Self-Compassion: a Potential Buffer Against Affliliate Stigma Experienced by Parents of Children with Autism...

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Self-compassion: A potential buffer against affiliate stigma experienced by parents of children with autism spectrum disorders

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Abstract

Affiliate stigma was found to be associated with negative outcomes among parents of children with autism spectrum disorders, but only limited research has explored a potential buffer in this association. The present study examined self-compassion as a potential protective factor. One hundred and eighty Chinese parents of children with autism spectrum disorders in Hong Kong participated in the study. After controlling for various types of social support (i.e., family support, friends support, and professional support) and positive parental perception, results of a hierarchical linear regression showed that affiliate stigma was significantly associated with psychological distress. In addition, the results identified self-compassion as a moderator in the association between affiliate stigma and psychological distress. Specifically, affiliate stigma was found to be significantly associated with psychological distress among parents with low levels of self-compassion but not among parents with high levels of self-compassion. These results pointed to the importance of cultivating self-compassion among parents of children with autism spectrum disorders. Future research may further explore the protective role of self-compassion in other stigmatized populations.

Keywords: self-compassion, affiliate stigma, autism, caregiver, Chinese
Introduction

Autism spectrum disorder is characterized by persistent deficits in social communication and social interaction across multiple contexts, as well as restricted, repetitive patterns of behavior or activities (American Psychiatric Association 2013). Caring for children with autism spectrum disorders (ASD) is demanding and overwhelming (Foo et al. 2014; Phetrasuwan and Miles 2009). On top of the financial and caregiving burden that is commonly experienced by most parents of children with disabilities (Altiere and von Kluge 2009; Benson et al. 2008; Gray 2006), parents of children with ASD face unique challenges (Bekhet et al. 2012). For example, certain public behaviors of children with ASD, such as tantrums and misbehavior in stores and shopping areas, maybe particularly difficult for parents to handle because of unpleasant responses from onlookers and bystanders (Gray 1993).

Recent meta-analysis has shown that parents of children with ASD experience more parenting stress than parents of typically developing children and children with other disabilities (e.g., Down syndrome; Hayes and Watson 2013). Because of this, parents of children with ASD tend to have poorer mental and physical health than other parents in the general population (Kheir et al. 2012; Montes and Halterman 2007). In addition to the caregiving burden, parents of those with ASD also suffer from the associative effect of stigma against their children. Because of the absence of physical markers of their children’s disorder, when their children display socially inappropriate behaviors in public (e.g., tantrums, flapping, smelling and mouthing objects, twirling, or self-destructive acts), parents are often criticized for not being competent or skilled enough to control or discipline their children (Gray 1993; Konstantareas and Homatidis 1989; Werner and Shulman 2013).

As a result, parents may internalize the external criticism (as affiliate stigma), assume responsibility and blame themselves for their children’s stigmatic condition, and believe that
they have little control over their children’s condition and corresponding stigmatization.

Indeed, a recent study showed a significant negative association between affiliate stigma and subjective well-being among caregivers of individuals with ASD, but such an association was not found among caregivers of individuals with intellectual or physical disabilities (Werner and Shulman, 2013). This finding points to the significance of examining protective factors against affiliate stigma, especially among parents of children with ASD.

Affiliate stigma is defined as the internalization of others’ negative evaluations and emotions toward themselves and their children with disabilities (Mak and Cheung 2008). It is negatively associated with caregivers’ psychological well-being and quality of life (Chiu et al. 2015; Dehnavi et al. 2011; Kwok et al. 2014; Mak and Kwok 2010). Indeed, the negative association between affiliate stigma and well-being among parents of children with ASD may be particularly salient among Chinese parents (Mak and Cheung 2008, 2012). The Chinese tend to emphasize the biological roots of mental illnesses (Kung 2001). Therefore, parents of children with ASD may be blamed for passing on to their children the unfavorable genes which lead to the development of ASD. Also, under the influences of Confucian values, the related concept of fate (Ludwig et al. 1990), and the cultural value on social face (i.e., mianzi and the desire to maintain social image and social worth; Hwang, 1997-1998), Chinese are more likely to agree with the public stereotype and internalize stigma (Fung et al. 2007). Accordingly, it is likely that raising a child with ASD may increase the vulnerability for affiliate stigma and its negative impact on psychological outcomes for Chinese parents.

