Mindfulness (2019) 10:415–433
https://doi.org/10.1007/s12671-018-0984-2

REVIEW

Hacking Stigma by Loving Yourself: a Mediated-Moderation Model of Self-Compassion and Stigma

Celia Ching Yee Wong[1] · C. Raymond Knee[1] · Clayton Neighbors[1] · Michael J. Zvolensky[1]

Published online: 4 July 2018

Abstract

Stigma is an important topic in public health and has significant impact on psychological and physical well-being of stigmatized individuals. Emerging evidence has suggested that self-compassion, a self-caring and compassionate attitude in the face of hardship, may buffer the negative effects of stigma. However, little research has been conducted to investigate the underlying mechanisms through which self-compassion may buffer the effects of public stigma on self-stigma and the associated negative outcomes. The goal of this paper is to present a theoretical framework that integrates the existing body of literature in self-compassion and stigma. This framework postulates that (1) self-compassion may be related to adaptive cognitive, emotional, and social processes, and (2) these processes may, in turn, prevent individuals with stigmatized identity from developing self-stigma and other health outcomes. Theoretical and empirical support for this mediated-moderation model is reviewed. Future directions to empirically evaluate this model, as well the potential applications of this model for stigma reduction interventions are presented.

Keywords Self-compassion · Stigma · Acceptance-commitment therapy · Coping · Identity

Stigma is an important topic in public health. The linkage between stigma and health has been well-established in the literature; meta-analyses and systematic reviews consistently indicate that stigma is associated with poorer physical and mental health, poorer quality of life, lower levels of hope, self-esteem, self-efficacy, and empowerment among stigmatized individuals and their associates (Ali et al. 2012; Livingston and Boyd 2010; Logie and Gadalla 2009; Mak et al. 2007; Malli et al. 2016). Given that stigma is costly to stigmatized individuals and the society, research on stigma reduction is particularly important. There is recent evidence that suggests self-compassion may be linked to reduced self-stigma and negative outcomes (e.g., Hilbert et al. 2015; Wong et al. 2016). However, the underlying pathways are not fully known. Therefore, the present review offers a theoretical framework to understand how self-compassion may buffer the effects of public stigma on self-stigma and associated negative outcomes.

✉ Celia Ching Yee Wong
celia.cyw@gmail.com

[1] Department of Psychology, University of Houston, Fred J. Heyne Building Rm 126, 3695 Cullen Boulevard, Houston, TX 77204-5022, USA

Conceptualization of Stigma

According to Goffman (1963), stigma is an attribute ("mark") that differentiates an individual from others, putting them in a less desirable category. Stigma affects a significant number of people in the population. The majority of stigma research has focused on specific racial and ethnic groups (Major and O'Brien 2005), people with mental illnesses (Livingston and Boyd 2010), and/or people living with HIV/ AIDS (Logie and Gadalla 2009). However, other studies show stigma also affects people with physical health conditions (e.g., physical disabilities, cancer, chronic pain, and obesity; Carrasco et al. 2013; Chambers et al. 2012; Kim and Yi 2014; Papadopoulos and Brennan 2015; Waugh et al. 2014), people with intellectual disabilities (Ali et al. 2012), and sexual minorities (Denton et al. 2014). The effects of stigma can extend beyond the stigmatized person and impact others close to that person, such as relatives (Koschade and Lynd-Stevenson 2011; Krupchanka et al. 2016) and parents (Ali et al. 2012; Green 2003; Mak and Kwok 2010).

Public Stigma Versus Self Stigma

When a stigma becomes the center of one's self-concept, it can affect the life of the stigmatized individuals (Fife and Wright 2000; Jones 1984). Link and colleagues proposed the "modified labeling theory" to describe the process of internalizing stigma (Link 1982; Link et al. 1989). They proposed that the development of negative stereotypes about stigmatized identities occurs in early life. When individuals acquire a stigmatized identity later in life, they attribute perceived cultural prejudices as personally relevant, and expect themselves to be devalued and discriminated against by society. These expectations may, in turn, demoralize stigmatized individuals, leading to reduced self-esteem and self-efficacy (Link 1987; Markowitz 1998).

Based on Link's model (Link 1987), the internalization of stigma and the experience of negative outcomes is a natural process that occurs to everyone who possesses a stigmatized identity. However, later research suggests otherwise. According to Crocker and Major (1989), the experience of self-stigma and negative outcomes is a result of three distinct processes: (1) being aware of stereotypes related to one's stigmatized identity, (2) agreeing with such stereotypes, and most importantly, (3) applying stereotypes to the self. Stigmatized individuals are not passive recipients of stigma; being aware of the existence of stigma against themselves does not necessarily cause the application of those negative stereotypes to the self (Camp et al. 2002; Cook et al. 2014; Corrigan et al. 2005; Mak et al. 2007; Rüsch et al. 2014a). Rather than unresistingly endorsing the negative stereotypes and attitudes associated with stigma, some people respond to public stigma with strength and indignation (Corrigan and Watson 2002). Instead of chronically attributing adversity to an internal stigmatized identity and often unfairly blaming the self, these individuals are better able to differentiate varied causes of their adversity and adequately attribute parts of their hardship to prejudice and discrimination (Corrigan and Watson 2002; Major et al. 2002, 2003a, b; Miller and Kaiser 2001). Some others may experience righteous anger toward their unfair treatments and feel empowered to advocate for themselves and similar others (Corrigan et al. 2005, 2013; Corrigan and Watson 2002; Heijnders and Van Der Meij 2006; Rüsch et al. 2014a; Schmader et al. 2013).

Acknowledging the vast diversity of responses toward stigma, Corrigan and colleagues (Corrigan et al. 2005; Corrigan and Watson 2002) proposed an alternative model of stigma and suggested that stigma manifests in two levels: public stigma (a.k.a. enacted stigma, social stigma, perceived stigma) and self-stigma (a.k.a. internalized stigma, felt stigma). Public stigma refers to the phenomenon of the majority endorsing stereotypes about and acting against a stigmatized group. On the other hand, self-stigma refers to the phenomenon during which stigmatized individuals internalize public stigma at the expense of their self-esteem and self-efficacy (Corrigan et al. 2005). Empirical studies show public stigma and self-stigma are distinct constructs, and they are only moderately associated with each other (e.g., Muñoz et al. 2011; Pachankis et al. 2015).

Conceptualization of Self-Stigma

Other researchers have also attempted to expand and refine the definition of self-stigma. For instance, Yano and colleagues defined self-stigma as a state of identity transformation during which a stigmatized individual loses their previously held, desirable identities and adopts stigmatizing views about the self (Yanos et al. 2008). Luoma et al. (2008) defined self-stigma as shame, evaluative thoughts, and fear of public stigma, which impedes stigmatized individuals from pursuing valued life goals. Livingston and Boyd (2010) defined self-stigma as a subjective process that is embedded within a socio-cultural context where an individuals' experiences, perceptions, or anticipation of negative social reactions based on their stigmatized identity typically results in negative feelings about the self, maladaptive behavior, identity transformation, and/or stereotype endorsement. Summarizing the essences of these definitions, this review defines self-stigma as a subjective experience of identity transformation, during which a stigmatized individual endorses the negative stereotype of their stigmatized identity, experiences negative feelings about the self, and behaves in ways that accord with the negative stereotypes of their stigmatized identity.

Self-Stigma and Well-Being

Self-stigma is a more proximal stressor than public stigma (Meyer 2003; Pachankis et al. 2015). It has been suggested and evidenced that stigma is most harmful when it is internalized (Ritsher and Phelan 2004). A growing body of research indicates that self-stigma is the major attributing factor that explains the association between public stigma and negative outcomes. Studies found that self-stigma mediates the effect of public stigma on negative mood symptoms (e.g., depression, anxiety, psychological distress), and social outcomes (e.g., personal autonomy, assertiveness, social anxiety, sexual compulsivity) (Feinstein et al. 2012; Kim and Yi 2014; Muñoz et al. 2011; Pachankis et al. 2008, 2015; Quinn and Crocker 1999).

The impact of self-stigma is far-reaching. The latest meta-analyses and systematic reviews indicate that self-stigma has significant negative impacts on multiple dimensions of well-being (Boyd et al. 2014; Livingston and Boyd 2010; Logie and Gadalla 2009; Mak et al. 2007; Papadopoulos and Brennan 2015). Cognitively, self-stigma is associated with lowered levels of self-esteem, self-efficacy, and sense of mastery (Ali et al. 2012; Boyd et al. 2014;

Livingston and Boyd 2010). Affectively, self-stigma is associated with lower levels of life satisfaction, poorer quality of life, more depressive and anxiety symptoms (Ali et al. 2012; Mak et al. 2007; Papadopoulos and Brennan 2015; Pérez-Garín et al. 2015). Socially, self-stigma is associated with poorer social adjustment, poorer relationship functioning, higher levels of loneliness, and less social support (Doyle and Molix 2015; Livingston and Boyd 2010; Logie and Gadalla 2009; Phelan et al. 2015). Physically, self-stigma is associated with poorer physical health, higher degrees of symptom severity, poorer treatment adherence, lower intention to seek help, and less motivation to practice healthy behaviors (Livingston and Boyd 2010; Logie and Gadalla 2009; Papadopoulos and Brennan 2015; Sharp et al. 2015; Vartanian and Porter 2016).

Coping with Self-Stigma

Elimination of public stigma requires global changes in attributions about stigmatized groups at the societal level. However, such macro-level changes, when they do occur, tend to emerge gradually over an extended period of time (Corrigan et al. 2005). Therefore, it is important to identify ways that protect stigmatized individuals against self-stigma and its associated negative impacts while pushing forward the macro societal change in reducing public stigma. The development of self-stigma reduction interventions has been blooming in the recent decade (Yanos et al. 2015). According to Mittal et al. (2012), there are two major approaches in reducing self-stigma: (1) altering stigmatizing beliefs and attitudes, and (2) accepting the existence of stigmatizing attitudes, and enhancing stigma-coping skills. The second approach has been gaining popularly; however, most interventions are not developed on the basis of a theoretical framework (Mittal et al. 2012). Acceptance-commitment therapy (ACT) is one of the few theory-based self-stigma reduction interventions (Skinta et al. 2015), and accumulating evidence has been promising (Lillis et al. 2009; Luoma et al. 2008; Luoma and Platt 2015; Skinta et al. 2015; Yadavaia and Hayes 2012).

ACT is a third-wave behavioral therapy, an application of the functional contextualism and the relational frame theory (Hayes et al. 2011). Functional contextualism focuses on the consequences of behaviors and recommends individuals to behave in ways that move toward what is important to them (a.k.a. "values" in ACT; Schoendorff et al. 2014). Accordingly, ACT views suffering as a normal part of human experience (Hayes and Smith 2005). Distress is not a direct result of suffering but rather the struggle to escape from the unwanted, aversive inner experience (e.g., thoughts and feelings), as well as the inconsistencies between one's behaviors and values (Schoendorff et al. 2014; Strosahl and Robinson 2009). Therefore, instead of targeting to identify and alter individuals' malfunctioning experiences, ACT aims to deconstruct individuals' malfunctioning experiences in the context of personal values, facilitate acceptance of both positive and negative parts of the experience, and broadening individuals' coping repertoires (Greco et al. 2008; Hulbert-Williams et al. 2015; Schoendorff et al. 2014).

Derived relational responding is a major concept in the relational frame theory, and is the result of the process in which individuals' sensational experience is transformed into mental experience (Hayes et al. 2001). During this transformation process, mental experience may acquire some of the functions of the sensational experience (e.g., arousing negative emotions), and individuals begin to respond to the mental experience (e.g., thoughts) even in the absence of the sensational experience (e.g., prejudice, discrimination). When being hooked by an aversive mental experience (e.g., thinking about potential discrimination), people may naturally want to escape from it. Oftentimes, social withdrawal response occurs in the cost of important life goals (e.g., enjoying companionship, having successful career; Schoendorff et al. 2014). Therefore, the "observing self" is emphasized in the ACT framework as an approach that allows individuals to have some psychological distance to observe their experience, and facilitates the distinction between sensational and mental experience, which in turn, reduces the controlling function of the mental experience on their behaviors (Hayes et al. 1999).

According to Hayes and colleagues (Hayes et al. 2006), ACT has six core processes: (1) contact with the present moment—being open, having mindful awareness of what is happening at the present moment; (2) cognitive diffusion—noticing thoughts as they are, simply thoughts, not necessary reality; (3) self-as-context—being aware of one's thoughts, feelings, and other internal states, and being able to distinguish those mental experiences from the experiencing self; (4) acceptance—not avoiding negative experiences but embracing both positive and negative experiences in the present moment; (5) values—connecting with valued directions that are personal, and intrinsically meaningful; (6) committed action—being willing to live a values-consistent life despite negative inner experience.

Recently, some ACT experts suggested that self-compassion (i.e., a self-caring and compassionate attitude in the face of hardship or perceived inadequacy; Neff 2003a) is inherent in the ACT approach (Skinta et al. 2015; Tirch et al. 2014), and that self-compassion may explain the effect of ACT in reducing self-stigma and negative outcomes (Luoma and Platt 2015). While research has been limited, one study found that self-compassion is the most robust mediator, among several mediators including psychological flexibility coping, acceptance, and values, in explaining the effect of ACT among chronic pain patients (Vowles et al. 2014). Other studies also show that self-compassion is associated with reduced self-stigma and negative outcomes (e.g.,

symptoms of depression, anxiety, and somatization) among individuals with stigmatized identities such as overweight individuals, people with eating disorders, people with HIV, and parents of children with autism spectrum disorders (Brion et al. 2014; Hilbert et al. 2015; Kelly and Tasca 2016; Wong et al. 2016). These findings provide preliminary evidence that self-compassion is a desirable construct in buffering the effects of public stigma on self-stigma and the associated negative outcomes.

