Self-compassion, camouflaging, and mental health in autistic adults

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Abstract

Background: Previous research shows that symptoms of anxiety and depression are positively correlated with camouflaging and negatively correlated with self-compassion in autistic adults. However, no study to date has considered the inter-relationships between autistic traits, camouflaging, self-compassion, and mental health in autistic adults.

Methods: In this study, autistic adults (N = 294) completed demographics (sex, age, and ethnicity), the Autism Spectrum Quotient, the Camouflaging Autistic Traits-Questionnaire, the Self-Compassion Scale, the Generalised Anxiety Disorder-7 Scale, the Patient Health Questionnaire-9 and the Liebowitz Social Anxiety Scale.

Results: We found a negative correlation between social camouflaging and self-compassion ($r_{partial}$=-.483, p<.001). Serial mediation analyses revealed that camouflaging and self-compassion may indirectly influence the association between autistic traits and mental health outcomes both independently and through each other.

Conclusions: The findings of this research provide greater insight into the mental health experiences of autistic adults and can inform the development of tailored interventions that target camouflaging and self-compassion.

Community Brief

“Why is this an important issue?”

Many autistic people are diagnosed with mental health conditions such as anxiety or depression. Previous research has shown that camouflaging and self-compassion are related to these mental health outcomes. The identification of possible intervention targets to improve mental health is important to effectively support autistic adults.

“What was the purpose of this study?”

The purpose of this study was to first establish whether there is a relationship between camouflaging autistic traits and levels of self-compassion, and, if there is, to examine the processes through which these variables may influence social anxiety, general anxiety, and depression.

"What did the researchers do?"

We designed an online survey and asked autistic adults to complete this survey. The participants responded to a series of questionnaires measuring personal information (sex, age, ethnicity, and health diagnoses), as well as their levels of autistic traits, social camouflaging, self-compassion, and three mental health outcomes: social anxiety, general anxiety, and depression. In total, 294 autistic adults completed the survey.

"What were the results of the study?"

We found a relationship between self-compassion and camouflaging, such that individuals who camouflaged more reported lower self-compassion. We also found that the connection between camouflaging and self-compassion could play an important role in how autistic traits are linked to mental well-being.

"What do these findings add to what was already known?"

Previous studies have investigated self-compassion and camouflaging in autistic people separately, but no study to date has looked at them together. The statistical analyses that we carried out showed that levels of self-compassion and camouflaging may influence the relationship between autistic traits and mental health outcomes. Specifically, this relationship appears to work both ways, meaning that camouflaging behaviours and self-compassion might

have an influence on each other, influencing the overall relationship between autistic traits and mental health.

“What are potential weaknesses in the study?”

The study has several potential weaknesses related to the online survey design and how we collected the data. We were unable to conduct diagnostic assessments to confirm the participant’s autism diagnosis and relied on their self-reported diagnosis. Also, the data were collected at one point in time, which makes it more difficult to determine the direction of the relationships between the variables.

“How will these findings help autistic adults now or in the future?”

This study provides a more nuanced understanding of the relationships between camouflaging one’s autistic traits, self-compassion, and mental health outcomes. Importantly, we have presented preliminary evidence that self-compassion and camouflaging in combination might influence mental health outcomes. This supports our proposal to develop therapeutic interventions that target both these variables to promote the mental wellbeing of autistic adults.

Autism is a neurodevelopmental condition characterized by diverse manifestations in social communication, sensory sensitivities, restricted interests, and repetitive behaviours.[1] Co-occurring mental health conditions are commonly reported by autistic individuals,[2] with anxiety and depressive disorder the most prominent of these conditions,[2,3] particularly in adulthood.[3,4] The identification of intervention targets that promote mental health in autistic people is a high priority of the autism community.[5] With this in mind, this study explored the inter-relationship between two possible intervention targets: camouflaging and self-compassion.

Previous research has found anxiety and depressive symptomatology to be positively associated with camouflaging[6,7] and negatively associated with self-compassion[8-12] in autistic adults. However, to our knowledge, no study to date has explored the inter-relationship between camouflaging and self-compassion, or how this combination of factors may influence pathways to mental health outcomes. We aimed to address this gap in the literature by investigating the influence of autistic traits, camouflaging, and self-compassion on social anxiety, depression, and generalised anxiety in a sample of autistic adults without intellectual disability.