It is important to investigate the impact of affiliate stigma among Chinese parents of children with ASD and the corresponding protective factors. However, so far, limited research has been conducted to examine the negative impact and potential buffers of affiliate stigma among parents of children with ASD. Recently, Werner and Shulman (2013)
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proposed a theoretical model in which they argued that the association between affiliate stigma and caregivers’ subjective well-being is moderated by psychosocial variables (e.g., self-esteem, social support, positive meaning in caregiving). Although none of the examined psychosocial variables in Werner and Shulman’s study were found to be significant moderators, other psychosocial variables such as self-compassion might potentially mitigate the negative association between affiliate stigma and subjective well-being.

Self-compassion is a caring and compassionate attitude towards oneself in the face of hardship or perceived inadequacy (Bennett-Goleman 2001). Neff (2003a, 2008) conceptualized self-compassion by three components: self-kindness (vs. self-judgment), common humanity (vs. isolation), and mindfulness (vs. over-identification). Self-kindness refers to being gentle and understanding towards the self when encountering suffering, inadequacy, or failure. Instead of judging oneself in difficult situations, people with self-kindness accept the reality of difficulties and treat themselves with sympathy and understanding. Common humanity refers to recognizing that all people experience suffering and feeling that they are not alone in facing hardships. Mindfulness refers to being aware of present experiences - positive, negative, or neutral – with acceptance and non-judgment (Brown and Ryan 2003). As a dimension of self-compassion, mindfulness helps one to accept negative inner experiences with equanimity as they arise within the present moment (e.g., Neff and Dahm, 2015). Mindfulness as a component of self-compassion is narrower in scope than general mindfulness; the former is related to maintaining a balanced awareness of “negative” thoughts and the latter refers to paying attention to any internal experiences, including positive, negative, or neutral thoughts and feelings (Neff and Dahm 2015).

Neff (2003a) describes that the three components of self-compassion (self-kindness, common humanity and mindfulness) engender one another. For example, the non-judgmental acceptance aspect of mindfulness is likely to lessen self-criticism and thus
enhance self-kindness. Moreover, the balanced perspective-taking stance of mindfulness can decrease egocentrism and separateness from others, thereby increase connection with the rest of humanity. On the other hand, self-kindness and common humanity can help lessen the severity of negative emotion, which in turn makes it easier to be aware of one’s thoughts and emotions.

Self-compassion can help individuals cope with negative life events. Self-compassionate individuals tend to have more adaptive emotional processing and higher emotional intelligence (Heffernan et al. 2010; Neff 2003b). With higher levels of self-acceptance, autonomy, environmental mastery, and purpose in life (Akin 2008), self-compassionate individuals tend to construe negative events in a less catastrophic way (Allen and Leary 2010). With these associated characteristics, self-compassion helps individuals deal with daily stressors, ranging from body image disturbances (Breines et al. 2014) to HIV status (Kemppainen et al. 2013). A recent review indicated that self-compassion is associated with positive mental health (Barnard and Curry 2011). In particular, correlational studies showed that self-compassion was associated with higher levels of positive affect, happiness, and life satisfaction, and lower levels of negative affect, depression, and anxiety (Neff 2003b; Neff et al. 2007; Neff and Vonk 2009), even when social support has been accounted for (Neely et al. 2009).

Promoting self-compassion among parents of children with ASD may help reduce their psychological distress. According to Perry’s (2004) model of stress in parents of children with disabilities, parental outcomes are influenced by personal resources (e.g., internal resources, coping abilities). Following Perry’s (2004) model and the aforementioned Werner and Shulman’s (2013) model, the present study examined self-compassion as a personal resource that might mitigate the association between affiliate stigma and psychological distress among Chinese parents of children with ASD.
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Indeed, experimental studies showed that structured self-compassion interventions, such as a mindful self-compassion program (Neff and Germer 2013), compassionate mind training (Gilbert and Procter 2006), and even brief self-compassion exercises such as self-compassion writing could reduce negative affect, depression, anxiety, stress, and physical symptoms (Baum and Rude 2013; Johnson and O'Brien 2013; Shapira and Mongrain 2010; Wong and Mak 2013). Other studies also support the idea that parents of children with ASD and other developmental disabilities could benefit from interventions which promote self-compassion. One study showed that upon completion of mindfulness interventions, parents reported significant reductions in stress and improvements in well-being (Bazzano et al. 2015; Benn et al. 2012). Researchers from these studies proposed that the increase in self-compassion due to training was the key mechanism of these mindfulness interventions (Bögels et al. 2010). The above theoretical and empirical evidence suggests that self-compassion may reduce distress among parents of children with ASD.

Self-compassionate parents of children with ASD are less likely to experience affiliate stigma. Previous research showed self-compassion to be negatively associated with social comparison, self-consciousness, and self-rumination (Neff 2003b; Neff and Vonk 2009). Instead of engaging in maladaptive social comparisons with parents of typically developing children, self-compassionate caregivers acknowledge that suffering and imperfection are shared human experiences (common humanity), and therefore feel less isolated in their role as a parent of child with ASD.

