Self-Compassion and Eating Disorder Symptoms in Adolescent Aesthetic Athletes: A Mixed Methods Exploratory Study

by

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Abstract

Aesthetic athletes are at increased risk for developing eating disorder (ED) symptoms, but few studies have examined protective factors. Self-compassion has been shown to protect against ED symptoms in the general population of adults, but few studies have examined SC and ED symptoms in athletes or adolescents. Furthermore, little is known about self-compassion as it relates specifically to one’s body appearance (i.e., body-related self-compassion; BRSC). Using a sample of 49 aesthetic athletes (24 dancers and 25 figure skaters), this study examined (a) attitudes toward SC and BRSC, (b) cross-sectional correlations between SC, BRSC, and ED symptoms, and (c) the effectiveness of a SC intervention aimed at reducing ED symptoms. Results showed that SC was negatively correlated with ED symptoms, especially perfectionism. In particular, participants who reported higher levels of self-judgment were more likely to report ED symptoms. As expected, BRSC accounted for many of the correlations between the SC subscales and ED subscales. Participants reported positive attitudes toward SC, believing that it may have many benefits to athletes’ emotional well-being, athletic success, and social connections. However, they also expressed concern that SC may undermine work ethic and may be difficult to achieve given a variety of barriers (e.g., having a harsh or critical training environment). Finally, the SC intervention led to significant improvements in overall SC, as well as self-kindness. The intervention did not produce measurable changes in ED symptoms; however, it was positively received by participants. In summary, this study provides preliminary evidence that SC may protect against ED symptoms in young aesthetic athletes.

Keywords: self-compassion, eating disorder; body image; athlete; sport; adolescent
For Annmarie, Lorne, and Erica

I’m finally getting my ticket
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Chapter 1.

Introduction

Over the last three decades, there has been an increased interest in the relationship between involvement in sports and eating disorders. By their nature, sports place a strong emphasis on attaining the ideal body physique in order to maximize performance. Given this heightened focus on the physical body, many authors have suggested that athletes may be at increased risk for eating disorders (e.g., Thompson & Sherman, 2011). Three decades of research has accumulated on this topic, and two major findings have emerged. First, although studies have typically demonstrated only slight increases in the prevalence of clinical eating disorders in athletes (e.g., Martinsen & Sundgot-Borgen, 2013; Schaal et al., 2011), studies examining subthreshold eating disorder symptoms such as body dissatisfaction and disordered eating (i.e., binge eating and extreme weight management strategies such as dietary restriction and purging) have documented rates as high as 78% in athletes (Byrne & McLean, 2001), suggesting that athletes are at increased risk for eating disorders. Importantly, although subthreshold eating disorder symptoms may not be associated with the same life-threatening consequences as clinical eating disorders, they nevertheless are associated with similar levels of functional impairment, distress, suicidality, and mental health problems. There is also evidence that subclinical eating disorder symptoms confer risk for later development of a full-blown eating disorder. In a longitudinal study with non-athletes, Stice, Marti, and Rhode (2013) showed that approximately 30 percent of individuals showing subclinical levels of bulimia nervosa or binge eating disorder go on to develop a full-blown eating disorder at follow-up.

The second major finding to emerge from the literature on eating disorder symptoms in athletes is that, while findings regarding the prevalence of eating disorder symptoms are somewhat equivocal when looking at athletes in general, studies clearly demonstrate that eating disorder symptoms are indeed more prevalent among certain types of athletes, especially female athletes competing at elite levels in aesthetic sports (e.g., dance, gymnastics, figure skating, etc.; Smolak, Mumen, & Ruble, 2000; Sundgot-Borgen & Torstveit, 2004; Byrne & McLean, 2002). This is not surprising given that many
aesthetic sports require a slender body shape and/or low weight for maximum performance. For example, in dance and figure skating competitions, athletes are subjectively evaluated based on the lines and positions they produce with their bodies; these positions are best facilitated by long slender limbs, giving thin athletes an advantage over athletes with a more average body type. Indeed, a longitudinal study by Krentz and Warschburger (2013) showed that athletes who believe that being thinner would facilitate better sports performance were more likely to develop eating disorder symptoms. Furthermore, female athletes in these sports are frequently lifted up by a partner and are therefore expected to conform to a certain weight. Finally, aesthetic athletes often practice in front of mirrors and/or are expected to wear makeup and form-fitting attire for performances and competitions. As such, aesthetic athletes may be particularly conscious of their overall appearance, body shape, and vigilant of their caloric consumption. In fact, there is evidence that aesthetic athletes tend to experience greater body dissatisfaction compared to women in the general population (Swami, Steadman, & Tovee, 2009), and that body dissatisfaction longitudinally predicts development of disordered eating (Stice & Shaw, 2002). Certainly, it may be challenging for these athletes to find a balance between eating to maintain an appropriate body weight for their sport while not succumbing to disordered eating.

Although research has been conducted on the factors that contribute to aesthetic athletes’ increased risk for eating disorder symptoms, few studies have explored protective factors or prevention strategies for eating disorder symptoms in this population. This is an important area of study because disordered eating is associated with a number of negative health outcomes such as nutritional deficits and osteoporosis (Polivy & Herman, 2002), as well as decreased performance and increased injury among athletes (Dosil, 2008; da Costa, Schtscherbyna, Soares, & Ribeiro, 2013; Dwyer et al., 2012; Thomas, Keel, & Heatherton, 2011). Because sports are generally associated with positive outcomes, such as higher self-esteem and a more positive outlook on life (Smolak et al., 2000; Steiner, McQuivey, Pavelski, Pitts, & Kraemer, 2000), it is imperative that researchers identify ways in which at-risk athletes may continue practicing their sport without this heightened risk for eating disorder symptoms. The present study aims to contribute to the literature on eating disorder prevention in athletes by exploring the potential protective effects of a relatively new concept within the psychological literature—self-compassion.
1.1. Eating Disorder Symptoms in Athletes: Risk Factors, Protective Factors, and Prevention Strategies

In order to develop effective prevention strategies for eating disorder symptoms in athletes, researchers must gain an understanding of the factors that confer both risk and resilience against eating disorder symptoms in this population. Research in this area has focused primarily on aesthetic athletes given that risk for eating disorder symptoms appears to be highest in this group. Because longitudinal studies are lacking, the risk factors for eating disorder symptoms in athletes are yet to be determined. However, cross-sectional research suggests that the correlates of eating disorder symptoms in aesthetic athletes may be similar to those in the general population. These include perfectionism (Penniment & Egan, 2012), psychosocial pressure to be thin (de Bruin, Woertman, Bakker, & Oudejans, 2007), and critical comments about body weight and shape (Kerr, Berman, & De Souza, 2006; Muscat & Long, 2008). While these factors may not be unique to athletes, they may be accentuated within the sports context, especially in aesthetic sports in which thinness and/or a low body weight is necessary for success. Furthermore, some researchers have highlighted risk factors which may be unique to the sports environment including anxiety about athletic performance, negative evaluation about one’s athletic achievement, and the level of importance of one’s body shape for athletic performance (Bratland-Sanda & Sundgot-Borgen, 2013; Toro, Guerrero, Sentis, Castro, & Puertolas, 2009). In short, athletes in aesthetic sports may be at increased risk for eating disorder symptoms because they are under increased pressure to be thin—pressure experienced by women in Western culture to conform to the thin-ideal of feminine beauty, and pressure within the sports environment to achieve thinness in order to facilitate athletic success.

Compared to research on risk factors, fewer studies have been conducted on protective factors. This is somewhat surprising given that not all aesthetic athletes develop eating disorder symptoms, and identifying the factors that promote resilience will likely be important in developing prevention programs. Nevertheless, a small handful of cross-sectional studies have highlighted potential protective factors. These include an athlete-centered coaching style (Biesecker & Martz, 1999; Miller & Kerr, 2002), a positive relationship between the coach and athlete, social support from parents, low levels of competitiveness among peers, and peer acceptance (Francisco, Alarcao, & Narciso, 2012; Scoffier Maïano, d’Arripe-Longueville, 2010). In addition to these external...
protective factors, Estanol, Shepherd, and MacDonald (2013) have explored the potential protective function of various psychological coping skills. They found that among female dancers, coping skills such as self-confidence, freedom from worry, and coping with adversity had a protective effect against eating disorder symptoms. In other words, dancers demonstrated resilience against eating disorder symptoms when they were able to maintain their confidence, refrain from worrying about failure or negative evaluations from others, and maintain a calm and positive attitude during setbacks and mistakes.

Research on prevention programs is also very limited with little research having been conducted to date. These programs have included a variety of prevention strategies including psychoeducation, nutritional education, strategies to increase self-esteem, raising awareness of body image pressures on athletes, coping with performance pressure, and dissonance inductions to provoke changes in eating attitudes and behaviors. While most of these programs have been successful (Elliot et al., 2004; Becker, McDaniel, Bull, Powell, and McIntyre, 2012; Torres-McGehee et al., 2011; Abood & Black, 2000; Smith & Petrie, 2008), some have not (Buchholz, Mack, McVey, Feder, & Barrowman, 2008). Moreover, it is difficult to know what the active ingredients of the effective programs are. Although there has been a fair amount of research on eating disorder prevention in the general population, the results have often been disappointing (Stice, Shaw, & Marti, 2007), suggesting that eating disorders may be an especially difficult problem to prevent. As such, more research is needed in this area, especially in relation to female aesthetic athletes since this is a population known to be particularly at risk.

1.2. Self-Compassion

Self-compassion is a construct that may potentially protect against eating disorder symptoms in aesthetic athletes. Self-compassion is related to the more general concept of compassion—feeling concern for the suffering of others—but instead of being directed outward towards others, it is directed inward toward the self (Neff, 2003a). A more elaborate definition of self-compassion is provided by one of the pioneering researchers in this field: “Self-compassion involves being open to and moved by one’s own suffering; experiencing feelings of caring and kindness toward oneself; taking an
understanding, nonjudgmental attitude toward one’s inadequacies and failures; and recognizing that one’s own experience is part of the common human experience,” (Neff, 2003b).

The theory behind self-compassion is best described by Neff (2003a). She describes self-compassion as being comprised of three components: (1) self kindness, which involves treating oneself with care and respect as opposed to critical self-judgment; (2) common humanity, which involves recognizing that no one is perfect, and having faults is part of being human; and (3) mindfulness, which involves having a balanced perspective on one’s experiences and emotions rather than exaggerating or suppressing them (Raes, Pommier, Neff, & Van Gucht, 2011). Each of these components has an opposite, negative pole: (1) self-judgment, which involves harsh judgment and criticism toward the self, (2) isolation, which involves feeling alone in one’s failures or suffering, and (3) over-identification, which involves getting wrapped up in or overwhelmed by one’s suffering or failures. By cultivating self-compassion (i.e., self-kindness, common humanity, and mindfulness), one is protected against the opposing negative poles. In theory, this should reduce a variety of psychologically damaging behaviours such as negative self-talk, withdrawal, social comparison, and rumination. This in turn should result in increased wellbeing and decreased psychopathology.

Self-compassion is a burgeoning construct within the psychological literature and is gaining increasing empirical support as a factor that promotes psychological resilience and well-being. Studies have shown that self-compassion is associated with increased levels of happiness (Neff & Vonk, 2009), a greater ability to cope with stress (Sbarra, Smith, & Mehl, 2012; Costa & Pinto-Gouveia, 2011), more positive relationship behaviors (Neff & Beretvas, 2013; Yarnell & Neff, 2013; Neff & Pommier, 2013; Baker & McNulty, 2011), and more adaptive personality traits (Heffernan, Griffin, McNulty, & Fitzpatrick, 2010; Hollis-Walker & Colosimo, 2011; Neff, Rude, & Kirkpatrick, 2007). Furthermore, several studies have demonstrated an inverse association between self-compassion and a wide variety of psychopathologies (for a recent meta-analysis, see MacBeth & Gumley, 2012). In short, this research suggests that self-compassion may be a significant protective factor against mental health problems.
1.3. Self-Compassion and Self-Esteem

It is important to distinguish self-compassion from self-esteem. Because self-esteem is a function of making positive evaluations of the self, the pursuit of self-esteem often promotes social comparison, ego-defensiveness, prejudice, self-enhancement, and narcissism. Whereas self-esteem is contingent upon outcomes and involves the need to feel unique or above average, self-compassion is an unconditional way of relating to the self in a kind manner—even during moments of failure (Neff, 2011). Self-esteem often necessitates admiration from others, whereas self-compassion is an unconditional way of treating the self, meaning that one can rely on self-compassion regardless of the circumstance. To borrow the words of a proverb, boosting someone’s self-esteem (e.g., through a compliment or award) is like giving a man a fish, whereas teaching someone self-compassion is like teaching them to fish.

Empirically, research demonstrates that both self-esteem and self-compassion are associated with increased happiness, optimism, and positive affect (Neff & Vonk, 2009); however, compared to self-esteem, self-compassion is associated with a more stable sense of self-worth and lower levels of social comparison, self-consciousness, self-rumination, and anger (Neff & Vonk, 2009). Thus, self-compassion may confer the same benefits as self-esteem but may be associated with fewer drawbacks. Self-compassion may represent a more constructive way of conceptualizing global self-concept.

Another benefit of self-compassion over self-esteem is that it may represent a more effective target for interventions. Self-esteem interventions have been disappointing. This was shown by the self-esteem movement beginning in the 1970’s in which efforts to enhance the self-esteem of school-age children were largely unsuccessful. Since then, more carefully designed self-esteem interventions for children have had some success, showing average gains of a medium effect size in a 1998 meta-analysis (Haney & Durlak, 1998). However, efforts to enhance children’s self-esteem have not actually led to desired outcomes, such as improvements in academic performance (Baumeister, Campbell, Krueger, & Vohs, 2003). On the other hand, emerging evidence suggests that self-compassion interventions lead to significant improvements in self-compassion, with a large effect size and with gains maintained at 6- and 12-month follow-ups (Neff & Germer, 2013). Self-compassion interventions also
lead to improvements in life satisfaction ($d = .51$) and decreases in anxiety and depression ($d = .76$, and $d = .86$, respectively; Neff & Germer, 2013). Even brief (i.e., 3-week) self-compassion interventions show impressive effects (e.g., Smeets, Neff, Alberts, & Peters, 2014; Albertson, Neff, & Dill-Shackleford, 2014). In summary, compared to self-esteem, self-compassion seems to be easier to change and is associated with more positive outcomes, likely because it involves an unconditional positive regard for the self.

1.4. Self-Compassion and Eating Disorder Symptoms

At present, very little is known about the potential protective effect of self-compassion on eating disorder symptoms in athletes. Given the robust link between low self-esteem and eating disorder symptoms (Welch & Ghaderi, 2013), it seems plausible that low self-compassion may also be implicated in eating disorder symptoms. Individuals with eating disorders tend to be perfectionistic (Bardone-Cone et al., 2007), self-critical (Lehman & Rodin, 1989), and prone to self-conscious emotions such as shame (Goss & Gilbert, 2002). Indeed, one of the central aspects of an eating disorder—body dissatisfaction—represents a critical attitude toward the self. Self-compassion may protect against body dissatisfaction and disordered eating by allowing individuals to take a more kind and understanding attitude toward their bodies. This may be especially important for aesthetic athletes who are frequently being evaluated for their body weight and aesthetics. Self-compassion may help these athletes cope with the pressure they are under to maintain an ideal body weight, as well as cope with the distress and self-criticism they may experience when their bodies do not measure up to the ideal body standard.

The research literature on self-compassion and eating disorder symptoms is still relatively recent; however, a number of studies have demonstrated promising findings (for a review of the literature, see Braun, Park, and Gorin, 2016). In particular, cross-sectional studies have shown that higher levels of self-reported self-compassion are associated with more adaptive eating habits (Schoenefeld & Webb, 2013) and lower levels of a variety of eating disorder symptoms including binge eating, body dissatisfaction, appearance-contingent self-esteem, concern about weight gain, and drive for thinness (Taylor, Daiss, & Krietsch, 2015; Duarte, Ferreira, Trindade, & Pinto-

Indeed, eating disorder patients have been shown to have lower levels of self-compassion overall compared to healthy controls (Kelly, Vimalakanthan, & Carter, 2014). Importantly, studies have also shown that eating disorder patients demonstrate especially poor responses to treatment when (a) they are low in self-compassion and demonstrate a fear of self-compassion (Kelly et al., 2013; Kelly & Carter, 2015), and (b) they are slow to develop self-compassion early in treatment (Kelly, Carter, & Borairi, 2014). These results suggest that low self-compassion may not only confer risk for eating disorder psychopathology but may also interfere with successful treatment outcomes.

Most of the studies conducted to date have been cross-sectional in nature. However, one experimental study (Adams & Leary, 2007) showed that when restrictive eaters (i.e., individuals who are trying to avoid unhealthy foods) were induced to feel compassionate toward their eating behaviors, they were less likely to demonstrate the disinhibition effect—the tendency for restrictive eaters to overeat after consuming unhealthy food (effect size $sR^2 = .07$). In other words, this study provided experimental evidence that self-compassion may protect against overeating and symptoms of bulimia.

Two daily diary studies are worth mention. In one study, healthy female participants completed daily diaries examining self-compassion, body dissatisfaction, and dietary restraint. Their results showed that day-to-day fluctuations in self-compassion promoted day-to-day fluctuations in body satisfaction and adaptive eating behaviours (Kelly & Stephen, 2016). Similar findings were revealed in another diary study (Thøgersen-Ntoumani, Dodos, Chatzisarantis, & Ntoumanis, 2017), in which healthy women completed daily diaries about state levels of self-compassion directed specifically toward one’s appearance (i.e., “appearance-related self-compassion”).
Results revealed that state appearance-related self-compassion predicted state decreases in body dissatisfaction, drive for thinness, and social physique anxiety.

In addition to the above studies, one qualitative study (Berry, Kowalski, Ferguson, & McHugh, 2010) has explored self-compassion directed specifically toward one’s body. In this study, researchers interviewed five female exercisers between the ages of 23 and 28 to obtain their perspectives on the experience of developing self-compassion for one’s body. Using an empirical phenomenology method, three structures of body-related self-compassion were identified: learning to appreciate one’s own unique body, taking ownership of the health of one’s body, and engaging in less social comparison. Although additional research is needed, these three structures may represent key intervention targets for reducing body dissatisfaction and risk for disordered eating.

Finally, four studies to date have successfully employed a self-compassion intervention to reduce eating disorder symptoms (for a review, see Rahimi-Ardabili, Reynolds, Vartanian, McLeod, & Zwar, 2017). In one randomized controlled trial (RCT), 98 healthy women aged 18 to 60 completed 20-minute self-compassion meditations daily for a duration of three weeks (Albertson, Neff, & Dill-Shackleford, 2014). Questionnaire data revealed significant increases in self-compassion as well as reductions in body shame, body dissatisfaction, and appearance-dependent self-esteem, with medium to large effect sizes for all changes. In a second RCT, Kelly and Carter (2015) randomly assigned 41 individuals with binge eating disorder to either a Compassion-Focused Therapy (CFT) group or a control group (i.e., behavioural intervention). Their results showed that, compared to control participants, those in the CFT group showed a significant drop in eating pathology and binge eating. In another study by the same research group (Kelly, Wisniewski, Martin-Wager, & Hoffman, 2017), patients receiving treatment for an eating disorder showed greater improvements than those in a treatment-as-usual (TAU) control group when a CFT group was added to TAU.

In a third intervention study, 99 patients completing cognitive behavioural therapy for eating disorders received an additional self-compassion component in their treatment. Results showed significant improvements on all eating disorder symptoms, and this was especially true for patients with a diagnosis of bulimia (Gale, Gilbert, Read,
& Goss, 2014). This study, however, did not include a control group, so conclusions regarding the specific effects of the self-compassion component cannot be drawn. In another intervention study (Duarte, Pinto-Gouveia, & Stubbs, 2017), 11 women diagnosed with binge eating disorder completed a low-intensity four-week intervention that included components of self-compassion and mindfulness. Results revealed significant reductions in overall eating pathology and binge eating symptoms, and increases in overall self-compassion.

The above studies provide preliminary evidence that self-compassion represents a promising protective factor against eating disorder symptoms. However, most of these studies have examined self-compassion in a general sense and have not explored various facets of self-compassion that may be especially relevant to eating disorder symptoms. Specifically, only one study to date has examined self-compassion specifically as it relates to one’s body appearance (i.e., having compassion for oneself when one notices aspects of their appearance that they dislike). In this daily diary study, researchers found that greater body-related self-compassion was associated with fewer eating disorder symptoms (Breines et al., 2013). However, because this study did not include a measure of general self-compassion, comparisons between body-related self-compassion and general self-compassion cannot be drawn.

1.5. Self-Compassion in Athletes

To date, research on self-compassion and eating disorder symptoms has not been conducted on athlete samples. Therefore, it is unclear whether self-compassion has similar protective effects for this population. However, it may be argued that self-compassion is particularly relevant for this population. Many athletes, especially those competing at elite levels, are strongly driven toward perfection and very self-critical when they experience failures or setbacks (Flett & Hewitt, 2005). In fact, due to the intense pressure they are often under from coaches, parents, the public audience, or themselves, some competitive athletes have a fear of failure of such magnitude that they are willing to engage in potentially damaging behaviors (i.e., disordered eating) in order to maximize their chances of success (Becker et al., 2012). For these athletes, self-compassion may be helpful in developing a more forgiving attitude toward their shortcomings such that they do not feel compelled to turn to unhealthy strategies in
order to change their body aesthetics or weight. Indeed, self-compassion has been shown to mediate the relationship between maladaptive perfectionism and body image dissatisfaction (Barnet & Sharp, 2016), suggesting that self-compassion interventions may be especially relevant for populations high in perfectionism. Furthermore, self-compassion may assist athletes in developing a sense of self-efficacy—a trait which is essential for facilitating optimal performance in athletes (Bandura, 1997).

Self-compassion may also be relevant to athletes through its relationship to mindfulness. As described above, mindfulness is a core component of self-compassion. Without the capacity to be mindful—to be nonjudgmentally aware of one’s emotional experiences and suffering—one cannot truly be self-compassionate. Mindfulness approaches have gained increasing popularity in sports psychology and have been shown to enhance performance and well-being among athletes (for a review, see Gardner & Moore, 2012). Thus, given the beneficial effect of mindfulness, self-compassion may have a beneficial effect on athletic performance, as well.

Although research has not focused specifically on self-compassion as a protective factor against eating disorder symptoms in athletes, one research team has published six studies providing supportive evidence for this hypothesis. Mosewich, Kowalski, Sabiston, Sedgwick, and Tracy (2011) found that among adolescent female athletes from a variety of sports, self-compassion was associated with higher levels of body appreciation (Ferguson, Kowalski, Mack, & Sabiston, 2014b) as well as lower levels of several eating disorder-related variables including body shame, anxiety about one’s appearance, and fear of negative evaluation (Mosewich, Kowalski, Sabiston, Sedgwick, and Tracy, 2011). Similarly, self-compassion was also associated with greater overall wellbeing in female athletes (e.g., autonomy, meaning and vitality in sport; Ferguson et al., 2014a; Ferguson et al., 2014b). In another study on adult female exercisers, the same research group found that females who were high in self-compassion were more likely to report adaptive exercise motives such as intrinsic motivation and less likely to report anxiety about their appearance or feelings of being obligated or compelled to exercise (Magnus, Kowalski, & McHugh, 2010).

This research team has also demonstrated how self-compassion can serve as a helpful resource when faced with athletic setbacks or emotionally difficult situations in sports. In a qualitative study, female athletes were interviewed to obtain their
perspectives on effective coping strategies during setbacks. These athletes described struggling with self-criticism, perfectionism, and rumination during setbacks and identified the need for a more positive attitude, more constructive rather than punitive self-criticism, letting go rather than dwelling on the setback, and stepping back to gain a more balanced perspective (Mosewich, Crocker, & Kowalski, 2013). Essentially, these athletes were describing the need for greater self-compassion, without identifying self-compassion directly. Indeed, in a later qualitative study by this research team (Ferguson, Kowalski, Mack, & Sabiston, 2014), female athletes were interviewed on their perspectives regarding self-compassion directly and agreed that it may be beneficial during setbacks by helping them react to setbacks with greater positivity and perseverance as opposed to rumination and passivity. These results have been replicated in quantitative studies in which female athletes responded to hypothetical sports setback scenarios; those athletes with higher self-compassion were more likely to endorse adaptive reactions to setbacks, such as responding with positivity and perseverance (Ferguson et al., 2014; Reis et al., 2015).

A study conducted by a different research group provides evidence that self-compassion may serve as a protective factor against eating disorder symptoms when external pressures to be thin are high. Specifically, this study showed that, among healthy adult women, greater levels of self-compassion attenuated the link between media pressures to be thin and eating disorder symptoms. Although this study was not conducted on athletes, it nevertheless shows that self-compassion may offset external pressures to be thin, thus decreasing risk for eating disorder symptoms. Because aesthetic athletes experience increased pressures to be thin, self-compassion may serve as a particularly relevant protective factor in this population.

Despite this evidence that self-compassion may confer many benefits for athletes, there may also be some barriers. Specifically, because competitive athletes are often perfectionistic and uphold very high standards, they may reject self-compassion for fear that it may undermine their motivation or success. In other words, athletes may fear that if they are too compassionate toward themselves during failures, they may become overly forgiving, complacent, passive, and/or lazy. In fact, this is precisely what was observed in a qualitative study by Ferguson and colleagues (2014); female athletes expressed concerns that self-compassion (a) may lead to complacency, passivity, and mediocre performance, and (b) fundamentally opposes self-criticism, which they
perceived as necessary for achieving high standards. Similarly, in studies on non-athletes, authors have recognized that some individuals have a fear of self-compassion, believing it is akin to self-indulgence (Gilbert, McEwan, Matos, & Rivis, 2011).

Despite these concerns, Neff (2003b) argues that, because self-compassion involves mindfulness, it necessarily involves an awareness of—rather than a disregard for—one’s shortcomings. Furthermore, just as compassion involves wanting the best for others, self-compassion involves wanting the best for oneself—including pursuing one’s goals. Indeed, when it comes to pursuing goals, some authors make a distinction between striving for perfection and reacting negatively to imperfection, such that it is possible to strive for success while still being compassionate toward oneself during failure (Stoeber, Stoll, Pescheck, & Otto, 2008). Indeed, one study (Lizmore, Dunn, & Dunn, 2017) showed that athletes who are high in self-compassion tend to show a more adaptive form of perfectionism (i.e., setting high standards for performance), compared to those who are low in self-compassion, who demonstrate more maladaptive forms of perfectionism (i.e., a fear of making mistakes). Lastly, self-compassion has been associated with intrinsic motivation and greater personal initiative (Neff, 2003b; Neff et al., 2007). In this way, it is possible that self-compassionate individuals may have similar levels of motivation as self-critical individuals but perhaps are motivated by different goals such as intrinsic enjoyment rather than fear of failure.

1.6. Self-Compassion Interventions

Only one study to date has focused on a self-compassion intervention for athletes. In this study, Mosewich, Crocker, Kowalski, and DeLongis (2013) randomized 51 female athletes to either a self-compassion intervention or an attention control group. The self-compassion intervention included a psychoeducation session as well as writing exercises completed for one week. According to their results, the intervention reduced self-criticism, rumination, and concern over mistakes.

