The Lived Experience of Barriers to Self-Compassion in Women Experiencing Weight Difficulties

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June 2019

Research submitted in partial fulfilment of the requirements for the degree of Doctor in Clinical Psychology (DClinPsy), Royal Holloway, University of London

Acknowledgments

I would like to thank everyone who supported me and shared their knowledge with me; the service users who contributed so generously to the data and design of this study; and my loved ones for their continuous support.

Dr Afsane Riazi and Dr Jane Vosper, thank you both for your assistance, encouragement and valuable insight. I appreciated your knowledge and experience you shared with me.

I am grateful to every participant who took their time to take part in my study. I was moved by your honesty and willingness to share your stories with me, which provided me with rich and thought-provoking data.

Gosia and Rowena, thank you for being there for me, for your continuous love and support during all the highs and lows, and for your belief in me throughout the whole journey. I would have not done this without you.

I am also thankful to the personnel of Royal Holloway who supported me and answered all the questions along the way.

Finally, I would like to thank my whole cohort for being lovely companions on this journey, providing me with encouragement and free advice along the way, and spreading the word about my study, which all massively contributed to me finishing thesis on time.

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1. Executive Summary

The thesis explored the experiences of self-compassion in women experiencing difficulties with weight management. Chapter 2 was a systematic review exploring the role of self-compassion in women facing problematic weight regulation; Chapter 3 was a qualitative paper exploring the lived experiences of self-compassion in overweight women who, following a number of previous dietary attempts, were actively trying to lose weight using community-based approaches; and Chapter 4 was a reflective overview of developing and disseminating both systematic review and empirical paper.

Chapter 2. The Role of Self-Compassion in Women Experiencing Problematic Weight Regulation

Introduction.

Self-compassion is conceptualised as a mindful awareness of oneself, which involves treating oneself kindly at all times including any challenging situations. There is a growing body of research that asserts a protective role of self-compassion in adults' psychological wellbeing including eating patterns and weight regulation. Following a number of successful compassion-based weight loss interventions, numerous explanations have been suggested that compassion for self may act as a booster against weight-related distressful thoughts and feelings and body image acceptance in people with problematic weight regulation. Despite the encouraging findings, there is uncertainty around which components may be more helpful or need more emphasis when developing weight management programmes. Therefore, the systematic review aimed to synthesise and critically evaluate the available research investigating the role of self-compassion in problematic weight regulation in women.

Methodology.

Studies were accessed through electronic databases, PsycINFO and PubMed. The review considered studies which: were published in English in a peer-reviewed journal between years 2008 and 2018; included empirical data collection and report quantitative process or outcome parameters; used the Self-Compassion Scale; participants of the studies were adult females and recruited from the general population. Titles and abstracts of articles were screened for eligibility by the author and papers considered appropriate were retrieved in full text that were then independently assessed for the eligibility by two independent reviewers. The quality assessment of accepted studies was completed by using the Critical Appraisal Skills Programme for a Cohort Study. In total, the databases generated 524 articles, 19 of which were accepted and contributed to the final 21 studies. Given that the included studies consisted of a range of methodologies, a narrative synthesis was employed.

Results.

The 21 studies were conducted and published between 2013 and 2018 in the USA (n=11), Canada (n=7), and Portugal (n=3). The 21 studies included a total of 6296 participants and used correlational cross-sectional design. Findings were extracted from the studies and grouped into two higher-order domains: undergraduate students (n=14) and the general population (n=7). Across these two categories three significant types of relationships were identified: direct correlation, mediation, and moderation.

Studies with female undergraduate students found a negative relationship between self-compassion and weight related variables such as body objectification, body preoccupation, and eating guilt. A positive relationship was also found between self-compassion and body appreciation and healthy eating patterns, intuitive eating, and rigid food rules adherence. In addition, the Self-Kindness and Self-Judgment

components of self-compassion significantly mediated the relationship between maladaptive perfectionism and body image satisfaction and the relationship between maladaptive perfectionism and disordered eating behaviours. Self-compassion was found to mediate the positive association between intrinsic weigh-related goals and healthy eating, the negative association between extrinsic weight goals and unhealthy eating, and the negative link between internalised negative weight beliefs and the likelihood of intuitive eating. Self-compassion was found to moderate: the positive association between recollection of negative caregiver eating messages and body consciousness; the negative link between time spent with body-focused others and both healthy eating and body appreciation; the positive relationship between BMI scores and eating psychopathology; the negative relationship between BMI scores and body image flexibility, and the positive link between anti-fat attitudes in women and engaging, via body shame, in fat talk.

In the studies with the general population self-compassion was found to be positively correlated with body appreciation and negatively correlated with shape and weight concerns, disordered eating, thinness-related pressures and thin-related internalisation. In addition, self-compassion mediated: the negative association between early positive experiences and disordered eating symptoms; the positive link between fear of negative evaluation and negative affect; and the positive relationship between recall of early memories of warmth and safeness with peers and body appreciation Also, the Self-Judgment component of self-compassion as well as fear of receiving compassion from others were reported to have significant mediating effects on the association between external shame and eating psychopathology. Self-compassion did not mediate the positive relationship between body dissatisfaction and dietary restraint(Maraldo, Zhou, Dowling, & Vander Wal, 2016)(Maraldo, Zhou,

Dowling, & Vander Wal, 2016). Self-compassion was found to have the moderating influence on: the negative relationship between body comparisons and body appreciation and between appearance self-worth and body appreciation; the positive relationship between media thinness-related pressure and both disordered eating and thin-ideal internalisation; and the positive association between emotional distress and disordered eating.