Also, by not being carried away by emotional disturbance or a sense of inadequacy, self-compassionate caregivers are able to embrace their suffering and shortcomings as well as maintain a balanced perspective on their caregiving experience (mindfulness). Studies have shown that self-compassion is negatively associated with rumination (Neff 2003a), and it is positively associated with adaptive emotion-focused coping such as acceptance, positive
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reinterpretation, and growth (Akin 2008; Neff et al. 2005). Such self-compassion qualities allow parents of children with ASD to see beyond their current difficulties and experience a sense of meaning and fulfillment, rather than over-contemplating their challenges and negative caregiving experience. As a result, they may have a more optimistic outlook, and they will perceive less parental distress and less parent-child dysfunctional interaction than their less self-compassionate counterparts (Neff and Faso 2014).

Furthermore, the non-judgmental and understanding attitude (*self-kindness*) inherent in self-compassion allows caregivers to reflect on their situations without experiencing self-critical and shaming reactions (Reid et al. 2014), give themselves and their children compassion and understanding when disappointments occur (Neff and Faso 2014), and remain confident in their abilities as effective parents. Also, a self-compassionate attitude allows caregivers to maintain a healthier balance between caregiving duties and self-care. Whereas many caregivers give up their dreams and leisure activities to prioritize the duties of caring for their children with ASD, self-compassionate parents are better able to comfort themselves for the disappointments of not achieving their desired goals, let go of the unattainable prior goals in order to pursue realistic new goals, and experience a fulfilling and purposeful life (Neff and Faso 2014).

Facing constant judgement by the public, some parents of children with ASD may internalize the negative evaluations and emotions (as affiliate stigma). Self-compassion has the potential to buffer the association between affiliate stigma and negative outcomes. Instead of being entangled with negative thoughts and defensive behaviors, self-compassionate individuals are able to accept the undesirable aspects of the self (Leary et al. 2007). Cross-sectional and longitudinal studies showed that self-compassion could buffer the effects of self-criticism on depression (*Wong and Mak 2013*), and reduce the negative impact of low self-esteem on mental health outcomes (*Marshall et al. 2015*). Experimental
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studies also support self-compassion as a moderator of negative self-evaluations.

One study showed that self-compassionate individuals had less negative emotional reactions and more adaptive responses when faced with potentially humiliating situations (Leary et al. 2007). Another study showed that experimentally induced self-compassion could promote incremental beliefs about personal weakness (i.e., belief that weakness is changeable) and motivate individuals to change (Breines and Chen 2012). These findings suggested that even when external criticism has been internalized as personal inadequacy, self-compassionate parents are less likely to be discouraged by the negative self-evaluation, and instead adjust and seek ways to improve the caregiving experience. With existing empirical support, it is likely that self-compassion could buffer the association between affiliate stigma and psychological distress among parents of children with ASD.

The present study aimed to: (1) examine the associations between affiliate stigma, self-compassion, and psychological distress among Chinese parents of children with ASD, and (2) test the moderating role of self-compassion between affiliate stigma and psychological distress when other potential psychosocial buffers, including social support and positive parental perception (which have been examined as moderators of affiliate stigma in a previous study; Werner and Shulman, 2013) were controlled for. It was expected that affiliate stigma and psychological distress would be positively correlated, but that self-compassion would be negatively associated with both affiliate stigma and psychological distress. An interaction effect between self-compassion and affiliate stigma on psychological distress was also expected, even when other psychosocial variables (i.e., family support, social support from friends and significant other, professional support, positive parental perception) were controlled for. It was expected that the association between affiliate stigma and psychological distress would be less salient among caregivers with high levels of self-compassion than their counterparts with low levels of self-compassion.
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Method

Participants

One hundred and eighty Chinese parents of children with ASD were recruited through non-governmental organizations (NGOs) and special schools in Hong Kong. The majority of participants were female (28 men, 149 women, and 3 with missing information), with a mean age of 42.56 years old ($SD = 6.68$)

Procedures

Invitation letters were sent to NGOs and special schools in Hong Kong. Participation was voluntary and informed consent was sought. Ten NGOs and two special schools agreed to participate. Upon receiving consent from parents of children with ASD, participating NGOs and schools shared the contact information of potential participants with the research team. Questionnaire packages were then mailed to participants. Upon completion, participants sent back the questionnaire and signed consent form using the stamp envelope provided by the research team. The study was approved by the Survey and Behavioral Research Ethics Committee of the Chinese University of Hong Kong.

