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Mental health attitudes, self-criticism, compassion, and role identity among UK social work students

Reference

Kotera, Y., Green, P., & Sheffield, D. (2018) Mental health attitudes, self-criticism, compassion, and role identity among UK social work students. British Journal of Social Work. doi: 10.1093/bjsw/bcy072

Abstract

Although many social work students suffer from mental health symptoms, the majority of them do not seek help, because of shame. Accordingly, the purposes of this study were to evaluate social work students' attitudes for mental health problems, and explore relationships among shame, mental health symptoms, self-criticism, self-compassion, and role identity. Firstly, 84 UK female undergraduate social work students completed a measure of attitudes toward mental health problems, and were compared with 94 UK female undergraduate students in other subjects. UK female undergraduate social work students had a higher level of negative perception in their community's attitudes toward mental health problems. Secondly, 87 UK social work students, completed the attitudes, mental health, self-criticism, self-compassion, and role identity measures. Self-criticism, self-compassion, and role identity were significantly related to mental health symptoms, and identified as significant, independent predictors of mental health symptoms. This study confirmed that social work students consider that their community perceives mental health problems negatively, and that their self-criticism, self-compassion, and role identity relate to their poor mental health. The findings may help social work students, educators, and researchers deepen the understanding of their mental health symptoms and identify better solutions.

Keywords: help-seeking, self-criticism, compassion, role identity, social work students

Introduction

More than a third of social work students indicate high levels of depressive symptoms and are at high risk of clinical depression. Additionally, 40% reported having suicidal thoughts at some point in their lives, with 4% reporting they were recent (Horton et al., 2009). Poor mental health is related to reduced academic achievement and higher dropout (Poh Keong et al., 2015). However, social work students do not seek help (Ting, 2011), and help-avoidance can be problematic; leaving mental health symptoms untreated worsens the problems. Help-avoidance was associated with depression in 700 social workers (Siebert, 2004). A major reason for help-avoidance was stigma about mental health problems (Byrne, 2000; Eisenberg et al., 2007; Ting, 2011). Common stigmatised beliefs include people with mental health problems are weak, incompetent, and could increase harmful attitudes, namely discriminatory behaviors toward people with mental health problems, causing social isolation (Corrigan et al., 2001). Stigmatised attitudes can also lead people to internalise negative views, which may cause feelings of shame (Byrne, 2000). Social work students are afraid to seek help, as they aspire to help people with mental health problems. About a quarter of 171 social work students reported stigma was the main barrier for their help-seeking (Ting, 2011). Despite its significance, research into help-avoidance in social work students has been limited, and requires more investigation (Reardon, 2012).

Though stigma and shame are highly related, they differ in that stigma is a social mark, an undesirable quality to cause isolation (Lewis, 1999), whereas shame is an individual's negative emotion of inadequacy, caused by failing to meet some standard (Tangney, 1990). Stigma leads to a sense of shame (Corrigan et al., 2014). This discernment may help to interpret previous findings. For example, while American university students with mental health problems

reported stigma was a major reason for their help-avoidance (Eisenberg et al., 2007), no significant relationship between stigma and help-seeking was found in a longitudinal study (Golberstein et al., 2009). It is possible that the students were aware of stigma yet still received help because they did not experience shame.

Shame and recognition are particularly important to social workers, as these concepts could impact their agency and empowerment (Frost, 2016). While recognition relates to feeling of trust and acceptance, misrecognition pertains to being denied citizenship in a social life, being evaluated unworthy of respect (Fraser, 2013). Shame is one salient psychosocial consequence of misrecognition (Frost, 2016). Indeed, shame involves a negative emotion such as global devaluation of the self, whereas guilt involves a condemnation of one's unethical behaviour and a concern about its negative influence on others (Tangney et al., 2007). Shame leads to concerns over one's image, causing hide, escape, and repair of one's self-image (de Hooge et al., 2010), whereas guilt leads to apology and compensation. Shame is general negative self-evaluations (Benetti-McQuoid and Bursik, 2005), relating to worries about others' judgement on them: a regret for who they are (Tangney and Dearing, 2002). This general, comprehensive nature distinguishes shame from guilt, which is a regret for violating their moral code (Tangney and Dearing, 2002). In other words, shame is comprehensive negative self-evaluations related to their identity, hence it is a stable, pervasive attribute, rather than a transient behaviour (Tangney et al., 2007). Gibson (2014) identified 'social worker shame' (p.417), thus shame is worthy and appropriate to be measured in social work populations. No study to date explored shame about mental health problems or about different dimensions of shame (internal, external, reflected shame, and related attitudes). Accordingly, the present study aimed to evaluate different dimensions of shame about mental health problems in social work students.