The majority of studies examining self-compassion interventions have been conducted on non-athlete samples, but nonetheless show promising results. In particular, in one randomized controlled trial, Neff and Germer (2012) demonstrated the efficacy of their Mindful Self-Compassion program in 54 healthy adults. This program
employs eight weekly two-hour group training sessions aimed at increasing self-compassion. Training consists of didactic instruction regarding self-compassion, mindfulness, and critical self-talk, as well as experiential exercises such as self-compassion meditations, breathing, and letter writing. Results showed that compared with the control group, intervention participants demonstrated significant gains in self-compassion, mindfulness, and life satisfaction, as well as significant decreases in depression and anxiety. Effect sizes for these changes were medium to large, and gains in self-compassion were maintained at 6- and 12-month follow-ups. (See Appendix A, Table 1, for a table outlining effect sizes for the self-compassion interventions discussed in this literature review.)

Other small-scale studies have demonstrated similarly promising findings in healthy samples. As mentioned above, Albertson and colleagues (2014) showed that brief daily self-compassion meditations lead to increased levels of self-compassion and reduced body dissatisfaction in healthy women. In a study on undergraduate students, three sessions of self-compassion training (which included writing exercises and meditations) produced greater gains in self-compassion, mindfulness, optimism, and self-efficacy, and greater reductions in rumination, compared to the active control group (Smeets, Neff, Alberts, & Peters, 2014). In another study (Shapira & Mongrain, 2010), healthy participants wrote daily self-compassion letters following distressing events for seven days and subsequently demonstrated increased happiness and decreased depression. In a study of overweight soldiers seeking to lose weight, three days of mindfulness training with supplemental self-compassion exercises lead to increased weight loss compared to a control group (Mantzios & Wilson, 2014). Last, in a study examining smoking cessation (Kelly, Zuroff, Foa, & Gilbert, 2010), smokers completed an intervention designed to enhance self-compassion imagery and self-talk during urges to smoke. Compared to a control group, intervention participants demonstrated a more rapid cessation of smoking—especially for those who were highly self-critical and/or low in readiness to change at baseline.

In addition to studies utilizing healthy samples, researchers have also demonstrated the efficacy of self-compassion interventions in clinical samples. In particular, Gilbert and colleagues (Gilbert & Proctor, 2006; Mayhew & Gilbert, 2008) have demonstrated the efficacy of Compassionate Mind Training (CMT), a 12-week program aimed at enhancing self-compassion in chronically self-critical mental health
patients. This program focuses on exploring the nature and function of self-criticism, developing self-compassion through imagery, keeping daily diaries of critical and compassionate self-talk, and addressing fears of self-compassion. In two small studies (i.e., $N < 10$) of chronically self-critical mental health patients, CMT produced increases in self-soothing abilities and/or decreases in depression, anxiety, self-criticism, inferiority, shame, and submissiveness (Gilbert & Proctor, 2006; Gilbert & Irons, 2004). CMT has also been utilized effectively in a small study (i.e., $N = 3$) of schizophrenic patients, leading to reductions in depression, anxiety, and psychotic symptoms (Mayhew & Gilbert, 2008).

In summary, although the literature on self-compassion interventions is small and marked by methodological limitations such as small sample sizes, it nevertheless provides preliminary evidence for the efficacy of self-compassion interventions in both healthy and clinical populations. Given these promising findings, as well as findings highlighting self-compassion as a potentially relevant variable for athletes, intervention studies aimed at enhancing self-compassion in athletes may prove to be especially important.

1.7. Self-Compassion in Adolescents

As described above, the vast majority of studies in the self-compassion literature—including those focused on athletes, eating disorder symptoms, and self-compassion interventions—have focused on adult samples. However, self-compassion may be especially important for the well-being of adolescents. In terms of cognitive development, adolescence represents a period of increased awareness of the self. Compared to young children, adolescents are increasingly able to evaluate the self, make social comparisons, and engage in self-criticism (Pomerantz, Ruble, Frey, & Greulich, 1995). In fact, several studies suggest that some, though not all, adolescents experience difficulties with their self-concept, and this may be especially true for females (Robins & Trzesniewski, 2005; Offer & Schnoert-Reichl, 1992), making self-compassion a potentially important psychological resource during this age period. Furthermore, risk for eating disorder symptoms rises during adolescence (Stice, Marti, & Rohde, 2013), and some authors believe that aesthetic athletes may be particularly at risk due to their exposure to the weight-obsessed culture of aesthetic sports at such a young and
impressionable age (Currie, 2010). For these reasons, aesthetic athletes may benefit from self-compassion interventions during their teen years in order to potentially decrease their risk of developing eating disorder symptoms.

To date, research has not explored the effects of self-compassion on eating disorder symptoms in adolescent aesthetic athletes. However, studies on adolescents from the general population have shown that the relationship between self-compassion and various mental health variables is likely comparable to that in adults. That is, among adolescents, self-compassion has been linked with greater body satisfaction; greater emotional well-being; more adaptive attachment relationships; more positive family experiences; superior skills in emotion regulation; and less anxiety, depression, anger, and historical abuse (Bluth et al., 2016c; Zessin, Dickhauser, & Garbade, 2015; Bluth, Campo, Futch, & Gaylord, 2016a; Pisitsungkagarn et al., 2013; Neff & McGehee, 2010; Tanaka, Wekerle, Schmuck, & Paglia-Boak, 2011; Ling, 2012; Bluth & Blanton, 2013; Cunha, Martinho, Xavier, & Espirito Santo, 2013). In a recent experimental study, adolescents high in self-reported self-compassion showed a lower physiologic stress response during a lab stressor compared to adolescents low in self-compassion (Bluth et al., 2016). There is also evidence from a longitudinal study that self-compassion may buffer adolescents against the negative effects of low self-esteem (Marshall et al., 2015).

One finding that warrants mention is the effect of age and gender. There is some evidence that older female adolescents may show lower levels of self-compassion compared to younger female adolescents, younger male adolescents, and older male adolescents (Bluth & Blanton, 2015; Bluth et al., 2016; Bluth et al., 2015; Muris, Meesters, Pierik, & de Kock, 2016). This is consistent with studies on adults showing that women have slightly lower levels of self-compassion than men (Yarnell et al., 2015; Neff, 2003b; Neff & Beretvas, 2013; Neff et al., 2005; Neff & McGehee, 2010; Yarnell & Neff, 2013). However, the evidence on gender differences is mixed. Some studies show no gender differences in adults (e.g., Iskender, 2009; Neff, Hsieh, & Dejitterat, 2005; Neff et al., 2007a; Neff & Pommier, 2013) or adolescents (Neff & McGehee, 2010). Similarly mixed results are observed for age. Some studies show higher levels of self-compassion in older adults compared to adolescents (Neff & Vonk, 2008) while other studies show no difference between teens and college students (Neff & McGehee, 2010). Clearly, more research is needed in order to better understand the effects of gender and developmental stage on self-compassion.
To date, only one self-compassion intervention for youth has been formally evaluated. In the pilot study for this intervention (Bluth, Gaylord, Campo, Mullarkey, & Hobbs, 2016b), thirty-four youth were randomized to either a waitlist control group or a 6-week mindful self-compassion course. Compared to the control group, intervention participants showed increased self-compassion and life satisfaction, and reduced depressive symptoms. As well, changes in self-compassion and mindfulness were shown to predict changes in anxiety, depression, perceived stress, and life satisfaction. In a follow-up study (Bluth & Eisenlohr-Moul, 2017), forty-seven youth participated in an 8-week mindful self-compassion course in five cohorts. Similarly, results showed significant increases in self-compassion, gratitude, and curiosity/exploration, and significant decreases in perceived stress, with changes in self-compassion co-varying with changes in depressive symptoms and resilience.

In addition to the above self-compassion intervention, several mindfulness-based interventions have been adapted for use with adolescents with successful results (for reviews, see Zenner, Herrmleben-Kurz, & Walach, 2014; Zoogman, Goldberg, Hoyt, & Miller, 2014). Thus, there is some preliminary support for the use of self-compassion interventions with youth, but more research is needed in order to adequately assess efficacy.

1.8. Summary

Research has shown that female aesthetic athletes are at increased risk for developing eating disorder symptoms. However, little is known about protective factors or prevention strategies for eating disorder symptoms in this population. Self-compassion is a burgeoning concept within the psychology literature and has been supported as a promising protective factor against numerous mental health problems, including eating disorder symptoms. Although there is little research on self-compassion in athletes, it is plausible that self-compassion is a relevant concept for this population. Athletes are often self-critical, perfectionistic, and driven toward success, and some are willing to make inappropriate sacrifices in order to maximize their chances of success. In particular, some aesthetic athletes may be willing to engage in disordered eating in order to achieve the ideal body that they are under so much pressure to obtain. Self-compassion may help these athletes take on a more realistic and understanding attitude.
toward their bodies such that they do not feel compelled to engage in drastic weight management strategies and disordered eating.

Despite the recent surge of interest in this area, the research literature on self-compassion is still quite small and contains a number of gaps. Although there have been several studies linking self-compassion with eating disorder symptoms, no study to date has examined the relationship between these variables in (a) athletes, (b) adolescents, or (c) adolescent athletes. As such, it is not yet clear whether self-compassion represents a protective factor against eating disorder symptoms in these populations. This is an important gap in the literature because each of these populations is at increased risk for the development of eating disorder symptoms (Stice, Marti, & Rohde, 2013; Thompson & Sherman, 2011), so identifying protective factors for these populations is key. Second, only one study to date has examined self-compassion specifically as it relates to one’s body appearance (Breines et al., 2013), and no research to date has compared body-related self-compassion to general self-compassion in terms of their relationship with eating disorder symptoms. Again, this is an important gap in the literature because it may be the case that eating disorder symptoms improve primarily as a result of increased body-related self-compassion as opposed to increased self-compassion more generally.

Last, a third gap in the literature is that no research has been done to date to examine the efficacy of self-compassion as an intervention target in athletes or adolescents. Given the promising results of self-compassion interventions with other populations, it is likely that such interventions may also be beneficial for young athletes. However, research is required to confirm this notion and to determine whether athletes have unique needs that warrant specific focus and tailoring of content within such an intervention.

1.9. The Current Study

The goal of the current study is twofold. The first aim is to explore self-compassion and body-related self-compassion (i.e., self-compassion toward the appearance of one’s body) in an adolescent aesthetic athlete population, especially as it
relates to eating disorder symptoms. Toward this aim, the first two research questions are as follows:

(1A) What are adolescent aesthetic athletes’ experiences of and perceptions of self-compassion? For example, how do they use self-compassion in their daily lives, and what do they see as the pros and cons of self-compassion?

(1B) What are adolescent aesthetic athletes’ experiences of and perceptions of self-compassion as it relates to one’s body appearance (i.e., body-related self-compassion)? What are the relationships between self-compassion, body-related self-compassion, and eating disorder symptoms? It is hypothesized that self-compassion and body-related self-compassion will be positively correlated, and that both of these variables will be inversely correlated with eating disorder symptoms.

The second aim of this study is to explore the efficacy of a self-compassion intervention in female adolescent aesthetic athletes. Toward this aim, the second research questions are as follows:

(2A) What are adolescent aesthetic athletes’ experience of and perceptions of the self-compassion intervention? For example, what aspects of the intervention do they find helpful or unhelpful?

(2B) Is the self-compassion intervention beneficial? Specifically, does it lead to changes in self-compassion, body-related self-compassion, and eating disorder symptoms? It is hypothesized that the intervention will increase self-compassion and body-related self-compassion, and decrease eating disorder symptoms.

This study will employ a mixed methods design. Mixed methods designs are valuable when the phenomenon under study is complex and multi-faceted, and when a rich and thorough understanding is being sought (Tashakkori, Teddlie, & Sines, 2013). Self-compassion is indeed a complex and multi-faceted concept, and a thorough understanding will be useful in identifying ways in which self-compassion can be used as an intervention target. Additionally, self-compassion has yet to be studied among an adolescent athlete population—a population that may experience unique benefits of and barriers toward cultivating self-compassion. For example, as previously mentioned, young athletes may have difficulty accepting self-compassion into their lives due to fear
that it may undermine their athletic motivation and success. On the other hand, it is possible that young aesthetic athletes may willingly embrace self-compassion as a welcome means of coping with athletic pressures and setbacks, ultimately allowing them to become more successful. Because self-compassion has yet to be explored within this population, obtaining both a qualitative and quantitative analysis of the research questions will provide a more rich and thorough understanding of this topic.
Chapter 2.

Methods

2.1. Participants and recruitment

Participants were recruited for the three portions of this study (i.e., questionnaire, interview, and intervention plus interview). In total, there were 49 participants. Forty-eight contributed data to questionnaires; 14 contributed data to interviews, and four contributed data to the intervention analyses. Some participants contributed data to more than one portion of this study (e.g., questionnaires and interview). See Appendix B, Figure 1, for a diagram clarifying how many participants contributed data to each portion of the study, and how many participants contributed data to multiple portions of the study.

2.1.1. Participants

Participants included 49 females aged 10 to 19 ($M = 14.16$, $SD = 2.13$) involved in either dance (including ballet) or figure skating. Although dance is not typically considered a “sport” in the way that figure skating is, both dance and figure skating share the common element of performance. That is, in both dance and figure skating, individuals aim to give their best performance, and their performance can be influenced by psychological factors. Consistent with this, more recently, the field of sports psychology has commonly been referred to using the more general term performance psychology. In this paper, the term “athlete” will be used broadly to refer to individuals who take part in a sport and/or a performance art (e.g., dance).

Among the 49 participants in this study, twenty-four were dancers, and twenty-five were figure skaters. Participants ranged in how competitively they trained, with some participants training for less than five hours per week and never having participated in competitions, and others training at the elite level for 30 to 40 hours per week and competing internationally. Details on the level of competitiveness, as well as demographic variables, are included below.
Ages for participants in this study ranged from 10 to 19. This is a relatively large age gap, especially during adolescence, a developmental period during which cognitive and emotional functioning changes significantly. Initial plans were to recruit youth between the ages of fourteen and eighteen. However, athletes are difficult to recruit, and indeed this researcher encountered numerous challenges in recruiting participants for this study. Thus, the decision was made to expand the age range to include preadolescents in order to increase the sample size. The number of preadolescents in this study was as follows: two participants were aged 10, 4 participants were age 11, 7 participants were age 12, and 11 participants were age 13.

The choice to exclude males from this study was based upon research showing that eating disorder symptoms are more prevalent among female athletes compared to male athletes (Sundgot-Borgen & Torstveit, 2004). Eating disorder symptoms may also differ in type across genders, with females demonstrating a greater drive for thinness and males demonstrating a greater drive for muscularity (Darcy & Lin, 2012). There were no other exclusion criteria.

2.1.2. Recruitment for questionnaires and interviews

Participants for the questionnaire and interview portion of the study (i.e., Research Questions 1A and 1B) were recruited from two sites: a recreational figure skating club and dance studio located in the Greater Vancouver Regional District and the Fraser Valley Regional District, British Columbia. These sites were identified based on the personal contacts of this researcher and her senior supervisor.

The dance studio has fifteen instructors and over six-hundred students. Approximately twenty percent of the students train competitively. Five-percent of students participate in provincial competitions and/or have been invited to train at prestigious ballet schools. The figure skating club has twelve coaches and approximately 100 students. Approximately thirty percent of the skaters compete locally, and five percent have competed provincially.

Among those participants who were recruited from the above sites \((N = 44)\), all but one completed the questionnaire portion of the study. Among these 44 participants, coaches were asked to select five of their more competitive athletes at random (i.e., five
dancers from the dance studio, and five skaters from the figure skating club) to complete the interview portion of the study. Thus, ten participants completed interviews, and 43 completed questionnaires. See Appendix B, Figure 2, for a diagram showing the recruitment process and number of participants completing each portion of the study.

2.1.3. Recruitment for the intervention

Participants for the intervention portion of the study were recruited from a figure skating club in the Greater Vancouver Regional District that trains elite-level figure skaters. This coach was also identified through personal contacts. She was asked to recruit approximately twelve female figure skaters whose schedule permitted involvement in the intervention. However, due to these skaters’ busy schedules, only five participants could be recruited (and one dropped out after the first intervention session for reasons that are discussed below). This was a much smaller sample size than desired and certainly limits the power, reliability, and validity of quantitative analyses. However, because elite athletes are extremely difficult to recruit, this sample size was accepted as appropriate for pilot testing the intervention.

All four of the remaining participants contributed data to all three portions of this study (i.e., baseline questionnaires, interviews, and intervention). The participant who dropped out of the intervention contributed data to the questionnaire portion of the study. See Appendix B, Figure 3, for a diagram showing the recruitment process and number of participants completing each portion of the study.

In exchange for participating in the questionnaire portion of the study, participants were offered a brief (30 minute) lesson on self-compassion and mindfulness. Those who took part in the interviews and intervention were not offered a reward for participation but were informed that, as a result of participating, they will learn about self-compassion and mindfulness. Great care was taken to ensure that participants understood that participation in this study was voluntary, confidential, anonymous, and would not have any effect on their standing within their training club.
2.2. Measures

2.2.1. Self-Compassion Scale (SCS; Neff, 2003b)

The SCS is a 26-item self-report questionnaire that measures various components of self-compassion (see Appendix C). The SCS has been established a psychometrically sound measure. Regarding test-retest reliability, correlations range from $r = .80$ to $r = .93$ for the SCS Total Score as well as the six SCS subscales (Neff, 2003b). Internal consistency for this instrument ranges from $\alpha = .92$ to $\alpha = .94$ (Neff, 2003b; Neff, Kirkpatrick, & Rude, 2007). The measure has also demonstrated good convergent and discriminant validity as it correlates with expected measures (e.g., self-esteem; $r = .59$; Neff, 2003b) and does not correlate with measures of unrelated constructs (e.g., narcissism; Neff, 2003b). Additionally, the SCS has been validated for use with adolescents, showing good internal consistency ($\alpha = .88$ to $\alpha = .96$; Tanaka et al., 2011; Neff & McGehee, 2010; Cunha, Xavier, & Castilho, 2016) and convergent validity (Cunha et al., 2016). Last, the SCS has demonstrated sensitivity to changes in self-compassion as demonstrated by medium to large effect sizes in numerous intervention studies aimed at enhancing mindfulness and/or self-compassion (see Appendix A, Table 1; Albertson et al., 2014; Neff & Germer, 2012; Shapiro, Astin, Bishop, & Cordova, 2005; Birnie, Speca, & Carlson, 2009).

Table 2 (Appendix A) shows good internal consistency for the SCS in the current study. Although the SCS has been validated with adolescents (Tanaka et al., 2011; Neff & McGehee, 2010; Cunha et al., 2016), the current study included some particularly young participants—as young as age ten. Thus, the internal consistency of the SCS for participants under age fourteen ($n = 24$) in this study was also examined and was acceptable ($\alpha = .94$). The internal consistency of each of the six subscales of the SCS were all above $\alpha = .70$, with the exception of the Self-Kindness subscale ($\alpha = .56$).

In addition to an overall score, the SCS produces scores on six subscales. The Self-Kindness subscale measures the extent to which one is kind and nonjudgmental toward the self during times of failure (e.g., “When I’m going through a very hard time, I give myself the caring and tenderness I need”). The Self-Judgment subscale measures the extent to which one is critical and judgmental toward her shortcomings and failures (e.g., “I’m disapproving and judgmental about my own flaws and inadequacies”). The
Common Humanity subscale measures feelings of connectedness to others in times of failure (e.g., “When things are going badly for me, I see the difficulties as part of life that everyone goes through”). The Isolation subscale measures feelings of isolation when faced with one’s faults or failures (e.g., “When I fail at something that’s important to me, I tend to feel alone in my failure”). The Mindfulness subscale measures the extent to which one takes a balanced perspective on painful emotions, neither exaggerating nor suppressing them (e.g., “When I fail at something important to me, I try to keep things in perspective”). Lastly, the Over-Identification subscale measures the extent to which one becomes overwhelmed with emotion during failure or fixated on one’s faults (e.g., “When something upsets me, I get carried away with my feelings”). Participants are asked to indicate the extent to which they agree with each statement on a 5-point likert scale ranging from “Almost never” to “Almost always.”

Total scores on the SCS range from 26 to 130, with lower scores indicating lower levels of self-compassion. Scores on the Self-Kindness subscale range from 5 to 25, with higher scores indicating higher levels of self-kindness. Scores on the Common Humanity and Mindfulness subscales range from 4 to 20, with higher scores indicating higher levels of each. Scores on the Self-Judgment subscale range from 5 to 25, with higher scores indicating higher levels of self-judgment. Scores on the Isolation and Over-Identification subscales range from 4 to 20, with higher scores indicating higher levels of each. When the total SCS score is being computed, items on the Self-Judgment, Isolation, and Over-Identification subscales are reverse-coded.

2.2.2. Body-Related Self-Compassion Scale (BR-SCS)

In addition to the SCS, six body-related self-compassion items were developed by this researcher to capture participants' level of self-compassion directed specifically toward the appearance of their body (see Appendix C). Items were modeled after those in the SCS, with one item representing each of the six subscales of the SCS. For example, the item representing the Self-Kindness subscale is, “I try to be understanding and patient towards aspects of my body that I don't like,” (which was modelled off of the SCS item “I try to be understanding and patient toward those aspects of my personality I don't like”). The item representing the Common Humanity subscale is, “When I feel bad about my body, I try to remind myself that other people feel bad about their body sometimes, too” (which was modelled off of the SCS item “When I feel inadequate in
some way, I try to remind myself that feelings of inadequacy are shared by most people”). Scores on the BR-SCS range from 6 to 30, with higher scores indicating higher levels of body-related self-compassion. Data regarding the internal consistency of the BR-SCS in the current study is shown in Table 2 (Appendix A). This measure included only six items, which may limit its reliability and validity to some degree. However, the measure was intentionally kept brief in order to minimize demands placed on participants, who were already completed two other long questionnaires.

2.2.3. Eating Disorder Inventory—3 (EDI-3; Garner, 2004)

The EDI-3 is a 91-item self-report questionnaire that measures cognitive, emotional, and behavioral symptoms of eating disorders (see Appendix C). It includes adolescent norms and has demonstrated high test-retest reliability ($r = .75$ to $r = .94$; Thiel & Paul, 2006) internal consistency ($\alpha = .73$ to .93; Thiel & Paul, 2006), discriminative validity, sensitivity, and specificity (Garner, 2004; Clausen, Rosenvinge, Friborg, & Rokkedal, 2011). The EDI-3 has been used extensively with adolescents (e.g., Cotrufo, Gnisci, & Caputo, 2005). Four subscales of the EDI-3 (including 31 items in total) will be used in this study: Drive for Thinness, Bulimia, Body Dissatisfaction, and Perfectionism. The former three subscales were selected because they have demonstrated the strongest correlations with eating pathology and have been commonly used by researchers as a short-form method for assessing general eating disorder symptoms (Garner, Olmstead, & Polivy, 1983; Hurley, Palmer, & Stretch, 1990). The latter subscale was selected for this study due to previous research demonstrating a strong link between perfectionism and self-compassion (Neff, 2003a).

Scores on the four subscales of the EDI-3 range from 0 to 28 for Drive for Thinness, 0 to 32 for Bulimia, 0 to 40 for Body Dissatisfaction, and 0 to 24 for Perfectionism. Higher scores on each of these subscales are indicative of higher levels of the respective symptom. Data regarding the internal consistency of the EDI-3 in the current study is shown in Table 2 (Appendix A).

2.2.4. Demographic questionnaire

In addition to the above questionnaires, participants were asked to provide information regarding their birth date, ethnicity, socioeconomic status, height, weight,
number of years spent training in their sport, number of hours per week spent training
during competition season, athletic aspirations, and whether or not they have ever been
diagnosed with an eating disorder, anxiety disorder, or mood disorder.

2.3. Procedure

All participants and their parents provided informed consent/assent. To collect
questionnaire data, participants met with this researcher in group sessions of four to
twenty-six participants. Groupings (i.e., which participants were in each group) were
based on participants’ schedules. Sessions were held at the participants’ training facility.
Participants’ parents provided informed consent, and participants provided informed
assent. Participants were informed that they could discontinue the study at any point
without penalty or need for explanation. In exchange for their participation, after
completing the questionnaires, participants received a 30-minute group lesson on self-
compassion and mindfulness. Participants completed questionnaires privately and at
their own pace.

Because some of the questionnaires in this study used language than may be
rather sophisticated for young teens, care was taken to ensure that all participants
understood the items. This researcher explicitly stated that some of the questionnaire
items may be difficult to understand, and participants were encouraged to approach her
if they were having difficulty understanding the questions (and in fact many of the
younger participants did approach her). Also, prior to completing the questionnaires, this
researcher provided a definition for some of the words that she anticipated may be
unfamiliar to younger participants (e.g., “preoccupied”).

Interviews were completed by this writer, one-on-one with each participant. They
were semi-structured in nature (see Appendix D for the Interview Guide). Interviews with
dancers took place at the personal residence of the dance coach, and interviews with
skaters took place in a private change room at the skating club. Interviews ranged from
forty to seventy minutes in length, depending on how verbose the participant was. Prior
to participating in the interview, participants provided informed assent, and their parents
provided informed consent. Participants were made aware that they could discontinue at
any time without penalty and could decline to answer any questions they did not feel
comfortable answering. Interviews were audio-recorded and transcribed verbatim.
2.3.1. The intervention

The intervention consisted of five 75-minute sessions held in group format. The intervention originally consisted of eight sessions but was condensed due to scheduling problems. Sessions took place in a private room in the participants’ training club. The scheduling of sessions was based on participants’ availability and took place on July 28, July 30, August 6, August 18, and August 20, 2015.

Two sessions were held prior to running the intervention. The first was an information session with parents in order to obtain informed consent. The second session was held with participants and included informed consent/assent, an orientation to the intervention, and completion of baseline questionnaires. Follow-up questionnaires were completed at the end of the last intervention session. Individual interviews were conducted by this writer in a private room at the figure skating club.

The intervention content was designed by this researcher, a clinical psychology doctoral student who has received training and supervised clinical experience in mindfulness-based interventions for youth. Content was drawn from Kristin Neff’s Mindful Self-Compassion Core Skills Training workshop, which this researcher attended in September, 2014, as well as previous self-compassion interventions described in the literature (McGehee, 2010; Albertson et al., 2014; Gale et al., 2014; Persinger, 2012; Neff & Germer, 2012; Gilbert & Procter, 2006). Content was modified by this researcher for an adolescent athlete population. Content included education on self-compassion and mindfulness, mindfulness exercises, self-compassion meditations, journaling exercises, imagery, and other experiential exercises. Appendix E provides an outline of the intervention content.