Measures

Demographics. Demographic information about the child and the parent was obtained, including gender, age, education, and participation in NGOs’ activities (see Table 1).

Psychological distress. The 24-item psychological distress subscale (including the subscales of anxiety, depression, and loss of control) of Psychological Well-Being from the Mental Health Inventory (MHI-38; Veit and Ware 1983) were used. Sample items are “How often did you become nervous or jumpy when faced with excitement or unexpected situations during the past month? (anxiety)”, “Did you feel depressed during the past month?” (depression), and “During the past month, have you had any reason to wonder if you were...
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losing your mind or losing control over the way you act, talk, think, feel, or of your memory? (loss of control)”.

The MHI-38 has been validated among Chinese patients, and demonstrated adequate reliability and validity (i.e., significant associations with depression and anxiety as measured by the Hospital Anxiety and Depression Scale; Liu et al. 2014). Participants rated on a 6-point scale from (1) never to (6) always. In the present study, internal consistencies (Cronbach’s alphas) of the anxiety, depression, and loss of control subscales were .86, .90, and .85, and the overall internal consistency was .86.

Affiliate stigma. The 22-item Affiliate Stigma Scale (Mak and Cheung 2008) was adapted and used to measure the extent of internalized stigma among parents of children with ASD. Participants rated on a 4-point scale from (1) strongly disagree to (4) strongly agree. Sample items are “I feel emotionally disturbed because I have a family member with autism spectrum disorder,” “Having a family member with autism spectrum disorder makes me think that I am lesser than others,” and “Given that I have a family member with mental illness/intellectual disability, I’ve cut down the contact with my friends and relatives.” The Affiliate Stigma Scale was originally developed and validated with Chinese samples of caregivers, and it showed adequate reliability and adequate predictive validity on subjective burden (Mak and Cheung 2008). In the present study, the internal consistency (Cronbach’s alpha) was .95.

Self-compassion. The 26-item Self-compassion Scale (Neff 2003b) was used to assess individuals’ acts toward themselves at difficult times. Participants indicated how often they behaved in the stated manner on a 5-point scale ranging from (1) almost never to (5) almost always. Sample items are “I try to be loving towards myself when I’m feeling emotional pain” (self-kindness), “When things are going badly for me, I see the difficulties as part of life that everyone goes through” (common humanity), and “When something upsets me I try to keep my emotions in balance” (mindfulness). The self-compassion scale has
been validated in Chinese samples, demonstrating adequate reliability and validity (i.e.,
significant associations with life satisfaction, positive and negative affect, and depression;
Chen et al. 2011; Wong and Mak 2013). In the present study, internal consistencies
(Cronbach’s alpha) of the self-kindness, common humanity, mindfulness, self-judgment,
isolation, and over-identification subscales were .80, .74, .75, .66, .78, and .72, and the
overall internal consistency is .91.

**Family support.** The 20-item Family Subscale in the Perceived Social Support
Scale (Windle and Miller-Tutzauer 1992) was used to measure perceived family and spousal
support. Participants rated on a 4-point scale from (1) disagree to (4) agree. A sample
item is “Members of my family are good at helping me solve problems.” The family
subscale has been used in Chinese samples, and demonstrated adequate reliability and
validity (i.e., significant association with psychological well-being; Mak and Kwok 2010).
Internal consistency of the scale (Cronbach’s alpha) in the present study was .93.

**Support from friends and significant others.** Two subscales (Support from
Significant Other, Support from Friends) of the Multidimensional Scale of Perceived Social
Support (Zimet et al. 1988) were used to assess individuals’ perceived social support from
friends and a significant other. Participants rated themselves on a 6-point scale from (1)
strongly disagree to (6) strongly agree. Sample items are “I can count on my friends when
things go wrong” (social support from friends), and “There is a special person who is around
when I am in need” (social support from a significant other). The Multidimensional Scale
of Perceived Social Support Scale has been validated in a sample of Hong Kong Chinese
adolescents, and results showed that the items of the Support from Significant Other and
Support from Friends subscales were loaded onto the same factor, and the combined factor
demonstrated adequate reliability and validity (i.e., significant associations with social
network, depression, and anxiety; Chou et al 2000). The mean score of the two subscales
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was used in present study, yielding an internal consistency (Cronbach’s alpha) of .93.