Shame and related psychological constructs

While psychological research generally has a segmented view on shame, focusing primarily on one's self, which may hinder our understanding of shame (Gilbert, 2007), social work research has taken an integral view, considering psychological, social, and cultural contexts, and including shame variants such as embarrassment and humiliation, acknowledging it may be misnamed (Brown, 2006). Social workers encounter shame in various settings. For example, people in poverty may feel shame about living in a poor area, leading to reduced dignity and self-esteem (Jo, 2013). Social workers may need to understand this shame, in order to support them effectively (Beddoe and Keddell, 2016). Social welfare beneficiaries may be fearful of benefit agency staff who control their benefits, which implies to the beneficiaries that accessing benefits is shameful, causing feelings of humiliation, distress and withdrawal (Morton et al., 2014). Another example is parents' shame about their children's mental health problems, which could harm their family and therapeutic relationships (Cohen-Filipic and Bentley, 2015). Thus, social work students need to be able to work with shameful issues of service users (Bentley et al., 2016).

Shame also exists among social workers themselves. Although shame has not been studied thoroughly in social work, Gibson (2016) found social worker shame negatively affects their job satisfaction, retention, and ethics: social workers may feel shame about telling anyone that they were assaulted (Enosh et al., 2013), bullied at work (van Heugten, 2010) or service users committing suicide (Ting et al., 2006). Social worker shame is related to the devalued and inadequate feelings (Gibson, 2006). Social workers perceive they are less respected by their service users and other professionals (Lynch, 2011): nurses are metaphorised as angels, while

social workers are metaphorised as child catchers (Bailey and Liyanage, 2012). Social workers reported that they feel devalued as they are not placed higher in the local authority hierarchy (Coffey et al., 2009). This creates shame-based fear where they feel fearful about their future position in the organisation, which is dependent on those of higher rank (Smith et al., 2003).

Feelings of inadequacy are experienced particularly in comparison with expectations on them. Many social workers perceive that their society does not condone any mistakes, feeling shame-based fear that they must always be a perfect practitioner (Gibson, 2016). For example, social workers reported being over-scrutinised, causing them to feel their work is not good enough (Smith et al., 2003). Some service users are disappointed in social workers as they are ordinary people (Pockett, 2002), while their code of ethics portray them as perfect practitioners (British Association of Social Workers [BASW], 2012). Often social workers feel torn between their understanding of their role and their perception of expectations of them (Leichtentritt, 2011). This gap between the ideal and reality may lead social workers to feel inadequate and incompetent (Weuste, 2005), which are strong indicators of shame (Nelson and Merighi, 2002). Shame and the fear of shame are a serious problem to social workers, because these feelings can be perceived as being worse than the fear of physical assault (Enosh et al., 2013). Additionally, shame can affect many behaviours that good social work practice entails: observations, communication, and judgements, which are crucial to develop healthy self-concept and therapeutic relationships (Gibson, 2016). Therefore, an exploration of shame is highly relevant to social work practice (Gibson, 2016).

Shame is associated with mental health symptoms (Tangney and Dearing, 2002), including depression (Matos and Pinto-Gouveia, 2009), anxiety (Tangney et al., 1992), paranoia (Matos et al., 2013), post-traumatic stress disorder (Harman and Lee, 2010), eating disorders

(Troop et al., 2008), and personality disorders (Rüsch et al., 2007). Unsurprisingly, shame predicts the levels of mental health problems in university students (Arimitsu, 2001).

Self-criticism and self-reassurance are related to shame and mental health symptoms (Gilbert et al., 2010). Self-criticism and shame can activate our threat system, while a low level of self-reassurance can hinder our well-being (Gilbert, 2010). However, no study has focused on whether shame and self-criticism are related to mental health symptoms in social work students.