One key modification to the intervention was the concept of self-coddling. According to the literature (Rodriguez & Ebbeck, 2015), one of the barriers to utilizing self-compassion is a fear of self-coddling. That is, some individuals fear that self-compassion will lead them to be overly “easy” on themselves, letting go of high standards, giving in to indulgences, and becoming complacent and/or lazy as a result (Gilbert et al., 2011). It was expected that, because elite athletes tend to be self-critical and perfectionistic, they may be especially sensitive to this line of thinking. Thus, early in
the intervention, the Meeting Halfway analogy was introduced with the aim of distinguishing self-compassion from self-coddling (see Appendix E).

As part of the intervention, participants were asked to complete daily diary cards (see Appendix E) logging (1) the intensity of their critical self-talk, (2) their use of self-compassion, and (3) the effectiveness of self-compassion. Participants were also asked to complete a longer version of the diary card (see Appendix E) approximately once a week. This longer version prompted participants to elaborate on their experiences of self-compassion. The rationale for including the Long Diary Card was to further facilitate participants’ learning and integration of intervention material without overburdening them with a long writing exercise on a daily basis. Because the intervention ran from July 28 to August 20, participants were asked to complete 27 short diary cards in total, and 4 long diary cards in total. Because the last session of the intervention focused on body-related self-compassion, participants were asked to reflect specifically on body-related self-compassion for their last long diary card (see Appendix E).

2.4. Credibility

Several steps were taken to increase the credibility of this study. Feedback on the interview questions was obtained by two clinical psychologists with experience working with athletes, and by a young female who formerly competed in an aesthetic sport. In order to decrease the social desirability effect and facilitate participants’ comfort in providing honest responses, the following points were strongly emphasized prior to data collection. Participants were made aware that their responses would be confidential and would not be shared with their parents or training coach under any circumstances (except where there might be concern of imminent harm). They were informed in detail about the confidential manner in which data would be stored. They were assured that there are no right or wrong answers, and that the researcher did not have any preconceived expectations or wishes regarding their responses. They were welcomed to ask questions of the researcher in a private manner if they did not understand any of the questions.

Also to facilitate honest responses, efforts were made to build rapport with participants. Prior to completing questionnaires and interviews, this researcher shared with participants a brief story about her own experience as a former young athlete who
struggled with self-criticism and body image issues. The purpose of sharing this story was to normalize these types of challenges and create a safe environment in which to share about these challenges. Care was taken to facilitate a comfortable, informal setting (e.g., providing a snack, sitting cross-legged on the floor, using humour and casual language).

Interview questions were carefully paced, such that participants had enough time to consider and relay their responses. For each question, the researcher continued to ask for further elaboration and did not move on to the next question until the participant had nothing further to add. At the end of each interview, this researcher went back through each of the questions, summarized the participant’s prior responses, and asked whether she had any further information to add.

Care was taken to avoid leading questions. Questions were posed using open-ended language. Care was taken to avoid Yes or No questions. When participant responses were unclear, this researcher was careful to ask for clarification rather than offering up her own assumptions to be confirmed or disconfirmed.

### 2.5. Researcher bias

Prior to conducting interviews and analyzing data, this researcher reflected on her personal experiences and biases. In particular, this researcher may be biased based on her identity as a clinical psychology graduate student and former aesthetic athlete. As a clinical psychology student, she values balance in life and holds a personal belief that athletic achievement should not be pursued at the expense of one’s mental health, especially among adolescents and children. She also believes that self-compassion is an effective coping strategy and worthwhile endeavor. She practices self-compassion in her own life and perceives it as difficult to achieve but having few if any drawbacks. However, she is aware that in previous years, as a teenager and athlete herself, she likely would have been less open to self-compassion than she is now and may have viewed it with skepticism. As an adolescent, she was involved competitively in ballet and struggled with self-criticism and body image issues. Last, as a clinical psychology graduate student, she holds a theoretical orientation that is based heavily in family systems and attachment theory. She believes a young person’s ability to engage in self-
compassion will be strongly influenced by the security of their attachment relationships and the atmosphere of their training environment.

Although these traits may result in bias, they may also confer benefits. This researcher’s experience as an adolescent aesthetic athlete likely allowed her to better connect with participants, experience empathy for their experiences, and have insight into what types of probes to use. Knowing that this researcher had a background in aesthetic sport may have helped these participants feel more comfortable sharing about their own experiences.

2.6. Content analysis

Interview transcripts from the four intervention participants were analyzed separately from the ten interview-only participants, given that the intervention may have influenced participants’ attitudes toward self-compassion.

Transcripts were analyzed using the steps for content analysis outlined in Hancock (1998). The ten interview-only transcripts (i.e., the transcripts of participants who did not take part in the intervention) were read and re-read by this researcher, and notes were taken about potential meaning units or codes. Transcripts were then imported into NVivo 10 Software and re-read a third time as codes were generated for new meaning units. As each unit of meaning was identified from transcripts, it was either coded in a previous code, or a new code was generated for it. Through this process, the researcher identified four categories under which codes could be organized (i.e., benefits of self-compassion, drawbacks of self-compassion, barriers to self-compassion, and ways in which self-compassion is related to eating disorder symptoms). At this point in analysis, 44 codes were identified under Benefits, 9 codes under Drawbacks, 17 codes under Barriers, and 11 codes under Self-Compassion and Eating Disorder Symptoms.

This researcher then reviewed the list of codes, as well as the excerpts of transcript that were coded within each code. She considered which codes were similar and might be condensed into one, and which codes might be expanded. She also chose to expand one of the categories of codes (i.e., Benefits of self-compassion) into two categories (i.e., Benefits of self-compassion, and Ways of Using self-compassion). From
this process, a new list of codes was generated (12 under Ways of Using, 10 under Benefits, 3 under Drawbacks, 14 under Barriers, and 13 under Self-Compassion and Eating Disorder Symptoms).

Transcripts were recoded from scratch into these new codes. The researcher then reviewed the excerpts of transcript coded within each code to (a) confirm that codes were appropriate and did not need to be further expanded or condensed, and (b) move any excerpts of transcript that might be more appropriately coded elsewhere.

Transcripts from intervention participants were then imported into NVivo and coded. A sixth category was created for these participants’ comments related specifically to the intervention. Comments related to their attitudes toward self-compassion in general (i.e., comments not relating specifically to the intervention) were coded into existing codes. One new code was identified under Benefits, and three new codes were identified under Barriers. Thirty-three codes were identified under the Intervention category.

After codes were confirmed and all transcripts were coded accordingly, the researchers reviewed the list of codes and considered which codes might be linked to form major themes. From this process, three themes were identified under the Ways of Using category, four under Benefits, one under Drawbacks, three under Barriers, two under Self-Compassion and Eating Disorder Symptoms, and four under Intervention.

2.7. Analysis Plan

Research Question 1A was analyzed primarily using interview data from all fourteen participants who completed interviews (i.e., the four who completed the intervention, as well as the ten who completed an interview only without intervention). In addition, descriptive statistics on scores for self-compassion, body-related self-compassion, and eating disorder symptoms were obtained.

For Research Question 1B, interview responses (from all fourteen interview participants) pertaining to body-related self-compassion and eating disorder symptoms were used. Additionally, Pearson Product-Moment Correlations were used to analyze quantitative relationships among variables. For these correlations, data for all
participants who completed questionnaires (including baseline questionnaire data from the four intervention participants) was included.

For Research Question 2A, interview data from the four intervention participants was used. Specifically, this research question focused on responses detailing participants’ attitudes toward the intervention, and what they found to be helpful or unhelpful about it. Descriptive statistics were also gathered for attendance and adherence rates.

For Research Question 2B, responses pertaining to the effectiveness of the intervention (that is, whether or not it produced changes in self-compassion, body-related self-compassion, and eating disorder symptoms) were analyzed ($N = 4$). Additionally, dependent samples t-tests were used to examine the differences between pre- and post-intervention scores on all study variables. Although power ($1 - \beta$ err prob) was low (6 percent, 11 percent, and 21 percent to detect a small [$d = 0.2$], medium [$d = 0.5$], or large [$d = 0.8$] effect, respectively) alpha was maintained at .05.

Also for Research Question 2B, diary cards were analyzed descriptively (inferential statistics were not pursued due to inconsistent adherence to diary cards across participants). Specifically, for each participant, a mean score was obtained for Questions 2, 3, and 4 for (a) each session of the intervention, and (b) all sessions combined. Within-subject analyses were performed by plotting mean scores for each diary card question for each session of the intervention (i.e., Participant 1 mean score Session 2, Participant 1 mean score Session 3, Participant 1 mean score Session 4; see Figure 4, Appendix B). Last, in order to permit longitudinal analysis of changes in diary card responses for all participants across the intervention, grand mean scores (i.e., the mean of each participants’ mean score) were obtained for each session of the intervention. These scores were calculated by obtaining a mean score for each participant and then averaging these scores for each session of the intervention (i.e., Participant 1 mean for Session 2 + Participant 2 mean for Session 2 + Participant 3 mean for Session 2 + Participant 4 mean for Session 2, divided by four). Descriptive terms for changes in scores (i.e., “slight,” “moderate,” and “large”) were chosen based on the observed data, with changes between 0.75 and 0.99 defined as “slight”, between 1.00 and 1.99 defined as “moderate,” and over 2.00 defined as “large.”
Chapter 3.

Results

3.1. Demographic variables

The following descriptive statistics are based on the entire sample ($N = 49$). Twenty-six (53.1%) identified as Caucasian, twenty-one (42.9%) as Asian, and two (4.1%) as Middle Eastern. Most (77.5%) were born in Canada, and some (22.4%) had immigrated from another country (China, Philippines, or France) before the age of eleven. Data on socioeconomic status (SES) is missing for many participants (40.4%) as they did not know their father’s highest level of education. However, for those who reported on SES, very few (6.4%) had fathers who had not completed at least some post-secondary education. Most participants (76.6%) lived with both parents, 17% with one parent, and 4.3% with their mother and step-father. One of the older participants lived away from her parents. Four participants (8.5%) reported having been diagnosed with depression, three (6.4%) with an anxiety disorder, and none with an eating disorder. Based on their self-reported height and weight (which many participants admitted guessing about), their mean body mass index (BMI) was $18.64$ ($SD = 3.01$) and ranged from $13.5$ to $25.8$.

Among the 48 participants who completed the questionnaires, 23 were dancers, and 25 were figure skaters. Nineteen had competed at local competitions, 13 at provincials, and 12 at national or international competitions. Three participants had not taken part in any competitions. The number of years they had been training ranged from less than one year to fifteen years ($M = 7.16$, $SD = 3.80$). The number of hours per week that participants trained ranged from “one to five” to “30 to 40”, with most (29.8%) participants training for 16 to 20 hours per week.

Among the fourteen participants who completed interviews, ages ranged from 12 to 19 ($M = 14.79$, $SD = 2.39$). Five were dancers and nine were figure skaters. Four of the figure skaters also contributed data to the intervention portion of the study. Among the fourteen, three had competed at local competitions, seven at provincial competitions, two at a national competition, and two at the international level. The number of years
they had been training for ranged from three to fifteen \((M = 8.93, SD = 3.63)\). The number of hours per week they spent training ranged from “6 to 10 hours” to “30 to 40 hours”. Eight identified as Caucasian, and six as Asian.

Among the four figure skaters who completed the intervention (as well as the questionnaires and interviews), ages ranged from 12 to 19 \((M = 14.75, SD = 3.11)\). One had competed at the provincial level, one at the national level, and two at the international level. On average, these skaters had been training for 10.75 years \((\text{min} = 9 \text{ years}, \text{max} = 15 \text{ years})\). Two trained for 30 to 40 hours per week, one for 21 to 25 hours per week, and one for 16 to 20 hours per week. Three identified as Caucasian, and one as Asian. Table 3 (Appendix A) shows a breakdown of demographic variables for the ten interview participants and the four intervention participants. Tables 4 and 5 (Appendix A) show the scores on study variables for interview participants and intervention participants.

Demographic variables \((N = 49)\) were not associated with scores on study variables, with a few exceptions. Correlations showed that age was significantly correlated with self-judgment \((r = .40, p \leq .05)\), drive for thinness \((r = .36, p \leq .05)\), bulimia \((r = .35, p \leq .05)\), and body dissatisfaction \((r = .37, p \leq .05)\). Correlations showed that years spent training also positively associated with drive for thinness, bulimia, and body dissatisfaction, but this was accounted for by age. Lastly, correlations showed that BMI was significantly correlated with self-judgment \((r = .34, p \leq .05)\), drive for thinness \((r = .56, p \leq .01)\), bulimia \((r = .47, p \leq .01)\), and body dissatisfaction \((r = .56, p \leq .01)\). Age and BMI were also significantly correlated \((r = .71, p \leq .001)\).

### 3.2. Group comparisons

Chi square and anova analyses showed that the three groups of participants (i.e., questionnaire-only, interview, and intervention) did not differ in terms of age, ethnicity, BMI, age when they started training, number of years spent training, or highest level of competition \((p > .05)\). They also did not differ in terms of study variables (i.e., scores on self-compassion, body-related self-compassion, and eating disorder symptoms). They did differ in terms of how many hours per week they spent training \((X^2 (10, N = 45) = 30.99, p \leq .001)\), with the intervention participants training for significantly more hours per week than the other two groups. (Note that hours per week spent training was
measured as a categorical variable using the following categories: 1 to 5 hours per week, 6 to 10 hours per week, 11 to 15 hours per week, 16 to 20 hours per week, 21 to 25 hours per week, 26 to 30 hours per week, 31 to 40 hours per week, 40 hours or more per week).

Dancers and skaters were also compared and did not differ in terms of age, the number of years they had spent training, their highest level of competition, or hours per week spent training ($p > .05$). The dancers reported a somewhat higher BMI (dancers $M = 19.69$, $SD = 2.81$; skaters $M = 17.52$, $SD = 2.88$; $t(35) = 2.33$, $p \leq .05$). Dancers and skaters also differed greatly in terms of ethnicity ($\chi^2 (2, N = 47) = 26.35$, $p \leq .001$), with the majority (75%) of skaters being Asian and the majority (91%) of dancers being Caucasian. This is most likely due to the geographical location of the recruitment site for dancers versus skaters. Of note, study variables did not differ as a function of ethnicity ($p > .05$).

Dancers and skaters did not differ in terms of their scores on study variables ($p > .10$), with one exception. Skaters showed significantly higher scores on the EDI Perfectionism subscale ($M = 13.04$, $SD = 6.33$) compared to dancers ($M = 9.55$, $SD = 5.15$; $t(44) = 2.04$, $p \leq .05$).

3.3. Research Question 1A: Qualitative Results

Research Question 1A inquires about adolescent aesthetic athletes’ experiences of and perceptions of SC. Table 6 (Appendix A) shows an outline of the codes and themes that emerged from the interviews with fourteen participants. In the section below, major themes are capitalized and italicized, and subthemes are italicized.

3.3.1. How to use self-compassion

Regarding how they use self-compassion in their daily lives, three major themes emerged: (1) Thinking Positively, (2) Acceptance, and (3) Self-Care.

Thinking Positively

In terms of the theme Thinking Positively, many participants ($n = 8$) talked about encouraging and believing in oneself. They described using motivating self-statements,
especially before performances, as well as statements encouraging themselves to keep trying, especially in the face of imperfections or failures. Comments included:

- I just told myself to keep trying, don’t give up. I’ll be able to get it eventually.
- I tell myself that I know I can do this, I’ve done it a million times. I just need to trust myself.

Some participants \((n=5)\) highlighted the importance of focusing on one’s strengths, especially in the face of imperfections or failures. That is, when they feel upset about one of their flaws or shortcomings, they remind themselves about the things they are good at. Comments included:

- I just tell myself, “Sure, you may not be the best at flexibility, but you’re pretty good at pirouettes, so you should just work on your flexibility, and it’ll all come together eventually.”
- I was struggling with my legs on this one jump and getting really frustrated. Then I was like, “You know what? My coaches said that my arms were good. So I’m just going to focus on my arms for now.”

Other participants \((n=8)\) discussed the importance of achieving a balance between positive self-talk and critical self-talk. They explained that, with too much self-criticism, one can become frustrated, unmotivated, anxious, or fatigued, but with too much positive self-talk, one can become complacent or lazy. Comments included:

- You need to find that middle. Like, you can’t be too nice to yourself; otherwise, you won’t improve anything. But then if you’re too hard on yourself, you still won’t improve anything because you’re focusing on the negative. You have to be right in the middle.
- I think moderation is key. You can be a little hard on yourself, but not too much. Cause when I’m thinking positively and being a little hard on myself, I know I do better.

**Acceptance**

Many participants \((n=8)\) talked about accepting flaws and failures. They pointed out that when one’s flaws or failures cannot be changed, acceptance allows one to better cope with painful emotions and move forward. Comments included:

- Like, if I fall on a really easy jump, I feel, like, embarrassed a bit... But I remind myself, like, “It’s ok to mess up. I can’t always land jumps perfectly.”
- I just need to let it go. I can’t fix everything about myself.
• I’ve realized how important it is to like accept yourself as you are, and like yourself as you are. Like, it doesn't mean that you don’t want to improve still. You still want to be able to set goals. But also be able to accept yourself along the way.

Participants (n = 5) talked about the importance of reminding oneself that no one is perfect. They recognized that everyone makes mistakes, and being imperfect is a normal part of being human. They indicated that this attitude helps them accept their flaws and failures. Comments included:

• I think it’s just realizing that other people go through the same things that you go through. Like, if you fall doing an easy move, like, a lot of people do that. It’s ok.
• You can’t be great at everything. Because someone who is great at everything isn’t real. Everyone has something that they don’t like about themselves.

Participants also discussed the importance of focusing on improvement (n = 8). That is, when they are faced with flaws or failures, they focus on what they can work on in order to improve their skills and possibly perform better next time. Again, this seemed to facilitate greater acceptance of flaws and failures. Comments included:

• Sometimes in practice, if I fall a lot, I’ll just be like, “Ok, I’m having a bad day. It’s ok. Tomorrow, I’ll work harder, and I’ll land all of the jumps that I didn’t today.”
• When I did bad in the competition, I told myself it was ok, and there is always next competition to improve.

In addition to accepting flaws and failures, participants also talked about accepting negative emotions (n = 3). They recognized that painful emotions cannot simply be willed away or turned off like a light switch. Instead, participants believed that one must acknowledge painful emotions and accept them as they are. They believed that this acceptance of painful emotions is necessary for coping with upsets and moving forward. For example:

• I think it helps you handle situations a little bit better. Sort of being mindful of how I’m feeling and not just ignoring it, because then it only gets worse.
• For example, today and yesterday, I was having a really bad training day, and I was in a lot of pain from my injury. So I just took a deep breath, and I recognized that yes, this is a lot to feel right now, and that’s ok.
**Self-care**

Participants \((n = 5)\) also talked about the importance of Self-Care. That is, they talked about engaging in pleasurable activities or taking breaks, especially when they are feeling upset, tired, or stuck on a skill.

- A month before my very first competition, I was working on back spin, and I just could not do it. And I got really upset. But I was like, “You know what, I’ll just take a break from this for a while, and when I come back to it, it’ll be great.”
- When I’m hurting, I’m like, “Ok.” And I take a step back. I have a bath or I read a book. I sit and take time to acknowledge what it is.

**3.3.2. Perceived benefits of self-compassion**

In addition to how they use self-compassion in their daily lives, participants were asked about perceived benefits of self-compassion. Three themes emerged: (1) Mental Health and Emotional Benefits, (2) Athletic Benefits, and (3) Social Benefits.

**Mental health and emotional benefits**

In terms of Mental Health and Emotional Benefits, participants \((n = 9)\) talked about increased self-esteem. They believed that having self-compassion would allow them to feel better about themselves, especially in the face of setbacks and failures. Comments included:

- I just feel like, instead of beating yourself up, if you use self-compassion, you’ll feel much better about yourself.
- Mentally, I’d be more happy with myself. And having a good mindset would always be helpful because you’re not like… always drilling on the bad things. You’re looking at the big picture, which helps you feel better about yourself.

In addition to increased self-esteem, another perceived benefit of self-compassion was increased happiness and quality of life \((n = 6)\). Participants discussed how self-compassion can lead to greater optimism and joy, as well as fewer negative emotions. Comments included:

- I believe it could make somebody generally more happy with themselves. And when you’re more happy with yourself, you’re more happy with the world. Because you’re more optimistic, and stuff like that. I feel like when you have
self-compassion, you’re generally just… You enjoy things more, and you find
the good in things more often.

• It would just make me feel better all around, and I won’t cry as much. I’ll just…
  have more smiles than frowns.

• I just feel like I’d enjoy my whole life overall better. Not just dance but like
  school, home time, free time, summer time. I wouldn’t always have to worry
  what others thought of me or how well I did at stuff. All these things would just
  be taken off my shoulders.

Another perceived benefit of self-compassion was lower anxiety and increased
confidence \((n = 5)\). Participants explained that self-compassion helps them feel confident
in themselves and thus allows them to worry less about social judgment or about
the outcome of performances. Comments included:

• With self-compassion, I probably wouldn’t be so sensitive. Like, I’m always
  sensitive to how people judge me. Like, I always think, “What are they saying
  about me?” or “They’re probably saying like, ‘oh she’s so short compared to all
  the other girls.’” But if I had self-compassion, it would be like, I could maybe
  get rid of some of my fears and put them behind me and be more bold, and
  just… not be so scared of my surroundings and what people think of me.

• With self-compassion, you feel good about yourself. And if you feel good
  about yourself, then you’re more confident in your ability to deal with things,
  and less anxious that you won’t be able to deal with it.

Another perceived benefit of self-compassion was coping with upsets and
setbacks \((n = 3)\). Participants expressed that when they experience setbacks, such as a
bad training day or a loss at a competition, self-compassion helps them accept the
situation, deal with their upset feelings, and move on. Comments included:

• I think it’s helpful when you’re in a situation that you can’t change. Like, you
  kind of just have to deal with it. And the way that you deal with it can kind of
  change the way that you think about it, and that can help you be easier on
  yourself and feel better about it. And I think self-compassion can help with
  that.

• I think it helps you handle situations a little bit better. Sort of being mindful of
  how I’m feeling, and like, thinking of the positives.

Participants also perceived self-compassion as a substitute for social support \((n
= 4)\). They explained that during upsetting moments, friends and family are not always
available to provide support and comfort, and one must learn how to cope
independently. Comments included:
• You won’t always have other people around. Like, for example, I sometimes allow myself to think more negatively when I know my friends are around to reassure me. Not on purpose, but subconsciously. But relying on yourself is definitely a skill. You are in control of what you do. You are responsible. So you should take responsibility for how you treat yourself and how you think. Like, it’s ok to feel happiness from other people, but it’s also important to be happy with yourself, rather than having all your happiness depend externally

• Like treating yourself how you would treat another person—with kindness and support—and kind of being able to rely on yourself that way. Like knowing when you can seek comfort from others, but also knowing how to do it for yourself.

**Athletic Benefits**

A second theme that emerged regarding benefits of self-compassion was Athletic Benefits. First, participants believed that self-compassion would result in *improved work habits* (*n* = 9), such as increased effort, motivation, and focus, and decreased procrastination. They explained that, because self-compassion evokes positive emotions, athletes are more likely to feel energetic and motivated, and less likely to avoid working on something that is difficult. Comments included:

• It helps you have confidence to push yourself and be motivated because it obviously... Like, if you don’t think you can do something, you’re not going to try. Or if you think your best isn’t good enough, you’re not going to push past it. Like you kind of create, like, borders for yourself. But self-compassion gives you the confidence to keep pushing and work harder.

• Self-compassion is like motivation for yourself. It’s like, “Ohhh, I see something that I’m doing well at; I should keep working hard at that,” because it feels good to see your improvements.

• Instead of being mad at myself and avoiding the spin altogether, I could have been like, “It’s ok, you can keep on trying. You’ll get it eventually.”

• When you’re happy with yourself, you have more to give. Because you’re full. Like a full tank of gas. You’re more efficient. You can work harder.

Participants also believed that self-compassion can lead to *improved skill* (*n* = 7). They explained that, because self-compassion facilitates motivation and effort, it in turn can lead to skill development and progress. Comments included:

• I feel like it can open up more ways to improve your dancing, because you accept your faults and you learn from them. Like you don’t just let them kind of like, embed themselves inside you, and kind of make you feel awful. You let them be learning curves.
With self-compassion, you might take more risks, because you feel better able to handle them, and also because you know that if you didn’t [achieve] it, it would be ok because you’re really nice to yourself and you understand that it’s ok to make mistakes. So I think self-compassion can make you more successful in that way.

The third athletic benefit identified by participants was enhanced performance ($n = 4$). Participants believed that, in addition to improved skill development, self-compassion could help them perform better at competitions because it allows them to cultivate the mindset needed to concentrate and execute difficult skills. Comments included:

- There’s like two voices, one that is really really negative and criticizes every little thing I do, and the other will just keep motivating me and be compassionate and understanding. And I’m usually able to land a hard jump once I kind of tune in to that positive side more.

- Self-compassion helps you stay positive. If you’re negative, you’re not going to do well. In skating, most of the jumps are mental. Like mentally, if you think you’re going to do bad, then you’re not going to land the jump. But if you think you’re going to do good, then you’ll probably land the jump.

The fourth athletic benefit identified by participants was retention in the sport ($n = 4$). Participants recognized that self-compassion allows them to stay positive, experience positive emotions, and generally enjoy their sport more, even during setbacks and failures. In this way, they perceived self-compassion has a method for avoiding burnout. Comments included:

- With self-compassion, I’d feel better about myself. Nothing will ever make me feel like, “You need to quit,” or like, “You’ll never be as good.”

- Once I started focusing on the good parts of my dancing, it really helped, because I looked forward to dance again.

- If you’re too hard on yourself and don’t have self-compassion, then you’re more likely to burnout and feel not motivated. And that’s a really big reason why a lot of people quit, or they kind of have, like, a meltdown.

**Social connections**

The third theme identified regarding benefits of self-compassion was Social Benefits. First, participants believed that self-compassion confers benefit to peers and the group ($n = 3$) as a whole. They explained that self-compassion could spread among
the club or training group, creating a culture of self-compassion that would promote better team work and greater success among all club members. Comments included:

- I feel like it could help the dance studio as a whole, because if you have somebody in the group who has self-compassion and loves herself, then she could kind of show other people how to love themselves too. Cause when one person kind of puts themselves down all the time, it kind of puts the whole group down.

- With self-compassion, you could be a better role model for younger kids. Because if they see this person exuding confidence, people usually gravitate toward those people.

- When you love yourself, you have more love to give. So if the whole group of kids loved themselves, they would be so much more successful. They’d work better as a team.

Second, participants believed that self-compassion could promote more positive relationships ($n = 4$) with others more generally. They explained that, when one has compassion for herself, she is more likely to have compassion for others and to treat others with respect. Comments included:

- I think that when you like yourself, it makes treating other people with kindness a lot easier, too. I just feel like, if you love yourself, or you treat yourself with respect, you are not going to treat someone else with disrespect.

- Self-compassion makes you happier. And people would probably like you more too. Because sometimes if you don’t have self-compassion, then you’re not as… You’re harsher on other people. Since you’re always beating yourself up, like, “Why can’t I do this? Argh!” People start talking to you, but you’re like, “No, leave me alone, I need to get this!” And you get really mad and stuff.