**Professional support.** The short Measure of Processes of Care (MPOC-20; Siebes et al. 2007) was used to measure the perception of support offered by professionals. In the present study, professional support was specified as any help offered by the children’s school, teacher, NGOs, or other professionals. A sample item is “How often do these organizations give you information about the types of services offered at the organizations or in your community?” Participants rated on a 7-point scale from (1) never to (7) to a great extent. The scale has been used in Chinese samples, and it demonstrated adequate reliability and validity (i.e., significant positive association with psychological well-being; Mak and Kwok 2010). Internal consistency (Cronbach’s alpha) of the scale in the present study was .96.

**Positive parental perception.** Four caregiving-related positive contribution subscales (i.e., learning through experience with special problems in life, strength and family closeness, personal growth and maturity, and expanded social network) of the Kansas Inventory of Parental Perceptions (Behr et al. 1992) were used to assess how much the parent feels that the child with ASD has contributed to the family. Sample items include “I have an increased awareness of people with disabilities” (learning through experience with special problems in life), “I am more accepting of things” (strength and family closeness), “I have learned to control temper” (personal growth and maturity), and “I have expanded social contact with other parents” (expanded social network). The Kansas Inventory of Parental Perceptions has been used among Chinese participants and demonstrated adequate reliability and validity (i.e., significant and negative associations with caregiving stress and affiliate stigma; Mak and Cheung 2008). Participants rated on a 4-point scale from (1) strongly disagree to (4) strongly agree. Internal consistencies of the learning through experience with special problems in life, strength and family closeness, personal growth and maturity, and expanded social network subscales were .81, .82, .89, and .80, respectively. Given that
the four subscales were strongly correlated ($r$s ranged from .49 to .76, $p$s < .001), the mean score of these four subscales was used in the present study, yielding an internal consistency (Cronbach’s alpha) of .94.

**Data Analyses**

Descriptive statistics and correlation analyses were conducted among the study’s variables (i.e., psychological distress, affiliate stigma, self-compassion, family support, friend support, professional support, and positive parental perception). Associations between the dependent variable (i.e., psychological distress) and demographic variables (i.e., all variables listed in Table 1) were examined to identify potential covariates to be controlled in later analysis. Hierarchical linear regression was conducted to examine the moderating role of self-compassion on the association between affiliate stigma and psychological distress.

**Results**

Of 600 questionnaires sent, 180 copies were returned, yielding a response rate of 39%. Detailed distribution of the demographic variables is presented in Table 1. The mean, standard deviation, and intercorrelations between all of the examined variables in the present study are presented in Table 2. As hypothesized, affiliate stigma was positively associated with psychological distress, and self-compassion was negatively correlated with affiliate stigma and psychological distress. Pearson correlations and chi-square tests were conducted to examine the association of caregivers’ psychological distress with demographic variables of the parents and their children. Psychological distress was found not significantly associated with any of the demographic variables ($p$s > .05). Therefore, none of these demographic variables were included as covariates in later analysis.

Based on the procedures recommended by Aiken and West (1991), regression analysis was conducted to examine the moderating effect of self-compassion on the association between affiliate stigma and psychological distress. The predictor (i.e., affiliate
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stigma) and moderator variable (i.e., self-compassion) were centered (i.e., each score was subtracted by the sample mean) before computing the interaction term to reduce multicollinearity. The independent variable (i.e., affiliate stigma) was entered as the first step. Covariates were entered as the second step (i.e., family support, support from friends and significant other, professional support, and positive parental perception), followed by the moderator variable (i.e., self-compassion) as the third step, and the interaction term as the final step. The result is presented in Table 3 and Figure 1.

In accordance with our hypothesis, controlling for various types of social support and positive parental perception, a significant interaction effect was still found between affiliate stigma and self-compassion. As recommended by Aiken and West (1991), simple slope tests were then conducted to compare the effect of affiliate stigma on psychological distress between caregivers with a high (1 SD above the mean, 3.84 out of 5-point scale) self-compassion quality and caregivers with a low (1 SD below the mean, 2.80 out of 5-point scale) self-compassion quality. The results showed that the significant association between affiliate stigma and psychological distress was found among caregivers with low levels of self-compassion ($\beta = 0.26, t = 3.33, p < .01$) but not among their counterparts with high levels of self-compassion ($\beta = 0.02, t = 0.28, p = .78$).

Discussion

There is limited research on affiliate stigma and, to our knowledge, only one study has explored protective factors against affiliate stigma among parents of children with developmental disabilities (Werner and Shulman 2013). The current study fills the gap in the literature by examining the role of self-compassion as a protective factor among Chinese parents in Hong Kong. The results supported our first hypothesis and revealed that affiliate stigma was positively correlated with psychological distress, whereas self-compassion was negatively correlated with both affiliate stigma and psychological distress. These findings
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are consistent with previous research (Neff and Faso 2014; Mak and Cheung 2008; Werner and Shulman 2013) and suggest that affiliate stigma is associated with poorer mental health among Chinese parents of children with ASD. More importantly, our results show that self-compassion plays a positive role in the mental health of these parents.

