SHORT TITLE: Psychological flexibility and self-compassion in gay and heterosexual men

Psychological flexibility and self-compassion in gay and heterosexual men: how they relate to childhood memories, shame and depressive symptoms

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Abstract

This study explores differences between gay men (N = 53) and heterosexual men (N = 52) regarding memories of shame events and of warmth and safeness experiences with parents during childhood and adolescence, self-compassion, psychological flexibility, internal shame and depression. Also, it aims to explore whether psychological flexibility and self-compassion play a role in the association between these memories and internal shame and depressive symptoms. Results confirmed the mediating role of psychological flexibility and self-compassion. These findings suggest the appropriateness of promoting acceptance and self-compassion towards difficult memories in a therapeutic setting with gay men experiencing shame and depressive symptoms.

Keywords: gay men; heterosexual men; shame; depressive symptoms; psychological flexibility; self-compassion.

Introduction

There is a considerable amount of evidence pointing to the lasting impact of negative experiences during childhood and adolescence in adult mental health, particularly at the hands of family members (e.g., Kessler et al., 2010; Springer, Sheridan, Kuo, & Carnes, 2007). Recently, there has been a growing interest in studying the impact of memories of early shame experiences and their role on later psychopathological symptoms (e.g., Matos & Pinto-Gouveia, 2010). Although shame is a self-conscious emotion that is part of our evolutionary emotional repertoire (e.g., Gilbert & McGuire, 1998), it arises from early interactions with parents and/or significant others (Tangney & Dearing, 2002). Proneness to feel shame seems to result from the internalization of these shame experiences (e.g. Claesson & Sohlberg, 2002; Gilbert & Gerlsma, 1999; Matos & Pinto-Gouveia, 2010). Shame experiences have been described as instances in which one is criticized, threatened, rejected or ignored and they lead to an internalization of a sense of self as unworthy, inferior, unacceptable and unlovable (Gilbert, 1998, 2003), which seems to be particularly impactful when the shamer is a parent or caretaker (Matos & Pinto-Gouveia, 2014).

Although the impact of early shame experiences on mental health is well-established (Gilbert, Allan, & Goss, 1996; Tangney & Dearing, 2002), particularly in depression (e.g. Cheung, Gilbert, & Irons, 2004), to our knowledge this impact has not been explored specifically in gay men. In fact, it seems to be of great importance to explore shame experiences in childhood family environment of gay men, as shame and shame-related constructs have for long been incorporated in clinical approaches for LGBT individuals (e.g., Malyon, 1982) and research suggests that these are relevant factors in gay men´s mental health. For example, one study found that shame is significantly associated to internalized homophobia (Allen & Oleson, 1999; Brown & Trevethan, 2010), which is a well-known risk factor for depression and anxiety in gay men (e.g. Barnes & Meyer, 2012; Igartua, Gill, &

Montoro, 2009; McLaren, 2016). Shame has also been associated with self-destructive behaviours (McDermott, Roen, & Scourfield, 2008) and suicide (Skerrett, Kõlves, & De Leo, 2016), and found to be a mediator between minority stressors and psychological and physical distress (Mereish & Poteat, 2015).

Although, to our knowledge, the impact of shame experiences with caregivers on depression and shame in adulthood has not been explored in gay men, there is a considerable amount of research reporting the nefarious results from parental maltreatment and rejection. Research has found that gay men report lower levels of parental support than bisexual and heterosexual men, and that parental support mediates the relationship of sexual orientation and depressive symptoms (Needham & Austin, 2010). In addition, gay men also seem to report higher rates of childhood emotional and physical maltreatment when compared to heterosexual men (Corliss, Cochran, & Mays, 2002), and sexual orientation seems to be a significant predictor of victimization (Balsam, Rothblum, & Beauchaine, 2005). On the contrary, results show that a childhood where feelings of warmth and safeness were promoted by the parents is associated with LGBTQ self-reported happiness (Greene & Britton, 2015). Also, it is especially appropriate to explore the impact of shame experiences in gay men´s mental health as they seem to be encoded in autobiographical memory and to be central to the development of personal identity (Pinto-Gouveia & Matos, 2011).