3.3.3. Perceived drawbacks of self-compassion

Participants were asked about potential drawbacks of self-compassion. Many identified a risk of becoming cocky or lazy ($n = 9$). They explained that, if self-compassion and self-kindness is “taken too far,” one could become overly forgiving of one’s flaws or overly confident in one’s skill level. As a result, one runs the risk of becoming arrogant, defensive toward constructive criticism, or complacent and unmotivated to improve. Comments included:

- If self-compassion goes too far, to the point where it becomes cocky, then you might kind of have these blinders on where you don’t see what things you
need to improve on. Like, “Oh, I’m the best.” And then you start being like a sore loser or something.

- If you had too much self-compassion, then you might be like, “Ok, I’m fine just right here, like this is fine.” When you could be so much more of a greater dancer. Like you probably have so much more potential than you’re giving out.

- Maybe you wouldn’t critique yourself enough. Like maybe if you fail at something, you might just say, “Maybe I’ll just work on this later.”

Other participants ($n = 5$) were not able to identify any drawbacks. Some of these participants highlighted the potential risk of becoming cocky or complacent, but reasoned that if self-kindness was taken to this extent, it would no longer constitute true self-compassion. Comments included:

- I think if it’s done right, then there are no drawbacks. Because I think moderation is key. Self-compassion means pushing yourself to do better but also remaining positive and understanding. And if you do both, then it’s really hard to go wrong.

- No, I don’t think there are any drawbacks. I think it’s pretty helpful to care about yourself and know that I can push myself this far, and I can ease up a little until this, but knowing that I need to keep pushing myself. I don’t think it’s bad to have self-compassion, as long as you have a happy medium.

### 3.3.4. Perceived barriers to self-compassion

All participants agreed that self-compassion is beneficial in many ways, but they also all agreed that self-compassion can be difficult to execute or achieve. They identified four themes as barriers to self-compassion: (1) Cognitive Barriers, (2) Emotional Barriers, (3) External Barriers, and (4) Age as a Barrier.

#### Cognitive Barriers

Regarding Cognitive Barriers, participants pointed out that self-compassion is difficult to do when you have a lack of knowledge or practice ($n = 4$) with it. Some explained that, before having learned about self-compassion, it had not even occurred to them that they could treat themselves in a kind and understanding manner. Others were aware of the concept of self-kindness but did not know how to go about doing it. Comments included:

- If you didn’t know much about self-compassion, it would be hard to understand it and use it. You might be like, “Oh this is kind of weird. I don’t know how to
use this.” And then you would go back to being hard on yourself, because everybody knows how to do that!

As a second Cognitive Barrier, participants \((n=7)\) stated that it is difficult to achieve a balance between being too kind to oneself and being too hard on oneself. That is, it is difficult to find that line where self-kindness becomes complacency or “self-coddling,” and where being critical of oneself becomes “self-bullying.” Comments included:

- Knowing when to stop is hard. Like knowing where the middle is. If you’re going too hard on yourself or if you’re going too easy on yourself. It’s like a tug of war.

- When you’re in a competitive sport, you always want to be getting better everyday. And like, it’s kind of hard to not be hard on yourself, because sometimes you don’t know when you’re like being too hard, and when you’re just like encouraging yourself. And it can get kind of confusing.

Participants \((n=3)\) also pointed out that metacognition is difficult. That is, it is challenging to notice and monitor one’s thoughts. In this way, it is difficult to notice when one is being too hard on oneself and is in need of self-compassion. Comments included:

- I think it’s difficult because it’s more to do with your thoughts, and trying to monitor that is difficult because you don’t actually see it. It’s not physical. And it’s very easy to let yourself slip and let your mind wander.

- I think that most people are just hard on themselves in general. Everyone is like that. But like, during that moment, you don’t notice it. And then like, you don’t have a clear mind, and it’s hard to do self-compassion.

**Emotional barriers**

In addition to Cognitive Barriers, participants pointed out two Emotional Barriers. First, many participants explained that it is difficult to have self-compassion when one is experiencing negative feelings towards oneself \((n=10)\). They explained that, during moments of failure, perceived shortcomings, upward social comparison, or negative self-talk, it is difficult to be kind to oneself or to conjure up examples of one’s strengths. Comments included:

- I have more negative thoughts about myself than I have good thoughts about myself. So when you have more negative, it kind of overpowers the positive.

- I try to use self-compassion, but I have the voices that tell me that like, I’ll never do good. I try to give myself a pep talk, but then like when every
competition comes and I don’t place, my self-compassion goes down a level, and the bully in my head goes up a level.

• Getting into the mindset is kind of hard, because like, it always seems like everyone else is always getting better than you are. And sometimes if you’re not having the best day, it’s hard to remind yourself of all the good things about you.

• It’s hard to say nice things to yourself when you mess up. Like if I mess up skating, or I make like a stupid mistake, I’m like, “How could I mess that up?” Like, “That was the stupidest thing ever! I just fell doing the easiest move.” And it’s really frustrating.

As a second Emotional Barrier, participants explained that it is difficult to use self-compassion when one is *too emotional or impulsive* (*n* = 3). They explained that intense emotions can cloud one’s thought processes and impede self-awareness. They also explained that intense emotions also make it difficult to act rationally, leading to impulsive behaviour. Comments included:

• When I’m really upset, I start thinking very impulsively. And I’m not thinking about anything else. I’m not very aware. And I don’t try to stay aware of myself. I don’t really fight the negativity. I feel weak in that moment.

• When you’re actually in the situation, it can be kind of hard to calm down, and you might be like, “Ok, I don’t care about this self-compassion thing right now.”

**Social Barriers**

In addition to Cognitive Barriers and Emotional Barriers, participants highlighted several Social Barriers. First, participants explained that it can be difficult to use self-compassion when one has a *harsh coach or training environment* (*n* = 3). That is, it can be difficult to be kind and forgiving toward one’s flaws when the training culture promotes a more harsh and critical stance. Comments included:

• I think it’s really hard to be self-compassionate when voices of authority are telling you the opposite. When your coaches are really hard on you, you just think that’s the norm.

• Self-compassion doesn’t really work when your coaches get mad. Like if your coaches are like, “I can’t believe you just did that,” and they’re mad at you… And you’re like, “Well, they’re right.” You can’t be nice to yourself and change that. Cause that would kind of be like saying, “Yeah, whatever, my coaches don’t know anything, and I’m perfect.”

A second Social Barrier to self-compassion identified by participants was *harsh or critical parents* (*n* = 4) They explained that it is difficult to be kind and forgiving toward
oneself when one’s parents are overly critical of them or do not believe in self-compassion themselves. Comments included:

I feel like people’s parents would influence them a lot. I have friends whose parents are really hard on them, and I think that would make it hard. Because, how can one person be so hard on you, and then you’re just so, like, happy about yourself. That would be kind of hard.

How you grow up, your household, your parents, your culture… That’s very influential, especially when you’re a child and still trying to develop your own sense of yourself. I think that’s why many people are so hard on themselves.

If I tried to be compassionate to myself, my parents wouldn’t approve of that. My parents expect me to be really hard on myself. They told me that if you don’t work hard, you can’t get a job.

The last Social Barrier identified by participants was lack of social support and guidance (n = 3). They explained that, especially at a young age, teenagers need someone else to treat them with compassion first, or to model self-compassion, before they themselves can use self-compassion. Comments included:

• If you feel really bad about yourself and your self-compassion is built way down, you’re probably going to need to borrow someone else’s self-compassion. Like if you have a friend there who can be like, “Ok, this is wrong to treat yourself this bad. Like, you just need to stick to you.” Like just, “You do you.” Like, it’s ok to be who you are.

• It’s, like, hard to find a good balance if you’re just doing it by yourself. Like, without my friend helping me, I’d definitely be like, “ Whatever, I just won’t do [self-compassion].”

• When kids are in their head, like, “Oh, I’m not good enough to be a dancer,” I think sometimes they need to be told, like…. They won’t just do it on their own. They need to be told to take a step back and consider what they are good at.

Age as a barrier

In addition to Cognitive, Emotional, and Social Barriers to self-compassion, several participants identified age as a barrier, explaining that self-compassion may be especially difficult during adolescence (n = 4) due to increased emotional reactivity, limited life experiences, and immaturity in general. Comments included:
• I had a lot more self-love when I was younger, before I was a teenager.

• When I was younger, like 12, 13, I just remember being so hurt. I would cry and cry and just shut everyone out. I didn’t want to talk about it or think about it. You’re going through so many emotions, and changes, and, like, the hormones. And then also not having all those life experiences behind you.

• [Young teens] can’t do self-compassion on their own. They can’t step back and do that for themselves. You learn that as you get older, through experience.

• I think when I was first, like, becoming a teenager, it was definitely harder because I didn’t have like a baseline to see what was normal. Like, I thought being hard on yourself was normal.

Some participants agreed that self-compassion should be taught \((n = 4)\). They recognized that self-compassion is not widely discussed and practiced in Western culture and may not even enter the consciousness of youth unless they are explicitly taught. They expressed a belief that self-compassion should be taught as an antidote to self-criticism. Comments included:

• Especially as girls are growing up, I think it’s important that we learn to love ourselves and care for ourselves really early on, and not just when it becomes a problem. Like I think in school and stuff, there was no preventative teaching of like learning to love yourself. Like, it’s a lot harder to kind of learn how to love yourself once you’re already in the habit of self-bullying.

• If I would have known how to be compassionate with myself at a younger age, it would have helped me through a lot of things. I could have been like, “Hmm, I’m not their cup of tea, but I’m someone else’s.” You just don’t think of that when you’re younger. It should be taught in studios more formally.

3.4. Research Question 1A: Quantitative analysis

Research Question 1A asks about participants’ experiences of and perceptions of self-compassion. Descriptive statistics including mean scores on study variables of the 48 participants that completed questionnaires are shown in Table 7 (Appendix A). The mean score on the SCS Total subscale in this study is comparable to that reported in studies with large samples of adolescents (e.g., \(M = 3.04, SD = 0.56\) in Cunha et al., 2016; \(M = 2.97, SD = 0.62\) in Neff & McGehee, 2010) and with large samples of female adolescent athletes (e.g., \(M = 2.97, SD = 0.52\) in Mosewich et al., 2011).
3.5. **Research Question 1B: Qualitative analysis**

Research Question 1B asks about participants' perceptions of and experiences with body-related self-compassion, as well as the relationships between self-compassion, body-related self-compassion, and eating disorder symptoms. Table 8 (Appendix A) summarizes the themes and codes that emerged from qualitative data based on the fourteen participants in the interview portion of the study.

3.5.1. **How to use body-related self-compassion**

Regarding the question of how to use body-related self-compassion, the themes that were identified were identical to those identified for general self-compassion. They were: (1) Thinking Positively, (2) Acceptance, and (3) Self-Care. Comments for these three themes, respectively, included:

- Even if you weren’t like a really thin girl, you could be like, “Ok, even though I’m not that skinny, I have a lot of muscles.” (Theme: Thinking Positively)

- I was just like, I have to accept my body how it is. And I can still make it look good even though I don’t have really long legs. (Theme: Acceptance)

- Knowing that, as long as you’re healthy and you’re happy, like that’s all that really matters. Like yes, you could exercise more, if you wanted to, but... Your body is your body. Every single cell is fighting to keep you alive, and they always are. So it’s important to care for it. (Theme: Self-Care)

Within these themes that were identical to those identified with general self-compassion, participants identified some unique codes for body-related self-compassion. Under the theme of Acceptance, they discussed the importance of **balanced eating** \((n = 3)\). They explained that being overly restrictive or disciplined with one’s eating habits is unrealistic and unhelpful because it sets one up for failure. Instead, one should strive to be accepting toward imperfect eating habits. Comments included:

- Yesterday I ate a waffle, and I was getting so upset about it. I was like, “I need to go to the gym. I ate too many calories.” But then I was like, “Why am I getting upset at myself for eating a different way than I planned?” Like, I should have a cheat day! If I want a waffle, I should have that stupid waffle! [Laughter.]

- I’m like “You are healthy. You eat healthy. You are allowed to every once in a while have things that you enjoy.”
Also under the theme of Acceptance, participants talked about the beauty of different body types \( (n = 6) \). They explained that no two bodies are alike, and being different from others can have its own benefits. They also believed that different body types contribute to a diverse and varied population of people. Comments included:

- With self-compassion, I could have more faith in myself and be like, this is who I am. If everybody was the same, then it would just be one boring world. Everybody has to be different, and this is who I was chosen to be.
- Oh that’s the beauty of it all! Like, everyone is so different.
- There’s really nothing you can do about the way you were made. You just have to learn how to like, accept that some things might be a little different. But like, the things that are different also make you unique. And you might stand out more to the judges that way.

A unique code under the theme of Positive Thinking was the need to scrutinize media \( (n = 3) \). Participants explained that it is important to be aware that media images of female bodies are not representative of the average female body, and one should be mindful about this when viewing media images. Comments included:

Self-compassion could help you be more aware of like advertisements and what they’re saying. Like I never realized it before, but most people in the real world are not as skinny as the people on TV. There’s a lot of people out there who have a normal body size.

- Whatever you see in the media isn’t accurate. It’s not good. You shouldn’t try to follow that.
- I think it’s kind of, like, ignoring what social media or what you see in public. Because like, models are, like, long skinny legs, and shiny, and their boobs and butts are perfect. But in reality, if you don’t have a good personal trainer, or your body shape was just not born that way, you’ll never look like that.

### 3.5.2. Barriers to body-related self-compassion

All of the participants \( (n = 14) \) agreed that having body-related self-compassion could be helpful in preventing and treating body image issues and disordered eating. However, several participants identified barriers to body-related self-compassion. In particular, and similar to the theme identified for general self-compassion, all participants mentioned the Emotional Barrier of having negative feelings towards oneself \( (n = 14) \).
They explained that it is difficult to have compassion towards one’s body when confronted with one’s body flaws or when experiencing a situation that provokes negative feelings about one’s body. For example, one comment was:

• When I see pictures of myself, I hate that. I'll be smiling for the picture and feel like I’m looking good, but then I’ll look at the picture and be like, “Oh, my arms look really big,” or something like that. And then it’s hard to feel good about myself or be nice to myself when I see that.

A unique code identified as a barrier to body-related self-compassion was that in some cases, the desire to be thin is too strong \((n = 3)\). Participants explained that at times, it is difficult to accept one’s body or to acknowledge positive aspects of one’s body because the desire to be thin overpowers or undermines such thoughts. Comments included:

• I think sometimes self-compassion might not work for negative body image. Let’s say someone is like, “Ugh, I’m so fat,” and you say to them, “No, you’re fine.” But like, some people don’t say any of that positive stuff to themselves. They just keep wishing their body was different.

• I remember being told, “You’re not going to be like everyone else, but you should just love yourself how you are.” And I was like, “Phh, yeah ok. But I want to be skinny.

Similar to the barrier identified for general self-compassion, participants identified Age as a barrier and referred specifically to puberty \((n = 3)\). They explained that the physical changes associated with puberty led them to feel dissatisfied with their body, thus making it more difficult to be kind and accepting toward one’s body. This is presumably because puberty involves increased fat deposits and the emergence of breasts and broader hips, which moves females away from the slender ideal sought in ballet and figure skating. Comments included:

• When I was younger, I used to have more confidence. I used to be able to talk to people more, because I was skinny. And then when puberty hit, my fat deposited differently in my body, and my metabolism slowed and stuff. Now it’s harder to have self-love.

• When I was younger, like 12, when I was going through puberty and getting hips and boobs and stuff, that was really hard. And it was hard to feel good about myself.
3.6. Research Question 1B: Quantitative results

Research Question 1B asks about the relationship between self-compassion, body-related self-compassion, and eating disorder symptoms. It was hypothesized that self-compassion and body-related self-compassion would be positively correlated, and both of these variables would be inversely correlated with eating disorder symptoms. Data from the 48 participants who completed questionnaires supported this hypothesis (Table 9, Appendix A). Total scores on the Self-Compassion Scale were inversely correlated with symptoms of bulimia ($r = -.34, p \leq .05$), and body dissatisfaction ($r = -.37, p \leq .05$), and perfectionism ($r = -.59, p \leq .01$). Body-related self-compassion was inversely correlated with all eating disorder symptoms including drive for thinness ($r = -.48, p \leq .01$), bulimia ($r = -.54, p \leq .01$), body dissatisfaction ($r = -.68, p \leq .01$), and perfectionism ($r = -.34, p \leq .05$).

Also examined were correlations between eating disorder symptoms and the subscales on the Self-Compassion Scale (i.e., Self-Kindness, Self-Judgment, Common Humanity, Isolation, Mindfulness, and Over-Identification). The Self-Judgment subscale was positively correlated with all eating disorder symptoms including drive for thinness ($r = .40, p \leq .01$), bulimia ($r = .48, p \leq .01$), body dissatisfaction ($r = .65, p \leq .01$), and perfectionism ($r = .54, p \leq .01$). The Over-Identification subscale was positively correlated with bulimia ($r = .37, p \leq .05$), body dissatisfaction ($r = .35, p \leq .05$), and perfectionism ($r = .39, p \leq .01$). The Self-Kindness subscale was inversely correlated with bulimia ($r = -.30, p \leq .05$) and perfectionism ($r = -.57, p \leq .01$). The Common Humanity subscale was inversely correlated with perfectionism ($r = -.32, p \leq .05$). Likewise, the Isolation subscale was also positively correlated with perfectionism ($r = .53, p \leq .01$). The Mindfulness subscale was not correlated with any of the eating disorder symptoms ($p > .05$).

Because the sample in this study was rather diverse in terms of age, these analyses were re-performed excluding preadolescents (i.e., participants under age 13, $n = 13$). All of the significant correlations listed above remained, with the exception of the correlations between Self-Kindness and bulimia, between Over-Identified and body dissatisfaction, and between BRSC and perfectionism; these correlations became non-significant at the .05 alpha level. This may have been due to decreased power, given
that the correlations were in the same valence (i.e., positive/negative) and were approaching significance (i.e., $p < .10$).

Post-hoc partial correlations were performed to determine whether or not body-related self-compassion accounted for the significant correlations between the self-compassion subscales and eating disorder symptoms. As expected, body-related self-compassion did account for many of these associations (Table 10, Appendix A). However, it did not account for all of them. In particular, it accounted for few of the significant correlations with the EDI Perfectionism subscale.

### 3.7. Research Question 2A: Qualitative Results

Research Question 2A inquires about participants’ experience of and perceptions of the intervention, especially what they found helpful and unhelpful. The results presented below refer to the intervention group only ($n = 4$).

#### 3.7.1. First impressions

Participants were asked how they felt about the intervention once they learned it was about self-compassion. One participant reported feeling skeptical about the utility of self-compassion.

- At first I was like, I don’t know if I want to do this. Cause I know that you have to think positively and stuff, but I didn’t really want to hear it from anyone else. I’ve heard it before, but I just kind of chose to brush it off and do my own thing.

One participant described being intrigued by the idea of self-compassion and feeling excited about the opportunity to express her feelings.

- I was kind of expecting a therapist kind of thing. Like talk about whatever you feel. And I thought it was really cool that I would get to learn about this kind of stuff. I was really excited to do it.

One participant expected the intervention to primarily involve strategies for “mental game.”

- I wasn’t really sure what to expect because I’ve never been to a psychologist before. I thought it would be more about… breathing I guess. And just, how you’re attacking on the ice. I didn’t expect it to be about like, what you’re thinking when you make a mistake. And when you told us about self-
compassion, I thought it would be kind of corny, and pretty easy to do, but it wasn’t at all. It’s actually not that easy to be nice to yourself! [Laughter.]

One participant reported feeling positive toward the intervention because she believed it was something she could personally benefit from given her struggles with self-esteem and self-criticism. She also expressed feeling optimistic about being a role model for other intervention members.

• I was kind of excited because, like, I knew that it was something that I struggled with. And then when I heard [Participant 1] was doing it, I was like, “Oh, it would be nice to support her too, and like, make her feel like she isn’t the only one who is struggling with this kind of stuff.”

3.7.2. Age and self-compassion

Participants were asked to reflect on the workshop (and self-compassion more generally) as it relates to age, and whether or not it is appropriate for adolescents. All participants (n = 4) agreed that the workshop was appropriate for adolescents. They believed that the intervention content was neither too complex nor too elementary.

Comments included:

• In the beginning, I thought the workshop might be kind of more useful to older people because they would understand it more. But then as the workshop went on, I understood everything because it was explained well, and I thought it was really helpful for someone my age.

• I kind of think you can learn about it at any age. I think probably the most important time to learn about it is like 13 to 20. Just because that’s the time when you’re going through so many changes. You’re exposed to more media at that time, and you’re kind of taught like how you’re supposed to be, and how you should look.

3.7.3. Strategies perceived as helpful

Participants were given a list of the strategies covered during the intervention and asked to identify the three things they found most helpful. All participants (n = 4) identified the Meeting Halfway analogy (Appendix E) as very helpful in achieving a balance between self-coddling (i.e., being overly kind to oneself and/or easy on oneself) and self-bullying (i.e., being overly hard or harsh on oneself). Comments included:

• [Meeting Halfway] really helped me a lot because when I first tried self-compassion, it was really hard to, like, believe something overly positive about
myself that I didn't think was true at all. So then if I kind of just went halfway, and then maybe go halfway again, until it starts to feel like it kind of fits. Otherwise, it just feels fake.

- It was really helpful because you know you’re not sugar coating anything, you’re just saying the truth.

Most participants \((n = 3)\) also identified the group format as one of the most helpful aspects of the intervention. They explained that the group format facilitated their use of self-compassion because they felt less alone in their experience of self-bullying and had the opportunity to hear examples of how others implemented self-compassion. Comments included:

- I thought it was cool to, like, meet in a group. And people shared things and examples of how they used self-compassion. I thought that was really helpful. Because there were times when the girls used it, and I was like, “Oh, I didn’t even think of using it like that.” So it helped me put it in place more.

- I never realized how many other people go through the same things that I go through, so it’s like, it made me feel a lot better. So doing in a group was helpful that way.

Two participants \((n = 2)\) also identified the personalities of self-compassion (Appendix E) as one of the most helpful strategies, especially for moments when self-compassion was not resonating. Comments included:

- Learning about self-kindness and self-compassion was really helpful, but what was most helpful was knowing what to do when it didn’t work. Because like, it’s so hard to put in place sometimes that like, knowing that there’s a bunch of different strategies and ways that you can try to put it in place, or slowly build up towards self-compassion, was helpful.

- I liked the Personalities of Self-Compassion. Because like, the gentle grandma one just didn’t work for me, so I always use the cheerleader or the jokester one.

Two participants \((n = 2)\) also identified mindfulness exercises (Intervention Outline, Appendix E) as one of the most helpful aspects of the intervention. They indicated that they enjoyed practicing mindfulness exercises and found them to be useful for noticing and coping with maladaptive thoughts. Comments included:

- These mindfulness games were helpful. It like takes my mind off of whatever happened that I don’t want to think about. It just helps take my mind off things. And I like how they were made to be fun too, because then you actually practice them more.
In the beginning, the mindfulness games felt kind of silly, but the more you practiced them, the easier they got. And I just found they helped me get better at noticing when I was doing self-bullying.

One participant \( (n = 1) \) identified the diary cards (Appendix E) as one of the most helpful strategies. She explained that the diary cards helped keep her accountable for practicing self-compassion and helped her evaluate her progress. Her comment was:

- I think without the Diary Cards, I would have forgotten to practice. So they were really helpful in terms of reminding me to practice. I thought they were really helpful, even in just becoming more aware of like, how I was thinking. Because like, knowing about self-compassion is one thing, but knowing how to put it in place is another thing. And I think the Diary cards helped you kind of evaluate how well you were using it.

### 3.7.4. Strategies perceived as unhelpful

Participants \( (n = 3) \) identified only one strategy that was unhelpful. This was the Self-Compassion Break (Intervention Outline, Appendix E). They explained that the Self-Compassion Break was confusing to learn and could not be applied to real life situations as flexibly as the other strategies. Comments included:

- The Self-Compassion Break was kind of hard to understand. I don’t know why; I just didn’t get it.

- It wasn’t confusing, it just… I don’t really use it that much because I have to say these three sentences when I could just… I could just say, like, whatever, just be self-kind. Cause like, whatever you say to yourself has to mean something to you. And just in that moment, it might not mean something to you, and something else might mean more.

### 3.7.5. Ways to improve the intervention

Participants \( (n = 4) \) were asked about ways in which the intervention could be improved. Their feedback was mostly positive, but they did express interest in different learning modalities and more coverage of certain topics. Comments included:

- Showing us more videos. And playing more games. That was fun. Maybe you could make like, a board game.

- It would be cool if you had videos to show that explained things. Then like, when you finish explaining something, if someone has a question, there’s a video you could show them. And maybe they could show other people too, so that more people learn about self-compassion.
• It would have been good to spend more time practicing how to find the middle [Meeting Halfway]. I thought that was hard, so it would have been good to like, learn other ways of practicing that.

• More role plays. Where we could like, model it out. And also, I thought we could go more into the performance anxiety stuff. It would have been nice to have a bit more time with that, because that's something I have a hard time with.

3.8. Research Question 2A: Quantitative Results

Research Question 2A inquires about participants’ experience of and perceptions of the intervention. Attendance rates and adherence to assigned homework represent one measure of participants’ experience of the intervention.

In terms of adherence, one of the five participants dropped out of the study after the first session. This was reportedly the choice of her parents and was for the purpose of focusing more closely on training for her upcoming competition. Among the four who completed the intervention, attendance was 100 percent. Diary card adherence was fair (Table 11, Appendix A). Rates of diary card completion (i.e., the percentage of assigned diary cards completed) ranged from 38.7% to 64.5%. Reasons for not completing the diary card included forgetting and losing the diary cards.

3.9. Research Question 2B: Qualitative Results

Research Question 2B inquires about the benefits of the intervention, and specifically, whether or not it lead to changes in self-compassion, body-related self-compassion, and eating disorder symptoms. All participants (n = 4) agreed that the intervention helped them better understand the concept of self-compassion. Comments included:

• It taught me a lot of things about self-compassion, and, like, believing in myself. I do that now. Instead of worrying about things, I just think about the good side of things. And like, now I know what self-bullying is and the bad things it can do. And now I know, like, if I do self-bullying, this will happen, but if I use self-compassion, then these good things can happen.

• It kind of changed the way I thought about self-esteem versus self-compassion and self-love. So it made it more applicable, rather than being like really fake or fluffy. So I found it easier to actually, like, put it in place than when I didn’t know that much about it, and it was just like, “Oh, you’re supposed to like...”
yourself,” which is, like, way harder if you just say it like that without any instruction.

• I think it did help. I mean, I always thought I shouldn’t be too hard on myself. But I never really thought about it, like, in this much detail. I just thought, like, whatever, just move on. But now I have different kinds of exercises that can help me. And I feel like, I’m not great at it yet, but I think it can help me more as I practice it more.

When asked directly whether the intervention helped them get better at using self-compassion, all participants (n = 4) agreed that it did but also described self-compassion as a work in progress, indicating that they still have room for improvement. Comments included:

• It did help. I mean, obviously I still need a lot of work on it, but it’s helped me a lot I think. Mostly, it became easier to notice self-bullying, and then try to find the middle with self-kindness.