Conceptualization of Self-Compassion

According to Neff (2003b), self-compassion is being touched by one's suffering, and having a desire to alleviate the suffering, and to heal oneself with kindness. Self-compassionate individuals are open to their suffering; they are less likely to avoid or disconnect from their negative experience. Self-compassion is particularly relevant in the face of painful life situations, as well as personal inadequacies and failures (Neff and Tirch 2013). It provides non-judgmental understanding of one's pain, inadequacies, and failures, and it also allows individuals to normalize their painful experience, see it as part of the larger human experience, and take a more balanced perspective to approach their negative experience.

Neff (2003b) operationally defined self-compassion by three components:

1. *Self-kindness versus self-judgment*. Self-kindness refers to the tendency to be sympathetic toward the self. It involves tolerance and understanding when relating to one's failings and inadequacies. When confronting painful situations, instead of harsh self-criticism and judgment, people with self-kindness give themselves the warmth, gentleness, and unconditional acceptance that are essential for emotional equanimity and healing (Neff 2003a, b; Neff and Tirch 2013).
2. *Common humanity versus isolation*. Common humanity refers to recognizing that all humans are connected, that we all fail, that we make mistakes and engage in dysfunctional behavior. People with a common humanity perspective tend to have a broader and more inclusive perspective in which they acknowledge life challenges and personal failures as parts of the shared human experience, and that they are not alone in their struggles (Neff 2003a, b; Neff and Tirch 2013).
3. *Mindfulness versus over-identification*. Mindfulness is a nonjudgmental and receptive mind state that allows awareness of present moment experience, acknowledgment of pain without reacting to it (Bishop et al. 2004; Kabat-Zinn 2003). Mindfulness is an essential component of self-compassion; it is impossible for individuals to offer themselves with compassion if their pain and suffering are not recognized (Neff 2003a, b; Neff and Tirch 2013).

Self-Compassion and Well-Being

The association between self-compassion and well-being has been well established in the literature. Research has shown that self-compassion is associated with higher levels of positive affect, happiness, optimism, and life satisfaction, and lower levels of negative affect, depressive, and anxiety symptoms (Neely et al. 2009; Neff 2003a; Neff and Vonk 2009; Neff et al. 2007). Consistently, meta-analyses have found self-compassion to be significantly associated with better cognitive well-being, better psychological well-being, and less psychopathology (MacBeth and Gumley 2012; Zessin et al. 2015). Other research has also shown that self-compassion is associated with better general health (Allen et al. 2012; Raque-Bogdan et al. 2011) and less physical symptoms (Hall et al. 2013).

Self-Compassion, ACT, and Stigma

There is a recent discussion that self-compassion may be the underlying mechanism through which ACT reduces self-stigma and negative outcomes, and that self-compassion is implicitly inherited in the core processes of ACT (Luoma and Platt 2015). The mindfulness component in self-compassion promotes stigmatized individuals' awareness of their inner experience without suppression or over-identification (contact with present moment). Self-compassion also provides the emotional safety that is required to clearly observe the self and reality (Allen and Leary 2010; Neff et al. 2007). As a result, stigmatized individuals can take a more balanced perspective of the self and the situation that they are going through, accept both positive and negative parts of themselves, and embrace their stigmatized identity as it is (acceptance). Also, self-compassionate individuals tend to have lower levels of self-consciousness, less concern about what others think of them, and less desire to please others (Barnard and Curry 2011; Neff and Vonk 2009). As such, self-compassionate individuals are more capable of distinguishing their sensory experience and mental experience of stigma (cognitive diffusion), and less likely to let those thoughts define the self (self-as-context), and internalize public stigma. In addition, with genuine concern and care about the self, self-compassionate individuals may have more intrinsic motivation to regulate their behaviors in ways that promote their physical and psychological well-being (Terry and Leary 2011) despite their experience of public stigma (values and committed action). These self-compassionate qualities, together, allow stigmatized individuals to go beyond the shadows of stigma and live a purposeful life despite their stigmatized identity.

Although studies have been limited, the protective role of self-compassion against stigma has been documented in the literature. Cross-sectional studies show that self-compassion is negatively associated with self-stigma (Heath et al. 2016, 2017; Hilbert et al. 2015; Wasylkiw and Clairo 2016) and affiliate stigma (i.e., internalized stigma applied to people who are affiliated with stigmatized individuals; Wong et al. 2016), as well as other self-stigma related constructs such as self-criticism, self-blame, and shame (Petrocchi et al. 2014; Reilly et al. 2013; Wong and Mak 2013). Experimental studies also reveal that individuals with high levels of trait self-compassion are less likely to feel defeated when asked to imagine themselves in hypothetical situations that are socially embarrassing and shameful (e.g., forgetting lines when performing on the stage), or to recall a previous failure, rejection, or loss that made them feel badly about themselves (Leary et al. 2007). These findings provide preliminary evidence that self-compassion may serve to buffer the effects of public stigma on self-stigma and negative outcomes among stigmatized individuals. However, the pathways underlying these associations remain unknown. To facilitate future development of self-stigma reduction interventions, it is important to develop a theoretical framework to identify the processes through which the effects of public stigma on self-stigma and its associated negative outcomes would be attenuated by increased self-compassion.

Hatzenbuehler (2009) has developed a conceptual model to explain how public stigma may adversely affect mental health among sexual minorities. It is postulated that public stigma is related to heightened maladaptive cognitive, emotional, and social processes that put sexual minorities at risk of psychopathology. Cognitively, chronic exposure of public stigma may engender negative self-schema (i.e., negative view of the self, low self-esteem; Beck et al. 1979) and hopelessness (i.e., belief that negative events will occur and desired events will not occur, and that there is nothing the individual can do to change the situation; Abramson et al. 1989), which in turn, increase sexual minorities' vulnerabilities to mental health problems. Emotionally, public stigma may engender aversive mood states such as shame, depression, anxiety, anger among sexual minorities (Huebner et al. 2005; Newcomb and Mustanski 2010; Skinta et al. 2014). With constant struggles with managing rejections and concealing their stigmatized identity, sexual minorities may be more apt to ruminate and thereby experience more mental health problems. Socially, public stigma may engender social isolation among sexual minorities. Prior experiences of social exclusion can lead to selective memories of negative social information (Gardner et al. 2000) and avoidance of future social interactions (Higgins et al. 1982). Fear of rejection and negative evaluation can also prevent individuals from developing close relationships (Pachankis 2007).

This paper is an attempt to address the stigma-related negative processes proposed by Hatzenbuehler (2009). Available literature on self-compassion and self-stigma that falls within this framework has been reviewed and summarized. A conceptual model is built to illustrate how self-compassion may buffer individuals from the negative effects of public stigma on self-stigma and negative outcomes by counteracting each of the negative processes discussed in Hatzenbuehler's model. We propose that (1) negative self-schema can be addressed by intrinsic self-affirmation, (2) hopelessness can be addressed by stress appraisal and benefit-finding, (3) rumination can be addressed by emotional processing and emotion regulation, (4) and social isolation can be addressed by social support and forgiveness (see Fig. 1).

Cognitive Mechanisms Through Which Self-Compassion Buffers Stigma

Intrinsic Self-Affirmation

One way to buffer the effects of public stigma on self-stigma and the associated negative outcomes is through intrinsic self-affirmation. According to self-affirmation theory (Steele 1988), people are motivated to maintain the integrity of the self; a defense response would result when individuals' self-integrity is threatened. Intrinsic self-affirmation can help

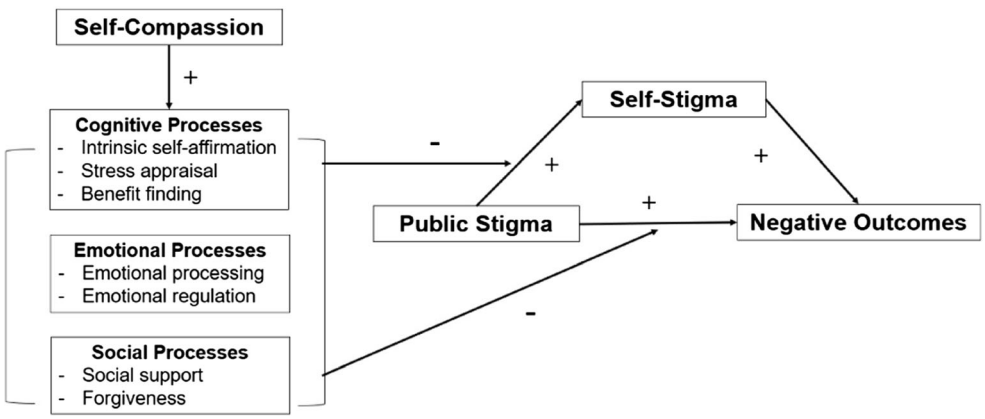

Fig. 1 Conceptual moderated mediation of self-compassion and stigma

reduce defense response by inoculating individuals against ego-threats by focusing on valued intrinsic aspects of self, such as unconditional relationships and core personal values (Arndt et al. 2002; Schimel et al. 2001). Thus, intrinsic self-affirmation allows individuals to be more open to negative self-identities that would otherwise be too painful to accept, and facilitate the utilization of more adaptive coping against ego threats (Sherman and Cohen 2006), and leads to a coherent though ever-changing sense of self (Deci and Ryan 1985; Ryan and Deci 2008). The process of integrating negative identities may be painful; however, it will bring flexibility in self-image that is associated with better well-being (Pasupathi 2001; Showers and Zeigler-Hill 2003).

Stigma can be viewed as an ego-threat; intrinsic self-affirmation may, thus, help combat against public stigma by reassuring stigmatized individuals' overall sense of self-integrity. Everyone has multiple identities (e.g., ethnic, familial, professional, religious, and political identities), and a stigmatized identity is just one of the many identities that people inhabit. The negative impact of stigma is largely dependent on its centrality in stigmatized individuals' self-concept (McCay and Seeman 1998; Quinn and Chaudoir 2009; Quinn et al. 2015). Intrinsic self-affirmation may help mitigate the threat from public stigma by reminding stigmatized individuals of their other valued identities and core personal values, and restoring their global sense of self-integrity (Cook et al. 2014; Sherman and Cohen 2006). Experimental studies show that participants perceived an ego-threatening situation (e.g., participating in the tier social stress task, receiving an evaluative social interaction feedback) as less stressful when their self-integrity has been affirmed (i.e., when their top-ranked value has been made salient) and reported less thoughts of social rejection (e.g., Creswell et al. 2005; Schimel et al. al. 2004; Tang and Schmeichel 2015). Additionally, a recent study showed that an intrinsic self-affirmation writing task can reduce self-stigma of seeking psychotherapy among clinically distressed individuals (Lannin et al. 2013).

Self-compassion may weaken the effects of public stigma on self-stigma and the associated negative outcomes by reducing the centrality of the stigmatized identity in one's self-concept and fostering intrinsic self-affirmation. Theoretically, self-compassion is unconditional and is founded on the basis that everyone deserves compassion and understanding (Neff and Vonk 2009). Self-compassionate individuals are, thus, less likely to judge themselves harshly because of their stigmatized identity (i.e., self-kindness), and they are also less likely to exaggerate their stigma experience to make it unnecessarily central to their self-concept (i.e., mindfulness) because they recognize that being imperfect or flawed is a shared human experience (i.e., common humanity). Thus, they are less likely to be fixated on their stigmatized identity. Instead, they can experience a balanced, global sense of self-integrity by equally valuing their stigmatized identity, alternative non-stigmatized alternative identities, and other core personal characteristics. While research on the association between self-compassion and intrinsic self-affirmation has been limited, one experimental study showed that an intrinsic self-affirmation writing task could promote feelings of self-compassion (Lindsay and Creswell 2014), suggesting that self-compassion and intrinsic self-affirmation may share some common mechanisms. Other cross-sectional studies also show that self-compassion is associated with higher capacities of identity integration such as integrative self-knowledge (i.e., adaptive capacity to integrate past and present self-experience) and ego-integrity (i.e., a composite of wisdom, wholeness, integration, and acceptance in relation to one's past experience), as well as lower levels of ego-focused reactivity (Ghorbani et al. 2012; Neff and Vonk 2009; Phillips and Ferguson 2013).

Stress Appraisal

Stigma can also be conceptualized as a stressor, and the effect of stigma largely depends upon the cognitive appraisal of stigmatized individuals (Berjot and Gillet 2011; Major and O'Brien 2005). According to the stress and coping model (Lazarus and Folkman 1984), there are two types of appraisals: (1) primary appraisal refers to the assessment of demands posed by a stressor (e.g., public stigma), whether the stressor is personally-relevant and harmful, and (2) secondary appraisal refers to the assessment of individuals' coping resources against the stressor, including intrapersonal resources (e.g., physical energy, sense of control) and interpersonal resources (e.g., social support from family and friends). Psychological distress would result when individuals appraise the demands of the stressor as self-relevant and as exceeding their coping resources.

In the context of stigma coping, self-stigma and negative outcomes would result when individuals perceive that the potential harm caused by public stigma exceeds their coping resources. Indeed, the application of the stress and coping model (Lazarus and Folkman 1984) on stigma coping has been evidenced in empirical research. Studies have shown that stigma stress appraisal is linked to higher levels of self-stigma, and more social anxiety and shame, which in turn, are associated with lower levels of self-esteem and poorer quality of life (Rüsch et al. 2009a, b, 2014b). Consistently, interventions that promote coping resources against stigma have also been found to be successful in reducing self-stigma and the associated negative outcomes (Fung et al. 2011; Russinova et al. 2014).