Self-compassion is related to shame, mental health, and self-criticism. Self-compassion promotes resilience against mental health problems, and reduces self-criticism (Trompetter et al., 2017). Self-compassion is an understanding and kindness to the self during times of suffering, aiming to ease the suffering (Neff, 2003). Good mental health is associated with self-compassion (Muris et al. 2016): compassion-based interventions (Gilbert, 2009) reduce mental health symptoms, shame, and self-criticism (Braehler et al. 2013; Gilbert and Procter 2006). Forgiveness of self, one of the effects of compassion, is positively related to self-esteem among American social work students (Turnage et al., 2012). To date, no study has explored relationships between self-compassion, mental health, and other related psychological constructs in social work students.

Lastly, as qualitative responses of 171 social work students about the reason for help-avoidance (Ting, 2011) suggested, social work students' caregiver identity might be related to their shame about mental health problems. Research has reported that caregivers in other professions (e.g. nursing, counselling) often fail to recognise their personal problems (Kottler and Hazler, 1996; Nace, 1995). Role identity theory (McCall and Simmons, 1978) posits that behaviour is shaped by perceptions of self in personal and professional roles. Social workers have multiple professional and personal identities (Brody, 2010) defining how they should

behave (e.g. helper, manager, mediator). This may make it difficult for them to acknowledge that they have similar problems to their service users, because their ideal self-image conflicts with their problems (Siebert and Siebert, 2005). However, no study to date explored correlations between role identity and shame about mental health problems in this population.

In this study, therefore, we first examined the levels of shame about mental health problems in UK social work students, comparing with similar university students from other disciplines (Gilbert et al., 2007). Because the comparison population comprised female undergraduate students, only female undergraduate social work students were used for this analysis. Second, we explored the relationships between shame, mental health, self-criticism, self-compassion, and role identity in the whole sample. Finally, we examined which of these variables predicted mental health levels. This study focused on symptoms of depression, anxiety, and stress because these were the most common types of mental health problems in both the general public and students (Aronin and Smith, 2016; European Community, 2005).

Method

Participants

Participants, aged 18 years or older, were social work students at a UK university. Of 106 full-time students (88 undergraduates and 28 postgraduates) completed the ATMHP, 84 were female undergraduate students (77 British, 6 African, 1 other European; age range 18-58, mean=30.29, SD=9.13 years). Though we did not explicitly exclude Asian students, there were no Asian student participants in this study. The representativeness of our sample to the general population was still maintained as the number of Asian students studying social work in the UK is small (Skills for Care, 2016). The 84 female undergraduate students were compared with 94 non-Asian

UK female undergraduate students from two UK universities in life science subjects including psychology (Gilbert et al., 2007). Asian students were excluded to permit comparison (age range 18-46; mean=20.93, SD=4.92 years).

For the second and third aims of the study, 87 social work students (80 female, 7 male) completed all five self-report measures. The age range was 18–58 (mean=30.76, SD=9.53) years; 14% were postgraduates; 8% were international students (from other European countries and Africa).

Instruments

Attitudes Towards Mental Health Problems (ATMHP). ATMHP comprises 35 four-point Likert items measuring attitudes towards mental health problems and shame, in four sections: i) their community's and family's attitudes towards mental health problems (their perception of how their community and family perceive mental health problems), ii) their community external shame and family external shame (their perception of how their community and family would perceive *them* if they had a mental health problem, respectively), iii) their internal shame (how they perceive *themselves* if they had a mental health problem), and iv) their family-reflected shame (how *their family* would be perceived if they had a mental health problem) and self-reflected shame (fears of *reflected shame on themselves*, associated with a close relative having a mental health problem). All of the subscales had good Cronbach's alphas of between .85 and .97 (Gilbert et al., 2007).

Forms of Self-Criticising/Attacking & Self-Reassuring Scale (FSCSR). FSCRS (Gilbert et al., 2004) evaluates people's perception of themselves in difficult times. The 22 five-point Likert scale items assess two forms of self-criticalness (inadequate-self and hated-self), and one form of

self-reassurance (reassured-self). Inadequate-self relates to a sense of personal inadequacy (e.g. 'I am easily disappointed with myself'; nine items), hated-self to a desire to hurt or persecute the self (e.g. 'I have become so angry with myself that I want to hurt or injury myself'; five items), and reassured-self to a sense of self-support (e.g. 'I am able to remind myself of positive things about myself'; eight items). Cronbach's alphas were between .86 and .90.