Consistent with previous research which showed that social support and positive parental perception are associated with better well-being among parents of children with disabilities (Benson et al. 1996; Davis and Gavidia-Paynes 2009; Greeff et al. 2012; Minnes et al. 2015), all the zero-order correlations between the four control variables (i.e., family support, support from friends/significant other, professional support, and positive parental perception) and psychological distress were found significant in the present study. When all the control variables were entered in the regression model, family support was the only significant predictor of psychological distress. Cultural factors may account for these findings. In the family-oriented and face-preserving Chinese culture, parents may be more likely to seek and benefit from family support than support from other sources (Mak et al. 2008; Wang and Michaels 2009; Zane et al. 1998)

The study’s second hypothesis of self-compassion as a moderator in the association between affiliate stigma and psychological distress was also supported. Specifically, the association between affiliate stigma and psychological distress was significant at low levels but not at high levels of self-compassion. Self-compassionate parents may be kind to themselves instead of being self-critical (Reid et al. 2014), which helps lessen the feelings of shame engendered by affiliate stigma. Also, recognizing that they are not the only ones suffering, self-compassionate parents may be less likely to feel isolated in their struggle with affiliate stigma. By being more mindful, self-compassionate parents may be less likely to be absorbed by their own self-blaming and over-identify with the negative feelings and thoughts (Neff 2003a). Self-compassion also entails acceptance of the self and current situation as
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well as embracement of hope for the future (Neff and Faso 2014). Perhaps through greater acceptance and hope, self-compassionate parents may be less affected by affiliate stigma, and therefore are less vulnerable to psychological distress.

Conversely, when parents with low self-compassion experience affiliate stigma, they may engage in further negative self-evaluation and self-judgment, which are likely to amplify the impact of affiliate stigma. Moreover, parents with low self-compassion may be less likely to engage in self-care activities that promote well-being, such as taking time off from caregiving duties before they become overly stressed (Neff and Faso 2014). As such, they become even more vulnerable to caregiving stress and subjective burden associated with affiliate stigma (Mak and Cheung 2008).

The above moderation effect was found after controlling for family support, support from friends and significant others, and professional support, suggesting that self-compassion is a powerful protective source above and beyond the effect of social support, which may not always be readily accessible. When parents of children with ASD have internalized public stigma, they may be reluctant to seek support in order to minimize further embarrassment and shame. Studies have found that people who reported high levels of self-stigma (a similar concept as affiliate stigma, but applied to the discredited individuals) are more likely to forego seeking help (Miller 1985; Vogel et al. 2007). Additionally, within the Chinese culture, due to the strong concern for “saving face,” parents may be more reluctant to seek social support (Mak et al. 2008; Zane et al. 1998). Self-compassion, on the other hand, may serve as an internal resource that can be cultivated and perhaps more accessible than external social support for Chinese parents.

Furthermore, self-compassion could also explain additional variance of psychological distress over and beyond that which is explained by positive parental perception. This suggests that self-compassion is distinct from finding meaning and benefits in caregiving,
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which may involve coping through cognitive restructuring of one’s perception and thoughts. Self-compassion may also serve as an emotion regulation strategy (Neff 2003b), which has the added benefits of helping parents to accept, explore, and understand the negative emotions associated with affiliate stigma. This allows them to approach negative emotions with kindness and a sense of shared humanity.

Our study has significant contributions to the existing body of literature. By examining self-compassion as a moderator, our study extends the previous research which only examined the direct associations between self-compassion and well-being (Neff and Faso 2014). The finding of self-compassion as a moderator corroborated Werner and Shulman’s (2013) as well as Perry’s (2004) theoretical models. Specifically, our study showed that self-compassion is an internal coping resource that can mitigate the association between affiliate stigma and psychological stress among parents of children with ASD.

In addition, our study is one of the few studies that have investigated affiliate stigma and potential buffers against it among Chinese parents of children with ASD. As mentioned previously, affiliate stigma may be particularly salient for Chinese parents due to their cultural value of face concern and their interpersonal orientation (Mak et al. 2008). Although East Asians (e.g., Chinese) tend to be more self-critical (i.e., less compassionate) than Westerners (Kitayama and Markus 2000), studies have found significant associations between self-compassion and well-being among Chinese (Neff et al. 2008; Wong and Mak 2013). Thus, these findings and the current study’s results suggest that cultivating self-compassion among Chinese parents of children with ASD is likely to benefit their well-being.