• Just knowing how to actually, like, put it in place. Like even knowing just what it was was really important. But then also getting the strategies for how to use it and put it in place.

When asked generally about the benefits they experienced as a result of the intervention, three participants (n = 3) offered that they have become more aware of their inner self-talk, especially noticing negative self-talk and the need for self-compassion in response. Comments included:

• It made me, like, think more. Like, I didn’t really think about that kind of stuff a lot. Like, when it comes to emotions, like, everyday I feel emotions but I don’t, like, really realize what I’m feeling. And also what I’m thinking. It made me more aware of what I’m actually thinking and, like, what I can do to stop bad thoughts.

• The workshop made me realize, like, how many of those behaviours I actually did. Like, I never really thought that I was that mean to myself because I just believed my negative thoughts were true. So I wasn’t really, like, being mean to myself, it was just the way it was. Now I see how ridiculous that type of thinking is!

All participants agreed that the intervention has helped them engage in less self-bullying. Comments included:

• I think it helped me be less hard on myself and helped me be more positive on the ice. It helped me not dwell on things.
• I’m slowly starting to do less self-bullying. But also like, I just catch it a lot faster. Like, before, one negative thought could turn into like ten more negative thoughts, whereas now, I can look at this one thought and think, “This is kind of ridiculous.” And kind of like throw that thought out and replace it with something more positive, instead of like letting it just go on and on and snowball into something bigger.

Participants were asked whether the intervention improved their body image and/or eating habits. None of the participants endorsed changes in eating habits. In terms of body image, one participant reported no changes in her body image and explained that her body image has always been positive. Three participants (n = 3) reported some improvement in their body image, but also acknowledged room for improvement in their body image. Comments included:

• I think it did help a little bit. Maybe not a lot, just because I think it’s something we have to practice. Like, even just knowing that it’s something everybody deals with. Because sometimes you feel so alone in that. Like you look at other people and think like, “I don’t look as good as her.” But she is looking at someone else and thinking the same thing. I think that was helpful. And I think realizing how much of my body image was self-bullying, I think that was helpful.

Participants were asked about any other ways in which they felt the intervention was helpful. Responses identified spontaneously by participants included decreased anxiety (n = 3), decreased performance anxiety (n = 2), increased quality of life (n = 1), and improved coping with setbacks (n = 1). Comments included:

• It helped me worry less. Because I worry about a lot! Especially on the ice. So I feel like this helped a lot for me to let go of what I didn’t do so well, and just move on and do something even better.

• Before I compete now, I always think about taking deep breaths. And it always just like, calms me down. I found that really helped for me.

• I feel more chill now. Although sometimes I’m still uptight! But like, it’s helped me a lot. I just feel like when I’m more relaxed, I can get more done and kind of live my life.

• It’s helped me not just as an athlete, but I think also as just a human being. Just being able to like yourself, even when you’re not successful, or when you’re not achieving some of your goals.
3.10. Research Question 2B: Quantitative Results

Research Question 2B inquires about whether the self-compassion intervention led to changes in self-compassion, body-related self-compassion, and eating disorder symptoms. It was hypothesized that the intervention would increase self-compassion and body-related self-compassion, and decrease eating disorder symptoms. Results from the questionnaire data from those who were in the intervention group ($N = 4$) partially supported this hypothesis (Table 12, Appendix A). The intervention did increase total scores on the Self-Compassion Scale ($t(3) = -4.98, p \leq .05$) and the Self-Kindness subscale ($t(3) = -3.67, p \leq .05$). However, it did not affect scores on any other Self-Compassion subscale ($p > .05$). It also did not decrease eating disorder symptoms ($p > .10$). It should also be noted that power was limited due to a small sample size ($N = 4$). Specifically, power to detect a small, medium, or large effect with alpha set at .05 was 6 percent, 11 percent, and 21 percent, respectively.

Post-hoc analyses on individual changes in scores on study variables reveals an interesting finding (Table 13, Appendix A). Participant 1 showed considerable decreases in her scores on all eating disorder symptoms. She also showed a sizeable increase in her body-related self-compassion score, but not in her scores on measures of overall self-compassion. None of the other participants showed this pattern.

In terms of descriptive statistics for Diary Card responses, for Question #2 (“How much did you use self-bullying during this [upsetting] situation?”), average responses for each participant across all of their diary cards ranged from 1.94 (“Not at all” to “A little”) to 3.75 (“A little” to “A lot”). For Question #3 (“How much did you use self-compassion during this [upsetting] situation?”), average responses ranged from 2.52 (A little) to 3.77 (“A little” to “A lot”). For Question 4 (“Was it helpful to be compassionate toward yourself?”), average responses ranged from 2.62 (“A little”) to 4.37 (“A little” to “A lot”).

Diary card responses did not seem to change markedly over the course of the intervention. Figure 4 (Appendix B) shows the grand mean scores (i.e., the average of the four participants’ mean scores) for diary card questions across the five sessions of the intervention. According to these results, participants’ self-reported use of self-bullying may have decreased very slightly over the course of the intervention. Participants’ self-reported use of self-compassion did not seem to change significantly over the course of
the intervention. Last, the self-reported effectiveness of self-compassion appears to have decreased slightly over the course of the intervention.

It may be noted that the most positive changes in Diary Card responses were observed after Session 4. Session 4 focused on teaching the concepts of Common Humanity and the Self-Compassion Break. After Session 4, grand mean scores show a slight decrease in reported self-bullying, a slight increase in the reported use of self-compassion, and a slight increase in the reported effectiveness of self-compassion. However, this effect may be driven by Participant 4, who had higher scores for reported use of self-compassion and reported effectiveness of self-compassion. Compared to other participants, this participant contributed a larger proportion of diary cards to Session 4 (40%) compared to Session 3 (0%), which may have artificially inflated grand mean scores for Session 4.

Figures 5 through 8 (Appendix B) show changes in mean diary card scores for each participant. Participant 1 showed decreases in all diary card responses including slight decreases in reported self-bullying (M = 2.25 after Session 3 to M = 1.33 after Session 5), slight decreases in reported use of self-compassion (M = 3.14 after Session 3 to M = 2.33 after Session 5), and a large decrease in the reported effectiveness of self-compassion (M = 3.43 after Session 2 to M = 1.00 after Session 5). Participant 2 showed consistent scores on all diary card responses across the intervention, with her average scores varying by no more than 0.5. Participant 3 showed no changes in her reported use of self-bullying, moderate decreases in her use of self-compassion (M = 4.50 after Session 2 to M = 3.00 after Session 5), and moderate decreases in the reported effectiveness of self-compassion (M = 4.83 after Session 2 to M = 3.50 after Session 5). Participant 4 showed moderate decreases in self-bullying after Session 4 (M = 3.33 after Session 2 to M = 2.00 after Session 4), but her average returned to near her baseline (M = 3.17) after Session 5. She also showed a moderate increase in her reported use of self-compassion after Session 4 (M = 3.50 after Session 2 to M = 4.50 after Session 4), but her average score returned to near baseline (M = 3.83) after Session 5. She showed slight to moderate improvements in the effectiveness of self-compassion (M = 3.83 after Session 2 to M = 4.80 after Session 5).
Chapter 4.

Discussion

Overall, results of this study provide preliminary evidence that self-compassion may be a beneficial strategy for female adolescent aesthetic athletes. Qualitative data revealed that participants were open to self-compassion, had used it in their personal lives, and saw it as beneficial. Themes identified in this study were consistent with those identified by other authors examining attitudes toward self-compassion among youth in the general population (Klingel & Van Vliet, 2017) and among adult female athletes (Ferguson et al., 2014a). All researchers, including the current researcher, identified themes related to positive thinking, self-acceptance, focusing on improvement, self-care, social connectedness, and emotional coping. This is consistent with the writing of previous researchers who argue that athletes’ sense of self-efficacy is best facilitated by helping the athlete focus on things they can control (i.e., personal improvement) rather than on things they cannot control (e.g., wins and losses; Bandura, 1997). In short, like adult athletes, adolescent aesthetic athletes appear to have a positive attitude toward self-compassion and see it as having a variety of benefits.

Results of this study are also consistent with previous research showing an inverse relationship between self-compassion and eating disorder symptoms (for a review, see Braun et al., 2016). In the current study, self-compassion was associated with lower body dissatisfaction, symptoms of bulimia, and perfectionism. Self-judgment seemed to be especially implicated in eating disorder symptoms; compared to other self-compassion subscales, it was correlated with all four eating disorder symptoms—and with the largest effect sizes. This finding is consistent with research showing that individuals with disordered eating tend to be highly self-critical (e.g., Steele, O’Shea, Murdock, & Wade, 2011). Also, as predicted, body-related self-compassion was associated with lower eating disorder symptoms, especially body dissatisfaction which showed an effect size that was moderate to large ($r = -.68$). This is consistent with findings from Breines et al. (2013), one of the only other studies to examine body-related self-compassion. However, the direction of causality is unclear. While it is possible that body-related self-compassion helps athletes harness a more positive body image, it is
also possible that a positive body image makes it easier to engage in body-related self-compassion.

Qualitatively, all participants in this study believed that body-related self-compassion could be beneficial for body image and eating habits. Many of the themes identified were similar to the themes identified for general self-compassion, including accepting body flaws, recognizing that no one’s body is perfect, focusing on non-appearance-related strengths, and on improving one’s body/appearance in healthy ways. Themes that were unique to body-related self-compassion (i.e., that were not identified for general self-compassion) were (a) acknowledging the beauty of different body types, and (b) focusing on the health of one’s body rather than appearance. Nearly identical themes were identified in a previous qualitative study (Berry et al., 2010) in which adult women were asked about their experiences of body-related self-compassion. Another theme in the current study that was unique to body-related self-compassion was balanced eating, the idea that being compassionate toward one’s body means giving in to indulgences occasionally rather than depriving oneself of the pleasures of food or attempting to adhere to a strict diet. Indeed, quantitative studies show that individuals who diet or avoid “off limit” foods tend to show higher levels of eating pathology (Heatherton & Polivy, 1992; Herman & Mack, 1975). Further, when individuals are induced to have compassion toward their eating habits, they tend to show healthier eating behaviours (Adams & Leary, 2007).

Although participants saw many benefits of self-compassion and body-related self-compassion, they also saw some barriers and drawbacks. One drawback consistently identified by participants was the possibility of taking self-compassion “too far” and becoming cocky, lazy, or complacent. This same barrier has been identified in other qualitative studies on female athletes (Ferguson et al., 2014a). That is, many athletes have expressed concern that if they are too kind toward themselves or too accepting of imperfections, they may become unmotivated and thus destined for mediocre success. Similarly, athletes in the study by Ferguson et al. (2014a) expressed a belief that in some circumstances, self-criticism may actually be necessary for progress and self-improvement, and self-compassion by definition would thus undermine progress. Interestingly, this attitude is in contrast to results of quantitative studies showing that self-compassion is actually associated with increased motivation and an active coping style (Ferguson et al., 2014b; Neff, 2003a; Neff et al., 2005), whereas self-
criticism is associated with poorer progress toward goals (Powers, Koestner, Lacaille, Kwan, & Zuroff, 2009). It seems apparent that, when the athletes in the Ferguson et al. (2014a) study expressed positive attitudes toward self-criticism, they were referring to *constructive* criticism (e.g., “I need to work on my technique,”) rather than *harsh* self-criticism (e.g., “I'm such a failure!”). However, even harsh self-criticism represents a method of motivation (Shahar, Kalnitzki, Shulman, & Blatt, 2006). As such, if an athlete is accustomed to this form of motivation, he/she may be reluctant to switch to self-compassion—especially since self-compassion is so contrary to what he/she already knows.

In teaching self-compassion to athletes, it therefore seems important to make some key distinctions. First, harsh self-criticism must be distinguished from constructive criticism. There is a difference between pushing oneself through harsh self-criticism (e.g., “Why can’t I master this skill? I’m such a failure. Get it together already!”) and pushing oneself through constructive criticism (e.g., “I didn’t properly use my technique here; I need to try again. I know can do it!”). As Ericsson writes in his theory on deliberate practice (Ericsson, Chamess, Feltovich, & Hoffman, 2006), expertise does not develop without hard work—without pushing oneself over and over again to surpass one’s current abilities. In other words, it is true that an athlete must “push” him- or herself in order to succeed—at times perhaps pushing oneself beyond what is physically or mentally comfortable. However, this need not be done with harsh self-criticism, nor is it at odds with self-compassion. Indeed, as Neff (2003) writes, compassion involves wanting the best for someone, including goal attainment, and thus, self-compassion involves wanting the best for oneself, including working hard toward one’s goals. This is the second distinction that must be made when teaching self-compassion to athletes; self-compassion is not akin to self-coddling, complacency, or giving up. To be self-compassionate is to accept one’s shortcomings or failures *in the moment* (e.g., “I accept that I did not win the gold medal”) *and* work to improve one’s skills in the immediate or distant future (e.g., “I need to refocus on this specific technique,” and “I need to set specific goals and keep working toward them”). Indeed, intervention participants in the current study seemed to especially appreciate the Meeting Halfway analogy which drew a distinction between self-compassion and self-coddling. This distinction seemed to remove one of the key barriers to adopting self-compassion.
Participants in this study also identified barriers to body-related self-compassion. In particular, several participants argued that at times, the desire to be thin may be too strong and may overpower attempts to engage in body-related self-compassion. This is consistent with quantitative data in this study showing that a high drive for thinness is associated with lower levels of body-related self-compassion. Indeed, previous research has shown a higher drive for thinness, compared to the general population, among aesthetic athletes (Smolak et al., 2000). This may stem in large part from their training environment, which may be characterized by strong pressures to be thin (de Bruin et al., 2007). In fact, with body shape playing such a strong role in their sport, some aesthetic athletes may feel as though their success is partially dependent on their weight. When an athlete’s success is apparently at stake, it makes sense that she would strive for thinness, despite the potential costs, and may find it difficult to be accepting toward her body flaws. Of course, a rational counterargument to this attitude would be that ideally, an athlete should strive to maintain an appropriate body shape but should offer compassion to herself if she struggles or comes up short. However, as participants in the current study have pointed out, it is difficult to achieve a balance between acceptance and change. That is, it is difficult to be compassionate toward one’s flaws while still striving to meet extremely high standards. Likewise, as athletes in other studies have pointed out, sometimes self-criticism feels necessary for change, leaving little room for self-compassion (Ferguson et al., 2014a).

Although some participants identified drawbacks to self-compassion, others identified none. Instead, they believed that when used effectively, self-compassion could offer only benefits. In particular, they believed that self-compassion would not undermine their motivation or work habits. In fact, they believed that it facilitates their motivation by helping them cope with setbacks, feel less anxious about their performance, pay more acknowledgment to their improvements, and have the confidence to take risks. This is consistent with quantitative research findings showing that self-compassion is associated with increased motivation (Ferguson et al., 2014b; Neff, 2003a; Neff et al., 2005). It is unclear why participants in the current study showed differing perspectives when it comes to self-compassion and work habits. Future research is needed to better understand which athletes feel threatened by self-compassion and why.

Research Question 2 focuses on the self-compassion intervention. Results of this study suggest that the intervention had some successes and some failures. Regarding
successes, quantitative data revealed that participants showed increases in self-compassion and specifically, self-kindness. Additionally, qualitative data suggest that participants experienced the intervention as both enjoyable and beneficial. In particular, they believed the intervention helped them better utilize self-compassion, engage in less self-bullying, and develop a greater awareness of their inner self-talk and emotions. They also believed the intervention led to decreased anxiety, increased quality of life, and more adaptive coping. This finding, however, should be interpreted with caution given that participant responses may have been influenced by social desirability. That is, participants may have felt some obligation to report positively upon the intervention in order to appease this researcher.

The fact that participants perceived several benefits of the intervention is noteworthy in light of the barriers that were also identified in this study. That is, even though participants perceived some barriers and drawbacks to self-compassion, this did not seem to interfere with their willingness to engage in the intervention. In fact, most participants reported that their first impression of the intervention was positive.

A third success of the intervention is that several of the athlete- and adolescent-specific modifications made to this intervention appear to have been well-received. Specifically, as mentioned above, participants reported particular appreciation for the Meeting Halfway analogy, which distinguishes self-compassion from harsh self-criticism and “self-coddling” (being overly forgiving or indifferent toward one’s flaws; Rodriguez & Ebbeck, 2015). Instead, self-compassion lies somewhere in between these two constructs, involving both constructive criticism as well as acceptance of shortcomings in the moment. Participants also reported an appreciation for the Personalities of Self-Compassion analogy designed by the current researcher that highlights the many different voices or styles that self-compassion can take on in one’s imagination. That is, compassionate self-talk does not need to be done in a saccharine or angelic tone, which for some individuals may feel overly maternal or pejorative. Instead, it can involve humour, boldness, or feistiness—whatever resonates for the individual.

Another modification that may be helpful for athlete populations is to avoid the term “self-compassion” altogether. In their book on Mindful Sport Performance Enhancement, Kaufman, Glass, & Pineau (2017) agree that self-compassion is tremendously important for athletic performance. However, they point out that many
athletes reject terminology that feels “too soft or touchy-feely” (p. 161), perhaps due to athletes’ merciless work ethic and “mental toughness” (Bandura, 1997). Instead, they recommend training the tenets of self-compassion without using the term explicitly. Given that mindfulness has been popularized and is a now widely regarded as beneficial to athletes, it is possible that self-compassion could be effectively taught under this rubric.

The intervention also had some failures. In particular, according to quantitative data, it did not produce increases on most self-compassion subscales or on body-related self-compassion, and it did not decrease eating disorder symptoms. With only four participants, this could be due to low power (.09, .32, and .66 to detect a small, medium, or large effect, respectively). It could also be due to the limited number of sessions focused on particular strategies. Indeed, the one subscale that showed significant change from baseline to post-intervention was the self-kindness subscale, and self-kindness probably received the most attention in the intervention. That is, self-kindness was covered near the beginning of the intervention (session 2) and was arguably the main focus of the diary cards. In contrast, mindfulness and common humanity were covered somewhat later in the intervention.

There are several reasons that may possibly explain why the intervention did not produce changes in eating disorder symptoms. First, body-related self-compassion was not covered until the last session, meaning that participants obtained relatively little practice with it. Also, floor effects were observed for one or more participants on several eating disorder subscales, making it difficult to measure any change. Last, one participant (Participant 2) with relatively high eating disorder symptoms informally confessed to this researcher that she had been explicitly told by key adult figures in her life that she should lose weight in order to become more successful in her sport. For this athlete, external pressures to be thin may have undermined her attempts to engage in body-related self-compassion. This is consistent with the qualitative theme that arose in this study, in which the desire to be thin may overpower body-related self-compassion. Indeed, Participant 2 did show a high drive for thinness and relatively low body-related self-compassion.

Although the intervention did not lead to significant changes on eating disorder symptoms on a group level, one participant (Participant One) did show large changes in
her eating disorder symptoms. Remarkably, this participant’s scores on eating disorder subscales dropped by fifty percent or more on several subscales. Interestingly, this participant also showed the greatest increase in body-related self-compassion compared to other participants. Thus, it is possible that for this participant, the intervention had its desired effect; it may have helped her develop greater body-related self-compassion, in turn leading her to experience fewer eating disorder symptoms. It is unclear why this participant may have experienced more positive effects than others. She did informally comment that she had recently become concerned about her body size but had not been explicitly encouraged to lose weight. Thus, the intervention may have occurred at an ideal time for her, when eating disorder symptoms were emerging but still malleable. This is in contrast to Participant Two, whose eating disorder symptoms were, according to her, more longstanding and entrenched. With this line of reasoning, it is possible that self-compassion interventions may be most effective when used as secondary prevention—offered to athletes who are showing early risk for eating disorder symptoms, but not yet full-blown clinical symptoms, with the aim of curbing the progression of the illness. In the general population, the onset of eating disorders is during late adolescence (Favaro, Caregaro, Tenconi, Bosello, & Santonastaso, 2009). In athletes, however, disordered eating is often triggered by the onset of puberty (Sundgot-Borgen, 1993). Thus, perhaps self-compassion interventions may be best utilized around age twelve or thirteen—after the onset of puberty, and at an age when youth have the cognitive capacity needed to best comprehend concepts associated with self-compassion. Future research is needed in order to confirm that early adolescence is the ideal time to utilize self-compassion interventions for aesthetic athletes.

Because most research to date has been conducted on adults, little is known about developmental considerations in self-compassion. This study highlights several developmental considerations. First, teens in this study commented on the challenges of meta-cognition. That is, they explained that self-compassion can be difficult because it is challenging to monitor and manage one’s thinking. Indeed, meta-cognition is a sophisticated cognitive function and thus understandably more difficult for children and adolescents whose cognitive abilities, especially frontal lobe functions, are still developing (Sowell, Thompson, Holmes, Jernigan, & Toga, 1999). However, interventions involving mindfulness—which also relies on meta-cognition—have been successful with adolescents (for reviews, see Zenner, Herrlieben-Kurz, & Walach, 2014;
Zoogman, Goldberg, Hoyt, & Miller, 2014), suggesting that the challenges of meta-cognition are manageable. Thus, there is little reason to believe that the challenges of meta-cognition would not also be manageable within a self-compassion intervention.

Another developmental consideration highlighted by the current study is that among teens, self-compassion may be hindered by the emotional reactivity and impulsivity characteristic of adolescence. Teens in this study explained that it can be difficult to engage in self-compassion during moments of intense upset because their emotions make it difficult for them to see the big picture, to focus on anything but the negative, and to “calm down” enough to inhibit impulses and organize one’s behaviour. Indeed, due in part to an immature frontal lobe, adolescents are known for acting impulsively on their emotions, which are often intense given the hormonal changes associated with adolescence (Dahl & Gunnar, 2009). Although emotional reactivity and impulsivity may represent a barrier to self-compassion for many adolescents, it also highlights adolescence as a particularly relevant time to teach self-compassion as teens are in need of emotional coping strategies during this time.

Another developmental consideration highlighted in this study, as well as previous studies (Bluth & Blanton, 2015; Bluth et al., 2016; Bluth et al., 2015; Muris et al., 2016), is the inverse relationship between self-compassion and age observed in females. Quantitative results of this study showed that as age increases, self-compassion decreases. Qualitative data in this study were consistent with this finding; several participants expressed a perception that from childhood to adolescence, self-compassion becomes more difficult. The finding that self-compassion declines over a female’s adolescence is consistent with other research showing that self-esteem also decreases over a female’s adolescence and depressive symptoms increase (Nolen-Hoeksema & Hilt, 2009). Indeed, the teenage years are a time marked by cognitive changes that foster self-criticism, such as the imaginary audience and egocentrism (Elkind, 1967). That is, teens often feel that they are on stage, being watched by everyone, and are unique and special in their experiences, and thus alone in their flaws and suffering. The fact that self-compassion decreases—and possibly becomes more difficult—throughout adolescence may have implications for the timing of self-compassion interventions. Future research is needed to determine whether self-compassion interventions should be targeted at late adolescence, when teens are more likely to be struggling with self-criticism and self-esteem issues, or during early
adolescence, before self-criticism becomes an issue. As mentioned earlier, among
athletes, puberty is a common trigger for disordered eating (Sundgot-Borgen, 1993), and
participants in this study identified puberty as a time when self-criticism and body
dissatisfaction increases. Thus, perhaps early adolescence is an ideal stage at which to
target self-compassion interventions, before self-criticism, body dissatisfaction, and
disordered eating have a chance to become entrenched.

Although most participants expressed a belief that self-compassion becomes
more difficult as one ages, two of the older participants in this study highlighted early
adolescence as the most difficult time to garner self-compassion. These participants
believed that their own self-compassion had improved rather than declined into their late
adolescence. More research is needed to determine whether there are individual
differences in the developmental trajectory of self-compassion and what contributes to
these individual differences.

Another developmental consideration highlighted in this study is that for young
athletes, self-compassion is influenced by the attitudes and behaviours of parents and
coaches. In this study, participants expressed a belief that parents and coaches can
create a barrier to self-compassion when they put undue pressure on youth to succeed,
or worse, when they chastise or punish youth for mistakes. Simply put, if important
adults do not treat a young athlete with compassion, then she is unlikely to know how to
treat herself with compassion or to believe that she is worthy of compassion. Indeed,
feelings of self-worth and self-esteem develop in the context of healthy attachment
relationships (McCormick & Kennedy, 1994). Children learn to see themselves as worthy
by repeatedly having a trusted adult, especially a caregiver, treat them as worthy, even
when they are imperfect. Through this lens, self-compassion may be viewed as an
internalized voice of a compassionate caregiver. If an athlete is lacking in
compassionate caregivers, then she may understandably be lacking in self-compassion.
Indeed, one study found that retrospective reports of harsh parenting during childhood
(i.e., low warmth, high rejection) was associated with low self-compassion, and this link
was accounted for by attachment anxiety (Pepping, Davis, O'Donovan, & Pal, 2015).
Similarly, in a qualitative study on the attitudes of female athletes selected for their high
self-reported self-compassion, parents were identified as a major factor that facilitated
the development of their self-compassion. Specifically, these athletes mentioned that
their self-compassion was fostered by (a) receiving help from parents, (b) having their
parents teach them self-kindness, and (c) having their parents help them put their experiences into perspective. Thus, it is understandable that if an athlete has experienced repeated harsh admonishment from a parent, or if she has rarely received compassion from a parent, then she may be plagued with self-criticism, finding it difficult to conjure compassion for herself.

Although there is good evidence to suggest that parents may have a strong influence on a young athlete’s level of self-compassion, it is not yet known how this influence compares to that of coaches. Parents play an immensely important role in a child’s socioemotional development, whereas a coach may be relevant primarily for athletic development. However, for elite athletes in particular, sport is an important part of their lives—a part which likely interacts with socioemotional development. Thus, a coach is likely highly relevant in the socioemotional lives of elite athletes. Indeed, research suggests that coaches can have a positive or negative effect on athletes’ overall well-being depending on their coaching behavior (Bandura, 1997; Reinboth, Duda, & Ntoumanis, 2004; Adie, Duda, & Ntoumanis, 2012), and that successful coaches are those who provide corrective feedback, focus on improvement, and avoid criticism of failures (Bandura, 1997). Studies also show that, when it comes to athletic success, parents play a key role up to early adolescence, but thereafter, coaches tend to play a more important role (Wuerth, Lee, & Alfermann, 2004).

A coach, like a parent, plays the role of teacher, mentor, and gatekeeper of resources, as well as authority on athletic success. A coach can decide when an athlete has been successful and can move on to the next level, and also when an athlete has failed and needs to work harder. Coaches also spend a great deal of time with elite athletes and sometimes play the role of caregivers, responsible for athletes’ basic needs and safety, when parents are absent. Coaches are also with athletes during important moments, such as wins, losses, and injuries, as well as during intense emotions, such as pride, shame, and embarrassment. It is in part through a coach’s voice that an athlete will make sense of her successes and failures. When a coach loses confidence in an athlete after a loss or failure, athletes are likely to experience a decrease in their self-efficacy, which in turn is likely to affect their athletic performance (Bandura, 1997). Thus, to the extent that an athlete internalizes the voice of her coach, coaches may indeed have a strong influence on a young athlete’s level of self-compassion. Indeed, research shows that when coaches treat athletes in an emotionally abusive manner, athletes
show a drop in their overall self-esteem and self-efficacy, and an increase in anxiety and body dissatisfaction (Stirling & Kerr, 2013). Future research is needed to determine what type of impact coaches have on athletes’ development of self-compassion; however, the current research suggests that this influence may be quite strong.

