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SHAME EXPERIENCES AND PSYCHOPATHOLOGY: THE MEDIATING ROLE OF SELF-COMPASSION AND SOCIAL SUPPORT IN SEXUAL MINORITY INDIVIDUALS

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Abstract

Sexual Minority (SM) individuals who are victims of stigma have reported higher levels of traumatic shame experiences and psychopathology symptoms (depression and social anxiety) when compared to heterosexual individuals. Self-compassion and social support have been described as protective factors. This study aimed to explore the mediating role of self-compassion and social support in the relationship between shame felt in traumatic experiences and psychopathology symptoms in a sample of SM individuals. The sample was composed of 264 adult SM individuals who reported traumatic shame experiences (56% men, 36% women, and 8% nonbinary). Correlations between variables were significant and ranged from very weak to moderate. Two models were performed, one for each dependent variable (depression and social anxiety symptoms). The mediating models revealed different results: compassionate actions was a significant mediator in the relationship of shame in traumatic experiences with depression symptoms and social anxiety symptoms, social support from friends had the same role on the prediction of depression, and social support from the family was a significant mediator on the prediction of social anxiety symptoms. These results suggest the importance of cultivating compassionate actions and promoting social support in intervention programs with SM individuals with early traumatic shame experiences, to target depression and social anxiety symptoms.

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Shame experiences are often traumatic and related to psychopathology in later life (Matos & Pinto-Gouveia, 2010). Among Sexual Minority (SM) individuals, more shame and traumatic experiences have been reported, in comparison to their heterosexual peers (70.5% vs. 44.2% in a Portuguese sample; Seabra et al., 2021a). Research has also consistently shown that stigmatized SM individuals are more vulnerable to psychopathology symptoms Meyer, 2003, 2015), such as depression (Wittgens et al., 2022), social anxiety (Mahon et al., 2022) and shame (Santos, 2021). In fact, due to living in a heteronormative and heterosexist environment that invalidates their sexual identity (Herek, 1990; Warner, 1991; Worthen, 2020), SM individuals experience chronic stress, which may help to explain the observed mental health disparities (Cardona et al., 2022; Meyer, 2003).

Chronic social stress is experienced from an earlier age by individuals who self-identify or are perceived as belonging to a SM; for instance, they are often victims of homophobic bullying in school (Gato et al., 2020; Mulvey et al., 2018). These young victims seem to resort to shame-avoidance strategies (e.g. minimization of homophobia; McDermott et al., 2008) and shame appears to mediate the relationship between homophobic discrimination and depressive symptoms among SM adults (Seabra et al., 2021b). Shame is a self-conscious and intense emotion involving feelings of inferiority, social unattractiveness, defectiveness, and powerlessness (Tracy et al., 2007) and is associated with general psychopathology (Cândea & Szentágotai, 2013).

Over time, researchers and clinicians have explored protection factors that buffer against the impact of stigma among SM individuals, and decrease their levels of psychopathology (Meyer, 2003, 2015). The role of individuals' protection factors such as resilience, openness to emotions, positive self-esteem, mental and physical self-care, hope and proactive coping strategies (Craig et al., 2014; Dickinson & Adams, 2014; Kwon, 2013; Meyer, 2015) has been considered. Self-compassion has recently merited research's attention as a possible buffer for stigma among SM individuals. In fact, meta-analytical studies found the self-compassion as a mediator in the relationship between minority stress and psychopathology (Helminen et al., 2022), and that higher levels of self-compassion seem to be associated with less psychopathology and internalized stigma, as well as, with more well-being and social support among SM individuals (Carvalho & Guiomar, 2022). Regarding the association between self-compassion and shame, there are few studies in SM. One study with people living with HIV found a negative and moderate association between self-compassion and internalized shame (Williams et al., 2019) and another one with gay men also find a negative and moderate association (Matos et al., 2017).

Social support also recurrently appears as a protective factor for the mental health of SM individuals. Family support has an important role in decreasing

depression in SM men of colour (Boyd et al., 2021) and support from friends helps to attenuate the impact of daily stress on the mental health of Caucasian gay men (Fingerhut, 2018). The specific effect of each source of social support is not yet clear and seems to depend on the stage of life (e.g. in transition for parenthood, social support is important for SM that are close to the family of origin and detached from SM community; Leal et al., 2021).