Self-compassion is a gentle way of relating to oneself through kindness, common humanity, and mindful awareness.[13] Together, these elements create a foundation for responding to personal difficulties in a more supportive relationship with oneself, and fostering acceptance, emotional well-being, and resilience.[14] Considering that research shows self-compassion is a malleable factor that can be cultivated with practice,[14,15] it has been suggested that self-compassion could be a potential therapeutic target to reduce mental health problems in autistic populations.[9,12]

Galvin and Richards[9] argued it is imperative for clinicians to gain greater insights into the most suitable and effective strategies for assisting autistic individuals in developing self-compassion. For example, conventional skills training in compassion-based therapies often

includes attention/sensory focusing, perspective-taking, and the use of imagery,[15] all of which may be inappropriate or more challenging for autistic individuals compared to non-autistic individuals. Alternatively, interventions focused on compassionate thought work, directly addressing affect, and intentionally emphasising the cultivation of compassionate feelings such as warmth, safeness, kindness, courage, and affiliation to self and other autistic individuals, might be more effective and beneficial for improving self-compassion in this population.[9]

A year-long three-wave longitudinal study conducted by our group found lower self-compassion in autistic compared to non-autistic adults, as well as an indirect pathway between autistic traits (at baseline) and anxiety/depressive symptoms (at 12 months) through levels of self-compassion (at 6 months).[16] In addition, Cai et al.[11] found preliminary evidence that emotion regulation may mediate the relationship between self-compassion and anxiety and depression. These studies highlighted the need to further explore the self-compassion experiences of autistic individuals, including predictors and pathways to mental health outcomes.

One potentially relevant factor, previously unexplored in self-compassion research, is camouflaging one's autistic traits. Social camouflaging involves the conscious or unconscious use of strategies to avoid standing out as being different in social situations.[17] Negative outcomes associated with social camouflaging include increased mental health problems and reduced access to support and diagnosis.[18,19] This might be, at least in part, because social camouflaging does not deal with, and/or may increase, and/or itself be increased by, underlying self-criticism and self-judgement.

Hull et al.[20] introduced the Camouflaging Autistic Traits Questionnaire (CAT-Q) to capture the extent to which both autistic and non-autistic adults engage in three dimensions of social camouflaging: compensation, masking, and assimilation. The goal of compensation is to

mitigate the autism-related challenges faced in social situations, and can involve strategies such as relying on pre-learned scripts or imitating others.

Masking refers to efforts to conceal autistic characteristics, and can involve monitoring and modifying one's behaviours, including eye contact, facial expressions, and gestures. Finally, assimilation captures specific behavioural strategies used to enhance social integration. This can include adopting certain behaviours, mannerisms, or interests that do not align with one's natural inclinations or preferences, but that help to fit in better with neurotypical social norms and expectations.[20]

Past studies adopting qualitative methodologies suggest a possible link between camouflaging and self-compassion in autistic people.[21-25] For example, Wilson et al.[23] investigated late-diagnosed autistic women's experiences of self-compassion and found that participants had difficulties extending compassion to themselves due to the pressure to conform to societal expectations. One of the themes in this study, which the authors named 'unmasking', described the process of self-understanding that participants went through after receiving their diagnosis. Specifically, participants expressed how increased self-understanding while unmasking contributed to their development of self-acceptance.

Other qualitative themes linking camouflaging and self-compassion can be found in the camouflaging literature, and include participants talking about their camouflaging experiences as "keeping it inside",[21] experiencing "feelings of shame",[24] a loss of "acceptance of self",[25] and "internalizing" criticism from others.[22] Furthermore, the positive aspects of camouflaging may also be linked to increased self-compassion, because some form of camouflaging may be inevitable at times for protection, and may in itself be an act of self-kindness (e.g., themes such as "protection from harm" in Bradley et al.[25]).

Previous studies have investigated self-compassion and camouflaging in autistic people separately, but no study to date has looked at them together. Considering the mental health

problems associated with camouflaging[6,7] and the potential benefits of self-compassion in autistic people,[9,16] this is a much-needed area of investigation. It would be useful to first determine whether camouflaging and self-compassion levels are correlated in autistic adults, and, if they are, the process through which these variables influence mental health outcomes.