It would also be interesting to explore what role a coach’s own personal level of self-compassion may play. Does self-compassion influence a coach’s behavior toward athletes? For example, when an athlete experiences a loss, his/her coach may experience a sense of frustration, anxiety, and/or threats to his/her personal adequacy as a coach (Bandura, 1997); this type of reaction may have a negative impact on coaching behavior. Self-compassion may help coaches better manage their responses to losses. Additionally, athletes may learn self-compassion through their coaches modeling—by observing their coach response to losses with compassion toward the self and the athlete.

Relationships with parents and coaches may represent only some of the ways in which the social environment influences an adolescent’s level of self-compassion. Several participants in this study indicated that social support, in the form of encouragement and positive affirmations, is a catalyst for self-compassion. Just as young athletes may need compassion from their caregivers and coaches in order to learn self-compassion, they may also rely on support from others more generally before they are able to offer support and compassion to themselves. Indeed, it is understandable that if an athlete feels as though she has a web of compassionate people around her willing to offer emotional support during difficult times, then she will find it easier to extend compassion and emotional support toward herself. Consistent with this, one large study on athletes ($N = 333$) showed that perceived social support was correlated with levels of self-compassion. In short, the development of self-compassion may be influenced not only by relationships with parents and coaches, but also by social support more generally.

A second way in which the social environment may influence self-compassion is through peer modeling. Participants in this study believed that if a few individuals learned and utilized self-compassion, it might spread throughout a training club. Indeed, adolescence is a time when social acceptance and group membership becomes especially important. Teens watch their peers closely, learn from them, compare
themselves to them, and want to fit in. Teens may be more inclined to attempt and persevere with self-compassion if their peer group is doing the same. Whether or not self-compassion can be learned vicariously, without formal teaching, is a question for future research. However, it seems likely that self-compassion might catch on more easily if it appeared to be the norm. Indeed, authors have argued that athletes are strongly influenced by peer modeling; when peer athletes demonstrate acquisition of a skill, observing athletes experience greater motivation, self-efficacy, and proficiency in acquiring the skill (Bandura, 1997). Furthermore, there is evidence that self-efficacy can spread among a sports team when team members show mastery of skills (McAuley, 1985; Corbin, Laurie, Gruger, & Smiley, 1984). With this information in mind, self-compassion interventions may have greater benefit if conducted in a group format. Indeed, the intervention participants in this study expressed precisely this opinion; they reported learning things from one another and enjoying the mutual sharing of experiences.

In summary, results of this study suggest that self-compassion is relevant for female adolescent aesthetic athletes and likely confers several benefits. Young female aesthetic athletes showed a positive attitude toward self-compassion and responded openly to an intervention. As expected, self-compassion—especially body-related self-compassion—was associated with lower eating disorder symptoms cross-sectionally. However, a self-compassion intervention did not produce measurable changes in eating disorder symptoms. Nevertheless, participants reported a number of benefits from the intervention, such as improved self-compassion, improved coping skills, decreased self-criticism, and decreased anxiety. However, they also identified possible barriers to self-compassion, such as a fear of complacency, pressure from parents and coaches, and a strong desire to be thin.

This study has some limitations. First, the sample size was relatively small, especially for the intervention portion of the study, thus limiting power and potentially limiting reliability and generalizability. Given evidence that self-compassion may change across the adolescent years (e.g., Bluth et al., 2016; Muris et al., 2016), a larger sample size would be helpful in order to conduct comparisons between younger, middle, and older adolescents. Second, most analyses in this study were cross-sectional in nature, preventing conclusions regarding the direction of causality. For example, it is unclear whether self-compassion (or body-related self-compassion) promotes greater body
satisfaction, or whether body satisfaction makes it easier to engage in self-compassion (or body-related self-compassion). Third, for the intervention portion of this study, floor effects in eating disorder symptoms (i.e., scores of zero on the EDI, suggesting zero eating disorder pathology) were observed, thus decreasing power.

A fourth limitation in this study is that it included participants with a wide range of competitiveness, with some participants being elite athletes and others having just started their sport/performance art. Previous studies have shown that eating disorder symptoms are most prevalent among elite competitors. With a heterogeneous sample of athletes, it is difficult to determine which types of athletes these results may generalize to. It is also difficult to determine whether experiences of self-compassion differ based on an athlete’s level of competitiveness. A final limitation of this study is that only females are included. Thus, these results may not generalize to males. In fact, the literature is starkly lacking in studies on self-compassion in male athletes. This is an important gap in the literature because although self-criticism and low self-esteem may be more prevalent in young females (Kling, Hyde, Showers, & Buswell, 1999), males are certainly not exempt from these difficulties.

This study also had a number of strengths. First, it is the only study to examine a self-compassion intervention in adolescent aesthetic athletes, and one of the only studies to examine a self-compassion intervention in teens. It is also the only study to examine attitudes toward self-compassion in adolescent aesthetic athletes, and one of the only studies to examine attitudes in teens. These are important extensions of the literature. Female adolescent aesthetic athletes are at especially high risk for eating disorder symptoms, making them particularly in need of self-compassion.

A second strength of this study was its examination of self-compassion directed specifically toward one’s body/appearance; few previous studies have examined this. There have also been few previous studies to examine barriers to self-compassion. This is also an important gap in the literature because, although self-compassion appears to be associated with a variety of benefits, it is only relevant to young athletes to the extent that they are open to learning about it.

A final strength of this study is the mixed methods approach. Mixed methods approaches are becoming increasingly popular in psychology research and allow for more
rich and well-rounded findings compared to either qualitative or quantitative data alone (Creswell, 2015; Levitt et al., 2018). Using mixed methods, this study was able to extend previous research findings as well as highlight topics for future research. More specifically, this study showed that (a) like adult female athletes, female adolescent aesthetic athletes have positive attitudes toward self-compassion, and (b) the relationship between self-compassion and eating disorder symptoms in adolescent athletes appears to be similar to that already observed in adult athletes. This study also highlighted a number of topics for future research. First, future longitudinal studies should examine the direction of causality between self-compassion, body-related self-compassion, and eating disorder symptoms. Longitudinal studies should also examine the developmental trajectory of self-compassion; whether there are gender differences or individual differences in the development of self-compassion in adolescent athletes; and what factors contribute to the development of self-compassion—especially the influence of parents, coaches, and peers.

This study provides preliminary evidence that a self-compassion intervention could be beneficial for preventing eating disorder symptoms in female adolescent aesthetic athletes. However, future research is needed in order to discern the active ingredients that must be included in this intervention, and what modifications are necessary given adolescent athlete participants. Research is also needed to determine the most appropriate timing for the intervention (i.e., at what development stage) and whether it should be used as primary prevention, secondary prevention, or as an adjunct to clinical treatment. Given that parents and coaches may play an important role in the development of self-compassion, research is also needed to determine what role, if any, parents and coaches should play in the intervention.

Finally, future research is needed to address athletes’ concerns that (a) self-compassion may lead to complacency, and (b) self-criticism may sometimes be necessary for progress. In the current study, these attitudes did not appear to interfere with the intervention, and a specific modification (i.e., the Meeting Halfway analogy) may have assisted with this. However, given that a large number of participants in the current study and previous studies have expressed these concerns, there is good reason to examine them further, especially since they are in contrast to quantitative findings showing that self-compassion is associated with greater motivation.
References


Hancock, B. Trent Focus for Research and Development in Primary Health Care: An Introduction to Qualitative Research. Trent Focus, 1998.


Appendix A.

Tables
Table 1. Effect Sizes for Studies Employing Self-Compassion Interventions
<table>
<thead>
<tr>
<th>Authors, Year</th>
<th>Participants</th>
<th>Intervention Details and Findings with Effect Sizes</th>
</tr>
</thead>
</table>
| Kelly, Wisniewski, Martin-Wagar, & Hoffman, 2017 | $n = 11$ (12 weeks of ED treatment as usual plus weekly Compassion-Focused Therapy groups)  
$n = 11$ (12 weeks of ED treatment as usual)  
Randomly assigned  
$M_{\text{age}} = 38$  
100% female  
Findings: Compared to the TAU group, the TAU + CFT group showed greater increases in self-compassion ($r = .57$), and decreased eating disorder pathology ($r = .46$). |
| Duarte, Pinto-Gouveia, & Stubbs, 2017 | $n = 11$ (treatment)  
$n = 9$ (wait-list control)  
Randomly assigned  
$M_{\text{age}} = 38$  
100% female  
Individuals with binge eating disorder | Intervention: A low intensity four-week intervention including one 2.5-hour psychoeducation session, then a manual for participants to follow in a self-guided manner for four weeks, as well as access to a website with audio guided medications. Content included mindfulness, soothing rhythm breathing (from Gilbert’s Compassion Focused Therapy), compassionate imagery, and informal practices focused on bringing compassion to one’s body shape and eating behaviours.  
Findings: Compared to the control group, intervention participants showed significant reductions in eating pathology ($n^2_p = .79$) and binge eating ($n^2_p = .80$), and significant increases in self-compassion ($n^2_p = .36$). |
| Kelly & Carter, 2015 | $n = 15$ (treatment)  
$n = 15$ (treatment control)  
$n = 13$ (wait-list control)  
Randomly assigned  
$M_{\text{age}} = 45$  
83% female  
Individuals with binge eating disorder | Intervention: A psychoeducational session followed by a three-week self-guided intervention including self-compassion letter writing, imagery, and self-talk. Participants were coached to use self-compassion especially toward binge eating. Incorporated were components of Goss’ (2011) self-help guide for overeating.  
Findings: Compared to a treatment control group (behavioural intervention), participants in the Compassion-Focused Therapy group showed greater reductions in global eating disorder pathology ($r = .18$), eating concerns ($r = .17$), and weight concerns ($r = .23$). |
<table>
<thead>
<tr>
<th>Study Reference</th>
<th>Sample Size</th>
<th>Sample Characteristics</th>
<th>Intervention Details</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Albertson, Neff, &amp; Dill-Shackleford, 2014</td>
<td>n = 98 (treatment group), n = 130 (waitlist control)</td>
<td>Randomly assigned, M_age = 38, 100% female, Women with body image concerns</td>
<td>A three-week intervention involving daily 20-minute self-compassion meditations. Each week, participants were given access to a new 20-min self-compassion meditation and instructed to listen to it daily. The podcasts included awareness of body sensations, body scan, breathing exercises, and loving-kindness meditation.</td>
<td>Compared to the control group, intervention participants showed greater increases in self-compassion (d = .82); greater increases in body appreciation (d = .62); and greater decreases in body dissatisfaction (d = .73), body shame (d = .68), and contingent self-worth based on appearance (d = .45).</td>
</tr>
<tr>
<td>Mosewich, Crocker, Kowalski, &amp; DeLongis, 2013</td>
<td>n = 29 (treatment), n = 22 (attention control)</td>
<td>Randomly assigned, M_age = 20, 100% female, Varsity athletes who identified as self-critical</td>
<td>One psychoeducation session followed by writing components completed over a seven-day period. Care was taken to explain why self-compassion is unlikely to promote complacency and/or passivity. Athletes were coached to use self-compassion in response to athletic setbacks.</td>
<td>Compared to an attention control group, intervention participants showed reductions in self-criticism (d = -0.91), rumination (d = -1.16), and concern over mistakes (d = -0.78).</td>
</tr>
<tr>
<td>Neff &amp; Germer, 2012</td>
<td>n = 24 (treatment), n = 27 (waitlist control)</td>
<td>Randomly assigned, M_age = 51, 78% female, General population</td>
<td>An eight-week intervention involving weekly 2-hour group sessions. Content includes psychoeducation about mindfulness and self-compassion, as well as instruction in self-compassion self-talk, letter writing, medication, and affectionate breathing. Participants were asked to complete 40 mins of a self-compassion practice daily.</td>
<td>Compared to the control group, intervention participants demonstrated greater increases in self-compassion (d = 1.67), mindfulness (d = .60), and a variety of well-being measures (d = .13 for social connectedness to d = .86 for depression).</td>
</tr>
<tr>
<td>Gale, Gilbert, Read, &amp; Goss, 2014</td>
<td>N = 99, M_age = 28, 95% females, Individuals seeking treatment for eating disorder psychopathology</td>
<td></td>
<td>A 16-week group-based intervention including standard CBT for eating disorders, as well as a Compassion Focused Therapy component that includes instruction on the origins and functions of self-criticism; self-compassion imagery and self-talk; and reducing fears of self-compassion.</td>
<td>Changes in self-compassion were not measured. Participants showed significant improvements on eating disorder symptoms and overall clinical outcomes, with effect sizes ranging from $r_p^2 = .40$ to $r_p^2 = .51$. The authors concluded that these results are comparable with other evaluations of eating disorder services.</td>
</tr>
</tbody>
</table>
Smeets, Neff, Alberts, & Peters, 2014  

- *n* = 27 (treatment group)  
- *n* = 25 (control group)  
- Randomly assigned  
- *M*<sub>age</sub> = 20  
- 100% female  
- First- or second-year European college students  

**Intervention:** Three group sessions held over three weeks. Sessions focused on psychoeducation, building awareness of suffering and negative self-talk, self-compassion journaling, loving-kindness meditation, and the self-compassion break (i.e., three phrases forming a mantra).

**Findings:** Compared to the control group (i.e., time management skills training), intervention participants showed greater increases in self-compassion (*d* = 1.19). Effect sizes for other outcomes variables ranged from *d* = .07 (negative affect) to *d* = 1.20 (mindfulness).

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McGehee doctoral dissertation, 2010  

- *N* = 17  
- *M*<sub>age</sub> = 15  
- 47% female  
- High school students  

**Intervention:** A two-day “self-compassion retreat” involving psychoeducation, small group exercises, and role plays focused on awareness of critical self-talk, developing compassionate self-talk, self-compassion letter writing, Crossing the Line activity, and mindfulness body scan.

**Findings:** Results were non-significant.

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Gilbert & Procter, 2006  

- *N* = 6  
- *M*<sub>age</sub> = 45  
- 67% female  
- Chronically self-critical patients receiving treatment at a cognitive-behavioural day centre  

**Intervention:** A 12-week group-based intervention exploring the nature of self-criticism, psychoeducation on self-compassion, self-compassion imagery and letter writing, and working through fears of self-compassion.

**Findings:** Changes in self-compassion were not measured. Significant results were obtained for increases in self-soothing behaviours and decreases in depression, anxiety, self-criticism, shame, inferiority, and submissive behaviours. Effect sizes are not provided.

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Shapira & Mongrain, 2010  

- *n* = 63 (intervention)  
- *n* = 55 (treatment control)  
- *n* = 70 (control)  
- *M*<sub>age</sub> = 34  
- 82% female  
- Online volunteers  

**Intervention:** A one-week intervention completed online. Participants received brief online instructions to think about an upsetting event that occurred to them that day and write a one-paragraph self-compassion letter to themselves daily for seven days.

**Findings:** Changes in self-compassion were not measured. Compared to the control group, the self-compassion intervention group showed greater increases in happiness (*n*<sup>2</sup> = .05) and greater decreases in depression (*n*<sup>2</sup> = .04). Gains were still evident at a 3- and 6-month follow-up.
<table>
<thead>
<tr>
<th>Study</th>
<th>Participant Details</th>
<th>Intervention</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shapiro, Astin, Bishop, &amp; Cordova, 2005</td>
<td>$n = 18$ (intervention) $n = 20$ (waitlist control) Randomly assigned Ages 18-65 Health care professionals</td>
<td>Two-hour group sessions for eight weeks focused primarily on mindfulness and meditations, but including a small component related to self-compassion (i.e., loving kindness meditation).</td>
<td>Intervention participants reported increased self-compassion, increased quality of life, and decreased stress. Effect sizes are not reported.</td>
</tr>
<tr>
<td>Birnie, Speca, &amp; Carlson, 2009</td>
<td>$N = 51$ $M_{age} = 47$ 69% female Mentally healthy volunteers</td>
<td>Eight 90-minute group sessions held weekly and focused primarily on mindfulness meditation (e.g., body scan, yoga, breathing). Also included was loving kindness meditation.</td>
<td>Participants showed significant increases in self-compassion ($d = .65$), mindfulness ($d = 1.06$), and spirituality ($d = .47$), and decreases in stress ($d = 1.23$) and low mood ($d = .84$).</td>
</tr>
</tbody>
</table>
Table 2. Internal Consistency on the Self-Compassion Scale, Body-Related Self-Compassion Scale, and Eating Disorder Inventory—3 in the Current Study

<table>
<thead>
<tr>
<th>Scale/Subscale</th>
<th>Chronbach’s Alpha</th>
<th>Qualitative Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>SCS Total</td>
<td>0.92</td>
<td>Acceptable</td>
</tr>
<tr>
<td>SCS Self-Kindness</td>
<td>0.61</td>
<td>Questionable</td>
</tr>
<tr>
<td>SCS Self-Judgment</td>
<td>0.89</td>
<td>Acceptable</td>
</tr>
<tr>
<td>SCS Common Humanity</td>
<td>0.72</td>
<td>Acceptable</td>
</tr>
<tr>
<td>SCS Isolation</td>
<td>0.80</td>
<td>Acceptable</td>
</tr>
<tr>
<td>SCS Mindfulness</td>
<td>0.77</td>
<td>Acceptable</td>
</tr>
<tr>
<td>SCS Over-Identification</td>
<td>0.71</td>
<td>Acceptable</td>
</tr>
<tr>
<td>Body-Related SCS</td>
<td>0.77</td>
<td>Acceptable</td>
</tr>
<tr>
<td>EDI Drive for Thinness</td>
<td>0.90</td>
<td>Acceptable</td>
</tr>
<tr>
<td>EDI Bulimia</td>
<td>0.72</td>
<td>Acceptable</td>
</tr>
<tr>
<td>EDI Body Dissatisfaction</td>
<td>0.90</td>
<td>Acceptable</td>
</tr>
<tr>
<td>EDI Perfectionism</td>
<td>0.81</td>
<td>Acceptable</td>
</tr>
</tbody>
</table>

Note. SCS = Self-Compassion Scale. EDI = Eating Disorder Inventory—3.
1. Based on Nunnally & Bernstein (1994) who recommended values of at least 0.7 or higher.
<table>
<thead>
<tr>
<th>Part of Study, Participant #</th>
<th>Age</th>
<th>Ethnicity</th>
<th>Yrs Spent Training</th>
<th>Hrs of Training/ Week</th>
<th>Highest Level of Competition</th>
<th>BMI</th>
<th>Dx Depression</th>
<th>Dx Anxiety</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention, 1</td>
<td>15</td>
<td>White</td>
<td>10</td>
<td>30 – 40</td>
<td>National</td>
<td>20</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intervention, 2</td>
<td>19</td>
<td>White</td>
<td>15</td>
<td>30 – 40</td>
<td>International</td>
<td>21.6</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>Intervention, 3</td>
<td>12</td>
<td>White</td>
<td>9</td>
<td>21 – 25</td>
<td>Regionals</td>
<td>17.8</td>
<td></td>
<td></td>
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<tr>
<td>Intervention, 4</td>
<td>13</td>
<td>White</td>
<td>7</td>
<td>11 – 15</td>
<td>International</td>
<td>15.8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intervention, 5</td>
<td>13</td>
<td>White</td>
<td>9</td>
<td>16 – 20</td>
<td>International</td>
<td>25.6</td>
<td></td>
<td></td>
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<tr>
<td>Intervention, 3</td>
<td>12</td>
<td>White</td>
<td>9</td>
<td>16 – 20</td>
<td>Provincial</td>
<td>16.8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interview, 4</td>
<td>13</td>
<td>White</td>
<td>9</td>
<td>1 – 5</td>
<td>Local</td>
<td>15.5</td>
<td></td>
<td></td>
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<tr>
<td>Interview, 5</td>
<td>19</td>
<td>White</td>
<td>10</td>
<td>16 – 20</td>
<td>International</td>
<td>--</td>
<td></td>
<td>--</td>
</tr>
<tr>
<td>Interview, 6</td>
<td>14</td>
<td>Asian¹</td>
<td>4</td>
<td>6-10</td>
<td>Local</td>
<td>17</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interview, 7</td>
<td>17</td>
<td>Asian</td>
<td>11</td>
<td>11 – 15</td>
<td>Provincial</td>
<td>19.1</td>
<td>Y</td>
<td>Y</td>
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<tr>
<td>Interview, 8</td>
<td>14</td>
<td>Asian²</td>
<td>11</td>
<td>16 – 20</td>
<td>Local</td>
<td>15.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interview, 9</td>
<td>14</td>
<td>Asian</td>
<td>3</td>
<td>11 – 15</td>
<td>Local</td>
<td>17.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interview, 10</td>
<td>17</td>
<td>Asian³</td>
<td>3</td>
<td>11 – 15</td>
<td>Local</td>
<td>21.2</td>
<td>Y</td>
<td></td>
</tr>
</tbody>
</table>

Note: BMI = Body mass index. Dx = diagnosed with.
1. Immigrated from China at age 2.
2. Immigrated from China at age 1.
3. Immigrated from China at age 8.
Table 4. Scores on the SC Scale and BRSC Scale for Participants in the Intervention and/or Interview Portion of Study

<table>
<thead>
<tr>
<th>Part of Study, Ppt #</th>
<th>SCS Tot</th>
<th>SCS SK</th>
<th>SCS SJ</th>
<th>SCS CH</th>
<th>SCS I</th>
<th>SCS M</th>
<th>SCS OI</th>
<th>BRSC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention, 1</td>
<td>2.88</td>
<td>2.60</td>
<td>3.80</td>
<td>3.50</td>
<td>2.75</td>
<td>3.25</td>
<td>3.25</td>
<td>2.17</td>
</tr>
<tr>
<td>Intervention, 2</td>
<td>2.88</td>
<td>3.20</td>
<td>4.00</td>
<td>2.75</td>
<td>3.25</td>
<td>3.75</td>
<td>3.00</td>
<td>2.17</td>
</tr>
<tr>
<td>Intervention, 3</td>
<td>4.19&lt;sup&gt;H&lt;/sup&gt;</td>
<td>3.40</td>
<td>1.00</td>
<td>3.50</td>
<td>1.00</td>
<td>4.25</td>
<td>2.00</td>
<td>4.67</td>
</tr>
<tr>
<td>Intervention, 4</td>
<td>3.96&lt;sup&gt;H&lt;/sup&gt;</td>
<td>2.80</td>
<td>1.80</td>
<td>4.50</td>
<td>2.25</td>
<td>4.25</td>
<td>1.50</td>
<td>3.83</td>
</tr>
<tr>
<td>Interview, 1</td>
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<tr>
<td>Interview, 2</td>
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<td>Interview, 3</td>
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<td>3.50</td>
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<tr>
<td>Interview, 4</td>
<td>4.08&lt;sup&gt;H&lt;/sup&gt;</td>
<td>4.40</td>
<td>1.80</td>
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<td>3.75</td>
<td>2.25</td>
<td>4.50</td>
</tr>
<tr>
<td>Interview, 5</td>
<td>--</td>
<td>--</td>
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<td>--</td>
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<td>--</td>
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<tr>
<td>Interview, 6</td>
<td>2.00&lt;sup&gt;L&lt;/sup&gt;</td>
<td>1.80</td>
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<td>3.50</td>
<td>3.00</td>
</tr>
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<td>Interview, 7</td>
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<tr>
<td>Interview, 8</td>
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<td>4.25</td>
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<td>3.67</td>
</tr>
<tr>
<td>Interview, 9</td>
<td>3.77&lt;sup&gt;H&lt;/sup&gt;</td>
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<td>4.00</td>
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<td>Interview, 10</td>
<td>2.58</td>
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<td>4.40</td>
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<td>3.25</td>
<td>3.25</td>
<td>3.75</td>
<td>2.50</td>
</tr>
</tbody>
</table>

Note. SCS = Self-Compassion Scale, Tot = Total Score, SK = Self-Kindness subscale, SJ = Self-Judgment subscale, CH = Common Humanity subscale, I = Isolation subscale, M = Mindfulness subscale, OI = Over-Identification subscale.

Note: VH = Very High (two SDs or more above the M, based on the sample in Cunha et al., 2016).
H = High (between one or two SDs above the M, based on the sample in Cunha et al., 2016).
L = Low (between one or two SDs below the M, based on the sample Cunha et al., 2016).
VL = Very Low (two SDs ore more below the M, based on the sample in Cunha et al., 2016).
### Table 5. Scores on Eating Disorder Inventory Subscales for Participants in the Intervention and/or Interview Portion of Study

<table>
<thead>
<tr>
<th>Part of Study, Ppt #</th>
<th>EDI DT</th>
<th>EDI B</th>
<th>EDI BD</th>
<th>EDI P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention, 1</td>
<td>23.00*</td>
<td>12.00*</td>
<td>20.00</td>
<td>14.00*</td>
</tr>
<tr>
<td>Intervention, 2</td>
<td>24.00*</td>
<td>11.00*</td>
<td>27.00*</td>
<td>16.00*</td>
</tr>
<tr>
<td>Intervention, 3</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>4.00</td>
</tr>
<tr>
<td>Intervention, 4</td>
<td>10.00</td>
<td>3.00</td>
<td>0.00</td>
<td>15.00*</td>
</tr>
<tr>
<td>Interview, 1</td>
<td>18.00*</td>
<td>16.00*</td>
<td>28.00*</td>
<td>18.00**</td>
</tr>
<tr>
<td>Interview, 2</td>
<td>11.00</td>
<td>5.00*</td>
<td>27.00*</td>
<td>14.00*</td>
</tr>
<tr>
<td>Interview, 3</td>
<td>2.00</td>
<td>0.00</td>
<td>2.00</td>
<td>6.00</td>
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<tr>
<td>Interview, 4</td>
<td>3.00</td>
<td>0.00</td>
<td>2.00</td>
<td>15.00*</td>
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<tr>
<td>Interview, 5</td>
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<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Interview, 6</td>
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<td>0.00</td>
<td>20.00</td>
<td>23.00**</td>
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<tr>
<td>Interview, 7</td>
<td>9.00</td>
<td>9.00*</td>
<td>12.00</td>
<td>13.00*</td>
</tr>
<tr>
<td>Interview, 8</td>
<td>0.00</td>
<td>5.00*</td>
<td>1.00</td>
<td>16.00</td>
</tr>
<tr>
<td>Interview, 9</td>
<td>3.00</td>
<td>1.00</td>
<td>5.00</td>
<td>9.00</td>
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<td>Interview, 10</td>
<td>14.00</td>
<td>2.00</td>
<td>19.00</td>
<td>8.00</td>
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</table>

Note. Ppt = Participant, EDI = Eating Disorder Inventory-3, DT = Drive for Thinness subscale, B = Bulimia subscale, BD = Body Dissatisfaction subscale, P = Perfectionism subscale.