Considering the necessity to clarify the protective role of individual and social protection factors for the mental health of SM individuals, this study aimed to explore the mediating role of the components of self-compassion (compassionate engagement and actions) and different perceived social supports sources (from family and friends) in the relationship between shame felt in traumatic experiences and psychopathology (depression and social anxiety symptoms) in a sample of SM individuals.

Method

Sample

The sample was composed of 264 adult SM individuals who reported having had traumatic shame experiences of any type (e.g. humiliation, homophobia, abuse). All participants were Portuguese, and most were cisgender, single, and did not have children. The sample characteristics are described in Table 1.

Table 1. Sociodemographic Characteristics of Participants

Sociodemographic variables	Sample	
	n	%
Gender		
Female	95	36.0%
Male	148	56.1%
Non-binary	21	8.0%
Gender identity		
Cisgender	236	89.4%
Transgender	21	8.0%
Other	5	1.9%
Sexual orientation		
Gay	126	47.7%
Lesbian	45	17.0%
Bisexual	53	20.1%
Pansexual	31	11.7%
Asexual	3	1.1%
Other	6	2.3%
Residence		
Rural	42	15.9%
Urban	222	84.1%
Highest educational level		

Sociodemographic variables	Sample	
	n	%
Basic	2	0.8%
Intermediate	34	12.9%
Post-intermediate non graduated	18	6.8%
Graduate	98	37.1%
Master	101	38.3%
PhD	8	3.0%
Post-PhD	3	1.1%
Employment		
Student	63	23.9%
Work-student	28	10.6%
Full-time employed	124	47.0%
Part-time employed	24	9.1%
Unemployment	25	9.5%
Marital status		
Single	232	87.9%
Married/living together as a couple	26	9.8%
Divorced/widowed	6	2.3%
Children [a]	11	4.2%
Previous psychological treatment [a]	62	23.5%

Note. N = 264. Participants were on average 28.4 years old (SD = 7.7).
[a] Reflects the number and percentage of participants answering "yes" to this question.

Procedures

Data for the present cross-sectional study were collected between January and October 2020, after approval of the Ethic Commission of the host institution. Data were collected using a web-based survey in the context of larger research (N = 375), selecting the participants who reported having had traumatic experiences. Confidentiality and voluntary participation were assured. After reading a page with information about the study, participants gave their free and informed consent and completed the research protocol. Inclusion criteria were: self-identification as a SM, being Portuguese, age between 18 and 65 years old, and full completion of the questionnaires. There was no financial compensation for participation.

Measures

Sociodemographic Information. Participants were asked about sociodemographic characteristics such as age, gender, gender identity, sexual orientation, residence, educational level, employment status, marital status, if they had children, and if they were receiving psychological treatment at the time of the study. All sociodemographic information is described in Table 1.

Trauma-Related Shame Inventory (TRSI) (Original version: Øktedalen et al., 2014; European Portuguese version: Cid, 2012). This scale has 24 items to assess

the negative evaluation of the self in the context of trauma with a painful affective experience, and a behavioural tendency to hide and withdraw from others to conceal one's own perceived deficiencies. The TRSI has a total score and two subscales (external and internal shame). Items are rated on a 4-point Likert scale from *Not true of me* (0) to *Completely true of me* (3). Higher mean scores indicate higher levels of shame felt in the traumatic experience. In this study, only the total score was used. The Cronbach's alpha was .97 in this study.

Compassionate Engagement and Action Scales (CEAS) (Original and European Portuguese Version: Gilbert et al., 2017). This scale assesses three different flows of compassion: compassion for others, compassion from others, and compassion toward the self. Each section has eight items about competencies that facilitate turning towards and engaging in suffering (compassionate engagement) and another five items about competencies that facilitate actions to alleviate and prevent suffering (compassionate actions). In this study, only the subscale *compassion toward the self* was used (e.g., "I notice, and am sensitive to my distressed feelings when they arise in me" and "I direct my attention to what is likely to be helpful to me"). Participants report their answers on a 10-point Likert scale from *Never* (1) to *Always* (10). Higher mean scores indicate higher levels of self-compassion. In our sample, the compassionate engagement toward the self presented a Cronbach's alpha of .71 and compassionate actions toward the self presented a Cronbach's alpha of .93.