In this study we investigated the relationship between camouflaging and self-compassion in a sample of autistic adults and predicted a negative relationship between the variables. We then explored the pathways between autistic traits and three mental health outcomes (social anxiety, generalized anxiety, and depression) with a series of mediation models. Specifically, we considered alternative serial mediation pathways through social camouflaging and self-compassion.

As there were no previous data available regarding the relationship between camouflaging and self-compassion, we did not make any specific hypotheses regarding the mediation models. The models explored 1) whether autistic individuals with higher autistic traits attempt to camouflage these traits more in social situations, and whether this is associated with reduced self-compassion, and in turn increased social anxiety, generalised anxiety, and depression (i.e., autistic traits → camouflaging → self-compassion → mental health), and 2) whether autistic individuals with higher autistic traits have reduced self-compassion, and whether this increases the amount of camouflaging, and in turn increases social anxiety, generalised anxiety, and depression (i.e., autistic traits → self-compassion → camouflaging → mental health).

Method

Ethical approval for the study was provided by the Department of Psychology, University of Warwick.

Participants

We used the Monte Carlo Power Calculator developed by Schoeman et al.[26] to determine the required sample size for the serial mediation models. Based on 10,000 replications, 80% power, and alpha set at $p<0.05$ (two-tailed), a minimum $n=252$ participants were required to observe a statistically significant serial indirect effect.

Participants ($n=310$) were recruited using the pre-screen feature on the Prolific platform (www.prolific.co). We selected the following selection criteria: autism diagnosis, equal male/female split, geography (UK based), and no intellectual disability. Thus, based on this inclusion criteria, participants must have self-reported a diagnosis of autism both at the time they set up their Prolific profile and at the start of this study. Participants were paid above the UK living wage (£10.42 per hour) for taking part, with the average reward per hour at the end of the study standing at £15.23.

Upon reviewing the data, it emerged that $n=10$ participants reported that they did not have a diagnosis of autism at the beginning of the study. These participants were, therefore, removed from the dataset but were still paid for participation. Furthermore, six participants failed attention checks and were subsequently removed from the dataset. These participants did not get paid for participation, but nor did they contest this decision. This process of removal resulted in a final sample of $n=294$ autistic adults ($n=142$ males, $n=152$ females) aged 18-65 (mean=30.53, standard deviation=12.57). Scores on the Autism Spectrum Quotient (AQ)-short[27] ranged from 12-28, with the majority of participants (86%, $n = 252$) scoring above the cutoff score of 16.

The ethnicity of most participants was White (78%), followed by Asian (10%), Black (9%), and Mixed (2%). Participants reported other conditions, including anxiety (52% diagnosed, 14% suspected), depression (54% diagnosed, 15% suspected), obsessive compulsive disorder (OCD) (12% diagnosed, 19% suspected), and attention deficit hyperactivity disorder (ADHD) (18% diagnosed, 20% suspected).

Procedure and measures

Participants reported their sex, age, ethnicity, and whether they have been previously diagnosed with or suspected anxiety, depression, OCD or ADHD. To measure autistic traits, we used the shortened 28-item version[27] of the AQ.[28] Items were rated on a four-point Likert scale ranging from *definitely agree* (1) to *definitely disagree* (4). Some items were reversed scored and then all items coded 0 (absence of autistic trait) or 1 (presence of autistic trait). These dichotomous variables were summed to provide an overall score between 0 and 28. The correlation between the 28-item and 50-item version of the AQ is very high (*r* ranging from .93 to .95). Internal consistency (Cronbach's alpha) in this study for AQ total score was $\alpha = .894$.

The CAT-Q[20] comprises 25 items which are responded to on a seven-point scale ranging from *strongly disagree* (1) to *strongly agree* (7). The CAT-Q can produce a total score and three subscales (compensation, masking, and assimilation). The total score is computed by summing the items (possible range 25 to 175), with higher scores reflecting more camouflaging behavior. The scale has demonstrated good test-retest stability ($r = .77$) as well as associations with theoretically linked constructs, including autistic traits, social anxiety, generalised anxiety, and depression ($r = .28$ to $.67$). Internal consistency for CAT-Q total score in this study was $\alpha = .939$.

The Self-Compassion Scale (SCS)[13] was used to measure self-compassion. The SCS is a 26-item questionnaire using a five-point scale ranging from *almost never* (1) to *almost always* (5). The SCS produces a total self-compassion score and six subscales (self-kindness, common humanity, mindfulness, self-judgement, isolation, and over-identification). In this study, we focused on the SCS total score only, which involves reverse scoring the negative subscale items and computing a total mean of all items.