Depression Anxiety and Stress Scale (DASS21). This 21-item, four-point Likert scale is a short-form of DASS42 (Lovibond and Lovibond, 1995) comprising three seven-item subscales; depression (e.g. 'I felt that I had nothing to look forward to'), anxiety (e.g. 'I felt I was close to panic') and stress (e.g. 'I found it difficult to relax'). These subscales had good reliability; α=.87-.94 (Antony et al., 1998).

Self-Compassion Scale-Short Form (SCS-SF). This self-report measure is a shortened version of the Self-Compassion Scale, comprising 12 five-point Likert items (Neff, 2003). Cronbach's alpha was high (.86).

Role Identity Scale (RIS). This eight-item measure evaluates participants' caregiver role identity by considering how they view themselves as a caregiver, and how they perceive others view themselves as a caregiver (Siebert and Siebert, 2005). Participants endorse how much they agree to each item (e.g. 'It is my responsibility to be helpful to family and friends') on a five-point Likert scale. The internal consistency was high (α=.78).

Procedure

After consenting to participate to the study, participants were sent links to the online scales, which were followed by the debrief. In case students were distressed by issues raised by the study, information about available mental health services was provided. Available mental health

services inside and outside the university were introduced to ensure any issues might be addressed in a sensitive manner. Ethics approval was obtained from the University Research Ethics Committee.

The collected data was, first, screened for the assumptions of parametric tests. Second, t-tests were conducted to examine difference between the two groups (Aim 1). Third, correlations between their attitudes, mental health, self-criticism, self-compassion, and caregiver role identity were explored (Aim 2). Finally, multiple regression analyses were conducted to examine the best independent predictors of depression, anxiety, and stress (Aim 3).

Results

Analyses were conducted using IBM SPSS version 23.0. There were no outliers in ATMHP responses for t-tests. Skewness values ranged from .26 to 1.55, Kurtosis values ranged from -.58 to 2.35 and the Cronbach's alpha was .94. For the correlation and regression analyses, two scores in RIS and one score in ATMHP were identified as outliers, using the outlier labelling rule (Hoaglin and Iglewicz, 1987), hence were winsorised (Tukey, 1962). Skewness values ranged from -1.41 to 1.64, and Kurtosis values from -.68 to 3.04. Cronbach's alpha for ATMHP was .95, FSCRS was .70, DASS was .93, SCS was .84, and RIS was .83; demonstrating high internal consistency.

Next, differences in attitudes toward mental health problems between the female social work students and the female life science students, were compared using t-tests.

Table 1 Comparison between female undergraduate social work students and life science students

	Female undergraduate social work students	Female undergraduate life science students

Subscale (Range)	M	SD	N	M	SD	N
CA (0-12)	4.87[a]	2.89	84	3.79[a]	2.74	94
FA (0-12)	2.46	2.59	84	2.06	2.79	94
CES (0-15)	5.14	3.30	84	5.51	3.88	94
FES (0-15)	2.01	2.60	84	2.52	4.14	94
IS (0-15)	6.46	4.14	84	6.66	4.57	93
FRS (0-21)	5.51	5.03	84	6.03	5.24	93
SRS (0-15)	3.04	3.69	84	2.71	3.50	93

CA=Community Attitudes; FA=Family Attitudes; CES=Community External Shame; FES=Family External Shame; IS=Internal Shame; FRS=Family-Reflected Shame; SRS=Self-Reflected Shame.
Superscript indicates significant difference between the two groups ([a]$P<.05$).

The female social work students had significantly higher community attitudes (how negatively they perceive their community viewed mental health problems) than the life science female students (Table 1). In our sample, there were no differences in any subscale between the male (n=4) and female social work students.

Correlations

Of total 15 subscales, data in eight subscales were square-root-transformed to satisfy the assumption of normality: family attitude, family external shame, family-reflect shame, self-reflected shame, role identity, depression, anxiety, and hated-self. Pearson's correlations were used to examine relationship between attitude, mental health, self-criticism, self-compassion, and caregiver role identity in 87 UK social work students.

Table 2 Correlations among ATMHP subscales and demographics in UK social work students (n=87)

	1	2	3	4	5	6	7
1 CA	-						
2 FA	.48**	-					
3 CES	.54**	.40**	-				
4 FES	.35**	.69**	.46**	-			
5 IS	.21	.21*	.44**	.17	-		
6 FRS	.33**	.35**	.51**	.39**	.48**	-	
7 SRS	.30**	.24*	.26*	.26*	.27*	.30**	-
GN	.02	-.002	.04	.20	.08	.17	.13
Age	.29**	.22*	.17	.20	-.15	.07	-.07

GN=Gender (1=male, 0=female); CA=Community Attitudes; FA=Family Attitudes; CES=Community External Shame; FES=Family External Shame; IS=Internal Shame; FRS=Family-Reflected Shame; SRS=Self-Reflected Shame. *p<.05; **p<.01.