Multidimensional Scale of Perceived Social Support (MSPSS) (Original version: Zimet et al., 1988; European Portuguese version: Carvalho et al., 2011). This scale has 12 items to assess subjective social support from three sources: Family, friends, and significant other. In this study only the family (e.g., "My family really tries to help me") and friends (e.g., "I can count on my friends when things go wrong") subscales were used. Items are rated on a 7-point Likert scale from I *very strongly disagree* (1) to *I very strongly agree* (7). Higher mean scores indicate higher levels of subjective social support from family or friends. The Cronbach's alphas were .94 for both in this study.

Depression, Anxiety and Stress Scales, 21-Item Version (DASS-21). (Original version: Lovibond & Lovibond, 1995; European Portuguese version: Laranjeira, 2009). This scale has 21 items divided into three subscales: depression, anxiety, and stress symptoms. Items are rated on a 4-point Likert scale from *Did not apply to me at all* (0) to *Applied to me very much or most of the time* (3), with higher scores indicating greater negative affect. In this study, only the depressive symptoms (symptoms usually associated with negative mood, e.g. "I could see nothing in the future to be hopeful about") subscale was used. The Cronbach's alpha was .93 in this study.

Social Interaction Anxiety Scale (SIAS). (Original version: Mattick & Clarke, 1998; European Portuguese version: Pinto-Gouveia & Salvador, 2001). This scale has 19 items and assesses fears of general social interaction (e.g. "When mixing socially, I am uncomfortable."). Items are rated on a 5-point Likert scale from *Not at all characteristic or true of me* (0) to *Extremely characteristic or true of me* (3), with higher total scores indicating higher levels of social anxiety. The Cronbach's alpha was .92 in this study.

Data analyses

All data analyses were conducted with the IBM Statistical Package for the Social Sciences version 27 (SPSS; IBM, 2020) and the PROCESS Macro for SPSS 4.1 (Hayes, 2022). The normality of data distribution was examined using Skewness (*Sk*) and Kurtosis (*Ku*) values. Only values above |*3*|, |*10*| for *Sk* and *Ku*, respectively, were considered to represent severe violations of normal distribution (Kline, 2016; Marôco, 2014). Pearson's correlation coefficients (*r*) were used to examine the association between variables. The correlations were interpreted according to Pestana and Gageiro (2014): correlation below .20 means a very weak association, between .21 and .29 means a weak association, between .30 and .69 means a moderate association, between .70 and .89 means a strong association, and above .90 means a very strong association. For mediation analyses, model 4 of PROCESS Macro was used. Two models have been tested: shame felt in traumatic experiences was always the independent variable, compassionate engagement, compassionate actions, perceived social support from family, and perceived social support from friends were used as mediator variables, depressive symptoms was the dependent variable in model one, and social anxiety symptoms was the dependent variable in model two. Pairwise contrasts between indirect effects were explored to detect possible significant differences between indirect effects (Hayes, 2018).

Results

Preliminary results and correlations between variables

No severe violations of normality were found (|*Sk*| < 1; |*Ku*| < 5). Fifteen outliers were found (5.7%) in shame felt in traumatic experiences, compassionate engagement, perceived social support from family, and depressive symptoms. However, as these outliers showed up in the SPSS boxplots as mild outliers (and not extreme), and to ensure ecological validity, the authors decided to keep them in the sample. There was no missing data across the questionnaires. Descriptive statistics and correlations between study variables are presented in Table 2.

Table 2. Descriptive Statistics and Correlations for Study Variables

Variable	*M*	*SD*	1	2	3	4	5	6	7
1. Shame	3.2	1.3	—						
2. Engagement	6.5	1.5	−.20**	—					
3. Actions	6.7	2.1	-.44**	.50**	—				
4. Family	4.9	1.7	-.32**	.15*	.22**	—			
5. Friends	6.1	1.1	−.32**	.14*	.21**	.28**	—		
6. Depression	6.3	5.7	.54**	−.19**	-.53**	-.27**	-.30**	—	
7. Social anxiety	33.7	18.9	.47**	−.19**	-.38**	−.32**	−.22**	.48**	—

*$p < .05$. **$p < .01$.