Self-compassion may help buffer the effects of public stigma on self-stigma and negative outcomes by improving individuals' stigma stress appraisal. In terms of primary appraisal, promoting self-compassion can deactivate individuals' threat system and activate their warmth/ soothing system (Gilbert and Irons 2005; Gilbert and Procter 2006). Empirical studies show self-compassion is linked to less ego-defensiveness (Neff and Vonk 2009), less self-esteem contingency on social approval (Neff and Vonk 2009), and more positive reframing

(Sirois et al. 2015; Wong and Yeung 2017). Being less ego-defensive and better able to view negative situations in a positive light, self-compassionate individuals may, thus, view their stigma experience as less threatening. Indeed, some studies also show brief self-compassion trainings could reduce defensiveness in the face of social threat. Participants who were asked to listen to the loving kindness meditation audio recording reported less sympathetic nervous system responses (i.e., lower levels of salivary alpha amylase) in a tier social stress test than those who were asked to listen to an attention control audiorecording (Arch et al. 2014, 2016).

In terms of secondary appraisal, self-compassionate individuals may perceive having more resources to cope with public stigma. Empirical studies have shown that self-compassion is associated with more intrapersonal resources such as self-efficacy, autonomy, sense of coherence, cognitive flexibility, and adaptive coping (Akin 2008; Costa and Pinto-Gouveia 2013; Iskender 2009; Martin et al. 2011; Neff et al. 2005; Sirois et al. 2015; Ying 2009), as well as more interpersonal resources such as perceived social support and sense of community (Akin and Akin 2015; Brodar et al. 2015; Jeon et al. 2016; Maheux and Price 2016). Other studies also showed that self-compassionate individuals are motivated to change for the better when their personal weaknesses are acknowledged (Breines and Chen 2012). As such, self-compassionate individuals may be less likely to feel defeated by public stigma. They may consider those negative stereotypes as qualities that are changeable and can be improved upon. Thus, they are less likely to be emotionally drained by public stigma.

Benefit-Finding

Adversity may not necessarily impede individuals from pursuing happiness and positive outcomes if they can derive a purpose in their suffering and see their stressors in a positive light. Benefit-finding is the process of identifying positive ways in which individuals' lives have changed as a result of negative life events (Helgeson et al. 2006). It allows individuals to rebuild their worldview and reconstruct their life structure, which has once been disrupted by the life stressors that they have encountered (Tedeschi and Calhoun 2004). It also guides individuals to gain insights from their negative experiences and move forward (Cadell et al. 2014; Larner and Blow 2011; Park 1998; Schmidt et al. 2012; Tedeschi and Calhoun 2004). Indeed, the adaptive roles of benefit-finding in the face of adversity have been well-documented in the literature. For example, benefit finding is significantly associated with reduced distress, reduced depressive symptoms, and better well-being (see Helgeson et al. 2006; for a review).

The advantages of benefit-finding in adversity coping may also be extended to stigma coping. Theoretically, benefit-finding helps individuals to realize that their stigma experience may not be entirely negative and that the stigmatized identity may have positively transformed parts of their life in ways that they would not, otherwise, experience. For instance, they may gain new possibilities, recognize personal strength, experience spiritual change, and have a better appreciation of life (Tedeschi and Calhoun 1996). Also, benefit-finding may remind individuals that having a purposeful life in the presence of stigma is possible. These positive mentalities may, in turn, provide stigmatized individuals with strength and indignation that allow them to stand tall against public stigma. Indeed, indirect evidence of the association between benefit-finding and self-stigma has been revealed in the literature. For example, benefit-finding has been shown to be positively associated with self-esteem and/ or self-efficacy (i.e., indicators of low self-stigma) in samples with stigmatized identities, including people with psychosis and people living with HIV (Luszczynska et al. 2007; Mazor et al. 2016). Further, a self-stigma reduction intervention (Narrative Enhancement Cognitive Therapy) that emphasizes constructing meaning out of individuals' stigma experience, has been found to be effective in reducing self-stigma, improving self-esteem, and quality of life among individuals with mental illnesses (Roe et al. 2010).

Self-compassion may facilitate benefit-finding among stigmatized individuals by allowing self-distancing. Self-distancing is an approach to take a step back when thinking and reasoning about one's past experiences (Kross and Ayduk 2011). Research has shown that participants who were asked to analyze their intense negative experiences from a self-distanced perspective were more capable of reconstructing their experiences in ways that bring insights and closure, compared with those who were asked to analyze their experiences from a self-immersed perspective (Kross and Ayduk 2008; Kross et al. 2005). Self-compassion offers the self with unconditional warmth and understanding, which in turn, allows emotional equanimity and psychological distance for stigmatized individuals to see the self and reality clearly (Allen and Leary 2010; Neff et al. 2005). Self-compassionate individuals may thus find it easier to derive benefits from their stigma experiences, and may be less likely to experience self-stigma and other associated negative outcomes when they encounter public stigma. Indeed, the association between self-compassion and positive reframing has been evidenced in research (Sirois et al. 2015; Thompson and Waltz 2008; Wong and Yeung 2017).

Emotional Mechanisms Through Which Self-Compassion Buffers Stigma

Emotional Processing

Emotional processing is defined as an active attempt to acknowledge and understand one's emotions (Stanton et al. 2000b), and has been shown to be an adaptive way to respond

to stressful events (Berghuis and Stanton 2002; Cho et al. 2013; Smith et al. 2002; Stanton et al. 2000a). However, the negative emotions associated with stigma can be overwhelming such that many stimgatized individuals would prefer to avoid their stigma-related thoughts and emotions over directly confronting them (Miller and Kaiser 2001). Avoidance and suppression are two common responses toward stigma (Hatzenbuehler et al. 2009a; Miller and Kaiser 2001). Avoidance refers to any efforts that minimize contact with potentially stigmatizing thoughts and social encounters (Abiri et al. 2016); suppression is the tendency to inhibit stigma-related emotional expression (Gross 2001). While avoiding and suppressing thoughts and emotions related to stigma may offer stigmatized individuals temporary relief, rebound effect is likely to result (Miller and Kaiser 2001). An experimental study showed that participants who were asked to conceal their stigmatized identity (i.e., having eating disorders) in a conversation with a stranger reported experience of more stigma-related thoughts after the conversation, compared with those who were asked to disclose their stigmatized identity during the conversation (Smart and Wegner 1999). Therefore, deliberate emotional processing may bring more long-term benefits to stigmatized individuals than avoidance and suppression.

Self-compassion may facilitate emotional processing of stigma experience. Theoretically, self-compassion holds stigmatized individuals in mindful awareness, which is a non-judgmental and receptive mind state that allows individuals to observe their negative thoughts and feelings with openness and clarity. The pain resulting from public stigma can, thus, be adequately acknowledged, without suppression or exaggeration. Also, self-compassion entails recognizing suffering as a part of shared human experience, and being able to offer oneself gentleness and understanding in the face of suffering. These qualities allow stigmatized individuals to experience emotional equanimity, and hence more capacity to acknowledge and understand their emotions in the face of public stigma (Neff 2003a, b), instead of experiencing avoidance or suppression.

The association between self-compassion and emotional processing has been documented in the literature. Self-compassion has been found to be positively associated with emotional processing (Neff 2003a), and negatively associated with experiential avoidance (Costa and Pinto-Gouveia 2013) and avoidant coping strategies (Krieger et al. 2013; Neff et al. 2005; Seligowski et al. 2015; Thompson and Waltz 2008). Other experimental studies also showed that self-compassion trainings (e.g., mindfulness-based stress reduction; self-compassion therapy) can help reduce qualities that impede emotional processing such as fear of negative emotions and rumination (Robins et al. 2012; Saeinia et al. 2016).

Emotion Regulation

The social devaluing nature of stigma often arouses negative affect among stigmatized individuals; emotion regulation is, thus, essential for stigma coping (Crocker et al. 1998; Hatzenbuehler 2009; Major and O'Brien 2005). However, the experience of chronic stressors can lead to emotion regulation deficits (Cicchetti and Toth 2005). Encountering public stigma on a regular basis, stigmatized individuals may exhaust their emotion regulation capacities and resort to maladaptive emotion regulation responses (Baldofski et al. 2016; Hatzenbuehler 2009; Pachankis et al. 2015), and thus, experience self-stigma and negative outcomes.

Rumination is one maladaptive emotion regulation process that is frequently experienced by stigmatized individuals (Miller and Kaiser 2001). It is the tendency to passively and repetitively focus on one's distress and related circumstances (Nolen-Hoeksema et al. 2008). Expectations of social rejection and hypervigilance (Mays et al. 2007) are frequently accompanied by rumination, which in turn, exacerbates and prolongs psychological distress experienced by stigmatized individuals (Nolen-Hoeksema et al. 2008). Indeed, the mediating role of rumination in the association between public stigma and psychological distress has been empirically demonstrated in previous studies (Hatzenbuehler et al. 2009a, b).

Self-compassion is an adaptive emotion regulation strategy in coping with chronic stressors. Existing studies show that self-compassion helps regulate emotions among people with chronic physical or mental illnesses, caregivers of people with chronic diseases, and mental health care professionals (Costa and Pinto-Gouveia 2013; Finlay-Jones et al. 2015; Neff and Faso 2015; Olson et al. 2015; Scoglio et al. 2015; Shapiro et al. 2007; Sirois et al. 2015). In the same way, self-compassion may help stigma coping by facilitating emotion regulation. Theoretically, a self-compassionate attitude provides emotional equanimity that allows stigmatized individuals to bring awareness to their stigma-related thoughts and feelings, and approach their distress with kindness, understanding, a sense of shared humanity, and a balanced perspective (Neff 2003a, b). With a more adaptive approach to their distress, self-compassionate individuals may be less likely to ruminate over their stigma-related thoughts and feelings. Furthermore, self-compassionate individuals may be more capable of reframing and transforming negative cognitions and emotions into more positive ones (Neff 2003a), thereby attenuating internalized stigma and facilitating more effective coping with public stigma (Fredrickson 2001).

Indeed, the association between self-compassion and emotion regulation has been well-established in the literature. Correlational studies found that self-compassion is significantly associated with less rumination (Galla 2016; Krieger et al. 2013; Neff and Vonk 2009; Raes 2010), and higher levels of emotional intelligence and emotion regulation capacities (Finlay-Jones et al. 2015; Heffernan et al. 2010; Neff 2003a; Scoglio et al. 2015). Consistently, experimental studies show that self-compassion inductions (e.g., self-compassion writing, imagination of a compassionate observer, and loving

kindness meditation) can effectively buffer the effects of a negative mood induction (Diedrich et al. 2014; Hofmann et al. 2015; Leary et al. 2007), and enhance individuals' emotion regulation capacities (e.g., reduced difficulties regulating emotions, fear of emotions, and worry; Saeinia et al. 2016; Robins et al. 2012).

Social Mechanisms Through Which Self-Compassion Buffers Stigma

Social Support

Social support is an important coping resource (Sherbourne and Stewart 1991); emotional support may be particularly relevant in the context of stigma coping (Takada et al. 2014). According to social-cognitive processing theory (Lepore 2001), positive social interactions encourage individuals to express their concern over their stressors, which in turn, facilitates their cognitive and emotional processing of the stressful events and leads to better outcomes. Adequate social support may buffer individuals from the negative effect of public stigma. Indeed, the negative association between social support and self-stigma has been evidenced in both cross-sectional and longitudinal data (Galvan et al. 2008; Li et al. 2016; Mak and Kwok 2010; Mak et al. 2007; Takada et al. 2014). One study showed that social support could buffer the effect of anticipated stigma on stress among people living with HIV (Earnshaw et al. 2015). However, there is a caveat of utilizing social support. Solicitation of social support often requires personal disclosure (Hobfoll and London 1986), and it may be an uncomfortable act for some stigmatized individuals, especially for those who have a concealable stigmatized identity.

Self-compassion buffers the effects of public stigma on self-stigma and associated negative outcomes because it facilitates more social resources and more willingness to solicit help from others. Theoretically, self-compassion promotes a more balanced perspective on suffering and embraces a sense of common humanity. As such, individuals higher in self-compassion may, thus, be less likely to feel isolated and self-absorbed in their stigma experience. Self-compassion also makes it easier to acknowledge that other people also experience rejection, and that one is not alone in this experience. Thus, those higher in self-compassion may be less likely to withdraw themselves from the social environment, but be more aware of the availability of social support in their surroundings and more willing to solicit help from others. Indeed, a few studies showed that self-compassionate individuals tend to have higher levels of perceived social support (Brodar et al. 2015; Jeon et al. 2016; Maheux and Price 2016), greater sense of community (Akin and Akin 2015), and lower levels of loneliness (Akin 2010) than less self-compassionate individuals. In addition, preliminary evidence has found that self-compassionate individuals perceive more benefits of personal disclosure (Wong et al. in preparation), and that HIV-infected individuals with higher levels of self-compassion are more willing to disclose their HIV status (Brion et al. 2014).

Forgiveness

Blame and feelings of resentment are common responses to interpersonal stressors such as perceived transgressions, offenses, and wrongs (Berry et al. 2001), which are often associated with negative outcomes (Worthington and Scherer 2004). It has been suggested and evidenced that forgiving a transgressor is associated with better health outcomes (e.g., reduced sympathetic nervous system, lower blood pressure; Huang and Enright 2000; Witvliet et al. 2001; Worthington and Scherer 2004). There are robust benefits of forgiveness on physical and mental health (for a review, see Riek and Mania 2012). Stigma is a severe interpersonal stressor; forgiveness may be a direct way to resolve public stigma, and reduce stigma internalization. Indeed, a cross-sectional study showed that forgiveness is associated with better adjustment among stigmatized individuals such as African Americans (Erguner-Tekinalp 2009). Consistently, an experimental study showed people with high levels of dispositional forgiveness tend to view a racially discriminating event as less intense, and experience less negative emotions as a result (Burrow and Hill 2012).