There were positive relations between the different dimensions of shame, and community and family attitudes (Table 2). Age was positively related to community and family attitudes. Among female students only, the same correlations were found.

Table 3 Correlations among ATMHP, DASS, FSCRS, RIS, and SCS in UK social work students (n=87)

	CA	FA	CES	FES	IS	FRS	SRS	Dep	Anx	Strs	ISelf	RSelf	HSelf	RIS
Dep	.03	.19	.31**	.23*	.39**	.21*	.21	-						
Anx	.04	.02	.23*	.09	.01	.15	.20	.58**	-					
Strs	.06	-.01	.20	.10	.34**	.13	.18	.67**	.75**	-				
ISelf	.08	.02	.37**	.21	.60**	.27*	.21	.44**	.27*	.36**	-			
RSelf	-.02	-.14	-.34**	-.17	-.33**	-.14	-.10	-.46**	-.26*	-.26*	-.44**	-		
HSelf	.12	.05	.28**	.10	.32**	.11	.15	.33**	.27*	.25*	.48**	-.59**	-	
RI	-.17	-.15	-.11	-.15	-.04	-.16	-.06	-.06	-.29**	-.40**	-.01	-.03	-.05	-
SC	.08	-.09	-.22*	-.17	-.51**	-.15	-.16	-.45**	-.28**	-.43**	-.72**	.60**	-.42**	-.05

Dep=Depression; Anx=Anxiety; Strs=Stress; CA=Community Attitudes; FA=Family Attitudes; CES=Community External Shame; FES=Family External Shame; IS=Internal Shame; FRS=Family-Reflected Shame; SRS=Self-Reflected Shame; ISelf=Inadequate-Self; RSelf=Reassured-Self; HSelf=Hated-Self; RI=Role Identity; SC=Self-Compassion. $^{*}p<.05$; $^{**}p<.01$.

Table 3 shows relationships between shame, self-criticism, mental health symptoms, role identity, and self-compassion. Shame was positively related to depression, inadequate- and hated-self; and negatively to reassured-self and self-compassion. Mental health symptoms were positively related to inadequate-self and hated-self, and negatively related to reassured-self, role identity and self-compassion. Self-compassion was positively related to reassured-self and negatively related to inadequate-self and hated-self.

Regression

Finally, multiple regression analyses were conducted to explore the relative contribution of self-criticism, role identity, and self-compassion measures to mental health in 87 UK social work students; ATMHP was excluded for its relation to mental health symptoms was not as strong as the others (Table 4). At step one, gender and age were entered to adjust for their effects, and at step two, all the scores for self-criticism, role identity, and self-compassion were entered. Because of the many predictor variables, adjusted coefficient of determination was reported. Multicollinearity was not a concern (tolerance values ≥ .88).

Table 4 Multiple regression: Mental health for shame, self-criticism, role identity, and self-compassion in UK social work students (n=87)

	Depression			Anxiety			Stress		
	B	SE_B	β	B	SE_B	β	B	SE_B	β
Step 1									

Gender	.82	.51	.17	.27	.57	.05	4.50	3.32	.14
Age	-.02	.02	-.11	-.02	.02	-.15	-.20	.10	**-.22***
Adj. R^2		.02			.002			.04	
Step 2									
Gender	.76	.45	.16	.14	.53	.03	4.08	2.79	.13
Age	.01	.01	.06	-.01	.02	-.09	-.09	.09	-.10
ISelf	.04	.02	.23	.01	.03	.05	-.02	.14	.02
RSelf	-.07	.03	**-.31***	-.02	.04	-.09	.01	.19	.003
HSelf	-.05	.15	-.04	.16	.17	.13	.33	.91	.04
RI	-.10	.13	-.07	-.46	.16	**-.30****	-3.86	.82	**-.42****
SC	-.28	.30	-.14	-.26	.36	-.12	-5.07	1.88	**-.39****
Δ Adj.R^2		.24			.13			.30	

ISelf=Inadequate-Self; RSelf=Reassured-Self; HSelf=Hated-Self; RI=Role Identity; SC=Self-Compassion; B=unstandardised regression coefficient; SE_B=standard error of the coefficient; β=standardised coefficient; ****p*<.05;** *****p*<.01**.