Additionally, gay men seem to be at particular risk for developing mental health problems and experiencing psychopathological symptoms. Epidemiological studies have shown that gay men are more likely to develop anxiety, depression and externalizing disorders when compared to heterosexual men (e.g. Feinstein, Goldfried, & Davila, 2012). Overall it seems that gay men present a greater lifetime incidence of mood and anxiety problems when compared to heterosexual men (Cochran, 2001; Meyer, 2003). However, an in-depth reading of these studies advises us to consider other demographic variables, such as

age, as important moderator. Nevertheless, research in this regard has produced inconsistent results with a study showing that older adult gay men present better indicators of mental health than younger adult gay men (Bybee, Sullivan, Zielonka, & Moes, 2009), while other studies suggest no significant correlation between age and psychological well-being and depressive symptoms (Kertzner, Meyer, Frist, & Stirratt, 2009).

The increased vulnerability among gay men to develop symptoms of depression and anxiety might be related to the stress of being part of a social minority (Meyer, 2003), which includes the experience of objective negative social events, the expectation of those events and the internalization of negative social attitudes (Meyer, & Dean, 1998). In fact, it seems that gay men present greater social interaction anxiety in situations where heterosexuality and stereotypical gendered behavior is expected (Pachankis & Goldfried, 2006) and it seems that life stress related to being gay is associated with depressive symptoms (Lewis, Delega, Griffin, & Krowinski, 2003).

Recent studies have stressed the protective role of psychological processes related to acceptance. Psychological flexibility (PF) is described as the ability to be in the present moment, regardless of the pleasantness or unpleasantness of the situation, and choosing to behave in such a way that our actions reflect chosen personal values (Hayes, Strosahl, Bunting, Twohig, & Wilson, 2004). From this definition, two major PF-related aspects can be derived. One is the ability to accept the present moment experience as it is, instead of avoiding difficult or uncomfortable events. This perspective-shifting way of relating to our experiences allows us to better assess the situation in which we are in, instead of behaving in an automatic way. The other fundamental aspect of PF is to act in a way that is congruent with personal values; that is, in the direction of the life one wants, instead of inflexibly avoiding stress-inducing events. In fact, avoidance seems to be a preferential emotional-

regulation strategy that is associated with poor mental health (see Chawla & Ostafin, 2007, for a review).

Furthermore, PF has been associated to a great array of positive mental health and mental well-being indicators (see Kashdan & Rothenberg, 2010, for a review). Although to our knowledge PF has never been explored in a sample of gay men, one study found that experiential avoidance – which is theoretically the opposite of acceptance (Hayes, Luoma, Bond, Masuda, & Lillis, 2006) – is a stronger predictor of depression symptom severity than internalized homophobia, and that it mediates the relationship of internalized homophobia and depressive symptoms severity (Gold & Marx, 2007). Indeed, psychological approaches that promote PF seem to be beneficial to reduce self-stigma around sexual orientation, anxiety and depression (Yadavaia & Hayes, 2012) and HIV-related stigma in gay and bisexual men (Skinta, Lezama, Wells, & Dilley, 2015. Additionally, these PF-focused approaches are proposed to be adequate for sexual and gender minorities (Stitt, 2014) and for addressing eating disorder symptoms in gay men (Walloch, Cerezo, & Heide, 2012).

Another psychological process that seems to potentially have a protective role in mental health is self-compassion. This psychological process is related to how one responds to difficult times and is thus a self-to-self form of self-regulating (Gilbert & Irons, 2005; Terry & Leary, 2011). According to Neff (2003), self-compassion has been described as having three core domains: (a) being self-kind and understanding towards oneself when things go wrong or when one perceives a personal attribute as negative and/or socially condemnable, as opposed to being self-judgmental and self-critical; (b) perceiving personal hardships as part of the larger shared experience of being human, instead of isolating oneself and perceiving these hardships as uniquely self-directed; and (c) experiencing personal difficulties in a mindful way and as transient events, instead of over-identifying with those difficulties and assuming that these have something to do with who we are as human beings.