Empirical studies showed that forgiveness is less likely to occur when individuals experience threatened self-esteem (Strelan and Zdaniuk 2015), identify strongly with the victim group (Wohl and Branscombe 2005) or have a tendency to ruminate over past offenses (Berry et al. 2001; Kachadourian et al. 2005; Riek and Mania 2012; Ysseldyk et al. 2007). Vice versa, forgiveness is more likely to occur when individuals experience higher levels of empathy or perspective taking (Berecz 2001; Hodgson and Wertheim 2007; McCullough et al. 1997; Riek and Mania 2012), and attribute the offense as unintentional (Fehr et al. 2010; Riek and Mania 2012).

Not taking one's stigma experience too personally and forgiving others' stigmatizing acts may be one major way through which self-compassion helps buffer the impact of public stigma. Self-compassionate individuals tend to have lower levels of public self-consciousness (Barnard and Curry 2011; Neff and Vonk 2009), but higher levels of social safeness (i.e., experiences and perceptions about one's social world as safe, warm, and soothing; Akin and Akin 2015). Thus, they may be less likely to perceive stigma as ego-threatening or to over-identify with the stigmatized identity. Also, self-compassionate individuals have a lower tendency to ruminate, which is commonly associated with being less forgiving (Liao et al. 2015; Neff and Vonk 2009). In addition, embracing the idea that everyone deserves care and warmth (Neff 2003b), self-compassionate individuals may be more likely to forgive interpersonal transgressions. Empirical

studies showed that self-compassionate individuals have higher levels of perspective taking and forgiveness (Chung 2016; Neff and Pommier 2013), and they also tend to employ more adaptive conflict resolution styles (more compromise and less self-subordination; Yarnell and Neff 2013) than less self-compassionate others.

Summary

While research on self-compassion and stigma has been limited, preliminary evidence suggests that self-compassion is an important coping resource for stigmatized individuals. Reviewing the existing body of literature on self-compassion and stigma, there seems to be multiple pathways (cognitive, emotional, and social processes) through which self-compassion may buffer the effects of public stigma on self-stigma and associated negative outcomes. While more research is warranted, this conceptual model has both theoretical and clinical implications.

Theoretical Implications and Future Directions

The application of self-compassion in coping with stigma has a strong theoretical foundation but remains an understudied topic. This paper attempted to expand on Link's modified labeling theory (Link 1982; Link et al. 1989) by incorporating self-compassion as a moderator of the effects of public stigma on self-stigma and the associated negative outcomes. By integrating existing literature in self-compassion and stigma, the conceptual mediated moderation model of self-compassion and stigma may shed some light on the underlying mechanisms through which self-compassion may weaken the effects of public stigma on self-stigma and the associated negative outcomes. Guided by the conceptual model by Hatzenbuehler (2009), three major pathways have been identified: cognitive, emotional, and social pathways.

Among the three major pathways, the emotional pathways (emotional processing and emotional regulation) are relatively well established. These processes are grounded in emotional processing theory (Miller and Kaiser 2001; Stanton et al. 2000b). Experimental studies have also consistently shown that self-compassion training improve regulation of negative moods (Diedrich et al. 2014; Hofmann et al. 2015; Leary et al. 2007). Other studies have also shown that self-compassion trainings can promote individuals' capacities to process and regulate emotions (e.g., reduced fear of emotions, worry, aggressive anger expression, and difficulties regulating emotions; Saeinia et al. 2016; Robins et al. 2012). One of the critical gaps in the existing literature is that emotional pathways have rarely been examined among stigmatized individuals, and their effect on stigma coping remains unknown. Future research should replicate existing research and more specifically examine whether self-compassion trainings improve emotion regulation capacities among stigmatized individuals, and, in turn, reduce self-stigma and other associated negative outcomes.

Existing theories/literature on stigma and stress coping (e.g., self-affirmation theory, stress and coping model; Lazarus and Folkman 1984; Steele 1988) have provided theoretical support for the proposed cognitive pathways. While research on the cognitive pathways has been relatively limited, compared to research on the emotional pathways, there is some empirical support in the literature. Self-compassion has been found to be significantly associated with qualities that are closely tied to the proposed cognitive processes, including intrinsic self-affirmation (e.g., integrative self-knowledge, ego-integrity; Ghorbani et al. 2012; Phillips and Ferguson 2013), stress appraisal (e.g., reduced ego defensiveness, increased perceived coping resources; Akin 2008; Brodar et al. 2015; Iskender 2009; Jeon et al. 2016; Maheux and Price 2016; Neff and Vonk 2009), and benefit-finding (Wong and Yeung 2017). However, research that has examined associations between self-compassion and these cognitive processes has mostly used cross-sectional designs. So far, an experimental design has only been utilized in the examination of the intrinsic self-affirmation process (Lindsay and Creswell 2014; Smeets et al. 2014). Therefore, more evidence is still needed to evaluate the remaining understudied cognitive processes (i.e., stress appraisal and benefit-finding).

Among the three proposed mechanisms, the social pathways are relatively unexplored. This may be due at least in part to the fact that the self-compassion literature has focused on the impact of self-compassion on the self and its impact on interpersonal behavior has not been researched until recently. While the number of studies has been very limited, preliminary evidence from cross-sectional studies suggests that self-compassion is associated with more perceived social support, more personal disclosure, and more forgiveness (Brion et al. 2014; Brodar et al. 2015; Chung 2016; Jeon et al. 2016; Maheux and Price 2016; Neff and Pommier 2013). Considering the nature of self-compassion and these social processes, it seems plausible that social support and forgiveness may enhance individuals' self-compassion, instead of the opposite. Future research could adopt experimental designs to investigate the directionality of influence between self-compassion and these social processes. For instance, future studies may examine the effectiveness of self-compassion trainings on changing individuals' perception of social networks (e.g., perceived supportiveness) and their willingness to forgive interpersonal transgressions (e.g., verbal abuse, deception, broken promises).

Finally, this conceptual mediated moderation model focuses on mechanisms that are shared among the self-compassion literature and the stigma literature. Given that self-compassion

research is relatively young in the field, there may be alternative processes through which self-compassion can help reduce self-stigma and negative outcomes. For instance, empowerment, self-efficacy, and hope have been extensively studied in the stigma literature (Livingston and Boyd 2010), but their associations with self-compassion have not been examined. Future studies should continue to explore alternative underlying pathways of self-compassion, which are not included in this proposed model. Indeed, contemporary behavioral therapies such as ACT may shed some light on potential alternative pathways. Future research should integrate models of clinical behavioral change with our proposed model to understand the roles of self-compassion in buffering individuals' stigma experience. Furthermore, with the recent debate about the dual process of self-compassion (e.g., Falconer et al. 2015; Gilbert 2009; Longe et al. 2010), future research should also explore potential differential implications of positive and negative dimensions of self-compassion on self-stigma—whether the positive and the negative dimensions of self-compassion will exert the same impact on reducing self-stigma and negative outcomes, and if so, whether the two dimensions will be mediated by the same underlying mechanisms.

Clinical Implications and Future Directions

There is some theoretical and empirical foundation for the potential use of self-compassion training(s) in reducing the impact of public stigma on self-stigma and the associated negative outcomes. A few ACT-based interventions have been found effective in reducing self-stigma and promoting well-being (e.g., increased quality of life, increased self-esteem, increased psychological flexibility, better health, reduced symptoms of depression, anxiety and stress, and reduced psychological distress) among people living with HIV/AIDS, individuals with substance abuse problems, and obese individuals and people with homosexual orientation (Lillis et al. 2009; Luoma et al. 2008; Luoma and Platt 2015; Skinta et al. 2015; Yadavaia and Hayes 2012).

Empirical studies that have explicitly examined the association between self-compassion and self-stigma have been very limited (Hilbert et al. 2015; Wong et al. 2016). While indirect evidence has been provided by other studies that demonstrate significant associations of self-compassion with constructs that are conceptually related to self-stigma (e.g., self-criticism, self-blame, and shame; Petrocchi et al. 2014; Reilly et al. 2013; Sirois et al. 2015; Wong and Mak 2013), most of these studies have used cross-sectional-designs, which prevents us from drawing any causal inferences between self-compassion and self-stigma. More basic research identifying causal directions and temporal associations between self-compassion and stigma is needed before undertaking larger-scaled self-stigma reduction interventions based on self-compassion.

First, experimental research designs (i.e., self-compassion induction) could be adopted in the investigation of the effect of self-compassion in reducing self-stigma and associated negative outcomes. These findings can provide more confidence in the directional association between self-compassion and self-stigma and help disentangle the effect of self-compassion from the effects of potential confounds (e.g., personality traits, childhood experience) on self-stigma. Second, the sustainability of self-compassion manipulation(s) should be examined. Public stigma is a chronic stressor, and thus a single, brief self-compassion training (e.g., 10-min loving kindness meditation, 15-min self-compassion writing, etc.) may only bring a short-term relief to stigmatized individuals. The effect may not be durable enough to help stigmatized individuals to cope with recurrent encounters of public stigma. Therefore, it is crucial to conduct longitudinal studies to identify self-compassion manipulation(s) that have sustainable effects in reducing self-stigma and associated negative outcomes. In addition, to enhance the cost-effectiveness of future interventions, the optimal dosage (e.g., frequency and duration of practice) of self-compassion training in maintaining low levels of self-stigma and other negative outcomes after the self-compassion trainings, should also be examined. Last but not least, self-compassion may not operate in the same way across stigmatized individuals. Instead of assuming that the effect of self-compassion is universal, future research should explore potential moderators in the effect of self-compassion trainings, such as the types of stigmatized identities, concealability of stigma, and fear of self-compassion (i.e., struggle in developing self-compassion, which may be caused by feelings of underserving of compassion and worries about lowering personal standards). Findings from this proposed research will provide important information and lay the foundation for future development of effective self-stigma-reduction interventions.

Other Methodological Considerations

Assessment

Based on the three-component theoretical framework, Neff (2003a) has developed a 26-item Self-Compassion Scale (SCS) to assess trait self-compassion. In this original study, confirmatory factor analyses (CFAs) were conducted to examine factor structure on each of the three proposed subscales (self-kindness vs. self-judgment, common humanity vs. isolation, and mindfulness vs. over-identification), and the results showed that one-factor models did not fit the data well, whereas two-factor models did. In other words, the findings indicated that the positive and negative items loaded on separate factors. CFAs were also conducted to examine the model fit of the six-factor model and the single higher-order factor model. Satisfactory model fit was found for both models, but the

six-factor model fits the data slightly better than the single higher-order factor model.

The findings in Neff's initial work did not provide strong evidence for the single higher-order factor model, and use of a total score of SCS has been criticized in later research. Other researchers have attempted to replicate the CFA findings of the single higher-order factor models, but failed to obtain satisfactory model fit (e.g., Costa et al. 2016; López et al. 2015; Williams et al. 2014). Other researchers conducted an exploratory factor analysis (EFA) and suggested that a two-factor model may be a better alternative (Brenner et al. 2017; López et al. 2015). This finding is in line with the neurobiological perspective that the soothing system and the threat system are dual processes that are not mutually exclusive (Falconer et al. 2015; Gilbert 2009; Longe et al. 2010). Emerging research also suggests that the positive and the negative dimensions of SCS have distinctive roles in mental health; the positive dimension tends to have stronger association with positive mental health outcomes while the negative dimension tends to have stronger association with psychopathologies (Gilbert et al. 2011; López et al. 2015; Muris and Petrocchi 2017; Phillips and Ferguson 2012). Therefore, researchers could consider different implications of the positive and the negative dimensions of SCS.

Experimental Manipulation

Participant recruitment is a major obstacle in advancing stigma research, especially among participants with a concealable stigmatized identity, such as mental illness and HIV (Pachankis 2007). As an alternative, researchers may consider conducting self-compassion and self-stigma research using experimental manipulations that create social rejection effects on college or community samples that should theoretically result in similar effects as those caused by a stigmatized identity. For instance, the cyberball paradigm is commonly adopted to examine the effect of social rejection (Williams et al. 2000). Examining the effect of self-compassion manipulation(s) in buffering the negative effect of social rejection on state self-esteem and self-efficacy (i.e., indicators of low self-stigma), and other negative outcomes may be helpful in providing indirect evidence to the protective role of self-compassion in stigma coping. Not restricted by participant recruitment, this approach may also help researchers to examine the underlying mechanisms of self-compassion on self-stigma more extensively.

Conclusion

Self-compassion may be a feasible alternative to reduce self-stigma and associated negative outcomes. However, given the dearth of studies in this area, future research should devote more effort to evaluate the proposed multi-mediation model, and its implications on the development of stigma reduction interventions.

Compliance with Ethical Standards

Conflict of Interest The authors declare that they have no conflicts of interest.

References

Abiri, S., Oakley, L. D., Hitchcock, M. E., & Hall, A. (2016). Stigma related avoidance in people living with severe mental illness (SMI): Findings of an integrative review. *Community Mental Health Journal, 52*(3), 251–261. https://doi.org/10.1007/s10597-015-9957-2.

Abramson, L. Y., Metalsky, G. I., & Alloy, L. B. (1989). Hopelessness depression: A theory-based subtype of depression. *Psychological Review, 96*(2), 358–372.

Akin, A. (2008). The scales of psychological well-being: A study of validity and reliability. *Educational Sciences: Theory and Practice, 8*(3), 741–750.

