What is the relationship between self-compassion and depression, anxiety, and resilience in adults with epilepsy?
Outline

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Epilepsy - prevalence and psychological impact

- In England, epilepsy affects between 362,000 and 415,000 (NICE, 2016)
- PWE have poorer QOL than the general population (Kobau et al., 2003)
- Depression and anxiety are highly prevalent (Beyenberg et al., 2005)
- Shame (self-focused and self-evaluative experience of being flawed or inadequate) has also been identified in PWE (de Souza & Salgado, 2006), with some describing the condition as shameful, not wanting others to know about their diagnosis, and feeling bad about themselves as a result of having the condition (Räty, Söderfeldt, & Larsson, 2007)
Shame and self-compassion

• Shame has been identified as an important predictor of depression and anxiety (Tangney et al., 1992)
• In contrast, self-compassion can help to protect against shame and lead to better mental health outcomes (Ferreira et al., 2013) including lower depression and anxiety (Neff & Faso, 2015)
• Self-compassion has also been associated with resilience (Kemper et al., 2015; Neff & McGehee, 2010; Smeets et al., 2014), although few studies have measured this directly and the empirical evidence is currently limited
• CFT aims to increase the capacity for high-shame individuals to be compassionate to themselves and others, with a view to increasing self-soothing, warmth, and kindness (Gilbert, 2009)
Aims and hypotheses

• Using a quantitative design, the aim of the study was to identify whether self-compassion predicted additional variance in measures of depression, anxiety, and resilience when other known predictors of wellbeing (including socio-demographic and illness-related variables) had been accounted for.

• It was hypothesised that self-compassion would be negatively associated with depression and anxiety and positively associated with resilience, even when other known influencing variables had been accounted for.
Method

• Quantitative cross-sectional survey design to examine predictors of depression, anxiety, and resilience in PWE
• Feedback on the design was obtained from a panel of service user representatives from the charity Epilepsy Action (the Epilepsy Action Research Network; EARN) and suggested changes were incorporated into the final design
• Participants were recruited online and from local NHS epilepsy services
• Survey included questions about demographic and clinical information and standardised measures of seizure severity (Liverpool Seizure Severity Scale), self-compassion (Neff Self-Compassion Scale), depression (HADS), anxiety (HADS), and resilience (Brief Resilience Scale)
Participants

• A total of 327 participants consented to take part in the study
• 305 were recruited online and 22 from epilepsy clinics
• Independent t-tests were carried out to compare the variable means of the clinical and online samples; no significant differences were identified between the two groups in relation to all of the main variables ($p > .01$), with the exception of level of education, which was found to be higher in the online sample ($t = 3.141, p = .004$)
• Of the 327 survey responses, 59 contained missing data
• 57 were excluded due to missing data on three or more main variables. In the remaining 2 cases, data was imputed for missing BRS responses using mean substitution
• A total of 270 responses that were included in statistical analyses
• $\alpha$ coefficients for responses observed indicated high internal consistency; alpha values ranged from 0.83 to 0.94
Analysis

• Statistical analyses completed in SPSS
• Correlation analyses were completed for all of the main variables
• Variables that were found to be significantly correlated with the outcome variables were entered as predictor variables into the regression model

The regression model was therefore structured as follows:

1. Sociodemographic variables: age, employment status
2. Illness-related variables: seizure severity, seizure type
3. Self-compassion

• The outcome variables were: 1) Depression, 2) Anxiety, and 3) Resilience
Results - Depression

- Steps 1 and 2 accounted for 9.4% variance in depression
- Self-compassion was found to increase the explanatory power of the final model to 43.5%
- Self-compassion therefore explained 34.1% of the variance in depression, and the overall model was significant ($F = 39.942, p < .001$)
- In the final model, the variables that were found to be significant were seizure severity ($\beta = .252, p < .001$), employment status ($\beta = -.115, p < .01$) and self-compassion ($\beta = -.596, p < .001$)
Results - Anxiety

• Steps 1 and 2 of the model accounted for 9.5% of the variance in anxiety.
• Self-compassion was found to increase the explanatory power of the final model to 41.7%. Self-compassion therefore explained 32.2% of the variance in anxiety, and the overall model was significant ($F = 37.127, p < .001$).
• In the final model, the variables that were found to be significant were seizure severity ($\beta = .182, p < .001$), seizure type ($\beta = .102, p < .01$) and self-compassion ($\beta = -.579, p < .001$).
Results - Resilience

- Steps 1 and 2 of the model accounted for 7.3% of the variance in resilience.
- Self-compassion was found to increase the explanatory power of the final model to 41%. Self-compassion therefore explained 33.7% of the variance in resilience, and the final model was again significant ($F = 36.150, p < .001$).
- In the final model, the variables that were found to be significant were seizure severity ($\beta = -.176, p < .001$) and self-compassion ($\beta = .593, p < .001$).
Discussion and clinical implications

• Higher self-compassion predicted lower depression and anxiety and higher resilience, therefore all hypotheses were supported
• The findings of this study have potentially significant implications in relation to psychological care and public health strategies for PWE
• At a clinical level, the most significant indicator arising from this study is that it suggests that CFT may be a useful intervention for PWE who are less resilient or at risk of experiencing depression or anxiety
• At a public health level, more may need to be done to tackle the negative societal judgement of the visible aspects of epilepsy (i.e. uncontrolled seizures), and to foster a compassionate view of the condition by both people with and without the condition
Limitations

- The use of self-report measures is also open to bias (Robins, Fraley, & Krueger, 2009) and is sensitive to culture (Hamamura, Heine, & Paulhus, 2008)
- The design fails to address chronological variability (Bowen, & Wiersema, 1999)
- It was not possible to verify with certainty who the respondents to the survey were and if the sample was truly valid
- Online recruitment may also have inadvertently excluded people who were not computer literate or did not have access to the technology
- While the study was open internationally, the majority of participants were White British and female
#Recruitment tips

- Online recruitment can be very effective
- Utilise support from charities and specialist groups
- Facebook support groups can be very helpful
- Use hashtags on Twitter and (politely!) request retweets from relevant people with lots of followers
- Combination of online and clinical sample provides access to credible but large population
References


Thanks for listening

Any questions?