Self-compassion has been positively associated to well-being (Neff, Kirkpatrick, & Rude, 2007), negatively correlated to psychopathology (MacBeth & Gumley, 2012) and it seems particularly adequate to address self-criticism and shame-related symptomatology (Gilbert & Procter, 2006).

Nevertheless, research on self-compassion in gay men is still scant. For example, one study found that gay men who have come out had a higher sense of self-compassion (Crews & Crawford, 2015). Another study found that self-compassion is a predictor of greater life satisfaction in a sample of gay men (Jennings & Tan, 2014). A recent study found that self-compassion is positively correlated to well-being in gay men (Beard, Eames, & Withers, 2016).

The current study has two major goals. The first is to explore if gay men and heterosexual men differ on memories of warmth and safeness, shame memories from childhood and adolescence, on psychological flexibility and self-compassion, and on internal shame and depressive symptoms. Secondly, the current study set out to test, in both gay and heterosexual men, if (lower levels of) psychological flexibility and self-compassion mediate the relationship between (a) shame memories and internal shame (b) shame memories and depressive symptoms; (c) memories of warmth and safeness and internal shame; (d) memories of warmth and safeness and depressive symptoms.

To our knowledge, this is the first study to explore shame memories from early life in gay men, as well as to explore the mediating role of psychological flexibility and self-compassion between memories of negative and positive parental experiences and internal shame and depressive symptoms.

Method

Participants

Participants in this study were 53 gay and 52 heterosexual. No significant differences were found between the samples regarding age (Gay: $M = 37.04$, $DP = 7.74$, Age range 18-52; Heterosexual: $M = 37.81$, $DP = 9.08$, Age range 21-57; $t = 0.47$, $p = .638$). Significant differences were found in terms of education, with gay men showing higher education levels ($\chi^2 = 19.99$, $p = .001$). Gay and heterosexual men also differed in terms of marital status ($\chi^2 = 42.04$, $p < .001$), with gay men being mostly single ($n = 28$, 52.8%), divorced ($n = 12$, 22.6%), and in civil partnership ($n = 11$, 20.8%), while heterosexual men were mainly married ($n = 29$, 54.7%), or single ($n = 16$, 30.2%).

Procedure

Participants were recruited as a convenience sample and a cross-sectional design was used for data collection. Gay men were invited to participate through social networking websites, community-based groups and LGBTQ associations (via standard invitation through their mailing list). Heterosexual men were recruited form the general community through a snowball procedure. Study participants were asked to recall a prominent and significant shame memory from childhood and adolescence and to complete self-report measures assessing the shame memory centrality, early affiliative memories, psychological flexibility, self-compassion, shame and depression. The order of the instruments was counterbalanced to control for the effect of current mood or past recollections on the filling of the subsequent measures. Data were collected mainly through an online survey (SurveyMonkey). In line with ethical requirements, participants were informed their co-operation was voluntary and their answers were confidential and only used for the purpose of the study.

Participants were recruited as part of a larger study examining the relationship between affiliative and shame memories, shame and psychopathology in gay and heterosexual men.

Measures

All participants completed a socio-demographics form including information regarding sexual orientation (one open question), age, marital status, and education level.

Priming for the shame memory. Firstly, participants were given a brief introduction on the concept of shame and were asked to recall a significant and stressful shame experience from their childhood or adolescence involving a parent or another caretaker. Afterwards, they were asked to briefly describe the shame event, identify who was the shamer and the age they were at that time. Then, they were instructed to answer the shame memory-related questionnaire based on that experience (i.e. Centrality of Event Scale).