Limitations and Future Directions

Regarding this study’s limitations, the cross-sectional nature of the data prevents us from making causal inferences among the variables. Future study might conduct experimental research to manipulate self-compassion (e.g., Adams and Leary 2010) or
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incorporate a longitudinal design to determine the causal relationships among the variables. Another limitation is the generalizability of the study. The moderation model was examined only among Chinese parents of children with ASD in Hong Kong; future studies should validate the model in parents of other ethnicities and parents of children with other developmental disabilities or mental illnesses, or caregivers of patients with chronic diseases.

Previous studies have shown that parents of children with developmental disabilities benefited from mindfulness-based interventions (Bazzano et al. 2015; Benn et al. 2012). Self-compassion is conceptually similar to mindfulness in that both concepts involve an accepting stance and being aware of painful experiences (Neff and Dahm, 2015). In addition to mindfulness, self-compassion also consists of elements of self-kindness and common humanity, which are likely to benefit parents of children with ASD (Neff and Faso, 2014). Indeed, one study showed that self-compassion explained more variance in psychological outcomes such as anxiety, worry, depression and quality of life than trait mindfulness (Van Dam et al. 2011). Therefore, it may be helpful for future studies to compare self-compassion and trait mindfulness (Brown & Ryan, 2003) as moderators for the associations between affiliate stigma and parental distress.

On the other hand, a recent study showed that parental mindfulness training could also benefit children’s functioning (Singh et al. 2006). Accordingly, future study may examine whether increased parental self-compassion will impact the well-being of children with ASD. In addition to self-compassion, future study may explore other internal resources such as how forgiveness of the self and contingency of self-worth could also serve as moderators between affiliate stigma and psychological distress.
Compliance with Ethical Standards

Funding: This study was not supported by any funding.

Ethical approval: All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

Informed consent: Informed consent was obtained from all individual participants included in the study.
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### Table 1. Demographic characteristics of participants and their children with Autism Spectrum Disorder (n=180)

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<tr>
<th>Variables</th>
<th>N (%)</th>
<th>Mean, SD</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Caregiver demographic variables</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>28 (15.8%)</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>149 (84.2%)</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td>( M = 42.31, )</td>
</tr>
<tr>
<td></td>
<td></td>
<td>( SD = 7.20 )</td>
</tr>
<tr>
<td>Marital status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>2 (1.1%)</td>
<td></td>
</tr>
<tr>
<td>Married/ Cohabitating</td>
<td>157 (87.2%)</td>
<td></td>
</tr>
<tr>
<td>Separated/ Divorce/ Windowed</td>
<td>16 (8.9%)</td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary school or less</td>
<td>12 (6.8%)</td>
<td></td>
</tr>
<tr>
<td>Junior secondary school</td>
<td>27 (15.3%)</td>
<td></td>
</tr>
<tr>
<td>Senior secondary school</td>
<td>87 (49.2%)</td>
<td></td>
</tr>
<tr>
<td>Diploma or higher</td>
<td>51 (28.8%)</td>
<td></td>
</tr>
<tr>
<td>Number of caregiving hours/ day</td>
<td></td>
<td>( M = 7.39, )</td>
</tr>
<tr>
<td></td>
<td></td>
<td>( SD = 6.32 )</td>
</tr>
<tr>
<td>Participation of activities organized by NGOs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>144 (81.4%)</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>33 (18.6%)</td>
<td></td>
</tr>
<tr>
<td><strong>Child demographic variables</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>154 (89.5%)</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>18 (10.5%)</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td>( M = 9.77, )</td>
</tr>
<tr>
<td></td>
<td></td>
<td>( SD = 4.11 )</td>
</tr>
<tr>
<td>Diagnosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Autism spectrum syndrome alone</td>
<td>94 (35.2%)</td>
<td></td>
</tr>
<tr>
<td>Autism spectrum syndrome with intellectual disability</td>
<td>71 (35.8%)</td>
<td></td>
</tr>
<tr>
<td>Month(s) since diagnosis</td>
<td></td>
<td>( M = 68.00, )</td>
</tr>
<tr>
<td></td>
<td></td>
<td>( SD = 52.46 )</td>
</tr>
<tr>
<td>Types of school</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mainstream</td>
<td>94 (54.7%)</td>
<td></td>
</tr>
<tr>
<td>Special</td>
<td>83 (44.2%)</td>
<td></td>
</tr>
</tbody>
</table>

