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Low self-compassion in patients with bipolar disorder

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Abstract

Background: Emerging research suggests that low self-compassion may be linked to psychopathology and in particular depressive symptoms. To further elucidate this topic, the present study investigated self-compassion in patients with Bipolar Disorder (BD).
Method: Thirty remitted BD patients were compared to thirty age- and sex matched controls on the Self-Compassion Scale (SCS). The BD patients also completed the Altman Self-Rating Mania Scale (ASRM), the Major Depression Inventory (MDI), the Work and Social Adjustment Scale (WSAS), the Satisfaction With Life Scale (SWLS) and the Internalized Stigma of Mental Illness Scale (ISMI-10) and further reported their illness history on a survey sheet.
Results: The BD patients were found to have significantly lower self-compassion than controls. In addition, self-compassion correlated positively and significantly with life-satisfaction but no significant correlations with functional impairment, internalized stigma or frequency of past affective episodes were found.
Limitations: The small sample size entailed reduced statistical power.
Conclusions: By suggesting that self-compassion is reduced and possibly linked to life-satisfaction in BD, the findings highlight a potential vulnerability meriting further investigations.

1. Introduction

Bipolar disorder (BD) is a debilitating and often chronic affective disorder characterized by affective episodes such as mania and depression interceded by intervals with remission [1]. BD often entails functional impairments [2] and reduced quality of life [3].

A central characteristic of BD is the marked variations in self-perception during affective episodes, with low self-esteem during depression and high or inflated self-esteem during mania. Abnormalities in self-conception are, however, not confined to mood episodes in BD. Previous studies suggest that during periods of remission BD is associated with self-criticism [4,5], low self-esteem [6], maladaptive self-schemas [7,8] and a dichotomized self-organization [9]. As a result of the cognitive focus within this research, less attention has been devoted to emotional aspects of self-conception. Acknowledging that BD is an affective disorder with major shifts in mood and emotion, emotional aspects of self-conception indeed appears relevant.

Self-compassion, which entails certain emotional inclinations towards the self, is a relatively new psychological concept that has been conceptualized in different but overlapping theories by Neff [10,11] and Gilbert [12,13]. High self-compassion involves being kind and understanding toward oneself in difficult times and perceiving difficulties as part of a larger human experience [10]. More broadly, it involves an accepting and nonjudgmental attitude toward one's experiences. Low self-compassion, on the other hand, involves being self-judgmental and inclined to over-identify with negative experiences as well as feeling isolated by suffering.

Self-compassion has to our knowledge not previously been examined in BD patients. There are, nevertheless, a number of reasons for assuming a relevance of self-compassion in BD.

One of these is empirical as previous studies indicate that self-compassion is related to psychopathology. A meta-analysis by Macbeth and Gumley [14] found that low self-compassion was associated with symptoms of depression and anxiety in both clinical and non-clinical populations. Also, in a study by

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Krieger et al. [15] patients with Major Depressive Disorder (MDD) exhibited lower self-compassion compared to a non-clinical control group, even when controlling for depressive symptoms. Thus, based on prior research it appears that low self-compassion may be linked to depression and depressive symptoms. However, it remains to be examined whether this association also applies to BD with its different affective symptomatology.

The other reason for assuming a relevance of the concept in BD is the theorized connection between low self-compassion and affective dysregulation. According to Gilbert [12,13], self-compassion is a critical component in the human capacity to regulate emotions. In his theoretical model, three neurobiological systems influence affect regulation; the threat system related to fear and avoidance, the drive system related to motivation and rewards and the soothing system related to feelings of calmness and affiliation. It is particularly the soothing system that is involved in compassion towards self and others. The soothing system contributes to handling both ups and downs and resisting psychological stress.

Drawing upon Gilbert's theory and the Behavioral Activation System theory of BD [16], Lowens [17] proposes that affect dysregulation in BD involves an over- and underactivation of the drive system, an unstable threat system and a limited soothing system. From this perspective, BD could involve a restricted capacity for a self-compassionate attitude due to a limited soothing system. The abnormal oxytocin levels [18,19] and increased amygdala activity [20] found in BD patients support the idea of a limited soothing system at a neurobiological level. However, it remains to be examined whether such presents as low self-compassion at the phenomenological level.

Based on the outlined empirical and theoretical reasons, self-compassion was investigated in a sample of BD patients. The purpose of the study was two-fold. Firstly, in order to examine the overall level of self-compassion, BD patients were compared to age- and sex matched controls. Secondly, to explore the potential impact of self-compassion in BD patients, associations between self-compassion and indicators of illness severity and psychological well-being were examined. In agreement with prior research, age of onset and frequency of past affective episodes were used as proxies for illness severity [21,22]. As indicators of psychological well-being measures of functional impairment, internalized stigma and quality of life were employed. In order to control for the confounding effects of mood symptoms, a remission design was employed with absence of affective episodes as an inclusion criteria for study participation.

2. Method

2.1. Sample and procedure

The present study was a naturalistic case-control study comparing remitted BD patients and age- and sex matched controls. Recruitment of participants was confined to a period of four months, from February to May 2014. All of the participants provided informed consent after receiving verbal and written descriptions of the study. Participation was entirely voluntary and independent of ongoing treatment. The study was approved by The National Committee of Health Research Ethics in Denmark.

Thirty BD patients were recruited from the Mood Disorders Clinic at Aarhus University Hospital in Denmark. Upon admission to this clinic, they had all received a diagnosis of BD conforming to the ICD-10 criteria [23]. The diagnostic assessments were conducted by trained psychiatrists on the basis of clinical judgments and SCAN-interviews [24]. To be included in the study, the BD patients were required to be in remission defined as a minimum of four weeks without major affective episodes. Only patients whom clinicians judged as being remitted were approached and invited to participate in the study. Furthermore, in accordance with established cut-off points for remission, only patients with self-reported scores of 5 or below on the Altman Self-Rating Mania Scale [25] and 25 or below on the Major Depression Inventory [26,27] were included. Additional exclusion criteria were schizoaffective disorder and current substance or alcohol abuse.

The participants constituting the control group were recruited among clerical staff, students and researchers at Aalborg University in Northern Denmark. The participants were first administered a short self-report survey probing information on socio-demographics (age, sex, level of education, employment status), alcohol or substance abuse and present or past mental disorders of self and parents. Exclusion criteria were alcohol and substance abuse, having a present or past mental disorder, or having a parent with a past or present affective disorder or other severe mental disorder. One hundred and ten individuals participated and 69 met the inclusion criteria. Among these, 30 individuals were selected to form a comparison group based exclusively on age and sex matching. The researchers were blind to all other information at this point in the study.

2.2. Measures

Both the BD patients and the controls completed the Self-Compassion Scale [11] which is a 26-item questionnaire designed to assess the degree of self-compassionate responding towards oneself during hard times. The items consist of statements which the respondents are requested to rate on a 5-point Likert Scale ranging from 1 (almost never) to 5 (almost always). The SCS contains six subscales measuring three components of self-compassion consisting of opposing pairs; Self-Kindness versus Self-Judgment, Common Humanity versus Isolation, Mindfulness versus Over-Identification. In the entire sample of the present study, the internal consistency as indicated by Cronbach's alpha coefficient was excellent for the SCS total (.89) and adequate to good (.65–.87) on the subscales. Since the factor structure