Centrality of Event Scale (CES; Berntsen & Rubin, 2006; Validated Portuguese version by Matos, Pinto-Gouveia, & Gomes, 2010). The CES is a 20-item (5-point Likert scale) measure that assesses the extent to which a memory of a stressful event (in this case a shame experience) forms a reference point for personal identity and attribution of meaning to other experiences in a person's life. CES measures three interdependent characteristics of a highly negative emotional event that load on to a single underlying factor: (a) central component of one's personal identity (e.g., "*I feel that this event has become part of my identity*."); (b) a landmark in one's life story (e.g., "*I feel that this event has become a central part of my life story*."); (c) acts as a reference point for inferences and attributions in everyday life (e.g., "*This event has colored the way I think and feel about other experiences*."). The adjustment in the instructions in order to prime a shame memory has been made in other studies (e.g., Pinto-Gouveia & Matos, 2011) and it does not affect the validity of this measure. In its original study and Portuguese version, CES showed sound psychometric properties with construct, convergent and divergent validities and a high internal consistency (Cronbach α = .94 and .96 respectively). Cronbach alphas in the current study were excellent (heterosexual men: Cronbach α = .97; gay men: Cronbach α = .99).

Early Memories of Warmth and Safeness Scale (EMWSS, Richter, Gilbert, & McEwan, 2009; Validated Portuguese version by Matos, Pinto-Gouveia, & Duarte, 2013). EMWSS is a single factor 21-items scale (e.g. '*I felt cared about'*, '*I felt appreciated the way I was*' and '*I felt part of those around me'*) that measures personal emotional memories (e.g. warmth, safeness, acceptance and being cared for) (0 = No; 4 = Yes, most of the time). Both in its original study and in the Portuguese version, the EMWSS presented good psychometric qualities and an excellent internal consistency, with a Cronbach's alpha of .97. Cronbach' alphas for the current study were also high (heterosexual men: Cronbach α = .98; gay men: Cronbach α = .99).

Acceptance and Action Questionnaire II (AAQ II; Bond et al., 2011; Validated Portuguese version by Pinto-Gouveia, Gregório, Dinis, & Xavier, 2012). The AAQ-II is a one-dimensional 7-item measure of psychological flexibility, on a 7-point Likert scale (ranging from 1 = Never true to 7 = Always true). Higher scores on the AAQ-II indicate higher levels of psychological flexibility. The AAQ-II demonstrated good construct, and convergent and divergent validities in both the original and Portuguese versions (Bond et al., 2011; Pinto-Gouveia et al., 2012). The AAQ-II demonstrated very good internal consistency in our study (heterosexual men: Cronbach α= .94; gay men: Cronbach α= .96).

Self-Compassion Scale (SCS; Neff, 2003; Validated Portuguese version by Castilho, Pinto-Gouveia, & Duarte, 2015). SCS is a 26-items scale that comprises two main components: a positive one (self-kindness, common humanity and mindfulness); and a negative one (self-judgment, isolation, and over-identification). The SCS presents good psychometric properties, construct, convergent and divergent validities, and internal reliability both in the original (.92; Neff, 2003a) and Portuguese versions (.89; Castilho et al., 2015). In this study, only the positive dimension (Self-compassion) was used. The Cronbach

alphas in this study were good to very good (heterosexual men: Cronbach α= .93; gay men: Cronbach α= .87).

Internalized Shame Scale (ISS; Cook, 1994; Validated Portuguese version by Matos, Pinto-Gouveia, & Duarte, 2012). The ISS is a 24-item measure of internal shame (e.g., "*compared with other people, I feel like I somehow never measure up*") and a 6-item subscale of self-esteem (e.g., "*all in all, I am inclined to feel that I am a success*"). All of the items are rated on a 0 to 4 scale ("never" to "almost always"). In this study, only the shame subscale was used as a measure of internal shame. Previous studies (Cook, 1996) have reported test–retest correlations of .84 and .69, respectively, and have reported good convergent and divergent validity. The Cronbach alphas for this study were excellent (heterosexual men: Cronbach α= .93; gay men: Cronbach α= .97).