Note. Qualitative descriptors based on non-clinical adolescent norms in the EDI-3:

- **Low Clinical** = (≤ 90th percentile for DT)  
   = (≤ 87th percentile for B)  
   = (≤ 70th percentile for BD)  
   = (≤ 86th percentile for P)

- **Typical Clinical** = (91st to 98th percentile for DT)  
  = (88th to 98th percentile for B)  
  = (71st to 96th percentile for BD)  
  = (87th to 98th percentile for P)

- **Elevated Clinical** = (≥ 99th percentile for DT)  
  = (≥ 99th percentile for B)  
  = (≥ 97th percentile for BD)  
  = (≥ 99th percentile for P)
Table 6. Codes and Themes that Emerged Within Each Interview Question for Research Question 1A ($N = 14$)

<table>
<thead>
<tr>
<th>Interview Question</th>
<th>Theme</th>
<th>Code</th>
<th>$N$ (C)</th>
</tr>
</thead>
<tbody>
<tr>
<td>How to Use Thinking Positively</td>
<td>Accepting Flaws and Failures</td>
<td>8 (14)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No One is Perfect</td>
<td>5 (9)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Focusing on Improvement</td>
<td>8 (25)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Accepting Negative Emotions</td>
<td>3 (4)</td>
<td></td>
</tr>
<tr>
<td>Acceptance</td>
<td>Focusing on One's Strengths</td>
<td>5 (13)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Achieving a Balance</td>
<td>8 (16)</td>
<td></td>
</tr>
<tr>
<td>Acceptance</td>
<td>Accepting Flaws and Failures</td>
<td>8 (14)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No One is Perfect</td>
<td>5 (9)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Focusing on Improvement</td>
<td>8 (25)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Accepting Negative Emotions</td>
<td>3 (4)</td>
<td></td>
</tr>
<tr>
<td>Self-Care</td>
<td>Increased Self-Esteem</td>
<td>9 (11)</td>
<td></td>
</tr>
<tr>
<td>Benefits</td>
<td>Increased Happiness and Quality of Life</td>
<td>6 (8)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lower Anxiety and Increased Confidence</td>
<td>5 (13)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Coping with Upsets and Setbacks</td>
<td>3 (10)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Substitute for Social Support</td>
<td>4 (7)</td>
<td></td>
</tr>
<tr>
<td>Mental Health and Emotional</td>
<td>Improved Work Habits</td>
<td>9 (16)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Improved Skill</td>
<td>7 (7)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Enhanced Performance</td>
<td>4 (5)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Retention in Sport</td>
<td>4 (6)</td>
<td></td>
</tr>
<tr>
<td>Athletic</td>
<td>Benefit to Peers and the Group</td>
<td>3 (6)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>More Positive Relationships</td>
<td>4 (4)</td>
<td></td>
</tr>
<tr>
<td>Social Connections</td>
<td>Becoming Cocky or Lazy</td>
<td>9 (15)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No Drawbacks</td>
<td>5 (7)</td>
<td></td>
</tr>
<tr>
<td>Drawbacks</td>
<td>Lack of Knowledge or Practice</td>
<td>4 (4)</td>
<td></td>
</tr>
<tr>
<td>Cognitive Barriers</td>
<td>Difficult to Achieve Balance</td>
<td>7 (15)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Metacognition is Difficult</td>
<td>3 (3)</td>
<td></td>
</tr>
<tr>
<td>Emotional Barriers</td>
<td>Negative Feelings Toward Oneself</td>
<td>10 (18)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Too Emotional or Impulsive</td>
<td>3 (3)</td>
<td></td>
</tr>
<tr>
<td>Social Barriers</td>
<td>Harsh Coach or Training Environment</td>
<td>3 (5)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Harsh or Critical Parents</td>
<td>4 (9)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lack of Social Support and Guidance</td>
<td>3 (7)</td>
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</tr>
<tr>
<td>Age as a Barrier</td>
<td>Difficult During Adolescence</td>
<td>4 (9)</td>
<td></td>
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<tr>
<td></td>
<td>Should be Taught</td>
<td>4 (14)</td>
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</table>

*Note. N = Number of participants who provided one or more comments indexed under a code, C = Number of total comments indexed under a code.*
<table>
<thead>
<tr>
<th>Subscale</th>
<th>N</th>
<th>Min</th>
<th>Max</th>
<th>Skew</th>
<th>Kurtosis</th>
<th>Median</th>
<th>Mean</th>
<th>SD</th>
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</thead>
<tbody>
<tr>
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<td>-.20</td>
<td>-.81</td>
<td>2.96</td>
<td>3.02</td>
<td>.66</td>
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<tr>
<td>SCS Self-Kindness</td>
<td>47</td>
<td>1.00</td>
<td>4.40</td>
<td>-.38</td>
<td>.90</td>
<td>3.00</td>
<td>3.03</td>
<td>.66</td>
</tr>
<tr>
<td>SCS Self-Judgment</td>
<td>48</td>
<td>1.00</td>
<td>4.80</td>
<td>-.07</td>
<td>-.96</td>
<td>3.20</td>
<td>3.11</td>
<td>1.03</td>
</tr>
<tr>
<td>SCS Common Humanity</td>
<td>47</td>
<td>1.00</td>
<td>4.50</td>
<td>-.16</td>
<td>-.18</td>
<td>3.00</td>
<td>2.88</td>
<td>.82</td>
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<tr>
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<td>.10</td>
<td>-.62</td>
<td>2.75</td>
<td>2.88</td>
<td>.99</td>
</tr>
<tr>
<td>SCS Mindfulness</td>
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<td>1.25</td>
<td>4.50</td>
<td>-.39</td>
<td>-.24</td>
<td>3.25</td>
<td>3.20</td>
<td>.81</td>
</tr>
<tr>
<td>SCS Over-Identification</td>
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<td>1.25</td>
<td>5.00</td>
<td>-.14</td>
<td>-.40</td>
<td>3.25</td>
<td>3.10</td>
<td>.89</td>
</tr>
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<td>2.00</td>
<td>4.67</td>
<td>.05</td>
<td>-1.36</td>
<td>3.33</td>
<td>3.24</td>
<td>.82</td>
</tr>
<tr>
<td>EDI Drive for Thinness</td>
<td>46</td>
<td>.00</td>
<td>24.00</td>
<td>.20</td>
<td>-.39</td>
<td>3.00</td>
<td>6.51</td>
<td>7.52</td>
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<td>16.00</td>
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<td>3.00</td>
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<td>EDI Body Dissatisfaction</td>
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<td>28.00</td>
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<td>8.00</td>
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<td>EDI Perfectionism</td>
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</table>

Note. SCS = Self-Compassion Scale, EDI = Eating Disorder Inventory-3.
Table 8. Codes and Themes that Emerged Within Each Interview Question for Research Question 1B ($N = 14$)

<table>
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<tr>
<th>Interview Question</th>
<th>Theme</th>
<th>Code</th>
<th>$N$ (C)</th>
</tr>
</thead>
<tbody>
<tr>
<td>How to Use BRSC</td>
<td>Acceptance</td>
<td>Accepting Flaws</td>
<td>7 (9)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No One is Perfect</td>
<td>6 (7)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Balanced Eating (unique)</td>
<td>3 (3)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Beautify of Different Body Types (unique)</td>
<td>6 (9)</td>
</tr>
<tr>
<td></td>
<td>Thinking positively</td>
<td>Focus on goals</td>
<td>6 (13)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Focus on other strengths</td>
<td>9 (13)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Scrutinize media (unique)</td>
<td>3 (4)</td>
</tr>
<tr>
<td></td>
<td>Self-care</td>
<td>Focus on health</td>
<td>7 (17)</td>
</tr>
<tr>
<td>Barriers</td>
<td>Emotional</td>
<td>Negative Feelings Toward Oneself</td>
<td>14 (17)</td>
</tr>
<tr>
<td></td>
<td>Barriers</td>
<td>Desire to be Thin is too Strong (unique)</td>
<td>3 (3)</td>
</tr>
<tr>
<td></td>
<td>Age</td>
<td>Puberty (unique)</td>
<td>3 (3)</td>
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</tbody>
</table>

*Note.* $N =$ Number of participants who provided one or more comments indexed under a code. $C =$ Number of total comments indexed under a code.

*Note.* "Unique" indicates that the code is unique to BRSC and did not emerge for general self-compassion (in Research Question 1A)
Table 9. Correlations Among Study Variables (N = 48)

<table>
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<th></th>
<th>SCS SK</th>
<th>SCS SJ</th>
<th>SCS CH</th>
<th>SCS I</th>
<th>SCS M</th>
<th>SCS OI</th>
<th>BRSC Tot</th>
<th>EDI DT</th>
<th>EDI B</th>
<th>EDI BD</th>
<th>EDI P</th>
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<tr>
<td>SCS Tot</td>
<td>.75**</td>
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<td>.64**</td>
<td>-.85**</td>
<td>.73**</td>
<td>-.85**</td>
<td>.59**</td>
<td>-.13</td>
<td>-.34*</td>
<td>-.37*</td>
<td>-.59**</td>
</tr>
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<td>SCS SK</td>
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<td>.54**</td>
<td>-.44**</td>
<td>.65**</td>
<td>-.47**</td>
<td>.34*</td>
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<td>-.23</td>
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</tr>
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<td>SCS SJ</td>
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<td>.64**</td>
<td>-.20</td>
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<td>-.68**</td>
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<td>.48**</td>
<td>.65**</td>
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<td>SCS CH</td>
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<td>.65**</td>
<td>-.38**</td>
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<td>.70**</td>
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<td>.22</td>
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<td>.35*</td>
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<td>-.54**</td>
<td>-.68**</td>
<td>-.34*</td>
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<td>EDI DT</td>
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<td>.70**</td>
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</tbody>
</table>

Note. SCS = Self-Compassion Scale, Tot = Total Score, SK = Self-Kindness subscale, SJ = Self-Judgment subscale, CH = Common Humanity subscale, I = Isolation subscale, M = Mindfulness subscale, OI = Over-Identification subscale, EDI = Eating Disorder Inventory-3, DT = Drive for Thinness subscale, B = Bulimia subscale, BD = Body Dissatisfaction subscale, P = Perfectionism subscale.

* p ≤ .05   ** p ≤ .01
Table 10. Correlations and Partial Correlations Controlling for Body-Related Self-Compassion ($N = 48$)

<table>
<thead>
<tr>
<th></th>
<th>EDI DT Cor.</th>
<th>Part. Cor.</th>
<th>EDI B Cor.</th>
<th>Part. Cor.</th>
<th>EDI BD Cor.</th>
<th>Part. Cor.</th>
<th>EDI P Cor.</th>
<th>Part. Cor.</th>
</tr>
</thead>
<tbody>
<tr>
<td>SCS Tot</td>
<td>--</td>
<td>--</td>
<td>-.34*</td>
<td>-.03</td>
<td>-.37*</td>
<td>.05</td>
<td>-.59**</td>
<td>-.50***</td>
</tr>
<tr>
<td>SCS SK</td>
<td>--</td>
<td>--</td>
<td>-.30*</td>
<td>-.14</td>
<td>--</td>
<td>--</td>
<td>-.57**</td>
<td>-.48***</td>
</tr>
<tr>
<td>SCS SJ</td>
<td>.40**</td>
<td>.11</td>
<td>.48**</td>
<td>.14</td>
<td>.65**</td>
<td>.34*</td>
<td>.54**</td>
<td>.41**</td>
</tr>
<tr>
<td>SCS CH</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>-.32*</td>
<td>-.26</td>
</tr>
<tr>
<td>SCS I</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>.53**</td>
<td>.46**</td>
</tr>
<tr>
<td>SCS OI</td>
<td>--</td>
<td>--</td>
<td>.37*</td>
<td>.09</td>
<td>.35*</td>
<td>-.05</td>
<td>.39**</td>
<td>.25</td>
</tr>
</tbody>
</table>

Note. SCS = Self-Compassion Scale, Tot = Total Score, SK = Self-Kindness subscale, SJ = Self-Judgment subscale, CH = Common Humanity subscale, I = Isolation subscale, OI = Over-Identification subscale, EDI = Eating Disorder Inventory-3, DT = Drive for Thinness subscale, B = Bulimia subscale, BD = Body Dissatisfaction subscale, P = Perfectionism subscale, Cor. = Correlation, Part. Cor. = Partial Correlation.

* $p \leq .05$    ** $p \leq .01$    *** $p \leq .001$
Table 11.  Daily Diary Card Adherence

<table>
<thead>
<tr>
<th>Ppt.</th>
<th>Session 1 July 28</th>
<th>Session 2 July 30</th>
<th>Session 3 Aug. 6</th>
<th>Session 4 Aug. 18</th>
<th>Session 5 Aug. 20</th>
<th>Fraction of Completed Diary Cards</th>
<th>% of Diary Cards Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0/2 Short</td>
<td>0/1 Long</td>
<td>1/2 Long</td>
<td>0/2 Short</td>
<td>0/1 Long</td>
<td>12/31</td>
<td>38.7%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>0/7 Short</td>
<td>7/10 Short</td>
<td></td>
<td>4/6 Short</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>0/2 Short</td>
<td>1/1 Long</td>
<td>1/2 Long</td>
<td>2/2 Short</td>
<td>0/0 Long</td>
<td>20/31</td>
<td>64.5%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>7/7 Short</td>
<td>9/10 Short</td>
<td></td>
<td>0/0 Short</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>0/2 Short</td>
<td>1/1 Long</td>
<td>2/2 Long</td>
<td>1/2 Short</td>
<td>1/1 Long</td>
<td>17/31</td>
<td>54.8%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>6/7 Short</td>
<td>3/10 Short</td>
<td></td>
<td>3/6 Short</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>0/2 Short</td>
<td>1/1 Long</td>
<td>0/2 Long</td>
<td>2/2 Short</td>
<td>1/1 Long</td>
<td>16/31</td>
<td>51.6%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>6/7 Short</td>
<td>0/10 Short</td>
<td></td>
<td>6/6 Short</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note:  Ppt = Participant, X/Y = Number of Completed Diary Cards / Number of Assigned Diary Cards
      Short = Short Diary Card, Long = Long Diary Card.
Table 12. Changes in Pre- and Post-Intervention Mean Scores for Self-Compassion, Body-Related Self-Compassion, and Eating Disorder Symptoms (N = 4)

<table>
<thead>
<tr>
<th></th>
<th>Pre-Intervention M (SD)</th>
<th>Post-Intervention M (SD)</th>
<th>t (df = 3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>SCS Total Score</td>
<td>3.48 (0.69)</td>
<td>3.64 (0.75)</td>
<td>-4.98*</td>
</tr>
<tr>
<td>SCS Self-Kindness</td>
<td>3.00 (0.37)</td>
<td>3.60 (0.37)</td>
<td>-3.67*</td>
</tr>
<tr>
<td>SCS Self-Judgment</td>
<td>2.65 (1.48)</td>
<td>2.70 (1.25)</td>
<td>-0.29</td>
</tr>
<tr>
<td>SCS Common Humanity</td>
<td>3.56 (0.72)</td>
<td>4.19 (0.69)</td>
<td>-2.61</td>
</tr>
<tr>
<td>SCS Isolation</td>
<td>2.31 (0.97)</td>
<td>2.31 (1.03)</td>
<td>0.00</td>
</tr>
<tr>
<td>SCS Mindfulness</td>
<td>3.88 (0.48)</td>
<td>3.69 (0.85)</td>
<td>0.73</td>
</tr>
<tr>
<td>SCS Over-identified</td>
<td>2.44 (0.83)</td>
<td>2.50 (0.58)</td>
<td>-0.40</td>
</tr>
<tr>
<td>BRSC Total Score</td>
<td>3.21 (1.25)</td>
<td>3.50 (0.93)</td>
<td>-0.93</td>
</tr>
<tr>
<td>EDI Drive for Thinness</td>
<td>14.25 (11.44)</td>
<td>9.50 (11.62)</td>
<td>1.31</td>
</tr>
<tr>
<td>EDI Bulimia</td>
<td>6.50 (5.92)</td>
<td>3.75 (4.50)</td>
<td>1.53</td>
</tr>
<tr>
<td>EDI Body Dissatisfaction</td>
<td>11.75 (13.87)</td>
<td>9.75 (12.45)</td>
<td>1.19</td>
</tr>
<tr>
<td>EDI Perfectionism</td>
<td>12.25 (5.56)</td>
<td>11.25 (5.06)</td>
<td>0.46</td>
</tr>
</tbody>
</table>

Note. SCS = Self-Compassion Scale, BRSC = Body-Related Self-Compassion Scale, EDI = Eating Disorder Inventory-3

*p ≤ .05
Table 13. Pre- and Post-Intervention Scores on Study Variables for Individual Participants (N = 4)

<table>
<thead>
<tr>
<th>Participant 1</th>
<th>Pre</th>
<th>Post</th>
<th>Change</th>
<th>Pre</th>
<th>Post</th>
<th>Change</th>
<th>Pre</th>
<th>Post</th>
<th>Change</th>
<th>Pre</th>
<th>Post</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>SCS Tot</td>
<td>2.88</td>
<td>3.04</td>
<td>0.16</td>
<td>2.88</td>
<td>2.96</td>
<td>0.08</td>
<td>4.19</td>
<td>4.38</td>
<td>0.19</td>
<td>3.96</td>
<td>4.19</td>
<td>0.23</td>
</tr>
<tr>
<td>SCS SK</td>
<td>2.60</td>
<td>3.20</td>
<td>0.60</td>
<td>3.20</td>
<td>3.40</td>
<td>0.20</td>
<td>3.40</td>
<td>4.00</td>
<td>0.60</td>
<td>2.80</td>
<td>3.80</td>
<td>1.00</td>
</tr>
<tr>
<td>SCS SJ</td>
<td>3.80</td>
<td>3.40</td>
<td>-0.40</td>
<td>4.00</td>
<td>4.00</td>
<td>0.00</td>
<td>1.00</td>
<td>1.20</td>
<td>0.20</td>
<td>1.80</td>
<td>2.20</td>
<td>0.40</td>
</tr>
<tr>
<td>SCS CH</td>
<td>3.50</td>
<td>3.50</td>
<td>0.00</td>
<td>2.75</td>
<td>3.75</td>
<td>1.00</td>
<td>3.50</td>
<td>4.50</td>
<td>1.00</td>
<td>4.50</td>
<td>5.00</td>
<td>0.50</td>
</tr>
<tr>
<td>SCS I</td>
<td>2.75</td>
<td>3.00</td>
<td>0.25</td>
<td>3.25</td>
<td>3.25</td>
<td>0.00</td>
<td>1.00</td>
<td>1.00</td>
<td>0.00</td>
<td>2.25</td>
<td>2.00</td>
<td>-0.25</td>
</tr>
<tr>
<td>SCS M</td>
<td>3.25</td>
<td>3.00</td>
<td>-0.25</td>
<td>3.75</td>
<td>3.00</td>
<td>-0.75</td>
<td>4.25</td>
<td>4.00</td>
<td>-0.25</td>
<td>4.25</td>
<td>4.75</td>
<td>0.50</td>
</tr>
<tr>
<td>SCS OI</td>
<td>3.25</td>
<td>3.00</td>
<td>-0.25</td>
<td>3.00</td>
<td>3.00</td>
<td>0.00</td>
<td>2.00</td>
<td>2.00</td>
<td>0.00</td>
<td>1.50</td>
<td>2.00</td>
<td>0.50</td>
</tr>
<tr>
<td>BRSC</td>
<td>2.17</td>
<td>3.17</td>
<td>1.00</td>
<td>2.17</td>
<td>2.33</td>
<td>0.16</td>
<td>4.67</td>
<td>4.17</td>
<td>-0.50</td>
<td>3.83</td>
<td>4.33</td>
<td>0.50</td>
</tr>
<tr>
<td>EDI DT</td>
<td>23.00</td>
<td>9.00</td>
<td>-14.00</td>
<td>24.00</td>
<td>26.00</td>
<td>2.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>10.00</td>
<td>3.00</td>
<td>-7.00</td>
</tr>
<tr>
<td>EDI B</td>
<td>12.00</td>
<td>4.00</td>
<td>-8.00</td>
<td>11.00</td>
<td>10.00</td>
<td>-1.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>3.00</td>
<td>1.00</td>
<td>-2.00</td>
</tr>
<tr>
<td>EDI BD</td>
<td>20.00</td>
<td>13.00</td>
<td>-7.00</td>
<td>27.00</td>
<td>26.00</td>
<td>-1.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>EDI P</td>
<td>14.00</td>
<td>7.00</td>
<td>-7.00</td>
<td>16.00</td>
<td>17.00</td>
<td>1.00</td>
<td>4.00</td>
<td>7.00</td>
<td>3.00</td>
<td>15.00</td>
<td>14.00</td>
<td>-1.00</td>
</tr>
</tbody>
</table>

Note. SCS = Self-Compassion Scale, Tot = Total Score, SK = Self-Kindness subscale, SJ = Self-Judgment subscale, CH = Common Humanity subscale, I = Isolation subscale, M = Mindfulness subscale, OI = Over-Identification subscale, EDI = Eating Disorder Inventory-3, DT = Drive for Thinness subscale, B = Bulimia subscale, BD = Body Dissatisfaction subscale, P = Perfectionism subscale.
Appendix B

Figures
Recruitment sites:

- Sections A, B, and C: Recreational figure skating club and dance studio
- Section D: Competitive figure skating club
- Note: One participant in Section A was recruited from the competitive figure skating club (i.e., to be involved in the intervention). However, she dropped out of the intervention after Session 1. She did complete questionnaires, however. Thus, she is included in the $N = 35$ participants who completed questionnaires.
Figure 2. Recruitment Process for Research Questions 1A and 1B

Recruitment site: Recreational figure skating club

Initially recruited  
$N = 20$

Completed questionnaires  
$N = 20$

Among these 20, coach was asked to select five for interviews  
$N = 5$

Total recruited:  
$N = 20$

- Questionnaire only: $N = 15$
- Questionnaire and interview: $N = 5$
- Interview only: $N = 0$

Recruitment site: Dance studio

Initially recruited  
$N = 23$

Completed questionnaires  
$N = 23$

Among these 23, coach was asked to select five for interviews, but one did not show  
$N = 4$

Total recruited:  
$N = 24$

- Questionnaire only: $N = 19$
- Questionnaire and interview: $N = 4$
- Interview only: $N = 1$

To replace the missing interview participant, coach identified one dancer who was not initially recruited for questionnaires  
$N = 1$
Figure 3. Recruitment Process for Research Questions 2A and 2B

Recruitment Site:
Figure skating club that trains elite-level figure skaters

Initially recruited
$N = 5$

Completed baseline questionnaires
$N = 5$

Completed the intervention
$N = 4$

Dropped out after one session of intervention
$N = 1$

Completed post-intervention questionnaires and interview
$N = 4$

Total recruited: $N = 5$
Completed baseline questionnaires only: $N = 1$
Completed questionnaires, intervention, and interviews: $N = 4$
Figure 4. Grand Mean Scores on Diary Card Questions Across the Intervention

*Note.* Q2 = Diary Card Question 2, Q3 = Question 3, Q4 = Question 4
Figure 5. Changes in Mean Diary Card Scores for Participant 1

Note: Q2 = Diary Card Question 2, Q3 = Question 3, Q4 = Question 4
Figure 6. Changes in Mean Diary Card Scores for Participant 2

*Note.* Q2 = Diary Card Question 2, Q3 = Question 3, Q4 = Question 4
Figure 7. Changes in Mean Diary Card Scores for Participant 3

Note. Q2 = Diary Card Question 2, Q3 = Question 3, Q4 = Question 4
Figure 8. Changes in Mean Diary Card Scores for Participant 4

Note. Q2 = Diary Card Question 2, Q3 = Question 3, Q4 = Question 4
## Self-Compassion Scale

**How I typically act toward myself in difficult times**

Please read each statement carefully before answering. To the left of each item, indicate how often you behave in the stated manner, using the following scale:

<table>
<thead>
<tr>
<th>Almost Never</th>
<th>Almost Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 2 3 4 5</td>
<td></td>
</tr>
</tbody>
</table>

1. I’m disapproving and judgmental about my own flaws and inadequacies.
2. When I’m feeling down I tend to obsess and fixate on everything that’s wrong.
3. When things are going badly for me, I see the difficulties as part of life that everyone goes through.
4. When I think about my inadequacies, it tends to make me feel more separate and cut off from the rest of the world.
5. I try to be loving towards myself when I’m feeling emotional pain.
6. When I fail at something important to me I become consumed by feelings of inadequacy.
7. When I’m down, I remind myself that there are lots of other people in the world feeling like I am.
8. When times are really difficult, I tend to be tough on myself.
9. When something upsets me I try to keep my emotions in balance.
10. When I feel inadequate in some way, I try to remind myself that feelings of inadequacy are shared by most people.
11. I’m intolerant and impatient towards those aspects of my personality I don’t like.
12. When I’m going through a very hard time, I give myself the caring and tenderness I need.
13. When I’m feeling down, I tend to feel like most other people are probably happier than I am.
14. When something painful happens I try to take a balanced view of the situation.
15. I try to see my failings as part of the human condition.
16. When I see aspects of myself that I don’t like, I get down on myself.
17. When I fail at something important to me I try to keep things in perspective.
18. When I’m really struggling, I tend to feel like other people must be having an easier time of it.
19. I’m kind to myself when I’m experiencing suffering.
20. When something upsets me I get carried away with my feelings.
21. I can be a bit cold-hearted towards myself when I’m experiencing suffering.
22. When I’m feeling down I try to approach my feelings with curiosity and openness.
23. I’m tolerant of my own flaws and inadequacies.
24. When something painful happens I tend to blow the incident out of proportion.
25. When I fail at something that’s important to me, I tend to feel alone in my failure.
26. I try to be understanding and patient towards those aspects of my personality I don’t like.
Coding Key:

Self-Kindness Items: 5, 12, 19, 23, 26
Self-Judgment Items: 1, 8, 11, 16, 21
Common Humanity Items: 3, 7, 10, 15
Isolation Items: 4, 13, 18, 25
Mindfulness Items: 9, 14, 17, 22
Over-identified Items: 2, 6, 20, 24
Body-Related Self-Compassion Scale

How I typically feel toward my body

The following statements are about ways that people sometimes feel when thinking about their body’s physical appearance. Please indicate how often you have felt this way, using the scale below. Please read each statement carefully before answering.

<table>
<thead>
<tr>
<th>Almost Never</th>
<th>Almost always</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

1. I’m disapproving and judgmental about my body’s flaws and inadequacies
2. When I feel bad about my body, I try to remind myself that other people feel bad about their body sometimes, too
3. When I see aspects of my body that I don’t like, I tend to fixate on everything that’s wrong with my body
4. I try to be understanding and patient towards aspects of my body that I don’t like
5. When I feel down about my body, I tend to feel like other people are probably happier with their body than I am
6. When I feel down about my body, I try to keep my emotions in balance

Coding Key:

- Self-kindness item: 4
- Self-judgment item: 1
- Common Humanity item: 2
- Isolation item: 5
- Mindfulness item: 6
- Over-identified item: 3
Eating Disorder Inventory—3

These questions ask about your attitudes, feelings, and behavior. Some of the questions are about food or eating. Other questions ask about your feelings about yourself.