All variables were significantly correlated. Shame felt in traumatic experiences presented a negative and very weak association with compassionate engagement ($r = .20$, $p = .001$), a negative and moderate association with compassionate actions, and perceived social supports (from family and friends) ($-.32 < r < -.44$, $p < .001$). Additionally, shame felt in traumatic experiences showed a positive and moderate association with depression and social anxiety symptoms ($.47 < r < .54$, $p < .001$). Correlations between self-compassion and perceived social support with depression and social anxiety symptoms were all negative. On one hand, compassionate engagement had a very weak correlation with both depression and social anxiety symptoms ($r = -.19$, $p = .002$) and compassionate actions presented a moderate correlation with the same variables ($-.38 < r < -.53$, $p < .001$). On the other hand, perceived social support from family presented a weak correlation with depressive symptoms ($r = -.27$, $p < .001$) and moderate with social anxiety symptoms ($r = -.32$, $p < .001$) and the inverse pattern was found with perceived social support from friends (moderate association with depressive symptoms; $r = -.30$, $p < .001$, and a weak association with social anxiety symptoms; $r = -.22$, $p < .001$).

Mediation analyses

The proposed models had four mediator variables: compassionate engagement, compassionate actions, perceived social support from family, and perceived social support from friends. Due to the very weak correlation of compassionate engagement (mediator variable) with shame felt in traumatic experience (independent variable), with depressive and with social anxiety symptoms (dependent variables), only compassionate actions and both perceived social support from family and friends were used as a mediator variable in the tested models.

Model one, represented in Figure 1, comprised shame felt in traumatic experiences as the independent variable, compassionate actions, perceived social support from family, and perceived social support from friends as a mediator variables, and depressive symptoms as the dependent variable. Only compassionate actions and perceived social support from friends presented a significant indirect

effect ($\beta_{actions}$ = 0.67, *SE* = .15; 95% CI [0.406; 0.987]; β_{family} = 0.08, *SE* = 0.07; 95% CI [-0.047; 0.233]; $\beta_{friends}$ = 0.14, *SE* = .09; 95% CI [0.006; 0.353]). Regarding pairwise contrasts, compassionate actions and perceived social support from friends showed a significant difference in their indirect effects ($\beta_{actions\text{-}friends}$ = 0.53, *SE* = .18; 95% CI [0.178; 0.894]).

Additionally, before the introduction of the mediator variables, the total effect was significant (β = 2.33, *SE* = .23; 95% CI [2.78; 0.535]), and after the introduction of the mediators, the model still presented a significant direct effect (β = 1.43, *SE* = .24; 95% CI [0.948; 1.912]). Both compassionate actions and perceived social support from friends partially mediated the relationship between shame felt during traumatic experiences and depressive symptoms, with compassionate actions having a significantly higher effect compared to perceived social support from friends.

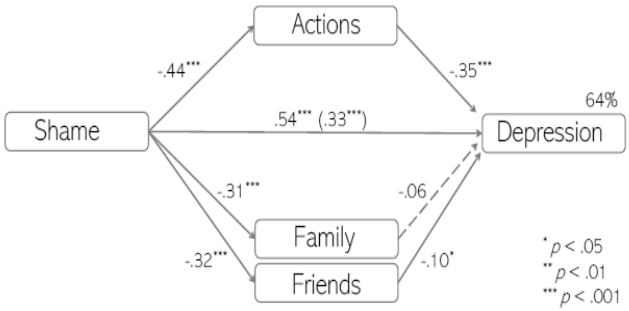

Figure 1. Mediating model predicting depressive symptoms with standardized effects.