After adjustment for the demographics, self-criticism, role identity, and self-compassion predicted 24% of the variance for depression, 13% for anxiety, and 30% for stress. Reassured-self was the only independent predictor for depression; role identity was the only independent predictor for anxiety; and role identity and self-compassion were independent predictors for stress.

Discussion

This study evaluated the attitudes toward mental health problems among UK social work students, and investigated relationships between their attitudes, mental health, self-criticism, role identity, and self-compassion. We found that female social work students perceived more negative attitudes toward mental health problems in their community than female life science

students, but there was no other difference between the two groups. Their attitudes and shame about mental health problems were highly correlated. Their mental health symptoms, shame, self-criticism, role identity, and self-compassion were also related to each other, albeit more modestly. Multiple regression analyses revealed self-criticism, role identity, and self-compassion were significant predictors of mental health symptoms. We will discuss each finding in turn below.

Community attitude was higher in social work students than life science students, who were younger than the social work students. Social work students reported that their community perceives mental health problems as something to be kept secret, and views people with mental health problems as weak (Gilbert et al., 2007). This may be related to their expectation of themselves as social workers who are exposed to mentally challenging situations (Cohen-Filipic and Bentley, 2015; Morton et al. 2014); thus, they need to be mentally well enough to help those who are mentally distressed. Students may perceive that social workers are not expected to have mental health problems and having those problems could mean they are not fit to be social workers. Previous research suggests that clients expect social workers to provide high-quality services (Malley and Fernandez, 2010) and make the society better (Braye and Preston-Shoot, 2006): having mental health problems may be perceived as a barrier to deliver those services and meet those expectations. Professional expectations of social workers contribute to stress and strain (Lev-Wiesel, 2003), and violations of these expectations can lead to self-doubt and workplace conflict (Savaya et al., 2011). A recent qualitative study revealed high expectations could cause distress and recommended the professional body to provide them with more psychological support (Graham and Shier, 2014). Additionally, social work is a client-centred profession, thus expectations could conflict with various policies they must follow (Beresford et

al., 2008). They often work inter-professionally but other professionals may not have a clear understanding of the role of social workers (Graham and Shier, 2014). The complexity of social work environments may hinder social workers from meeting their expectation (Ruch, 2002). The high score in community attitudes may betray high expectations of themselves, difficulty of meeting those expectations, and the consequences of failing to meet them. The lack of clarity about social workers' role and duties may cause unrealistic expectations in social workers (Graham and Shier, 2014), so clarification of the role and duties of social workers to other professionals and service users may be useful. Students can learn and practice informing others of their boundaries during their studies, which may reduce their perceived negative attitudes. Additionally, in order to reduce their overall shame about mental health problems, compassion training may help them cope with shame (Gilbert, 2009), as it reduced shame and self-criticism in high shame participants (Gilbert and Procter, 2006). For example, inter-professional conferences may be an appropriate setting to implement this type of training. The researchers of this study were involved in a compassion training workshop at such a conference, and the attendants (including practitioners and students in social work, nursing, and occupational therapy) left positive feedback: student attendants learned that self-compassion was important to professionals too, to help overcome their shameful feelings. Indeed, shame is less visible in our daily life, thus such an irregular setting with professionals and trainees who value caring and are aware of safety, would help to facilitate discussions of shame in a compassionate manner. Another form of implementation may be action learning groups, where a small number of students/practitioners meet regularly to discuss complicated and challenging issues (Abbott and Taylor, 2013). Sensitive, yet potent affects such as shame can be coped with compassionately in such settings.

The positive relations between the different dimensions of shame and attitudes may illustrate the multi-dimensional nature of shame. Internal, external, and reflected shame are interlinked with each other (Gilbert, 2002), and one's perception of how their community and family see mental health problems are related to these shame dimensions (Gilbert et al., 2007). Though not as strong, the relations among mental health symptoms, shame, and self-criticism accord with previous findings in Japanese workers (Kotera et al., 2018). Shame was strongly related to depression and self-criticism. This aligns with previous findings suggesting the significant impact of shame on mental health (Tangney and Dearing, 2002), and may support attempts to target shame as a means to reduce self-criticism and improve mental health. For example, education about mental health problems may be useful: learning that mental health problems could happen to anybody and having those problems does not mean they are not fit to be a social worker, may reduce shame about mental health problems (Watson et al., 2017).