Depression, Anxiety and Stress Scale (DASS-42; Lovibond & Lovibond, 1995; validated Portuguese version by Pais-Ribeiro, Honrado, & Leal, 2004). DASS is a self-report measure composed of 42 items and designed to assess three dimensions of psychopathological symptoms: depression, anxiety and stress. The items indicate negative emotional symptoms and are rated on a 4-point Likert scale (0-3). This self-report instrument presented adequate psychometric properties and the original version found the subscales to have high internal consistency (Depression: α = .91; Anxiety: α = .84; Stress: α = .90). In the present study, only the Depression subscale will be considered. Cronbach alphas for this subscale in this study were high (heterosexual men: Cronbach α= .91; gay men: Cronbach α= .98).

Data Analyses

Data analyses were carried out using Predictive Analytics SoftWare (PASW, v. 22 SPSS, Chicago Inc.). Independent samples T tests and Chi-Square tests were performed to compare the groups in the socio-demographic and the study variables. Pearson correlation

coefficients were conducted to explore the association between the independent variables (CES and EMWSS), the mediators (AAQ-II and SCS) and the outcome variables (ISS and DASS depression) (Cohen, Cohen, West & Aiken, 2003). We have conducted all mediational analyses using the SPSS PROCESS macro (Hayes, 2013) due to its fairly simple-to-use procedures to assess unconditional indirect effects (Hayes, 2012). We tested the mediator effect of psychological flexibility and self-compassion on the associations between centrality of shame memory and affiliative memories, and internal shame and depression. Each mediation model was tested separately. Bootstrapping resampling method was further used to test the significance of the mediational path, using 5000 bootstrap samples and 95% confidence intervals (CIs) (Kline, 2005). Effects were considered significant ($p < .050$) if zero is outside of the upper and lower bounds of the 95% confidence interval (Hayes & Preacher, 2010).

Results

Differences between Heterosexual and Gay Men

Shame memories features. Results from *t*-test analyses showed there were no significant differences between gay ($M = 10.15$-years old) and heterosexual men ($M = 11.38$-years old) regarding the age when the recalled shame experience occurred ($t = 1.55$, $p = .123$).

Chi-square difference test showed there were significant differences between gay and heterosexual men regarding the shamer ($\chi^2 = 21.45$, $p < .001$). Specifically, while the majority of gay men reported the father as their primary shamer ($n = 32$ gay men; $n = 8$ heterosexual), heterosexual men reported a caregiver other than their parents as the shamer ($n = 8$ gay men; $n = 18$ heterosexual men).

Psychological processes and symptoms. Results from comparative analyses according to sexual orientation is depicted in Table 1.

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Results showed there were significant differences between heterosexual and gay men in all variables. Specifically, gay men reported having experienced fewer feelings of warmth, safeness, of being accepted and of being cared for during childhood and adolescence in their families. Additionally, gay men reported that their memories of being shamed and put-down during childhood and adolescence were more central to their self-identity, when compared to heterosexual men. In fact, our sample of gay men had significantly higher levels of internal shame than the heterosexual sample. Furthermore, gay men presented higher levels of depressive symptoms when compared to heterosexual men in our sample. Finally, regarding psychological processes, gay men reported less self-compassion and psychological flexibility.

Correlation Analyses

Results show that all variables in the study were significantly correlated, with the exception of correlations between centrality of shame experience and depression, memories of warmth and safeness and internal shame, and self-compassion and depression in heterosexual men. These associations were all significant and in the expected direction in our sample of gay men. Both in gay and heterosexual men, centrality of shame was associated positively with internal shame, and negatively with psychological flexibility and self-compassion. Early memories of warmth and safeness were inversely correlated to depression and negatively related to psychological flexibility and self-compassion both in gay and heterosexual men. Psychological flexibility was negatively associated with internal shame and depression, and positively associated with self-compassion in gay and heterosexual men. Worth mentioning is the fact that these associations were stronger in our sample of gay men than in heterosexual men (see Table 1).

Mediation

Table 2 depicts results from mediation analyses.