The second model, represented in Figure 2, had shame felt in traumatic experiences as an independent variable, compassionate actions, perceived social support from family, and perceived social support from friends as a mediator variables, and social anxiety symptoms as the dependent variable. Only compassionate actions and perceived social support from family presented a significant indirect effect ($\beta_{actions}$ = 1.27, *SE* = .46; 95% CI [0.430; 2.239]; β_{family} = 0.74, *SE* = 0.31; 95% CI [0.203; 1.429]; $\beta_{friends}$ = 0.16, *SE* = .27; 95% CI [-0.310; 0.766]). Regarding pairwise contrasts, compassionate actions and perceived social support from family did not show a significant difference in their indirect effects ($\beta_{actions\text{-}family}$ = 0.53, *SE* = .60; 95% CI [-0.628; 1.716]).

Additionally, before the introduction of the mediator variables, the total effect was significant (β = 6.76, *SE* = .79; 95% CI [5.196; 8.315]), and after the introduction of the mediators, the independent variable maintained a significant direct effect (β = 4.57, *SE* = .90; 95% CI [2.801; 6.341]). In sum, both compassionate actions and perceived social support from family partially mediated the relationship between shame felt during traumatic experiences and social anxiety symptoms.

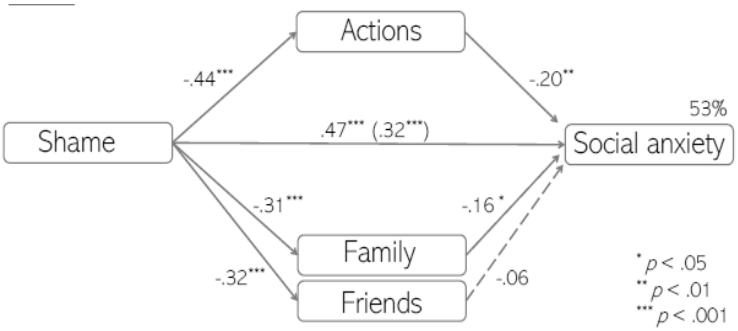

Figure 2. Mediating model predicting social anxiety symptoms with standardized effects

Discussion

The present study aimed to explore the mediation effect of self-compassion and perceived social support in the relationship between shame felt in shame traumatic experiences and psychopathology among SM individuals.

All the associations between study variables were, as expected, significant. Shame felt in traumatic experiences showed a positive and moderate association with the two psychopathology indicators (depression and social anxiety symptoms). That is, higher levels of shame felt in traumatic experiences were associated with higher levels of depressive and social anxiety symptoms. Johnson and Yarhouse (2013) clarify the association between shame and depressive symptoms as due to self-condemnation of shame, and the association between shame and social anxiety symptoms as due to fear of condemnation of shame. These expected results reinforce the negative association between self-criticism and positive sexual minority identity (Petrocchi et al., 2020) and the higher prevalence of social anxiety in SM individuals (Cohen et al., 2016).

Regarding self-compassion, the compassionate engagement component revealed a negative and very weak associations with both shame felt in traumatic experiences and psychopathology. In case of compassionate actions the same associations were moderate, in line with Matos et al. (2017) that found a negative and moderate association between self-compassion and internalized shame in gay men.

Our findings clarify the association between the components of self-compassion and traumatic shame experiences: compassionate actions seem to be the self-compassion component more negatively associated with shame. In fact, Seabra et al. (2022) found a similar result: compassionate actions presented a higher negative association with shame when compared with compassionate engagement. Regarding the association between self-compassion and psychopathology, our

results are in line with two meta-analyses in SM individuals: self-compassion showed a medium negative pooled association with psychological distress (Carvalho & Guiomar, 2022; Helminen et al., 2022).

Both perceived social support (from family and friends) presented a moderate and negative association with shame felt in traumatic experiences. That is, high levels of perceived social support are associated with lower levels of shame felt in traumatic experiences. In fact, SM individuals presented more levels of withdrawal and avoidance as coping with shame when compared with heterosexual individuals (Santos, 2021). In SM individuals with traumatic shame experiences, withdrawal or avoidance are more prone to have difficulties in developing close relationships with other individuals and feel supported. Since those were early experiences, SM individuals could have felt inadequate and unlovable from an early age and this might have contributed to their social isolation and their current reduced social network. Regarding depression and social anxiety symptoms, perceived social support from friends was more associated with depressive symptoms and perceived social support from family was more associated with social anxiety symptoms. Depressive symptoms are associated with low interest/pleasure and isolation (APA, 2022) and friends may have an important role in fostering companionship and maintaining social activities. In turn, social anxiety symptoms are associated with fear of being negatively evaluated by others (APA, 2022) and family, as the first model of "others", when supportive, conveys feelings of safeness with the others outside the family. One frequent phenomenon in SM individuals is self-vigilance and expectations of rejection (Meyer, 2003) and this can explained the higher levels of rejection sensitivity in SM individuals when compared with heterosexual individuals (Maiolatesi et al., 2022).