Akin, A. (2010). Self-compassion and loneliness. *International Online Journal of Educational Sciences, 2*(3), 702–718.

Akin, U., & Akin, A. (2015). Examining the predictive role of self-compassion on sense of community in Turkish adolescents. *Social Indicators Research, 123*(1), 29–38. https://doi.org/10.1007/s11205-014-0724-5.

Ali, A., Hassiotis, A., Strydom, A., & King, M. (2012). Self stigma in people with intellectual disabilities and courtesy stigma in family carers: A systematic review. *Research in Developmental Disabilities, 33*(6), 2122–2140. https://doi.org/10.1016/j.ridd.2012.06.013.

Allen, A. B., Goldwasser, E. R., & Leary, M. R. (2012). Self-compassion and well-being among older adults. *Self and Identity, 11*(4), 428–453. https://doi.org/10.1080/15298868.2011.595082.

Allen, A. B., & Leary, M. R. (2010). Self-compassion, stress, and coping. *Social and Personality Psychology Compass, 4*(2), 107–118. https://doi.org/10.1111/j.1751-9004.2009.00246.x.

Arch, J. J., Brown, K. W., Dean, D. J., Landy, L. N., Brown, K. D., & Laudenslager, M. L. (2014). Self-compassion training modulates alpha-amylase, heart rate variability, and subjective responses to social evaluative threat in women. *Psychoneuroendocrinology, 42*, 49–58.

Arch, J. J., Landy, L. N., & Brown, K. W. (2016). Predictors and moderators of biopsychological social stress responses following brief self-compassion meditation training. *Psychoneuroendocrinology, 69*, 35–40. https://doi.org/10.1016/j.psyneuen.2016.03.009.

Arndt, J., Schimel, J., Greenberg, J., & Pyszczynski, T. (2002). The intrinsic self and defensiveness: Evidence that activating the intrinsic self reduces self-handicapping and conformity. *Personality and Social Psychology Bulletin, 28*(5), 671–683.

Baldofski, S., Rudolph, A., Tigges, W., Herbig, B., Jurowich, C., Kaiser, S., . . . Hilbert, A. (2016). Weight bias internalization, emotion dysregulation, and non-normative eating behaviors in prebariatric patients. International Journal of Eating Disorders, 49(2), 180–185.

Barnard, L. K., & Curry, J. F. (2011). Self-compassion: Conceptualizations, correlates, & interventions. *Review of General Psychology, 15*(4), 289–303 http://dx.doi.org.ezproxy.lib.uh.edu/10.1037/a0025754.

Beck, A. T., Rush, A. J., Shaw, B. F., & Emery, G. (1979). *Cognitive therapy of depression*. New York: Guilford Press.

Berecz, J. M. (2001). All that glitters is not gold: Bad forgiveness is counseling and preaching. *Pastoral Psychology, 49*(4), 253–275.

Berghuis, J. P., & Stanton, A. L. (2002). Adjustment to a dyadic stressor: A longitudinal study of coping and depressive symptoms in infertile

couples over an insemination attempt. *Journal of Consulting and Clinical Psychology, 70*(2), 433–438. https://doi.org/10.1037//0022-006X.70.2.433.

Berjot, S., & Gillet, N. (2011). Discrimination and stigmatization. *Frontiers in Psychology, 2*, 33.

Berry, J. W., Worthington Jr., E. L., Parrott III, L., O'Connor, L., & Wade, N. G. (2001). Dispositional forgivingness: Development and construct validity of the Transgression Narrative Test of Forgivingness (TNTF). *Personality and Social Psychology Bulletin, 27*(10), 1277–1290.

Bishop, S. R., Lau, M., Shapiro, S., Carlson, L., Anderson, N. D., Carmody, J., . . . Devins, G. (2004). Mindfulness: A proposed operational definition. Clinical Psychology: Science and Practice, 11(3), 230–241.

Boyd, J. E., Adler, E. P., Otilingam, P. G., & Peters, T. (2014). Internalized Stigma of Mental Illness (ISMI) scale: A multinational review. *Comprehensive Psychiatry, 55*(1), 221–231.

Breines, J. G., & Chen, S. (2012). Self-compassion increases self-improvement motivation. *Personality and Social Psychology Bulletin, 38*(9), 1133–1143. https://doi.org/10.1177/0146167212445599.

Brenner, R. E., Heath, P. J., Vogel, D. L., & Credé, M. (2017). Two is more valid than one: Examining the factor structure of the Self-Compassion Scale (SCS). *Journal of Counseling Psychology, 64*(6), 696–707.

Brion, J. M., Leary, M. R., & Drabkin, A. S. (2014). Self-compassion and reactions to serious illness: The case of HIV. *Journal of Health Psychology, 19*(2), 218–229. https://doi.org/10.1177/1359105312467391.

Brodar, K. E., Crosskey, B. L., & Thompson Jr., R. J. (2015). The relationship of self-compassion with perfectionistic self-presentation, perceived forgiveness, and perceived social support in an undergraduate Christian community. *Journal of Psychology & Theology, 43*(4), 232–242.

Burrow, A. L., & Hill, P. L. (2012). Flying the unfriendly skies?: The role of forgiveness and race in the experience of racial microaggressions. *Journal of Social Psychology, 152*(5), 639–653.

Cadell, S., Hemsworth, D., Smit Quosai, T., Steele, R., Davies, E., Liben, S., . . . Siden, H. (2014). Posttraumatic growth in parents caring for a child with a life-limiting illness: A structural equation model. American Journal of Orthopsychiatry, 84(2), 123–133.

Camp, D. L., Finlay, W. M. L., & Lyons, E. (2002). Is low self-esteem an inevitable consequence of stigma? An example from women with chronic mental health problems. *Social Science & Medicine, 55*(5), 823–834. https://doi.org/10.1016/S0277-9536(01)00205-2.

Carrasco, L. F., Martin, N., & Molero, F. (2013). Stigma consciousness and quality of life in persons with physical and sensory disability. *Revista de Psicologia Social, 28*(3), 259–271.

Chambers, S. K., Dunn, J., Occhipinti, S., Hughes, S., Baade, P., Sinclair, S., & O'Connell, D. L. (2012). A systematic review of the impact of stigma and nihilism on lung cancer outcomes. *BMC Cancer, 12*(1), 184. https://doi.org/10.1186/1471-2407-12-184.

Cho, D., Park, C. L., & Blank, T. O. (2013). Emotional approach coping: Gender differences on psychological adjustment in young to middle-aged cancer survivors. *Psychology & Health, 28*(8), 874–894. https://doi.org/10.1080/08870446.2012.762979.

Chung, M. S. (2016). Relation between lack of forgiveness and depression: The moderating effect of self-compassion. *Psychological Reports, 119*(3), 573–585.

Cicchetti, D., & Toth, S. L. (2005). Child maltreatment. *Annual Review of Clinical Psychology, 1*, 409–438. https://doi.org/10.1146/annurev.clinpsy.1.102803.144029.

Cook, J. E., Purdie-Vaughns, V., Meyer, I. H., & Busch, J. T. (2014). Intervening within and across levels: A multilevel approach to stigma and public health. *Social Science & Medicine, 103*, 101–109. https://doi.org/10.1016/j.socscimed.2013.09.023.

Corrigan, P. W., Kerr, A., & Knudsen, L. (2005). The stigma of mental illness: Explanatory models and methods for change. *Applied and Preventive Psychology, 11*(3), 179–190. https://doi.org/10.1016/j.appsy.2005.07.001.

Corrigan, P. W., Kosyluk, K. A., & Rüsch, N. (2013). Reducing self-stigma by coming out proud. *American Journal of Public Health, 103*(5), 794–800. https://doi.org/10.2105/AJPH.2012.301037.

Corrigan, P. W., & Watson, A. C. (2002). The paradox of self-stigma and mental illness. *Clinical Psychology: Science and Practice, 9*(1), 35–53. https://doi.org/10.1093/clipsy.9.1.35.

Costa, J., & Pinto-Gouveia, J. (2013). Experiential avoidance and self-compassion in chronic pain. *Journal of Applied Social Psychology, 43*(8), 1578–1591. https://doi.org/10.1111/jasp.12107.

Costa, J., Marôco, J., Pinto-Gouveia, J., Ferreira, C., & Castilho, P. (2016). Validation of the psychometric properties of the Self-Compassion Scale. Testing the factorial validity and factorial invariance of the measure among borderline personality disorder, anxiety disorder, eating disorder and general populations. *Clinical Psychology & Psychotherapy, 23*(5), 460–468.

Creswell, J. D., Welch, W. T., Taylor, S. E., Sherman, D. K., Gruenewald, T. L., & Mann, T. (2005). Affirmation of personal values buffers neuroendocrine and psychological stress responses. *Psychological Science, 16*(11), 846–851.

Crocker, J., & Major, B. (1989). Social stigma and self-esteem: The self-protective properties of stigma. *Psychological Review, 96*(4), 608–630. https://doi.org/10.1037/0033-295X.96.4.608.

Crocker, J., Major, B., & Steele, C. (1998). Social stigma. In S. Fiske, D. Gilbert, & G. Lindzey (Eds.), *Handbook of social psychology* (4th ed., pp. 504–553). Boston: McGraw-Hill.

Deci, E., & Ryan, R. M. (1985). *Intrinsic motivation and self-determination in human behavior*. New York, NY: Pleum Press.

Denton, F. N., Rostosky, S. S., & Danner, F. (2014). Stigma-related stressors, coping self-efficacy, and physical health in lesbian, gay, and bisexual individuals. *Journal of Counseling Psychology, 61*(3), 383–391. https://doi.org/10.1037/a0036707.

Diedrich, A., Grant, M., Hofmann, S. G., Hiller, W., & Berking, M. (2014). Self-compassion as an emotion regulation strategy in major depressive disorder. *Behaviour Research and Therapy, 58*, 43–51. https://doi.org/10.1016/j.brat.2014.05.006.

Doyle, D. M., & Molix, L. (2015). Social stigma and sexual minorities' romantic relationship functioning: A meta-analytic review. *Personality and Social Psychology Bulletin, 41*(10), 1363–1381.

Earnshaw, V. A., & Quinn, D. M. (2012). The impact of stigma in healthcare on people living with chronic illnesses. *Journal of Health Psychology, 17*(2), 157–168. https://doi.org/10.1177/1359105311414952.

Earnshaw, V. A., Lang, S. M., Lippitt, M., Jin, H., & Chaudoir, S. R. (2015). HIV stigma and physical health symptoms: Do social support, adaptive coping, and/or identity centrality act as resilience resources? *AIDS and Behavior, 19*(1), 41–49.

Erguner-Tekinalp, B. (2009). Daily experiences of racism and forgiving historical offenses: An African American experience. *International Journal of Humanities and Social Science, 3*(9), 1784–1792.

Falconer, C. J., King, J. A., & Brewin, C. R. (2015). Demonstrating mood repair with a situation-based measure of self-compassion and self-criticism. *Psychology and Psychotherapy: Theory, Research and Practice, 88*(4), 351–365.

Fehr, R., Gelfand, M. J., & Nag, M. (2010). The road to forgiveness: A meta-analytic synthesis of its situational and dispositional correlates. *Psychological Bulletin, 136*(5), 894–914.

Feinstein, B. A., Goldfried, M. R., & Davila, J. (2012). The relationship between experiences of discrimination and mental health among lesbians and gay men: An examination of internalized homonegativity and rejection sensitivity as potential mechanisms. *Journal of Consulting and Clinical Psychology, 80*(5), 917–927. https://doi.org/10.1037/a0029425.

Fife, B. L., & Wright, E. R. (2000). The dimensionality of stigma: A comparison of its impact on the self of persons with HIV/AIDS and cancer. *Journal of Health and Social Behavior, 41*(1), 50–67 Retrieved from http://www.jstor.org/stable/2676360.

Finlay-Jones, A. L., Rees, C. S., & Kane, R. T. (2015). Self-compassion, emotion regulation and stress among Australian psychologists: Testing an emotion regulation model of self-compassion using structural equation modeling. *PLoS One, 10*(7). https://doi.org/10.1371/journal.pone.0133481.

Fredrickson, B. L. (2001). The role of positive emotions in positive psychology: The broaden-and-build theory of positive emotions. *American Psychologist, 56*(3), 218–226 http://dx.doi.org.ezproxy.lib.uh.edu/10.1037/0003-066X.56.3.218.

Fung, K. M., Tsang, H. W., & Cheung, W. M. (2011). Randomized controlled trial of the self-stigma reduction program among individuals with schizophrenia. *Psychiatry Research, 189*(2), 208–214.

Galla, B. M. (2016). Within-person changes in mindfulness and self-compassion predict enhanced emotional well-being in healthy, but stressed adolescents. *Journal of Adolescence, 49*, 204–217 http://dx.doi.org.ezproxy.lib.uh.edu/10.1016/j.adolescence.2016.03.016.

Galvan, F. H., Davis, E. M., Banks, D., & Bing, E. G. (2008). HIV stigma and social support among African Americans. *AIDS Patient Care and STDs, 22*(5), 423–436.

Gardner, W. L., Pickett, C. L., & Brewer, M. B. (2000). Social exclusion and selective memory: How the need to belong affects memory for social information. *Personality and Social Psychology Bulletin, 26*(4), 486–496.

Ghorbani, N., Watson, P. J., Chen, Z., & Norballa, F. (2012). Self-compassion in Iranian Muslims: Relationships with integrative self-knowledge, mental health, and religious orientation. *The International Journal for the Psychology of Religion, 22*(2), 106–118. https://doi.org/10.1080/10508619.2011.638601.