The SCS has been found to be a reliable and valid measure of self-compassion in various clinical samples and has previously been used in autistic samples[8-11] showing

associations with theoretically linked constructs including anxiety and depression (r = -.39 to -.46 in Galvin & Richards[9]). Internal consistency for SCS total score in this study was α = .947.

Anxiety symptoms were assessed using the Generalized Anxiety Disorder-7 Scale (GAD-7),[29] which measures the frequency of seven symptoms of anxiety by asking participants to rate how often they have experienced the symptoms in the last two weeks. A 4-point scale is used, ranging from *not at all* (0) to *nearly every day* (3), with higher sum scores indicating higher levels of anxiety. It has good reliability, construct validity, and criterion validity.[26] Internal consistency in this study for GAD-7 was α = .916.

The Patient Health Questionnaire-9 (PHQ-9)[30] is a 9-item measure of current symptoms of depression. Items are rated on a 4-point scale ranging from *not at all* (0) to *nearly every day* (3), with higher sum scores indicating higher levels of depression. The PHQ-9 has good test-retest reliability, predictive validity, and criterion validity[30]. Internal consistency in this study for PHQ-9 was α = .914.

The Liebowitz Social Anxiety Scale (LSAS)[31] was used to measure social anxiety symptoms. It asks participants to imagine a wide range of social situations that are described as difficult for individuals with social anxiety. It contains 24 items, 13 concerning performance anxiety and 11 concerning social interaction anxiety. Each item is rated separately for fear (ranging from none 0 to severe 3) and avoidance behaviour (ranging from never 0 to 3 usually). The LSAS has shown good psychometric properties including test-retest reliability, convergent, and discriminant validity. Internal consistency in this study for LSAS was α = .972.

Data analysis

IBM SPSS version 28 was used to analyze the data, with Hayes' PROCESS plug-in for the mediation models. All statistical assumptions were met, with normal distributions of variables and normality of residuals. No multicollinearity issues, no univariate outliers, and no

multivariate outliers were identified. Pearson's correlations examined associations between the main study variables.

A series of serial multiple mediation models (PROCESS model 6), with bias-corrected bootstrapping (10,000 resamples) examined whether associations between autistic traits and mental health (specifically, social anxiety, generalised anxiety, and depression) were mediated by camouflaging and subsequently self-compassion, and/or by self-compassion and subsequently camouflaging.

In mediation models, the indirect pathway refers to the amount that a variable (e.g., autistic traits) influences an outcome variable (e.g., depression) *through* some mediator(s) (e.g., the influence of levels of autistic traits on levels of depression *through* self-compassion levels). An indirect effect was considered statistically significant ($p<.05$) when the range of the two confidence intervals (CIs) fell outside zero.[32] Given sex differences in camouflaging[33] and self-compassion,[9] as well as mixed evidence for the relationship between self-compassion and age,[34] all analyses included age and sex as covariates.

Results

Descriptive statistics and correlations are presented in Table 1. Significant relationships were found among all the main study variables ($r_{partial}$ ranged 0.468-0.833), and a negative correlation was found between social camouflaging and self-compassion ($r_{partial}$=-0.483, $p<.001$).

Mediation models

Each mediation model differed based on the sequence of the two mediators. Therefore, we present two variations for each model (model a and model b). The model in figure 1 included autistic traits as the predictor variable and social anxiety as the outcome variable. The model accounted for unique variance in social anxiety R^2=.563, $F(5, 292)=75.412$, $p<.001$.

The first variation of the model (Figure 1a) showed that the indirect effect of autistic traits on social anxiety through camouflaging was significant (*b*=.15, 95%CI [.08, .24]), as was the indirect effect of autistic traits on social anxiety through self-compassion (*b*=.11, 95%CI [.05, .17]). The indirect effect of autistic traits on social anxiety was serially mediated by camouflaging and self-compassion (*b*=.06, 95%CI [.02, .10]), with the serial indirect pathway accounting for 20% of the total effect of autistic traits on social anxiety.