Unexpectedly, mediation analyses showed different results according to the dependent variables. Additionally to compassionate actions (that was a mediator variable for both depressive and social anxiety symptoms), only perceived social support from family mediated the relationship between shame felt in traumatic experiences and social anxiety symptoms. In turn, perceived social support from friends mediated the relationship between shame felt in traumatic experiences and depressive symptoms. On one hand, the lack of actions directed at preventing or alleviating one's suffering (compassionate actions), partially explains the impact of traumatic shame experiences on depression and social anxiety symptoms among SM individuals. On the other hand, the lack of perceived social support also seems to mediated this relationship. Specifically, the lack of perceived social support from friends seems to have had a mediator role in the development of depressive symptoms, and the lack of perceived social support from the family may have had the same role in the development of social anxiety symptoms.

Our study has further contributed to refine the finding that self-compassion mediates the relationship between minority stress and mental health (Helminen et al., 2022), by highlighting the role of compassionate actions as a component of self-compassion with a mediator effect. Regarding perceived social support, family

support presented a positive role against social anxiety symptoms and friends support against depressive symptoms. These results are not in line with others studies. For example, Milton and Knutson (2021) found that social support from biological family was the only negative predictor of depressive symptoms among SM individuals (compared to chosen families). Even if friends can be considered as part of chosen family, we hypothesized that participants considered friends as peers and not as a surrogate family. Another study has highlighted the importance of chosen families with African American SM as a protective factor against distress (Hailey et al., 2020). In this study, rejection by the family of origin was not assessed, and we hypothesize that this variable could help explaining which family and friends they considered. Maybe the results would be different considering the family of origin, chosen family and friends. Future research is warranted to explore this hypothesis further. In any case, some authors referred that the relevance of social support is overestimated in the relationship with well-being (la Roi et al., 2022) and our results seem to corroborate this statement. Predicting depressive symptoms, compassionate actions had a stronger effect compared to social support from friends, suggesting that compassionate actions have a more relevant role. That is, the lack of perceived social support from friends partially explains the relationship between shame felt in traumatic experiences and depressive symptoms but the lack of compassionate actions explains even more of these symptoms. These results suggested that emotional processing of traumatic shame experiences through self-compassion seems to be more important than perceived social support from friends, and reinforcing the Psychological Mediation Framework (Hatzenbuehler, 2009) that recognizes that stigma-related stress in SM individuals impacts cognitive processing and allows higher psychopathology.

Despite the important findings, some limitations should be considered. All measures were self-reported, and the results did not consider other variables like rejection by family (mentioned above), cognitive distortions, and rejection sensitivity. Future studies should consider a more representative sample and explore other variables.

In sum, both individual and community factors have a positive impact on psychopathology in SM with traumatic shame experiences, namely self-compassion and perceived social support. In particular, compassionate actions, and perceived social support from family and friends. Our results seem to reinforce the stronger role of compassionate actions, instead of perceived social support. Skills to facilitate compassionate actions to alleviate and prevent suffering seem to be the most important element to cope with depression and social anxiety symptoms in SM individuals with traumatic shame experiences and may therefore justify interventions that aim to develop this competency.

Authors' note

Informed consent: Informed consent was obtained from all participants involved in the study.

Human rights: The study was conducted following the Declaration of Helsinki, and approved by the Ethics and Deontology Committee of the Faculty of Psychology and Educational Sciences of the University of Coimbra (2.11.2019).

Consent of ethics: The study was conducted following the Declaration of Helsinki, and approved by the Ethics and Deontology Committee of the Faculty of Psychology and Educational Sciences of the University of Coimbra (2.11.2019).

Conflict of interest: The authors declare no conflict of interest.

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