Mental health symptoms were strongly related to self-criticism, role identity, and self-compassion. As previously reported (Gilbert et al., 2010), high self-reassurance and low self-criticism may be conducive to mental health. The relation between mental health symptoms and role identity may highlight social work students' expectations about their future job role, as discussed above. High expectations of the caregiver role may cause them mental distress (Lev-Wiesel, 2003). The negative relation between mental health symptoms and self-compassion echoes previous findings (Braehler et al. 2013; Gilbert and Procter 2006): the impact of self-compassion on mental health was illustrated in this study too. Considering those correlations with mental health symptoms, it may be helpful to include compassion training in the social work curriculum (Toole and Craighead, 2016). Developing self-compassion may reduce self-criticism and improve mental health. For role identity, self-awareness training may be useful so

that students are more aware of their own values and attitudes that may affect their work (O'Connor et al., 2003). Although self-awareness training has been already used in some social work programmes (Australian Association of Social Workers, 1994), this type of training, focusing on their caregiver identity, may protect their mental health.

Finally, multiple regression analyses revealed self-criticism, role identity, and self-compassion predicted 13-30% of mental health symptoms. Reassured-self, role identity, and self-compassion were significant predictors of mental health symptoms. These results resonate with our correlational analyses; mental health was related to self-criticism, self-compassion, and role identity. Again, compassion training and self-awareness training may help social work students to reduce self-criticism, enhance self-compassion, and develop a sound identity as a social worker.

These findings and suggestions need to be considered in relation to the values and principles of social workers which highlight challenging injustice, discrimination, and abuse of the human rights, while maintaining confidentiality, accurate records, and trustful relationships with other professionals and service users (BASW, 2012). These high and diverse demands on social workers may explain their high levels of shame and self-criticism, as they constantly compare themselves against their values and principles. Additionally, social workers have diverse internal moral standards to evaluate their own work, hence their self-image (Stanford, 2010) and moral dilemma can cause psychological distress, often experienced in caring professions (Weinberg, 2009). Believing that you have not met these expectations can lead to feelings of inadequacy (Weuste, 2005), which relates to shame and poor mental health (Gibson, 2016). This imbalance between the demands/expectation and self-care in social workers emphasises the importance of our findings and suggestions such as the provision of compassion

training to increase self-compassion and self-care (Dunne et al., 2016). Especially recently, the importance of self-evaluation, acknowledging imperfection of one's work, has been highlighted among social workers (e.g. Brown, 2010), who believe in high personal accomplishment (McFadden, 2015). While self-efficacy is essential for successful social work, recognising inadequacy is equally important. For example, the Mirror method– self- and peer-evaluation of practice using the internal mirror and rear-view mirror –has been practiced among Finnish social workers to accumulate tacit knowledge and cope with imperfection (Yliruka, 2011). Similarly, our suggested training would also help to embrace imperfection, as perfectionism is fostered by high self-criticism (Shafran et al., 2010), which can be mitigated by self-compassion (Gilbert and Procter, 2006).

There are several limitations to this study. First, the sample sizes were relatively small. Second, in our t-test analysis, we compared only female undergraduate students; while the majority of social work students are female, this finding requires replication in a larger and more diverse sample. Third, 20% of the respondents dropped out. Though no compensation for participation might explain this, the length of the scales might also, especially the ATMHP. Fourth, though there was no association between shame and perceived risk of disclosing personal information in UK samples (Gilbert et al., 2007), measuring shame using a self-report scale might limit its accuracy. Fifth, the participants were recruited through convenience sampling. Sixth, the causal direction of these related psychological constructs has not been evaluated. In the future, longitudinal data would help illuminate the temporal patterning of the observed relationships and may help develop interventions that would increase our understanding of causality. Additionally, evaluation of training for self-compassion, self-criticism, and role identity would be valuable.

Conclusion

Despite poor mental health, high help-avoidance in social work students has been focused upon in previous research. This study highlighted social work students' negative perception of their community's attitudes toward mental health problems, and relationships between self-compassion, self-criticism, role identity and mental health symptoms. The findings in this study will help UK social work students, educators, and researchers deepen their understanding of their mental health symptoms, as well as help identify better solutions

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