For the next variation of the model, the variables remained the same, but we changed the serial positioning of the mediators (Figure 1b). The indirect pathway of autistic traits on social anxiety through self-compassion was significant (*b*=.17, 95%CI [.12, .22]). The indirect effect of autistic traits on social anxiety through camouflaging was also significant (*b*=.13, 95%CI [.07, .20]). Finally, the serial mediation effect through self-compassion and camouflaging was significant (*b*=.02, 95%CI [.01, .04]), with the serial indirect pathway accounting for 7% of the total effect of autistic traits on social anxiety.

The model in Figure 2 included autistic traits as the predictor variable and depression as the outcome variable. The model accounted for unique variance in depression R^2=.466, F(5, 292)=50.929, p<.001. The first variation of the model (Figure 2a) showed a significant indirect effect of autistic traits on depression through camouflaging (*b*=.16, 95%CI [.08, .25]), and through self-compassion (*b*=.16, 95%CI [.08, .24]), as well as a serial mediation through camouflaging and self-compassion (*b*=.08, 95%CI [.03, .14]). The serial indirect pathway accounted for 21% of the total effect of autistic traits on depression.

For the alternative variation of the model (Figure 2b), the indirect effect of autistic traits on depression through self-compassion was significant (*b*=.24, 95%CI [.18, .31]), as was the indirect effect through camouflaging (*b*=.14, 95%CI [.07, .22]), and the serial mediation effect through self-compassion and camouflaging (*b*=.02, 95%CI [.01, .04]. The serial indirect pathway accounted for 5% of the total effect of autistic traits on depression.

Finally, we examined generalised anxiety (Figure 3) and found that the model accounted for unique variance in the outcome R^2=.504, F(5, 292)=59.419, p <.001. The first variation of the model (Figure 3a) showed the indirect effects of autistic traits on generalised anxiety through camouflaging (b=.14, 95%CI [.06, .23]), through self-compassion (b=.17, 95%CI [.09, .25]), and serially through camouflaging and self-compassion (b=.09, 95%CI [.04, .15]) were all significant. The serial indirect effect accounted for 23% of the total effect of autistic traits on generalised anxiety.

For the alternative variation of the model (Figure 3b), the indirect effect through self-compassion (b=.25, 95%CI [.19, .32]), through camouflaging (b=.12, 95%CI [.05, .20]), and serially through self-compassion and camouflaging (b=.02, 95%CI [.01, .04] were also significant, with the serial indirect effect accounting for 5% of the total effect of autistic traits on generalised anxiety.

Discussion

This study investigated the relationship between autistic traits, camouflaging, self-compassion, and mental health in autistic adults. A moderate and negative correlation was observed between camouflaging and self-compassion ($r_{partial}$ = -.483, p < .001), supporting our hypothesis. The study also explored two further possibilities: 1) whether autistic people with higher autistic traits attempt to camouflage these traits more in social situations, and whether this was associated with reduced self-compassion, and in turn increased social anxiety, generalised anxiety, and depression, and 2) whether autistic people with higher autistic traits have reduced self-compassion, and whether this increases the amount of camouflaging, and in turn increases social anxiety, generalised anxiety, and depression. The data (although cross-sectional) provided support for both models.

Previous studies support the finding of a bi-directional relationship between camouflaging and self-compassion. For example, participants in Chapman et al.[21] reported

several internal experiences as driving their camouflaging behaviours, including having a negative self-image, low-self-confidence, and feeling ashamed for being different (i.e., low self-compassion leads to more camouflaging). Conversely, participants in the same study also reported that camouflaging reinforced their feelings of self-criticism and shame (more camouflaging leads to low self-compassion).

It is worth noting that the indirect effects for camouflaging and self-compassion were observed both independently and serially in all models. This suggests that both camouflaging and self-compassion may influence the association between autistic traits and mental health outcomes independently and through each other. Regarding the independent indirect effects, these findings support previous research showing camouflaging and self-compassion play a separate indirect role in the association between autistic traits and mental health outcomes.[9,16]

Regarding the serial indirect pathways, although all were statistically significant, stronger associations were observed for the camouflaging to self-compassion indirect pathway (range b = .06 to .09), accounting for between 20% to 23% of the total effect of autistic traits on mental health outcomes. This is compared to the self-compassion to camouflaging indirect pathway (all bs = .02), which accounted for between 5% and 7% of the total effect of autistic traits on mental health outcomes.