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In regard to depression, results from mediational analyses showed that psychological flexibility mediates the association between memories of warmth and safeness and centrality of shame memory, and depression, both in gay and heterosexual men. However, self-compassion mediated these associations in gay men, but not on heterosexual men. Similar results were found for internal shame. Psychological flexibility mediated the relationship between memories of warmth and safeness and centrality of shame memory and internal shame, but self-compassion seemed to only mediate these associations in gay men.

Discussion

This study explored memories of shame experiences and memories of safeness and warmth in childhood and adolescence in gay men and heterosexual men, as well as its impact on current internal shame and depressive symptoms. Additionally, this is the first study to explore the role of psychological flexibility and self-compassion as mediators between negative (shame) and positive (safeness) memories and internal shame and depression.

The exploration of memories of shame events in childhood and adolescence showed that the majority of gay men reported that these experiences occurred at the hands of their fathers, while heterosexual men reported these experiences happened with caregivers other than their parents. These results might provide a possible explanation to why shame experiences in childhood and adolescence are more impactful in gay men than in heterosexual men. In fact, there is considerable evidence that gay (and bisexual) men report higher rates of child maltreatment than heterosexual men (e.g. Corliss et al., 2002). Specifically in regard to shame memories, recent studies suggest that the impact of shame experiences in childhood and adolescence is particularly nefarious when the shamer is a parent rather than a significant other (e.g. Matos & Pinto-Gouveia, 2014). Additionally, we suggest that it is not without meaning that the shamer is mostly the father in gay men. This

result echoes other studies in which gay men report higher rates of physical maltreatment by their parents than heterosexual men do (e.g. Corliss et al., 2002). Also in accordance with this is the result that gay men report less memories of feeling warmth, cared-for and safe in their family than heterosexual men do, which seems to be in line with existing studies that suggest gay men report less parental support than heterosexual men (Needham & Austin, 2010).

Results from correlation analyses show that the associations between memories of shame experiences, memories of warmth and safeness, depression and internal shame were significant and in the expected direction both in gay men and heterosexual men. Indeed, research shows that having rearing experiences in which one is criticized, put-down and/or ignored (shame experiences) leads to an internalized sense of self as unworthy, inferior, unacceptable and unlovable (e.g. Gilbert, 1998; Gilbert & Gerlsma, 1999; Pinto-Gouveia & Matos, 2011) and to depressive symptomatology (e.g. Cheung et al., 2004; Matos & Pinto-Gouveia, 2010). On the other hand, a childhood characterized by parental support, warmth and safeness has been correlated with mental adjustment in samples where sexual orientation was not controlled for (e.g. Gilbert, 1998, 2003), and with happiness in gay men (Greene & Britton, 2015). It is worth noting that although these associations were significant regardless of sexual orientation, the magnitude of the associations was stronger in gay men than in heterosexual men. Although this might be linked to the fact that gay men reported significantly higher levels of these variables (see Table 1), one can also hypothesize that in fact these results suggest that depressive symptoms and internal shame are particularly connected to memories of being criticized and put-down by the parents in gay men, more than in heterosexual men. Additionally, gay men seem to be less self-compassionate and psychologically flexible than heterosexual men, and these two psychological processes are also more strongly correlated with depression and internal shame in gay men than in heterosexual men. This is in line with general research on both self-compassion and

psychological flexibility, which have extensively suggested that lower levels of these potential affect regulation processes are associated with psychopathological symptoms and mental health maladjustment (Chawla & Ostafin, 2007; Gilbert & Procter, 2006; Kashdan & Rottenberg, 2010; MacBeth & Gumley, 2012), specifically in gay men (Beard et al., 2016; Gold et al., 2007). Nevertheless, to our knowledge, this is the first study to explore these processes both in gay and heterosexual men, and to provide evidence for the different associations separately by sexual orientation.

Finally, we aimed at exploring the role of self-compassion and psychological flexibility on the relationship between memories of shame and safeness in childhood and adolescence, and current depressive symptoms and internal shame. Results from mediation analyses seem to suggest that, while psychological flexibility is a mediator both in gay and heterosexual men, self-compassion seems to operate as a mediator in gay men only.