\(^a\) Number may not add up to total sample size due to missing data
### Table 2. Descriptive Statistics, and Correlation Matrix of Main Study Variables of Interest (n=180)

<table>
<thead>
<tr>
<th>Variables</th>
<th>Mean</th>
<th>SD</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychological distress</td>
<td>2.74</td>
<td>0.56</td>
<td>.44**</td>
<td>-.64**</td>
<td>-.43**</td>
<td>-.30**</td>
<td>-.25**</td>
<td>-.34**</td>
</tr>
<tr>
<td>Affiliate stigma</td>
<td>2.20</td>
<td>0.47</td>
<td>-</td>
<td>-.49**</td>
<td>-.35**</td>
<td>-.39**</td>
<td>-.30**</td>
<td>-.39**</td>
</tr>
<tr>
<td>Self-compassion</td>
<td>3.32</td>
<td>0.52</td>
<td>-.39**</td>
<td>.42**</td>
<td>.27**</td>
<td>.52**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family support</td>
<td>2.85</td>
<td>0.61</td>
<td>-.37**</td>
<td>.26**</td>
<td>.35**</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support from friends and significant others</td>
<td>3.72</td>
<td>1.05</td>
<td>-.33**</td>
<td>.38**</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professional support</td>
<td>3.55</td>
<td>1.20</td>
<td>-</td>
<td></td>
<td>.28**</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Positive parental perception</td>
<td>2.95</td>
<td>0.40</td>
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*p < .05, **p < .01
Table 3. Hierarchical Regression Analysis Predicting Psychological Distress from Affiliate Stigma, Self-Compassion, and the Affiliate Stigma x Self-Compassion Interaction

<table>
<thead>
<tr>
<th>Step</th>
<th>Variable</th>
<th>B</th>
<th>SE B</th>
<th>β</th>
<th>ΔR²</th>
<th>ΔF(df)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
<td>Affiliate stigma</td>
<td>.53</td>
<td>.08</td>
<td>.44***</td>
<td></td>
<td>42.00***</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(1, 172)</td>
</tr>
<tr>
<td>Step 2</td>
<td>Affiliate stigma</td>
<td>.33</td>
<td>.09</td>
<td>.28***</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Family support</td>
<td>-.26</td>
<td>.07</td>
<td>-.29***</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Support from friends and significant other</td>
<td>-.02</td>
<td>.04</td>
<td>-.03</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Professional support</td>
<td>-.03</td>
<td>.03</td>
<td>-.06</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Positive parental perception</td>
<td>-.14</td>
<td>.11</td>
<td>-.10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Step 3</td>
<td>Affiliate stigma</td>
<td>.17</td>
<td>.08</td>
<td>.14*</td>
<td></td>
<td>51.14***</td>
</tr>
<tr>
<td></td>
<td>Family support</td>
<td>-.19</td>
<td>.06</td>
<td>-.21**</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Support from friends and significant other</td>
<td>.02</td>
<td>.04</td>
<td>.05</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Professional support</td>
<td>-.03</td>
<td>.03</td>
<td>-.05</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Positive parental perception</td>
<td>.09</td>
<td>.10</td>
<td>.06</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Self-compassion</td>
<td>-.57</td>
<td>.08</td>
<td>-.52***</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Step 4</td>
<td>Affiliate stigma</td>
<td>.17</td>
<td>.08</td>
<td>.14*</td>
<td></td>
<td>8.20**</td>
</tr>
<tr>
<td></td>
<td>Family support</td>
<td>-.17</td>
<td>.06</td>
<td>-.19**</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Support from friends and significant other</td>
<td>.03</td>
<td>.04</td>
<td>.05</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Professional support</td>
<td>-.03</td>
<td>.03</td>
<td>-.06</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Positive parental perception</td>
<td>.08</td>
<td>.10</td>
<td>.06</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Self-compassion</td>
<td>-.56</td>
<td>.08</td>
<td>-.52***</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Affiliate stigma x Self-compassion</td>
<td>-.27</td>
<td>.10</td>
<td>-.16**</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*p < .05, **p < .01, ***p < .001
SELF-COMPASSION AND AFFILIATE STIGMA

Figure 1. Interaction of affiliate stigma and self-compassion on psychological distress.

![Graph showing the interaction of affiliate stigma and self-compassion on psychological distress. The graph includes two lines: one dotted line labeled 'Low Self-Compassion' and one solid line labeled 'High Self-Compassion.' The x-axis represents affiliate stigma (Low and High), and the y-axis represents psychological distress (0 to 3.5). The lines show an increase in psychological distress with higher affiliate stigma and self-compassion.](View publication stats)