Correlation matrix between research variables in university students in Tehran

	1	2	3	4	5	6	7
1. Early experiences of shame	1						
2. Traumatic memory of shame	0.319**	1					
3. Self-compassion	-0.554**	-0.679**	1				
4. Cognitive fusion	-0.396**	-0.578**	0.528**	1			
5. Experiential avoidance	-0.289**	-0.496**	0.390**	0.474**	1		
6. Self-as-context	-0.486**	-0.639**	0.444**	0.669**	0.286**	1	
7. Anxiety	0.329**	0.388**	-6.59**	-0.573**	-0.393**	-0.572**	1
8. Depression	0.375**	0.603**	-0.249**	0.676**	-0.585**	-0.669**	0.660**

(P < 0.001; = 0.25), and psychological flexibility significantly reduces sadness (P < 0.001; = 0.54) and anxiety (P < 0.001; = 0.37). As a result, the findings suggest that students' levels of anxiety and sadness can be reduced by fostering greater flexibility and self-compassion. The results of the direct and indirect effects of the research model are presented in table 4.

Discussion

According to our findings, people who have experienced the trauma of shame concerning others and have made this experience the focus of their lives are more likely to report depression and anxiety symptoms. However, this research also revealed that early traumatic events, including shame, might have a negative impact on psychological flexibility, specifically experiencing avoidance (Thompson & Goodman, 2010). This makes the intensity of the symptoms of anxiety and sadness more likely.

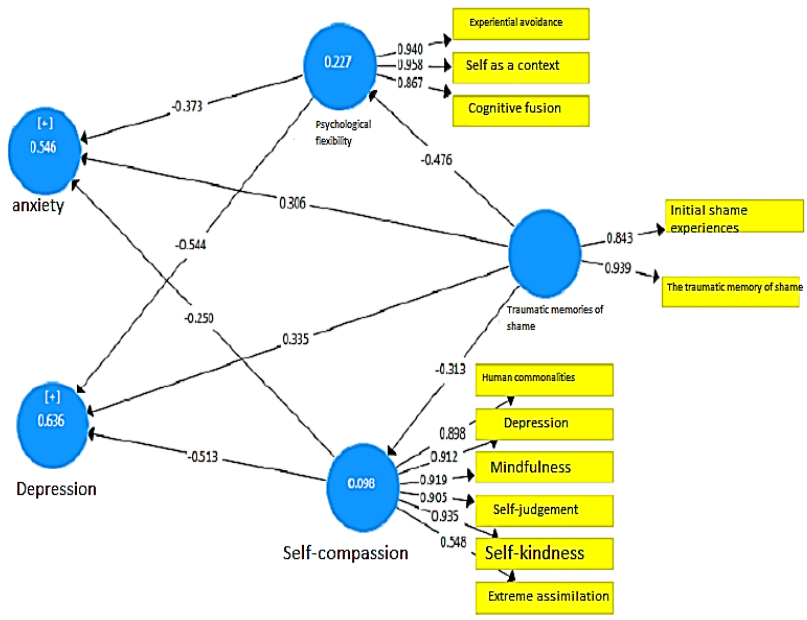

Figure 1. Structural model of the research (standard regression coefficients)

Table 3. The results of direct and indirect effects of the research model

Paths	β	t	CI 95%		Effect size (f^2)	P
			Lower bound	Upper bond		
Direct effects						
Traumatic memories of shame-→ self-compassion	-0.313	6.305	-0.406	-0.222	0.109	< 0.001
Traumatic memories of shame -→ psychological flexibility	-0.476	9.350	-0.584	-0.401	0.293	< 0.001
Traumatic memories of shame -→ anxiety	0.306	7.225	0.226	0.388	0.158	< 0.001
Traumatic memories of shame-→depression	0.335	2.690	0.275	0.409	0.176	< 0.001
Self-compassion -→ anxiety	-0.250	5.066	-0.344	-0.153	0.102	< 0.001
Self-compassion-→ depression	-0.513	10.792	-0.601	-0.383	0.187	< 0.001
Psychological flexibility -→ anxiety	-0.373	0.565	-0.454	-0.289	0.195	< 0.001
Psychological flexibility-→Depression	-0.544	11.311	-0.636	-0.402	0.465	< 0.001
Mediating effects						
Traumatic memories of shame---> self-compassion---> anxiety	0.078	3.291	0.031	0.103		< 0.001
Traumatic memories of shame-→psychological flexibility-→anxiety	0.178	6.841	0.130	0.234		< 0.001
Traumatic memories of shame ---> self-pity --->depression	0.160	6.533	0.119	0.206		< 0.001
Traumatic memories of shame-→psychological flexibility-→depression	0.258	8.604	0.192	0.303		< 0.001

CI: Confidence interval at the 95% level

This outcome is consistent with the findings of Masuda, Akihiko, and Tully (2012). This study's second hypothesis, which stated that self-compassion mediates the link between painful memories of shame and the intensity of anxiety and depressive symptoms, was also shown to be true.