Regardless of strength of association, the evidence from this study suggests that camouflaging and self-compassion may be linked in their influence on autistic adults' mental health outcomes. In particular, the findings suggest that interventions targeting self-compassion and camouflaging in combination may result in mental health benefits that may not be realized by focusing on one factor alone.

Future studies should investigate how a lack of societal acceptance and external stigma may shape the dynamics within these relationships. The importance of promoting autism acceptance, particularly within societal and support frameworks, remains crucial for

understanding and addressing both camouflaging and self-compassion, as well as the link between the two. For camouflaging, high levels of stigma and social/peer rejection found in autistic people[35] could result in maladaptive forms of camouflaging as a necessary coping response.[36,37]

For self-compassion, stigma is also attached to extending kindness to oneself. This is particularly the case in Western societies and cultures, in which the practice of self-compassion is often viewed as self-centered, self-indulgent, indicative of self-serving motives, and a sign of self-pity or weakness.[38] However, contrary to these perceptions, empirical research indicates otherwise. Individuals with high self-compassion report they are happier, less stressed, less prone to succumbing to self-pity, and exhibit greater generosity towards others (see Neff[39] for an overview of this research).

A fruitful area for future research may be focused on the development of tailored intervention strategies which target the connection between camouflaging and self-compassion to improve the mental health of autistic adults. Given the lack of therapeutic interventions aimed specifically at camouflaging, such adaptations will likely take the form of compassion-based skills training techniques primarily, such as those found in Compassion Focused Therapy[15] or the Mindful Self-Compassion Programme,[40] with adaptations of these techniques to tap into autistic social responses and experiences.

A few limitations should be considered. Autism diagnostic status was self-reported, and we used the AQ to measure traits as opposed to more established measures such as the Autism Diagnostic Observation Schedule.[41] The exclusion of people with an intellectual disability limits the generalisation of the findings, and the cross-sectional design limits the ability to make causal inferences. Future research is needed to address these limitations, including more diverse samples and longitudinal designs. Notwithstanding these limitations, the findings of this study enhance researchers' and clinicians' understanding of how the interplay between

autistic traits, camouflaging, and self-compassion can influence mental health outcomes in autistic adults.

In conclusion, this study represents the first investigation into the relationship between camouflaging and self-compassion, as well as the combined influence of these factors on the mental health of autistic adults. The findings show a moderate and negative correlation between camouflaging and self-compassion, plus support for a bi-directional serial mediation pathway connecting autistic traits with mental health through these variables. The findings provide greater insight into the mental health experiences of autistic adults and can inform future research aimed at developing tailored interventions to improve the mental health of autistic people.

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	M	***SD***	**AQ**	**CAT-Q**	**SCS**	**LSAS**	**PHQ-9**	**GAD-7**
AQ	19.70	5.23	-					
CAT-Q	118.91	25.04	.679***	-				
SCS	2.26	0.68	-.520***	-.483***	-			
LSAS	78.09	31.87	-.670***	.607***	-.609***	-		
PHQ-9	12.60	7.11	.468***	.502***	-.622***	.609***	-	
GAD-7	11.39	5.58	.504***	.517***	-.651***	.591***	.833***	-

Table 1. Descriptive and partial correlations (controlling for sex and age).
*=p<.05,**=p<.01,***=p<.001

Figure Legends:

Figure 1. Mediation models (bootstrap 10,000 resamples). *=*p*<.05, **=*p*<.01, ***=*p*<.001
Note: X=Predictor variable (autistic traits), M1=Mediator 1 (in model a camouflaging, in model b self-compassion), M2=Mediator 2 (in model a self-compassion, in model b camouflaging), Y=Outcome variable (social anxiety).

Figure 2. Mediation models (bootstrap 10,000 resamples). *=*p*<.05, **=*p*<.01, ***=*p*<.001
Note: X=Predictor variable (autistic traits), M1=Mediator 1 (in model a camouflaging, in model b self-compassion), M2=Mediator 2 (in model a self-compassion, in model b camouflaging), Y=Outcome variable (depression).

Figure 3. Mediation models (bootstrap 10,000 resamples). *=*p*<.05, **=*p*<.01, ***=*p*<.001

Note: X=Predictor variable (autistic traits), M1=Mediator 1 (in model a camouflaging, in model b self-compassion), M2=Mediator 2 (in model a self-compassion, in model b camouflaging), Y=Outcome variable (generalised anxiety).