Please answer ALL of the questions. Make sure to circle only ONE answer for each question.

Body Dissatisfaction Subscale

1. I think that my stomach is too big.
2. I think that my thighs are too large.
3. I think that my stomach is just the right size.
4. I feel satisfied with the shape of my body.
5. I like the shape of my buttocks.
6. I think my hips are too big.
7. I feel bloated after eating a normal meal.
8. I think that my thighs are just the right size.
9. I think my buttocks are too large.
10. I think that my hips are just the right size.

Bulimia Subscale

11. I eat when I am upset.
12. I stuff myself with food.
13. I have gone on eating binges where I felt that I could not stop.
15. I eat moderately in front of others and stuff myself when they’re gone.
16. I have the thought of trying to vomit in order to lose weight.
17. I eat or drink in secrecy.
18. When I am upset, I worry that I will start eating.

Drive for Thinness Subscale

19. I eat sweets and carbohydrates without feeling nervous.
20. I think about dieting.
21. I feel extremely guilty after overeating.
22. I am terrified of gaining weight.
23. I exaggerate or magnify the importance of weight.
24. I am preoccupied with the desire to be thinner.
25. If I gain a pound, I worry that I will keep gaining.
Perfectionism Subscale

26. Only outstanding performance is good enough in my family.
27. As a child, I tried very hard to avoid disappointing my parents and teachers.
28. I hate being less than best at things.
29. My parents have expected excellence of me.
30. I feel that I must do things perfectly or not do them at all.
31. I have extremely high goals.
Appendix D

Interview Guide
Semi-structured Interview Guide

Introductory Script

As part of our study, we want to know what you think about self-compassion, and what you think about the activities we did together. Because you are the ones who did the intervention, your opinions are really important to us. By asking you some questions, we can really learn a lot about the topic we are studying.

Consent to audiorecording:

In order to help me remember everything you say, I would like to audio-record this conversation. The audio-recording will be kept in a secure location and typed out word-for-word. Nobody but me and the other researchers will have access to it. Is this OK with you?

Limits to confidentiality:

Remember that everything you tell me about will be kept confidential. I won’t be sharing it with anyone else except the other researchers. However, because your opinion is so helpful, I might want to include some quotes in my research report. If I do that, I will not include your name or any identifying information, so no one reading the report will know it’s you. Is that OK with you?

Lastly, because of laws, there is certain information that I cannot keep private. If you were to tell me about a child or teenager who is being abused (or at risk of being abused), I would have to share that information with the appropriate authorities. Does that make sense?

Voluntary participation:

Remember that anything you do in this study is up to you. So, if there are any questions that you don’t feel comfortable answering, you can just say “Pass.” Or, if you decide you don’t want to do the interview at all, that’s OK too.

<table>
<thead>
<tr>
<th>Topic</th>
<th>Question</th>
<th>Research Aim</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall experience of the intervention</td>
<td>1. What did you think of the intervention?</td>
<td>2A</td>
</tr>
<tr>
<td>Initial impressions</td>
<td>2. What did you think of the intervention:</td>
<td>2A</td>
</tr>
<tr>
<td></td>
<td>- before the first session?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- after the first session?</td>
<td></td>
</tr>
<tr>
<td>Understanding of self-compassion as a concept</td>
<td>3. What is self-compassion? How would you explain it to a friend?</td>
<td>1A</td>
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<td></td>
<td>What is body-related self-compassion? How would you explain it to a friend?</td>
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<tr>
<td>The utility of self-compassion</td>
<td>4. In your opinion, is self-compassion helpful? Why or why not?</td>
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<tr>
<td></td>
<td>How is it helpful?</td>
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<tr>
<td>Are there any ways the self-compassion is not helpful? What are the pros and cons of self-compassion?</td>
<td>The utility of self-compassion for athletes</td>
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<td>5. In your opinion, is self-compassion helpful for athletes? Why or why not? Was it helpful for you as an athlete?</td>
<td>1A</td>
<td></td>
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<tr>
<td>The relationship between self-compassion and eating disorder symptoms</td>
<td></td>
<td></td>
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<tr>
<td>6. In your opinion, does self-compassion help people have a healthier body image? Why or why not? In your opinion, can self-compassion help people be more kind to themselves when they notice parts of their body that they don’t like? In your opinion, can self-compassion help prevent people from getting an eating disorder? [Allow participants to share about their personal experiences, but don’t need to probe as question 11 covers this.]</td>
<td>1B</td>
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<tr>
<td>Barriers to self-compassion</td>
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<td>7. Do you think it is hard to be self-compassionate? What makes it hard? What would make it easier?</td>
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<tr>
<td>Pre-intervention personal experience with self-compassion</td>
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<td>8. Before the intervention, how much were you hard on yourself during difficult moments? How much did you use self-compassion? How did you use self-compassion?</td>
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<tr>
<td>Post-intervention personal experience with self-compassion</td>
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<tr>
<td>Overall effectiveness of the intervention</td>
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<td>10. In your opinion, was the intervention helpful for you? Why or why not?</td>
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<tr>
<td>Effectiveness of the intervention at increasing self-compassion and decreasing eating disorder symptoms</td>
<td></td>
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<tr>
<td>11. Did the intervention help you become more self-compassionate? Did the intervention help you become more self-compassionate toward your body? Did the intervention help you develop a healthier body image? Healthier eating habits?</td>
<td>2B</td>
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<tr>
<td>Effectiveness of the intervention related to athletic goals</td>
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<td>12. Did the intervention help you as an athlete? Why or why not?</td>
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<tr>
<td>Components of the intervention</td>
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<td>13. What parts of the intervention were the most helpful? Least helpful?</td>
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<td>Intervention feedback/suggestions</td>
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<td>14. Are there any parts of the intervention you think we should change? What would make the intervention better?</td>
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Closing Script

Thank you for answering our questions. Your opinions are really helpful to us.
Do you have any last questions or comments for us? If you come up with questions later, you can email me at [...]@sfu.ca

Would you like to learn about the results of this study? If so, please give me your address, and a brief summary of the results will be mailed to you when the study is done.
Appendix E

Intervention Materials
Intervention Outline

The following outline was developed by the author and includes intervention strategies modified from previous studies exploring self-compassion interventions in youth and adults (McGehee, 2010; Albertson et al., 2014; Gale et al., 2014; Persinger, 2012; Neff & Germer, 2012; Gilbert & Procter, 2006).

Summary:

**Session 1:** Introduction to self-bullying and self-compassion

**Session 2:** Introduction to self-kindness, mindfulness, and the three states of mind (over-identification, denial/suppression, and mindfulness)

**Session 3:** Self-kindness strategies, and using self-compassion for performance anxiety

**Session 4:** Introduction to Common Humanity, and the Self-Compassion Break

**Session 5:** Body-related self-compassion, the Self-Compassion Letter, and group gratitude activity

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**Session 1: Introduction to Self-Compassion**

Introductions, icebreaker activity, & orientation to workshop

Imagery Exercise: Compassion for self vs. other

- Participants are walked through a guided imagery exercise in which they imagine how they might respond to a loved one who is going through a difficult time or has failed at something important to them. They are then asked to imagine how they might respond when they themselves are going through a difficult time or have failed at something.

- We then have a group discussion comparing and contrasting participants’ responses in these two different scenarios. We discuss the fact that compassion is often extended more easily to others than to oneself. Many people respond to their own failures with harsh self-criticism or derogation but respond to other people’s failures with support and compassion.

Self-Bullying
• Group discussion on negative self-talk (i.e., definitions, examples, normalizing the experience).

• Self-bullying in athletes is not uncommon. Athletes are sometimes hard on themselves in order to maintain motivation and strong work ethic.

• Participants can volunteer to share about their own experiences with self-bullying.

Self-Compassion

• Definitions of compassion and self-compassion. Participants brainstorm examples of each.

• Participants brainstorm the pros and cons of self-compassion versus self-bullying. The main point to be made is that, while both self-compassion and self-bullying serve to motivate athletes, self-bullying is associated with a number of drawbacks (e.g., decreased self-confidence, risk for mental health problems, risk of burnout, etc.).

• Self-compassion versus self-coddling. Self-compassion does not involve being “too easy” on oneself (e.g., relaxing one’s standards, indulging urges to be lazy, etc.). This is called “self-coddling.” Self-compassion involves working hard toward your goals while maintaining respect for oneself, in the same way you would encourage a friend to work toward his/her goals.

• The benefits of self-compassion according to research

• Self-compassion versus self-esteem. Self-esteem is dependent upon a positive evaluation of the self. We tend to evaluate ourselves positively when we achieve something or perform well at a task. Thus, self-esteem is a “fair-weathered friend.” Self-compassion, on the other hand, involves unconditional positive regard for the self and may thus be considered a preferable way to treat/evaluate the self.

• Self-compassion and perfectionism. Perfectionism involves (1) striving for perfection, and (2) reacting negatively to failure. Self-compassion involves only the former, without the latter, and thus may be considered a preferable way of pursuing one’s goals.

Writing Exercise

• Participants were asked to complete a brief writing exercise in which they wrote about two situations in which they are often hard on themselves, ways in which they use self-bullying in these situations, and ways in which they could
try using self-compassion. The purpose of this exercise is to have participants begin to apply some of the concepts learned today to their personal lives.

Diary Cards

• Participants are instructed on how to complete the daily diary cards. They complete one in session for practice.

Session 2: Self-Kindness and Mindfulness

Brainstorming Activity: Keeping your Tank Full

• Using the analogy of a vehicle’s fuel tank, participants are asked to brainstorm the things that an athlete needs to "keep her tank full." Participants begin by identifying their physical needs (i.e., food, shelter, sleep) and are then asked to identify what their emotional and mental needs. The purpose of this activity is to help athletes recognize that the important role that mental health plays in the success of an athlete.

Diary Card Check-In

• Participants are invited to ask questions about the diary cards or clarify any misunderstandings.

Three Steps of Self-Compassion

• Participants are instructed on the three steps of self-compassion (according to Neff), including mindfulness, self-kindness, and common humanity.

Self-Kindness

• Participants are asked to reflect on how they treat themselves versus others during challenging moments. They are asked to imagine treating themselves with the same kindness with which they treat others. In a group brainstorming activity, participants are given various scenarios and are asked to brainstorm how they could be (a) kind to others, and (b) kind to themselves.
• Myths about self-kindness. In a group discussion, participants challenge three myths about self-kindness: (1) It will make me lazy, (2) I don’t need it, (3) I don’t deserve it, and (4) It’s too hard; I’m too used to self-bullying.

Mindfulness

• Participants receive instruction on mindfulness include definitions, examples, and benefits according to research.

• Mindfulness involves (a) paying attention, and (b) withholding judgment and just accepting.

• Mindfulness is important for self-compassion because in order to treat oneself with kindness, one has to first notice that he/she is suffering and in need of kindness.

• Mindfulness requires practice, like strengthening a muscle at the gym.

• Participants are guided through a mindfulness exercise in which they pay attention to the colours in a room, and then sounds in a room. They are asked to practice this exercise for homework.

Three States of Mind

• To help participants better understand the benefits of mindfulness, they receive instruction comparing and contrasting mindfulness with two other mind states—denial (i.e., suppressing painful emotions, pretending everything is fine) and overwhelmed (over-identifying with one’s emotions, allowing oneself to be swept away by emotion). Examples are drawn from the movie Frozen.

• Participants receive instruction on emotions and the role of acceptance in emotion regulation.

• Participants brainstorm a list of emotions. No emotion is “bad;” all emotions have a “job” (function). Examples are drawn from the movie Inside Out.

• Emotions do not have an “off switch.” Like the weather, emotions cannot be controlled.

• Radical acceptance is an effective tool for coping with upsetting situations. Suffering = Pain + Resistance. The analogy of weather is used. One can either be miserable about the rain and stay inside all day, or one can use an umbrella and make the best of it. This writer shares a personal story about using radical acceptance as a tool to cope with migraine headaches.
Homework

- Continued diary cards
- Teach a friend or family member about self-compassion
- Practice the mindfulness exercise we practiced today once a day
- Choose a pendant to clip to your clothing or water bottle to remind you to use self-kindness during figure skating practices

Session 3: Self-Kindness Trouble Shooting & Performance Anxiety

Review

- Participants review material learned last session and are provided an opportunity to ask questions.
- Participants discuss the homework they completed last session and how it went.

Self-Kindness Trouble Shooting

- In the psychological literature, many participants report difficulty using self-compassion. Two complaints are common: (1) I attempted to use self-compassionate statements, but these statements did not resonate for me and did not help me feel any better, and (2) I attempted to use self-compassionate statements but it felt painful, perhaps because I do not feel as though I deserve self-compassion, or because it threatens my core beliefs that I am worthless.

- Participants are invited to share about any difficulties they experienced while attempting to use self-kindness. These difficulties are normalized, and participants are reminded that self-kindness is like a muscle that needs repeated practice in order to become strong.

- Participants learn seven strategies that can help build their “self-kindness muscles.”
  
  - (1) *Use the “Reverse Golden Rule.”* Ask yourself what you would say/do for a friend.
o **Different Personalities of Self-Kindness.** Participants are asked to imagine different personalities/tones with which self-kindness could be used. Examples include “Gentle Grandma” (e.g., “I love you just the way you are honey!”), the Nice Coach (e.g., “You just need to tighten your spin a bit; I know you can do it!”), and the Jokester (e.g., finding humour in the situation, learning to laugh at oneself).

o **Meeting Halfway.** Participants are asked to imagine a continuum with self-bullying on one side and self-kindness on the other. If they are having difficulty going all the way to the self-compassion side, they might try going only halfway (e.g., using a more moderate statement of self-kindness).

o **Go Back to Mindfulness.** Participants are asked to think about self-compassion in three steps: paying attention to one’s suffering, accepting the current situation, and being kind to oneself. If self-kindness is failing, one can fall back on using the first two steps (i.e., mindfulness), which may be easier.

o **Practice During Easy Moments.** Participants are encouraged to expand their practice of self-kindness. They are asked to try using self-kindness not only in moments of pain or failure, but also in moments that are neutral or joyful (e.g., praising oneself for working hard).

o **Try Again Next Time.** Self-kindness is like learning a new skill. You may not get it the first time, and it is ok to take a break and try again next time. Do not give up.

o **Choose a Song.** Participants are asked to choose a song that helps them invoke self-compassion and to sing this song to themselves in moments when they would like to use self-compassion.

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**Performance Anxiety**

- In a group discussion, participants learn about performance anxiety including definitions, physical sensations of anxiety, and the function of anxiety. Performance anxiety is normalized, and participants share their own examples. Participants learn that optimal performance is associated with moderate levels of anxiety.

- Participants learn several Thinking Traps that the Self-Bully uses to create performance anxiety. Two thinking traps are emphasized: (1) Focusing on winning (i.e., “You have to win or else your coach will be mad at you”), and (2) Measuring One’s Skill by Their Performance (i.e., “If I lose this competition, it means I’m a bad skater”). Participants are taught ways to combat these thinking traps including (1) using mindfulness to focus on the process rather than the outcome, and (2) viewing their current performance as a snapshot of their skill level at present, rather than the defining measure of their potential.

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**Mindfulness Exercise**

- Participants learn diaphragmatic breathing and practice in session.
• Participants practice a mindfulness exercise that involves focusing on one’s breath.

• Participants learn that diaphragmatic breathing can be a useful strategy in coping with performance anxiety.

Homework

• Continue Diary Cards.

• Practice a mindfulness exercise daily.

• Choose one of the Self-Kindness Strategies we covered today and practice it for homework.

• Choose one of the Self-Kindness Personalities to practice for homework.

Session 4: Common Humanity (“Being Human”)

Mindfulness Exercise

• Participants watch a four-minute video depicting a series of two- or three-second clips of emotional experiences that many humans share (e.g., receiving an injection, popping a balloon, kissing someone, watching a balloon rise into the sky). While watching the video, participants are asked to pay attention to the thoughts and emotions that arise within them. The rationale for this exercise is to help participants practice paying attention to their thoughts and feelings. Paying attention to one’s thoughts and feelings is a primary step involved in self-compassion.

Review Homework

• Participants were invited to share or ask questions about the homework they completed:
  o Diary Cards
  o Mindfulness exercise daily
  o Self-Kindness Strategies

Activity: Cross the Line
• Participants close their eyes and are asked to respond to a list of increasingly personal questions. Participants respond using a sign that reads Yes on one side and No on the other. Participants keep their eyes closed but hold up their sign so that this writer can see the responses but other participants cannot. As participants respond to questions, this writer verbalizes the responses of the group aloud (e.g., “one Yes and three No’s), keeping individual’s responses private. Examples of questions include, “Have you ever been teased or bullied?” “Have you ever felt like a failure?” and “Have you ever wished your body looked different?” The purpose of the activity is to help participants see that difficult experiences are shared by everyone.

Being Human

• Participants are introduced to the third step of self-compassion, common humanity, the notion that suffering and failure is shared by all humans.

• This writer shares a personal story about her own struggles as an athlete when she was a teenager. The purpose of this story to help normalize struggles with body image, perfectionism, and negative self-talk, and facilitate participants’ comfort in sharing their own stories.

• Participants are invited to share candidly about their own struggles with negative self-talk, perfectionism, body image issues, athletic setbacks, and pressure from coaches and parents. Care was taken to ensure that participants felt safe and comfortable sharing their personal experiences, but did not feel pressured to share. This group discussion is meant to be thorough, taking up a good portion of the session, to allow participants to fully share about their experiences.

Writing Exercise: Self-Compassion Break

• Participants learn how to integrate the three steps of self-compassion using the “Self-Compassion Break.” The self-compassion break involves noticing that one is feeling upset, then consciously taking a brief moment to use self-compassion in the form of positive self-talk, taking a few deep breaths, taking a break from the activity that is upsetting, and/or reminding oneself that upsetting moments are shared by everyone (common humanity).

• In a writing exercise, participants are asked to identify two situations in which they are often hard on themselves. Then, they are asked to identify a self-statement corresponding to each of the three steps of self-compassion (e.g., “I’m having a hard time right now. But everyone makes mistakes. I know I can do this.”) They are asked to write out their three statements and commit this to memory.
Imagery Exercise: Self-Compassion Break

- Participants are guided through an imagery exercise in which they imagine using the Self-Compassion Break during a recent moment that was upsetting.

Homework

- Diary Cards
- Practice the Self-Compassion Break
- Continue practicing mindfulness exercise and self-kindness strategies

Session 5: Body-Related Self-Compassion

Review

- Participants are given the opportunity to provide comments or ask questions about their homework
  - Diary Cards
  - Self-Compassion Break
  - Mindfulness exercises
  - Self-Kindness strategies

Body Image and Eating Disorders

- Participants watch a short video clip normalizing negative body image.
- Body image is defined, and prevalence is discussed. Approximately 80% of teenage girls are unhappy with their body appearance.
- Participants brainstorm and learn about reasons why body dissatisfaction is so prevalent among girls and women in Western Society.
- Participants learn about eating disorder symptoms, prevalence rates, risk factors, and the warning signs.
- Participants learn about how self-compassion may be a helpful tool to combat body dissatisfaction and disordered eating.
Writing Exercise: The Self-Compassion Letter

- Participants are asked to complete a private writing exercise (i.e., a piece of writing that they will keep for themselves and not show anyone else).

- On a handout, participants are asked to identify something that they do not like about themselves. If they experience body dissatisfaction, they are encouraged to write about that part of their body that they do not like. If they do not experience body dissatisfaction, or if they do not wish to write about their body, they are encouraged to choose something different. They are asked to write down the thoughts and emotions that they experience when they are thinking about this aspect of themselves that they do not like.

- Once participants have completed this handout, they are guided through an imagery exercise in which they imagine an “imaginary friend” who always treats them with compassion. The friend can be someone they know in real life, or someone they have conjured using their imagination. The rationale for this exercise is that compassion is occasionally easier to accept when it is coming from someone else, rather than oneself. They are asked to conjure a vivid image of this person and hold this person in memory to “turn to” during painful moments when one is in need of self-compassion.

- Last, participants are asked to write a letter to themselves from their imaginary friend. Instructions are, “Pretend that your friend knows you are feeling sad about that thing that you don’t like about yourself. Write a letter to yourself from your imaginary friend, comforting you about that thing that you don’t like.”

- Participants are encouraged to keep their letter in a safe place and refer to it when they are feeling down.

Goodbye and Gratitude Activity

- Participants and this author participate in a goodbye exercise together. Participants and this author write messages to one another in which they express gratitude for one another’s participation in the workshop. (E.g., “It was fun to participate in the group with you. You had a good sense of humour. I learned a lot from you when you discussed your experiences with…”).

Jeopardy Review Game

- Participants play a jeopardy game in which they can earn points for answering questions about workshop content.
Meeting Halfway

Self-Bullying

Self-Compassion
Being kind to yourself like you would a friend. Working toward your goals in a healthy way. Giving yourself what you need to succeed. Letting go of mistakes. Staying positive and using positive self-talk.

Self-Coddling
Personalities of Self-Compassion

The Gentle Grandma

I love you just the way you are darling!

The Critical but Caring Coach

Watch your technique! One more time! I believe in you!

The Cheerful Cheerleader

I can do it! Go me!

The Jokester

LOL

The Feisty Cheerleader

Who run the world?
Short Daily Diary

Having self-compassion during difficult moments

**Definitions:**

**Difficult moments:** Sometimes, people have difficult moments. They may have something upsetting happen to them. They may fail at something important to them. They may be going through a hard time. They may feel bad about themselves. They may be suffering or feeling down for some reason.

**Being hard on yourself:** During difficult moments, people are sometimes hard on themselves. They may use negative self-talk or call themselves names. They may feel bad about themselves. They may think they should have done something better. They may feel angry, embarrassed, or ashamed of themselves.

**Being compassionate toward yourself:** Sometimes, people try to be compassionate toward themselves during difficult moments. They may try to be understanding toward their difficulties/flaws and say nice things to themselves. They may try to remind themselves that other people have flaws and experience difficult moments, too. They may try to stay calm and not get carried away by their feelings. They may try to keep a balanced perspective on the situation instead of just focusing on all the bad stuff.

Continued on next page...
Please answer the following 4 questions:

- Think about a difficult moment/situation you had today. What was the situation?

2. How much were you hard on yourself during this situation?

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3. How much did you try to be compassionate toward yourself?

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4. Was it helpful to be compassionate toward yourself?

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Long Daily Diary

Having self-compassion during difficult moments

Definitions:

**Difficult moments:** Sometimes, people have difficult moments. They may have something upsetting happen to them. They may fail at something important to them. They may be going through a hard time. They may feel bad about themselves. They may be suffering or feeling down for some reason.

**Being hard on yourself:** During difficult moments, people are sometimes hard on themselves. They may use negative self-talk or call themselves names. They may feel bad about themselves. They may think they should have done something better. They may feel angry, embarrassed, or ashamed of themselves.

**Being compassionate toward yourself:** Sometimes, people try to be compassionate toward themselves during difficult moments. They may try to be understanding toward their difficulties/flaws and say nice things to themselves. They may try to remind themselves that other people have flaws and experience difficult moments, too. They may try to stay calm and not get carried away by their feelings. They may try to keep a balanced perspective on the situation instead of just focusing on all the bad stuff.

Continued on next page...
Please answer the following questions
***Please complete only ONE of these each week***

- Think about a difficult moment/situation you had today. What was the situation?

2A. How much were you hard on yourself during this situation?

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2B. Did you have any negative self-talk (e.g., “I’m no good at all”) during this difficult moment? If so, please write it down if you are comfortable:

2C. Did you have any painful feelings during the difficult moment? Please circle each feeling that you had:

Sad    Angry    Lonely    Embarrassed    Guilty
Ashamed    Depressed    Mad    Regretful    Frustrated

Other: ___________________________    Other: ___________________________

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3A. How much did you try to be **compassionate toward yourself** during the difficult moment?

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3B. Please circle all the ways that you tried to be compassionate toward yourself:

- Reverse golden rule
- Common humanity
- Self-compassion break
- Self-kindness
- Mindfulness
- Compassionate self-talk

Other: __________________________________________

Other: __________________________________________

3C. Did you use any compassionate self-talk (e.g., “It’s OK that I messed up, I tried my best”) during the difficult moment? If so, please write it in the space below. If not, please write down some compassionate self-talk that might have helped during your difficult moment.

Thoughts I had: __________________________________________

________________________________________

Thoughts that might have been helpful: __________________________________________

________________________________________

4A. If you tried to be compassionate toward yourself, **was it helpful?**

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4B. Please describe how being compassionate toward yourself was helpful or unhelpful.
Long Daily Diary #2
Having Self-Compassion for Your Body

Definitions:

Noticing parts of your body you don’t like: Sometimes, people notice parts of their body they don’t like. They may think their hips are too big/small. They may think their legs are too long/short. They may not like the shape of their torso. They may not like the way their body looks in general.

Being hard on yourself: When people notice parts of their body they don’t like, they are sometimes hard on themselves. They may use negative self-talk or call themselves names. They may feel bad about themselves. They may think their body should look different/better. They may feel angry, embarrassed, or ashamed of themselves.

Being compassionate toward yourself: When people notice parts of their body they don’t like, they sometimes try to be compassionate toward themselves. They may try to be understanding toward their flaws imperfections and say nice things to themselves. They may try to remind themselves that other people have flaws in their body, too. They may try to stay calm and not get carried away by their feelings. They may try to keep a balanced perspective on the situation instead of just focusing on all their imperfections.

Continued on next page...
Please answer the following questions
***Please complete only ONE of these each week***

- Think about a time today when you felt bad about your body or noticed parts of your body that you didn’t like. What was the situation?

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2A. How much were you **hard on yourself** during this situation?

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2B. Did you have any negative self-talk (e.g., “My stomach is too big,” “I’m ugly”) during this difficult moment? If so, please write it down if you are comfortable:

---

2C. Did you have any painful feelings? Please circle each feeling that you had:

- Sad
- Angry
- Lonely
- Embarrassed
- Guilty
- Ashamed
- Depressed
- Mad
- Regretful
- Frustrated
- Other: ____________________________

Continued on next page...
3A. How much did you try to be compassionate toward yourself or your body?

1 2 3 4 5
Not at all A little A lot

3B. Please circle all the ways that you tried to be compassionate toward yourself or your body:

Reverse golden rule Common humanity Self-compassion break
Self-kindness Mindfulness Compassionate self-talk

Other: ________________________________

Other: ________________________________

3C. Did you use any compassionate self-talk (e.g., “My body may not be perfect, but everyone has flaws”)? If so, please write it in the space below. If not, please write down some compassionate self-talk that might have helped in the moment.

Thoughts I had: ____________________________________________

__________________________________________________________

Thoughts that might have been helpful: ________________________

__________________________________________________________

4A. If you tried to be compassionate toward yourself or your body, was it helpful?

1 2 3 4 5
Not at all A little A lot

Continued on next page...
4B. Please describe how being compassionate toward yourself or your body was **helpful or unhelpful**.