Table 4. The results of the direct and indirect effects of the research model

Paths	β	t	CI 95%		Effect size (f^2)	P
			Lower bound	Upper bond		
Direct effects						
Traumatic memories of shame ---> psychological flexibility	-0.475	9.455	-0.547	-0.397	0.292	< 0.001
Traumatic memories of shame ---> anxiety	0.310	7.075	0.221	0.388	0.165	< 0.001
Traumatic memories of shame ---> depression	0.336	7.787	0.248	0.410	0.171	< 0.001
Psychological flexibility ---> anxiety	-0.358	7.877	-0.443	-0.265	0.177	< 0.001
Psychological flexibility---> depression	-0.539	10.611	-0.625	-0.475	0.466	< 0.001
Self-compassion ---> anxiety	-0.257	5.414	-0.184	-0.336	0.108	< 0.001
Self-compassion---> depression	-0.513	11.877	-0.613	-0.425	0.385	< 0.001
Mediating effects						
Traumatic memories of shame ---> psychological flexibility ---> anxiety	0.170	6.348	0.121	0.225	-	< 0.001
Traumatic memories of shame ---> psychological flexibility ---> depression	0.256	8.593	0.179	0.312	-	< 0.001
Moderating effect						
Self-compassion × traumatic memories of shame ---> depression	-0.078	2.180	-0.156	-0.022	-	0.030
Self-compassion × traumatic memories of shame ---> anxiety	-0.175	3.794	-0.243	-0.098	-	< 0.001

CI: Confidence interval at the 95% level

The present research investigated the effectiveness of self-compassion-based interventions on depression symptoms Self-compassion can improve interpersonal relationships and intimacy (Neff et al., 2007). This alone has the power to combat sadness and anxiety (Sollman and Gilbert, 2000). Communication improves as a result of having a sense of self-acceptance and self-kindness, as well as the capacity to view events as being a natural part of existence as a person. Additionally, self-compassion results in a better understanding of emotions, and consequently, a better ability to control them (Ross et al., 2019).

The findings of this study help to clarify the mechanism through which traumatic experiences of shame affect the intensity of anxiety and depression symptoms. Our study not only supports the findings of other studies in this area, but also adds fresh knowledge about the mechanism through which traumatic experiences of shame influence the severity of depression and anxiety symptoms. More specifically, the findings of this study imply that self-compassion and psychological adaptability may be significant mediators in the association between the intensity of depression and anxiety symptoms and the traumatic experiences of shame. Although it was not performed on a clinical population, this research can nonetheless be deemed clinically valuable. More specifically, ACT helps to lessen psychopathology, including anxiety and depression, by decreasing experiential avoidance, bolstering the position of acceptance, and increasing the desire to experience unpleasant events like traumatic memories of shame. Instead of adjusting the traumatic memories of shame, it is preferable to change how people view their shame memories because doing so fosters more acceptable ways of experiencing them, a connection to the present, and a commitment to actions that are consistent with one's values and life goals (Risert et al., 2016; Su et al., 2011; Bai et al., 2020, Zettel et al., 2009).

Students with anxiety issues may find success by thinking about therapies that emphasize self-compassion. Due to the heavy workload and amount of studying, anxiety issues are widespread among students, which affect both their emotional and behavioral abilities and self-related suffering (Armisto, 2016, Ferrari et al., 2019). Additionally, the potential of self-compassion to lessen the cognitive and emotional aspects of anxiety makes it a useful tactic for treating all anxiety disorders (Kanda and Tatar).

Conclusion

Although this study has increased our understanding of the connection between psychopathology and painful memories of shame, it is not without its limits. Because of the cross-sectional form of this study, it is challenging to establish the direction of the observed associations or to discuss causation. Additionally, because the sample of the present study was drawn from the general community, it is challenging to extrapolate its findings to clinical patients. Thus, it may be a good idea to focus future studies in this regard on individuals who have been given a diagnosis of depression or anxiety disorders. Finally, the instruments used in the current study were entirely self-report tools, which might skew the study findings. To gather more precise and trustworthy information, it is advised that approaches based on structured interviews with individuals be employed in future studies.

Conflict of Interests

Authors have no conflict of interests.

Acknowledgments

None.

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