Gilbert, P. (2009). *The Compassionate Mind: A new Approach to the Challenge of Life*. London: Constable & Robinson.

Gilbert, P., & Irons, C. (2005). Therapies for shame and self-attacking, using cognitive, behavioural, emotional imagery and compassionate mind training. In *Compassion: conceptualisations, research and use in psychotherapy*. London: Routledge.

Gilbert, P., & Procter, S. (2006). Compassionate mind training for people with high shame and self-criticism: Overview and pilot study of a group therapy approach. *Clinical Psychology & Psychotherapy, 13*(6), 353–379. https://doi.org/10.1002/cpp.507.

Gilbert, P., McEwan, K., Matos, M., & Rivis, A. (2011). Fears of compassion: Development of three self-report measures. *Psychology and psychotherapy: Theory, Research and Practice, 84*(3), 239–255.

Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. New York: Prentice Hall.

Greco, L. A., Lambert, W., & Baer, R. A. (2008). Psychological inflexibility in childhood and adolescence: Development and evaluation of the Avoidance and Fusion Questionnaire for Youth. *Psychological Assessment, 20*(2), 93–102.

Green, S. E. (2003). "What do you mean 'what's wrong with her?'": Stigma and the lives of families of children with disabilities. *Social Science & Medicine, 57*(8), 1361–1374 http://dx.doi.org.ezproxy.lib.uh.edu/10.1016/S0277-9536(02)00511-7.

Gross, J. J. (2001). Emotion regulation in adulthood: Timing is everything. *Current Directions in Psychological Science, 10*(6), 214–219.

Hall, C. W., Row, K. A., Wuensch, K. L., & Godley, K. R. (2013). The role of self-compassion in physical and psychological well-being. *The Journal of Psychology, 147*(4), 311–323. https://doi.org/10.1080/00223980.2012.693138.

Hatzenbuehler, M. L. (2009). How does sexual minority stigma "get under the skin"? A psychological mediation framework. *Psychological Bulletin, 135*(5), 707–730. https://doi.org/10.1037/a0016441.

Hatzenbuehler, M. L., Dovidio, J. F., Nolen-Hoeksema, S., & Phills, C. E. (2009a). An implicit measure of anti-gay attitudes: Prospective associations with emotion regulation strategies and psychological distress. *Journal of Experimental Social Psychology, 45*(6), 1316–1320. https://doi.org/10.1016/j.jesp.2009.08.005.

Hatzenbuehler, M. L., Nolen-Hoeksema, S., & Dovidio, J. (2009b). How does stigma "get under the skin"? The mediating role of emotion regulation. *Psychological Science, 20*(10), 1282–1289. https://doi.org/10.1111/j.1467-9280.2009.02441.x.

Hayes, S. C., Barnes-Holmes, D., & Roche, B. (2001). *Relational frame theory: A past-Skinnerian account of human language and cognition*. New York: Kluwer Academic/ Plenum.

Hayes, S. C., Luoma, J. B., Bond, F. W., Masuda, A., & Lillis, J. (2006). Acceptance and commitment therapy: Model, processes and outcomes. *Behaviour Research and Therapy, 44*(1), 1–25.

Hayes, S. C., & Smith, S. (2005). *Get out of your mind and into your life: The new acceptance and commitment therapy*. Oaklands: New Harbinger Publications.

Hayes, S. C., Strosahl, K. D., & Wilson, K. G. (1999). *Acceptance and commitment therapy: An experiential approach to behavior change*. New York: Guilford Press.

Hayes, S. C., Strosahl, K. D., & Wilson, K. G. (2011). *Acceptance and commitment therapy: The process and practice of mindful change*. New York: Guilford Press.

Heath, P. J., Brenner, R. E., Lannin, D. G., & Vogel, D. L. (2016). Self-compassion moderates the relationship of perceived public and anticipated self-stigma of seeking help. *Stigma and Health*. https://doi.org/10.1037/sah0000072.

Heath, P. J., Brenner, R. E., Vogel, D. L., Lannin, D. G., & Strass, H. A. (2017). Masculinity and barriers to seeking counseling: The buffering role of self-compassion. *Journal of Counseling Psychology, 64*(1), 94–103.

Heffernan, M., Griffin, M. T. Q., McNulty, S. R., & Fitzpatrick, J. J. . (2010). Self-compassion and emotional intelligence in nurses. *International Journal of Nursing Practice, 16*(4), 366–373. https://doi.org/10.1111/j.1440-172X.2010.01853.x.

Heijnders, M., & Van Der Meij, S. (2006). The fight against stigma: An overview of stigma-reduction strategies and interventions. *Psychology, Health & Medicine, 11*(3), 353–363. https://doi.org/10.1080/13548500600595327.

Helgeson, V. S., Reynolds, K. A., & Tomich, P. L. (2006). A meta-analytic review of benefit finding and growth. *Journal of Consulting and Clinical Psychology, 74*(5), 797–816.

Higgins, E. T., King, G. A., & Mavin, G. M. (1982). Individual construct accessibility and subjective impressions and recall. *Journal of Personality and Social Psychology, 43*(1), 35–47.

Hilbert, A., Braehler, E., Schmidt, R., Lowe, B., Hauser, W., & Zenger, M. (2015). Self-compassion as a resource in the self-stigma process of overweight and obese individuals. *Obesity Facts, 8*(5), 293–301. https://doi.org/10.1159/000438681.

Hobfoll, S. E., & London, P. (1986). The relationship of self-concept and social support to emotional distress among women during war. *Journal of Social and Clinical Psychology, 4*(2), 189–203. https://doi.org/10.1521/jscp.1986.4.2.189.

Hodgson, L. K., & Wertheim, E. H. (2007). Does good emotion management aid forgiving? Multiple dimensions of empathy, emotion management, and forgiveness of self and others. *Journal of Social and Personal Relationships, 24*(6), 931–949.

Hofmann, S. G., Petrocchi, N., Steinberg, J., Lin, M., Arimitsu, K., Kind, S., et al. (2015). Loving-kindness meditation to target affect in mood disorders: A proof-of-concept study. *Evidence-based Complementary and Alternative Medicine, 2015*. https://doi.org/10.1155/2015/269126.

Huang, S. T. T., & Enright, R. D. (2000). Forgiveness and anger-related emotions in Taiwan: Implications for therapy. *Psychotherapy, 37*(1), 71–79.

Huebner, D. M., Nemeroff, C. J., & Davis, M. C. (2005). Do hostility and neuroticism confound associations between perceived discrimination and depressive symptoms? *Journal of Social and Clinical Psychology, 24*(5), 723–740.

Hulbert-Williams, N. J., Storey, L., & Wilson, K. G. (2015). Psychological interventions for patients with cancer: Psychological flexibility and the potential utility of acceptance and commitment therapy. *European Journal of Cancer Care, 24*(1), 15–27.

Iskender, M. (2009). The relationship between self-compassion, self-efficacy, and control belief about learning in Turkish university students. *Social Behavior and Personality: An International Journal, 37*(5), 711–720. https://doi.org/10.2224/sbp.2009.37.5.711.

Jeon, H., Lee, K., & Kwon, S. (2016). Investigation of the structural relationships between social support, self-compassion, and subjective well-being in Korean elite student athletes. *Psychological Reports, 119*(1), 39–54. https://doi.org/10.1177/0033294116658226.

Jones, E. E. (1984). *Social stigma: The psychology of marked relationships*. New York: WH Freeman.

Kabat-Zinn, J. (2003). Mindfulness-based interventions in context: Past, present, and future. *Clinical Psychology: Science and Practice, 10*(2), 144–156. https://doi.org/10.1093/clipsy.bpg016.

Kachadourian, L. K., Fincham, F., & Davila, J. (2005). Attitudinal ambivalence, rumination, and forgiveness of partner transgressions in marriage. *Personality and Social Psychology Bulletin, 31*(3), 334–342.

Kato, A., Takada, M., & Hashimoto, H. (2014). Reliability and validity of the Japanese version of the Self-Stigma Scale in patients with type 2 diabetes. *Health and Quality of Life Outcomes, 12*(1), 179. https://doi.org/10.1186/s12955-014-0179-z.

Kelly, A. C., & Tasca, G. A. (2016). Within-persons predictors of change during eating disorders treatment: An examination of self-compassion, self-criticism, shame, and eating disorder symptoms. *International Journal of Eating Disorders, 49*(7), 716–722.

Kim, M. A., & Yi, J. (2014). Life after cancer: How does public stigma increase psychological distress of childhood cancer survivors? *International Journal of Nursing Studies, 51*(12), 1605–1614. https://doi.org/10.1016/j.ijnurstu.2014.04.005.

Koschade, J. E., & Lynd-Stevenson, R. M. (2011). The stigma of having a parent with mental illness: Genetic attributions and associative stigma. *Australian Journal of Psychology, 63*(2), 93–99. https://doi.org/10.1111/j.1742-9536.2011.00009.x.

Krieger, T., Altenstein, D., Baettig, I., Doerig, N., & Holtforth, M. G. (2013). Self-compassion in depression: Associations with depressive symptoms, rumination, and avoidance in depressed outpatients. *Behavior Therapy, 44*(3), 501–513. https://doi.org/10.1016/j.beth.2013.04.004.

Kross, E., & Ayduk, O. (2008). Facilitating adaptive emotional analysis: Distinguishing distanced-analysis of depressive experiences from immersed-analysis and distraction. *Personality and Social Psychology Bulletin, 34*(7), 924–938.

Kross, E., & Ayduk, O. (2011). Making meaning out of negative experiences by self-distancing. *Current Directions in Psychological Science, 20*(3), 187–191.

Kross, E., Ayduk, O., & Mischel, W. (2005). When asking "why" does not hurt: Distinguishing rumination from reflective processing of negative emotions. *Psychological Science, 16*(9), 709–715.

Krupchanka, D., Kruk, N., Murray, J., Davey, S., Bezborodovs, N., Winkler, P., & Sartorius, N. (2016). Experience of stigma in private life of relatives of people diagnosed with schizophrenia in the Republic of Belarus. *Social Psychiatry and Psychiatric Epidemiology, 51*(5), 757–765. https://doi.org/10.1007/s00127-016-1190-y.

Lannin, D. G., Guyll, M., Vogel, D. L., & Madon, S. (2013). Reducing the stigma associated with seeking psychotherapy through self-affirmation. *Journal of Counseling Psychology, 60*(4), 508–519.

Larner, B., & Blow, A. (2011). A model of meaning-making coping and growth in combat veterns. *Review of General Psychology, 15*(3), 187–197.

Lazarus, R. S., & Folkman, S. (1984). *Stress, appraisal, and coping*. New York: Springer.

Leary, M. R., Tate, E. B., Adams, C. E., Allen, A. B., & Hancock, J. (2007). Self-compassion and reactions to unpleasant self-relevant events: The implications of treating oneself kindly. *Journal of Personality and Social Psychology, 92*(5), 887–904. https://doi.org/10.1037/0022-3514.92.5.887.

Lepore, S. J. (2001). A social-cognitive processing model of emotional adjustment to cancer. In A. Baum & B. L. Andersen (Eds.), *Psychosocial interventions for cancer* (pp. 99–116). Washington, DC: American Psychological Association.

Li, Z., Hsieh, E., Morano, J. P., & Sheng, Y. (2016). Exploring HIV-related stigma among HIV-infected men who have sex with men in Beijing, China: A correlation study. *AIDS Care*. https://doi.org/10.1080/09540121.2016.1179713.

Liao, K. Y. H., Kashubeck-West, S., Weng, C. Y., & Deitz, C. (2015). Testing a mediation framework for the link between perceived discrimination and psychological distress among sexual minority individuals. *Journal of Counseling Psychology, 62*(2), 226–241.

Lillis, J., Hayes, S. C., Bunting, K., & Masuda, A. (2009). Teaching acceptance and mindfulness to improve the lives of the obese: A preliminary test of a theoretical model. *Annals of Behavioral Medicine, 37*(1), 58–69.

Lindsay, E. K., & Creswell, J. D. (2014). Helping the self help others: Self-affirmation increases self-compassion and pro-social behaviors. *Frontiers in Psychology, 5*, 421.

Link, B. G. (1982). Mental patient status, work, and income: An examination of the effects of a psychiatric label. *American Sociological Review, 47*, 202–215 Retrieved from http://www.jstor.org/stable/2094963.

Link, B. G. (1987). Understanding labeling effects in the area of mental disorders: An assessment of the effects of expectations of rejection. *American Sociological Review, 52*(1), 96–112 Retrieved from http://www.jstor.org/stable/2095395.

Link, B. G., Cullen, F. T., Struening, E. L., Shrout, P. E., & Dohrenwend, B. P. (1989). A modified labeling theory approach to mental disorders: An empirical assessment. *American Sociological Review, 54*(3), 400–423 Retrieved from http://www.jstor.org/stable/2095613.

Livingston, J. D., & Boyd, J. E. (2010). Correlates and consequences of internalized stigma for people living with mental illness: A systematic review and meta-analysis. *Social Science & Medicine, 71*(12), 2150–2161. https://doi.org/10.1016/j.socscimed.2010.09.030.

Logie, C., & Gadalla, T. M. (2009). Meta-analysis of health and demographic correlates of stigma towards people living with HIV. *AIDS Care, 21*(6), 742–753. https://doi.org/10.1080/09540120802511877.

López, A., Sanderman, R., Smink, A., Zhang, Y., van Sonderen, E., Ranchor, A., et al. (2015). A reconsideration of the Self-Compassion Scale's total score: self-compassion versus self-criticism. *PloS one, 10*(7), e0132940. https://doi.org/10.1371/journal.pone.0132940.