According to our results, the ability to adopt an attitude of kindness and reassurance towards the self mediates the association between memories of shame and memories of safeness, and depressive symptoms and internal shame only in gay men. It is important to note that there are new compassion-based psychological interventions specifically developed to target shame and self-criticism (e.g.; Gilbert & Procter, 2006), In particular, compassion focused therapy (Gilbert, 2010; Gilbert & Irons, 2005) focuses on cultivating compassion as a means to deactivate an overstimulated threat-defense affect regulation system in which shame operates, and to promote self-soothing and self-regulating abilities underpinning the development of a safeness-soothing system, crucial for healthy emotional regulation. The ability to be in the present moment and willingly experience difficult internal events (such as painful shame memories) in order to adopt values-based actions (i.e., psychological flexibility) seems to be involved in how these internal events are related to depression and internal shame. These results seem to suggest that when these negative internal experiences

are particularly intense and pervasive there may be other important psychological processes involved. Our results suggest that self-compassion might be one of these processes. Although self-compassion involves an ability to be present and accepting of difficult experiences (Neff, 2003), as psychological flexibility also does (Hayes et al., 2004), self-compassion adds an emotional texture of kindness and involves an additional attitude of non-judgment, which seems to be particularly important in gay men (who were found to present lower levels of it).

Results from this study should be interpreted with caution and taking some limitations into account. For one, the relatively small sample prevents us from drawing definite conclusions. Further studies should replicate these results using a larger sample, which would make it possible to conduct robust statistical procedures (e.g. structural equation modeling) that would test all variables at once in a comprehensive model, instead of testing them in simple linear regressions, as this study did. Additionally, the cross-sectional nature of the study does not allow us to infer causality between variables. Furthermore, all participants were part of the general population, thus extrapolating our results to clinically depressed heterosexual and gay men is unwarranted. The results should be interpreted considering the two groups were different in terms of education level and future studies should be conducted in more homogenous samples. Finally, it is particularly important to bear in mind that this study did not explore the nature nor the theme of the shame experience. Although this study suggests that gay men have more shame memories than heterosexual men, we cannot conclude that their sexual orientation or perhaps their behavior non-conformed with gender stereotypes during childhood and adolescence were the core of what motivated the shame experience. Future studies should explore the phenomenology of shame in gay men using a structured clinical interview specifically developed to grasp shame memories (Matos & Pinto-Gouveia, 2015). This would provide a more accurate depiction on how being gay

and/or expressing behaviors that are not socially expected for male individuals can render gay men to a higher risk for experiencing shame experiences.

This study adds information that might guide empirically based clinical work with gay men. On the one hand, these results point out to the importance of assessing and addressing shame memories when conducting clinical interventions with gay men, particularly those who present depressive symptoms and who are high in internal shame. More specifically, this study implies that clinical therapists and consultants should promote psychological flexibility, through which the clients learn to relate to these difficult memories in a more accepting and non-judgmental way, as opposed to trying to avoid or alter these memories, as a way of ameliorating their impact on internal shame and depressive symptoms. Acceptance-based approaches such as acceptance and commitment therapy (ACT; Hayes et al., 2004) might provide a theoretical and practical background that can help therapists and clients navigate these difficulties. Additionally, therapists working with gay men high in shame and experiencing depressive symptoms should also cultivate (self-) compassion through guided imagery and meditation exercises specifically developed to promote compassion and kindness and stimulate brain pathways associated to self-soothing. Promoting a compassionate attitude towards adverse early experiences (e.g., shame and or the absence of warmth) might help to attenuate the impact of these memories on current shame feelings and depressive symptoms. Compassion focused therapy (CFT; Gilbert, 2010; Gilbert & Procter, 2005) was specifically developed to target shame and self-criticism, thus being an appropriate psychotherapeutic approach when working with gay men who have high levels of shame and depressive symptoms.

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