Longe, O., Maratos, F. A., Gilbert, P., Evans, G., Volker, F., Rockliff, H., & Rippon, G. (2010). Having a word with yourself: Neural correlates of self-criticism and self-reassurance. *NeuroImage, 49*(2), 1849–1856.

Luoma, J. B., Kohlenberg, B. S., Hayes, S. C., Bunting, K., & Rye, A. K. (2008). Reducing self-stigma in substance abuse through acceptance and commitment therapy: Model, manual development, and pilot outcomes. *Addiction Research and Theory, 16*(2), 149–165. https://doi.org/10.1080/16066350701850295.

Luoma, J. B., & Platt, M. G. (2015). Shame, self-criticism, self-stigma, and compassion in acceptance and commitment therapy. *Current*

Opinion in Psychology, 2, 97–101. https://doi.org/10.1016/j.copsyc.2014.12.016.

Luszczynska, A., Sarkar, Y., & Knoll, N. (2007). Received social support, self-efficacy, and finding benefits in disease as predictors of physical functioning and adherence to antiretroviral therapy. *Patient Education and Counseling, 66*(1), 37–42.

Lyubomirsky, S., Tucker, K. L., Caldwell, N. D., & Berg, K. (1999). Why ruminators are poor problem solvers: Clues from the phenomenology of dysphoric rumination. *Journal of Personality and Social Psychology, 77*(5), 1041–1060.

MacBeth, A., & Gumley, A. (2012). Exploring compassion: A meta-analysis of the association between self-compassion and psychopathology. *Clinical Psychology Review, 32*(6), 545–552. https://doi.org/10.1016/j.cpr.2012.06.003.

Maheux, A., & Price, M. (2016). The indirect effect of social support on post-trauma psychopathology via self-compassion. *Personality and Individual Differences, 88*, 102–107. https://doi.org/10.1016/j.paid.2015.08.051.

Major, B., Kaiser, C. R., & McCoy, S. K. (2003b). It's not my fault: When and why attributions to prejudice protect self-esteem. *Personality and Social Psychology Bulletin, 29*(6), 772–781.

Major, B., & O'Brien, L. T. (2005). The social psychology of stigma. *Annual Review of Psychology, 56*, 393–421. https://doi.org/10.1146/annurev.psych.56.091103.070137.

Major, B., Quinton, W. J., & McCoy, S. K. (2002). Antecedents and consequences of attributions to discrimination: Theoretical and empirical advances. *Advances in Experimental Social Psychology, 34*, 251–330. https://doi.org/10.1016/S0065-2601(02)80007-7.

Major, B., Quinton, W. J., & Schmader, T. (2003a). Attributions to discrimination and self-esteem: Impact of group identification and situational ambiguity. *Journal of Experimental Social Psychology, 39*(3), 220–231. https://doi.org/10.1016/S0022-1031(02)00547-4.

Mak, W. W., & Kwok, Y. T. (2010). Internalization of stigma for parents of children with autism spectrum disorder in Hong Kong. *Social Science & Medicine, 70*(12), 2045–2051 http://dx.doi.org.ezproxy.lib.uh.edu/10.1016/j.socscimed.2010.02.023.

Mak, W. W., Poon, C. Y., Pun, L. Y., & Cheung, S. F. (2007). Meta-analysis of stigma and mental health. *Social Science & Medicine, 65*(2), 245–261. https://doi.org/10.1016/j.socscimed.2007.03.015.

Malli, M. A., Forrester-Jones, R., & Murphy, G. (2016). Stigma in youth with Tourette's syndrome: A systematic review and synthesis. *European Child & Adolescent Psychiatry, 25*(2), 127–139. https://doi.org/10.1007/s00787-015-0761-x.

Markowitz, F. E. (1998). The effects of stigma on the psychological well-being and life satisfaction of persons with mental illness. *Journal of Health and Social Behavior, 39*(4), 335–347 Retrieved from http://www.jstor.org/stable/2676342.

Martin, M. M., Staggers, S. M., & Anderson, C. M. (2011). The relationships between cognitive flexibility with dogmatism, intellectual flexibility, preference for consistency, and self-compassion. *Communication Research Reports, 28*(3), 275–280. https://doi.org/10.1080/08824096.2011.587555.

Mays, V. M., Cochran, S. D., & Barnes, N. W. (2007). Race, race-based discrimination, and health outcomes among African Americans. *Annual Review of Psychology, 58*, 201–225.

Mazor, Y., Gelkopf, M., Mueser, K. T., & Roe, D. (2016). Posttraumatic growth in psychosis. *Frontiers in Psychiatry, 7*, 202. https://doi.org/10.3389/fpsyt.2016.00202.

McCay, E. A., & Seeman, M. V. (1998). A scale to measure the impact of a schizophrenic illness on an individual's self-concept. *Archives of Psychiatric Nursing, 12*(1), 41–49.

McCullough, M. E., Worthington Jr., E. L., & Rachal, K. C. (1997). Interpersonal forgiving in close relationships. *Journal of Personality and Social Psychology, 73*(2), 321–336.

Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin, 129*(5), 674–697.

Miller, C. T., & Kaiser, C. R. (2001). A theoretical perspective on coping with stigma. *Journal of Social Issues, 57*(1), 73–92. https://doi.org/10.1111/0022-4537.00202.

Mittal, D., Sullivan, G., Chekuri, L., Allee, E., & Corrigan, P. W. (2012). Empirical studies of self-stigma reduction strategies: A critical review of the literature. *Psychiatric Services, 63*, 974–981. https://doi.org/10.1176/appi.ps.201100459.

Muñoz, M., Sanz, M., Pérez-Santos, E., & de los Ángeles Quiroga, M. (2011). Proposal of a socio–cognitive–behavioral structural equation model of internalized stigma in people with severe and persistent mental illness. *Psychiatry Research, 186*(2), 402–408. https://doi.org/10.1016/j.psychres.2010.06.019.

Muris, P., & Petrocchi, N. (2017). Protection or vulnerability? A meta-analysis of the relations between the positive and negative components of self-compassion and psychopathology. *Clinical Psychology & Psychotherapy, 24*(2), 373–383.

Neely, M. E., Schallert, D. L., Mohammed, S. S., Roberts, R. M., & Chen, Y. J. (2009). Self-kindness when facing stress: The role of self-compassion, goal regulation, and support in college students' well-being. *Motivation and Emotion, 33*(1), 88–97. https://doi.org/10.1007/s11031-008-9119-8.

Neff, K. D. (2003a). The development and validation of a scale to measure self-compassion. *Self and Identity, 2*(3), 223–250. https://doi.org/10.1080/15298860309027.

Neff, K. D. (2003b). Self-compassion: An alternative conceptualization of a healthy attitude toward oneself. *Self and Identity, 2*(2), 85–101. https://doi.org/10.1080/15298860309032.

Neff, K. D., & Vonk, R. (2009). Self-compassion versus global self-esteem: Two different ways of relating to oneself. *Journal of Personality, 77*(1), 23–50. https://doi.org/10.1111/j.1467-6494.2008.00537.x.

Neff, K. D., & Faso, D. J. (2015). Self-compassion and well-being in parents of children with autism. *Mindfulness, 6*(4), 938–947. https://doi.org/10.1007/s12671-014-0359-2.

Neff, K. D., Hsieh, Y. P., & Dejitterat, K. (2005). Self-compassion, achievement goals, and coping with academic failure. *Self and Identity, 4*(3), 263–287. https://doi.org/10.1080/13576500444000317.

Neff, K. D., & Pommier, E. (2013). The relationship between self-compassion and other-focused concern among college undergraduates, community adults, and practicing meditators. *Self and Identity, 12*(2), 160–176.

Neff, K. D., Rude, S. S., & Kirkpatrick, K. L. (2007). An examination of self-compassion in relation to positive psychological functioning and personality traits. *Journal of Research in Personality, 41*(4), 908–916.

Neff, K., & Tirch, D. (2013). Self-compassion and ACT. In T. B. Kashdan & J. Ciarrochi (Eds.), *Mindfulness, acceptance, and positive psychology: The seven foundations of well-being* (pp. 78–106).

Newcomb, M. E., & Mustanski, B. (2010). Internalized homophobia and internalizing mental health problems: A meta-analytic review. *Clinical Psychology Review, 30*(8), 1019–1029.

Nolen-Hoeksema, S. (1991). Responses to depression and their effects on the duration of depressive episodes. *Journal of Abnormal Psychology, 100*(4), 569–582.

Nolen-Hoeksema, S., Wisco, B. E., & Lyubomirsky, S. (2008). Rethinking rumination. *Perspectives on Psychological Science, 3*(5), 400–424.

Olson, K., Kemper, K. J., & Mahan, J. D. (2015). What factors promote resilience and protect against burnout in first-year pediatric and medicine-pediatric residents? *Journal of Evidence-Based Complementary & Alternative Medicine*. https://doi.org/10.1177/2156587214568894.

Pachankis, J. E. (2007). The psychological implications of concealing a stigma: A cognitive-affective-behavioral model. *Psychological Bulletin, 133*(2), 328–345. https://doi.org/10.1037/0033-2909.133.2.328.

Pachankis, J. E., Goldfried, M. R., & Ramrattan, M. E. (2008). Extension of the rejection sensitivity construct to the interpersonal functioning of gay men. *Journal of Consulting and Clinical Psychology, 76*(2), 306–317.

Pachankis, J. E., Rendina, H. J., Restar, A., Ventuneac, A., Grov, C., & Parsons, J. T. (2015). A minority stress—Emotion regulation model of sexual compulsivity among highly sexually active gay and bisexual men. *Health Psychology, 34*(8), 829–840.

Papadopoulos, S., & Brennan, L. (2015). Correlates of weight stigma in adults with overweight and obesity: A systematic literature review. *Obesity, 23*(9), 1743–1760.

Park, C. L. (1998). Implications of posttraumatic growth for individuals. In R. G. Tedeschi, C. L. Park, & L. G. Calhoun (Eds.), *Posttraumatic growth: Positive change in the aftermath of crisis* (pp. 153–177). Mahwah: Lawrence Erlbaum Associates, Inc..

Park, C. L. (2010). Making sense of the meaning literature: An integrative review of meaning making and its effects on adjustment to stressful life events. *Psychological Bulletin, 136*(2), 257–301.

Pasupathi, M. (2001). The social construction of the personal past and its implications for adult development. *Psychological Bulletin, 127*(5), 651–672.

Pérez-Garín, D., Molero, F., & Bos, A. E. (2015). Perceived discrimination, internalized stigma and psychological well-being of people with mental illness. *The Spanish Journal of Psychology, 18*, E75. https://doi.org/10.1017/sjp.2015.74.

Petrocchi, N., Ottaviani, C., & Couyoumdjian, A. (2014). Dimensionality of self-compassion: Translation and construct validation of the self-compassion scale in an Italian sample. *Journal of Mental Health, 23*(2), 72–77.

Phelan, S. M., Burgess, D. J., Puhl, R., Dyrbye, L. N., Dovidio, J. F., Yeazel, M., et al. (2015). The adverse effect of weight stigma on the well-being of medical students with overweight or obesity: Findings from a national survey. *Journal of General Internal Medicine, 30*(9), 1251–1258.

Phillips, W. J., & Ferguson, S. J. (2012). Self-compassion: A resource for positive aging. *Journals of Gerontology Series B: Psychological Sciences and Social Sciences, 68*(4), 529–539.

Phillips, W. J., & Ferguson, S. J. (2013). Self-compassion: A resource for positive aging. *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences, 68*(4), 529–539. https://doi.org/10.1093/geronb/gbs091.

Quinn, D. M., & Chaudoir, S. R. (2009). Living with a concealable stigmatized identity: The impact of anticipated stigma, centrality, salience, and cultural stigma on psychological distress and health. *Journal of Personality and Social Psychology, 97*(4), 634–651.

Quinn, D. M., & Crocker, J. (1999). When ideology hurts: Effects of belief in the protestant ethic and feeling overweight on the psychological well-being of women. *Journal of Personality and Social Psychology, 77*(2), 402–414.

Quinn, D. M., Williams, M. K., & Weisz, B. M. (2015). From discrimination to internalized mental illness stigma: The mediating roles of anticipated discrimination and anticipated stigma. *Psychiatric Rehabilitation Journal, 38*(2), 103–108.

Raes, F. (2010). Rumination and worry as mediators of the relationship between self-compassion and depression and anxiety. *Personality and Individual Differences, 48*(6), 757–761. https://doi.org/10.1016/j.paid.2010.01.023.

Raque-Bogdan, T. L., Ericson, S. K., Jackson, J., Martin, H. M., & Bryan, N. A. (2011). Attachment and mental and physical health: Self-compassion and mattering as mediators. *Journal of Counseling Psychology, 58*(2), 272. https://doi.org/10.1037/a0023041.

Reilly, E. D., Rochlen, A. B., & Awad, G. H. (2013). Men's self-compassion and self-esteem: The moderating roles of shame and masculine norm adherence. *Psychology of Men & Masculinity, 15*(1), 22–28.

Riek, B. M., & Mania, E. W. (2012). The antecedents and consequences of interpersonal forgiveness: A meta-analytic review. *Personal Relationships, 19*(2), 304–325.

Ritsher, J. B., & Phelan, J. C. (2004). Internalized stigma predicts erosion of morale among psychiatric outpatients. *Psychiatry Research, 129*(3), 257–265.

Robins, C. J., Keng, S. L., Ekblad, A. G., & Brantley, J. G. (2012). Effects of mindfulness-based stress reduction on emotional experience and expression: A randomized controlled trial. *Journal of Clinical Psychology, 68*(1), 117–131. https://doi.org/10.1002/jclp.20857.

Roe, D., Hasson-Ohayon, I., Derhi, O., Yanos, P. T., & Lysaker, P. H. (2010). Talking about life and finding solutions to different hardships: A qualitative study on the impact of narrative enhancement and cognitive therapy on persons with serious mental illness. *The Journal of Nervous and Mental Disease, 198*(11), 807–812.

Rüsch, N., Corrigan, P. W., Heekeren, K., Theodoridou, A., Dvorsky, D., Metzler, S., & Rössler, W. (2014a). Well-being among persons at risk of psychosis: The role of self-labeling, shame, and stigma stress. *Psychiatric Services, 65*(4), 483–489.

Rüsch, N., Corrigan, P. W., Powell, K., Rajah, A., Olschewski, M., Wilkniss, S., & Batia, K. (2009b). A stress-coping model of mental illness stigma: II. Emotional stress responses, coping behavior and outcome. *Schizophrenia Research, 110*(1), 65–71.

Rüsch, N., Corrigan, P. W., Wassel, A., Michaels, P., Olschewski, M., Wilkniss, S., & Batia, K. (2009a). A stress-coping model of mental illness stigma: I. Predictors of cognitive stress appraisal. *Schizophrenia Research, 110*(1), 59–64.

Rüsch, N., Müller, M., Lay, B., Corrigan, P. W., Zahn, R., Schönenberger, T., . . . Rössler, W. (2014b). Emotional reactions to involuntary psychiatric hospitalization and stigma-related stress among people with mental illness. European Archives of Psychiatry and Clinical Neuroscience, 264(1), 35–43.

Russinova, Z., Rogers, E. S., Gagne, C., Bloch, P., Drake, K. M., & Mueser, K. T. (2014). A randomized controlled trial of a peer-run antistigma photovoice intervention. *Psychiatric Services, 65*(2), 242–246.

Ryan, R. M., & Deci, E. L. (2008). From ego depletion to vitality: Theory and findings concerning the facilitation of energy available to the self. *Social and Personality Psychology Compass, 2*(2), 702–717.

Saeinia, M., Barjoee, L. K., & Bozorgi, Z. D. (2016). The effect of self-compassion training on the emotion regulation of married women who referred to counseling center. *International Journal of Humanities and Cultural Studies (IJHCS) ISSN 2356–5926, 2*(1), 726–735.

Schimel, J., Arndt, J., Pyszczynski, T., & Greenberg, J. (2001). Being accepted for who we are: evidence that social validation of the intrinsic self reduces general defensiveness. *Journal of Personality and Social Psychology, 80*(1), 35–52.

Schimel, J., Arndt, J., Banko, K. M., & Cook, A. (2004). Not all self-affirmations were created equal: The cognitive and social benefits of affirming the intrinsic (vs. extrinsic) self. *Social Cognition, 22*(1), 75–99.

Schmader, T., Croft, A., Whitehead, J., & Stone, J. (2013). A peek inside the targets' toolbox: How stigmatized targets deflect discrimination by invoking a common identity. *Basic and Applied Social Psychology, 35*(1), 141–149.

Schmidt, S. D., Blank, T. O., Bellizzi, K. M., & Park, C. L. (2012). The relationship of coping strategies, social support, and attachment style with posttraumatic growth in cancer survivors. *Journal of Health Psychology, 17*(7), 1033–1040.

Schoendorff, B., Webster, M., & Polk, K. (2014). Under the hood: Basic processes underlying the matrix. In K. Polk, B. Schoendorff, & K.

G. Wilson (Eds.), *The ACT matrix: A new approach to building psychological flexibility across settings and populations* (pp. 15–40). Oakland: New Harbinger.

Scoglio, A. A., Rudat, D. A., Garvert, D., Jarmolowski, M., Jackson, C., & Herman, J. L. (2015). Self-compassion and responses to trauma the role of emotion regulation. *Journal of Interpersonal Violence*, 1–21. https://doi.org/10.1177/0886260515622296.

Seligowski, A. V., Miron, L. R., & Orcutt, H. K. (2015). Relations among self-compassion, PTSD symptoms, and psychological health in a trauma-exposed sample. *Mindfulness, 6*(5), 1033–1041. https://doi.org/10.1007/s12671-014-0351-x.

Shapiro, S. L., Brown, K. W., & Biegel, G. M. (2007). Teaching self-care to caregivers: Effects of mindfulness-based stress reduction on the mental health of therapists in training. *Training and Education in Professional Psychology, 1*(2), 105. https://doi.org/10.1037/1931-3918.1.2.105.

Sharp, M. L., Fear, N. T., Rona, R. J., Wessely, S., Greenberg, N., Jones, N., & Goodwin, L. (2015). Stigma as a barrier to seeking health care among military personnel with mental health problems. *Epidemiologic Reviews, 37*(1), 144–162.

Sherbourne, C. D., & Stewart, A. L. (1991). The MOS social support survey. *Social Science & Medicine, 32*(6), 705–714.

Sherman, D. K., & Cohen, G. L. (2006). The psychology of self-defense: Self-affirmation theory. *Advances in Experimental Social Psychology, 38*, 183–242.

Showers, C. J., & Zeigler-Hill, V. (2003). Organization of self-knowledge: Features, functions, and flexibility. In M. R. Leary & J. P. Tangney (Eds.), *Handbook of self and identity* (pp. 47–67). New York, NY: US: Guilford Press.

Sirois, F. M., Molnar, D. S., & Hirsch, J. K. (2015). Self-compassion, stress, and coping in the context of chronic illness. *Self and Identity, 14*(3), 334–347. https://doi.org/10.1080/15298868.2014.996249.

Skinta, M. D., Brandrett, B. D., Schenk, W. C., Wells, G., & Dilley, J. W. (2014). Shame, self-acceptance and disclosure in the lives of gay men living with HIV: An interpretative phenomenological analysis approach. *Psychology & Health, 29*(5), 583–597.

Skinta, M. D., Lezama, M., Wells, G., & Dilley, J. W. (2015). Acceptance and compassion-based group therapy to reduce HIV stigma. *Cognitive and Behavioral Practice, 22*(4), 481–490.

Smart, L., & Wegner, D. M. (1999). Covering up what can't be seen: Concealable stigma and mental control. *Journal of Personality and Social Psychology, 77*(3), 474–486.

Smeets, E., Neff, K., Alberts, H., & Peters, M. (2014). Meeting suffering with kindness: Effects of a brief self-compassion intervention for female college students. *Journal of Clinical Psychology, 70*(9), 794–807.

Smith, J. A., Lumley, M. A., & Longo, D. J. (2002). Contrasting emotional approach coping with passive coping for chronic myofascial pain. *Annals of Behavioral Medicine, 24*(4), 326–335. https://doi.org/10.1207/S15324796ABM2404_09.

Stanton, A. L., Danoff-Burg, S., Cameron, C. L., Bishop, M., Collins, C. A., Kirk, S. B., ... , & Twillman, R. (2000a). Emotionally expressive coping predicts psychological and physical adjustment to breast cancer. Journal of Consulting and Clinical Psychology, 68(5), 875–882. doi:https://doi.org/10.1037//0022-006X.68.5.875.

Stanton, A. L., Kirk, S. B., Cameron, C. L., & Danoff-Burg, S. (2000b). Coping through emotional approach: Scale construction and validation. *Journal of Personality and Social Psychology, 78*(6), 1150–1169. https://doi.org/10.1037//0022-3514.78.6.1150.

Steele, C. M. (1988). The psychology of self-affirmation: Sustaining the integrity of the self. *Advances in Experimental Social Psychology, 21*, 261–302.

Strelan, P., & Zdaniuk, A. (2015). Threatened state self-esteem reduces forgiveness. *Self and Identity, 14*(1), 16–32.

Strosahl, K. D., & Robinson, P. J. (2009). Teaching ACT: To whom, why and how. In J. T. Blackledge, J. Ciarrochi, & F. P. Deane (Eds.), *Acceptance and commitment therapy: Contemporary theory, research and practice* (pp. 59–85). Bowen Hills, Qld: Australian Academic Press.

Takada, S., Weiser, S. D., Kumbakumba, E., Muzoora, C., Martin, J. N., Hunt, P. W., More Authors, & Tsai, A. C. (2014). The dynamic relationship between social support and HIV-related stigma in rural Uganda. *Annals of Behavioral Medicine, 48*(1), 26–37.

Tang, D., & Schmeichel, B. J. (2015). Self-affirmation facilitates cardiovascular recovery following interpersonal evaluation. *Biological Psychology, 104*, 108–115.

Tedeschi, R. G., & Calhoun, L. G. (1996). The posttraumatic growth inventory: Measuring the positive legacy of trauma. *Journal of Traumatic Stress, 9*(3), 455–471.

Tedeschi, R. G., & Calhoun, L. G. (2004). Posttraumatic growth: Conceptual foundations and empirical evidence. *Psychological Inquiry, 15*(3), 1–18.

Terry, M. L., & Leary, M. R. (2011). Self-compassion, self-regulation, and health. *Self and Identity, 10*(3), 352–362.

Thompson, B. L., & Waltz, J. (2008). Self-compassion and PTSD symptom severity. *Journal of Traumatic Stress, 21*(6), 556–558. https://doi.org/10.1002/jts.20374.

Tirch, D., Schoendorff, B., & Silberstein, L. R. (2014). *The ACT practitioner's guide to the science of compassion: Tools for fostering psychological flexibility*. Oakland: New Harbinger Publications.

Vartanian, L. R., & Porter, A. M. (2016). Weight stigma and eating behavior: A review of the literature. *Appetite, 102*, 3–14.

Vowles, K. E., Witkiewitz, K., Sowden, G., & Ashworth, J. (2014). Acceptance and commitment therapy for chronic pain: Evidence of mediation and clinically significant change following an abbreviated interdisciplinary program of rehabilitation. *The Journal of Pain, 15*(1), 101–113.

Wasylkiw, L., & Clairo, J. (2016). Help seeking in men: When masculinity and self-compassion collide. *Psychology of Men & Masculinity*. https://doi.org/10.1037/men0000086.

Waugh, O. C., Byrne, D. G., & Nicholas, M. K. (2014). Internalized stigma in people living with chronic pain. *The Journal of Pain, 15*(5), 550–e551.

Williams, K. D., Cheung, C. K. T., & Choi, W. (2000). Cyberostracism: Effects of being ignored over the Internet. *Journal of Personality and Social Psychology, 79*(5), 748–762.

Williams, M. J., Dalgleish, T., Karl, A., & Kuyken, W. (2014). Examining the factor structures of the five facet mindfulness questionnaire and the self-compassion scale. *Psychological Assessment, 26*(2), 407–418.

Witvliet, C. V. O., Ludwig, T. E., & Vander Laan, K. L. (2001). Granting forgiveness or harboring grudges: Implications for emotion, physiology, and health. *Psychological Science, 12*(2), 117–123.

Wohl, M. J., & Branscombe, N. R. (2005). Forgiveness and collective guilt assignment to historical perpetrator groups depend on level of social category inclusiveness. *Journal of Personality and Social Psychology, 88*(2), 288–303.

Wong, C. C. Y., & Mak, W. W. S. (2013). Differentiating the role of three self-compassion components in buffering cognitive-personality vulnerability to depression among Chinese in Hong Kong. *Journal of Counseling Psychology, 60*(1), 162–169.

Wong, C. C. Y., Mak, W. W. S., & Liao, K. Y. H. (2016). Self-compassion: A potential buffer against affiliate stigma experienced by parents of children with autism spectrum disorders. *Mindfulness, 7*(6), 1385–1395.

Wong, C. C. Y., Petit, W., Zhang, R. R., & Mak, W. W. S. (in preparation). Self-love to conquer stigma: A mediation model to understand the relationship between self-compassion and help-seeking intention.

Wong, C. C. Y., & Yeung, N. C. Y. (2017). Self-compassion and posttraumatic growth: Cognitive processes as mediators. *Mindfulness*. https://doi.org/10.1007/s12671-017-0683-4.

Worthington, E. L., & Scherer, M. (2004). Forgiveness is an emotion-focused coping strategy that can reduce health risks and promote health resilience: Theory, review, and hypotheses. *Psychology & Health, 19*(3), 385–405.

Yadavaia, J. E., & Hayes, S. C. (2012). Acceptance and commitment therapy for self-stigma around sexual orientation: A multiple baseline evaluation. *Cognitive and Behavioral Practice, 19*(4), 545–559.

Yanos, P. T., Lucksted, A., Drapalski, A. L., Roe, D., & Lysaker, P. (2015). Interventions targeting mental health self-stigma: A review and comparison. *Psychiatric Rehabilitation Journal, 38*(2), 171–178.

Yanos, P. T., Roe, D., Markus, K., & Lysaker, P. H. (2008). Pathways between internalized stigma and outcomes related to recovery in schizophrenia spectrum disorders. *Psychiatric Services, 59*(12), 1437–1442.

Yarnell, L. M., & Neff, K. D. (2013). Self-compassion, interpersonal conflict resolutions, and well-being. *Self and Identity, 12*(2), 146–159.

Ying, Y. W. (2009). Contribution of self-compassion to competence and mental health in social work students. *Journal of Social Work Education, 45*(2), 309–323.

Ysseldyk, R., Matheson, K., & Anisman, H. (2007). Rumination: Bridging a gap between forgivingness, vengefulness, and psychological health. *Personality and Individual Differences, 42*(8), 1573–1584.

Zessin, U., Dickhäuser, O., & Garbade, S. (2015). The relationship between self-compassion and well-being: A meta-analysis. *Applied Psychology Health and Well-Being, 7*(3), 340–364.