Discussion.

The findings consistently suggested that higher levels of self-compassion were associated with higher levels of body appreciation, healthy eating patterns, and intuitive eating. Self-compassion also significantly predicted lower levels of: rigid food rules adherence, body objectification, body preoccupation, eating guilt, shape and weight concerns, disordered eating behaviours, and thinness-related pressures. In addition, the findings suggested that self- compassion had the important mediating and moderating influence on a number of positive and negative associations between weight regulation and psychological variables. The reported associations provided empirical evidence that self-compassion played the protective role in women with problematic weight regulation in non-clinical population. This was in line with existing theoretical models of self-compassion that suggest that self-compassion may act as a buffer against eating psychopathology and body image related concerns.

It was hoped that the evidence for the protective role of self-compassion in women experiencing difficulties with negative eating- and weight-related thinking and emotional patterns would encourage healthcare professionals and policy makers to ensure that overweight and obese women have access to self-compassion weight-loss interventions.

Strengths included a robust number of eligible peer-reviewed articles, transparency and clarity of the paper, and a good level of quality and academic scrutiny. Limitations included a large variability in the outcome measures, variability in the relationships between self-compassion and weight-related variables, correlational cross-sectional design, studies reporting the total score of SCS rather than specific subscales.

Future research could focus on examining the role of self-compassion in women from clinical samples (e.g. those with a diagnosis of an eating disorder) and male samples and identifying which components of the SCS scale contribute to improved psychological weigh-related outcomes.

Chapter 3. The Lived Experience of Barriers to Self-Compassion in Women Experiencing Weight Difficulties

Introduction.

In the recent years, overweight has consistently been on the rise due to a number of biological, psycho-social, and environmental factors. Also, the existing clinical evidence worryingly suggests that traditional approaches to weight loss such as restrictive eating are not sustainable as they often cause re-gain of weight. Reviews of research on self-compassion revealed that self-kindness and self-care could have a direct and indirect effect on problematic eating patterns and other factors related to being overweight. Consequently, researchers have developed a number of innovative compassion-focused approaches to losing weight. Thus far a small number of randomised control trials provided preliminary evidence that compassion for self can facilitate improved weight management and weight loss in overweight women. However, a proportion of individuals did not seem to respond to these interventions and some studies suggested that individuals with eating disorders may experience fear of

self-compassion. Given that self-compassion and weight management in women have largely been studied by using quantitative designs, it was difficult to conclude why some participants may find it difficult to cultivate self-compassion. Therefore, the current study aimed to explore the lived experiences of self-compassion in overweight women who, following a number of previous weight loss attempts, were actively trying to lose weight.

Methodology.

Participants were recruited by using a purposive sampling process. Participants needed to: be over 18 years old and female, have a BMI over 25, and have had at least three episodes of dietary attempts. Participants were recruited through local weight loss groups and by word of mouth. Monetary incentives were introduced in the form of £10 vouchers. Overall, 10 participants agreed to take part in semi-structured interviews that were audio recorded and transcribed verbatim. Data was analysed using an Interpretative Phenomenological Analysis (IPA). The analysis was audited by an independent researcher. A reflective journal was introduced and kept throughout the research process to assist with bracketing.

Results.

Data analysis revealed 10 sub-ordinate themes, which were grouped into three super-ordinate themes. The nature of each super-ordinate theme was summarised by a number of subthemes and each subtheme was supported by a selection of the most representative quotes coming from the majority of participants. The first super-ordinate theme, “I don’t think I really consider myself enough”, revealed that the majority of participants prioritised a number of other responsibilities over being self-compassionate whilst attempting to lose weight. The reasons for this were multi-fold and therefore this super-ordinate theme was divided into three subthemes: ‘Prioritising other needs over

self-compassion', 'Prioritising other people over self-compassion', and 'Feeling guilty over prioritising self-compassion'. The second super-ordinate theme, 'Re-learning a new way of life' comprised of three subordinate themes: "It's a very new thing, it's odd", 'The impact of growing up', and 'Unconscious barriers to self-compassion'. The third and final super-ordinate theme, "I have very high standards for myself", revealed the impact that high standards had on participants' lives and the way they managed their weight and comprised of four sub-ordinate themes: 'Striving for perfection', 'Judgment from self and from others', 'Comparing yourself to others', and 'Negative perceptions of self-compassion'.

Discussion.

Most participants had un understanding that cultivating self-compassion had a significant positive effect on their weight management which included feeling happier and more optimistic about dieting, losing weight in a more sustainable way, and a decrease in self-criticism and negative affect related to being overweight. However, one of the key findings was that the women experienced a conflict between practising self-compassion and fulfilling other responsibilities related to the self and others. Furthermore, the majority of women found that developing a new more self-compassionate stance towards themselves required time and effort and it involved a change to their long-standing habitual behaviours. The women also reflected that traumatic experiences such as emotional trauma may have impacted on their ability to be self-compassionate. The women also reported having very high standards for themselves in regards to their weight and self-image and striving for perfection when they started a new food or exercise plan. The interviewees also shared that they did not have self-compassion when trying 'crash diets' that were not sustainable and may have led to overeating and feeling a sense of failure. Finally, the women's ability to be self-

compassionate was compromised due to frequent judgement from self and from other people and from the negative perception of self-compassion.

A better awareness of factors that impact on women's experiences of practising self-compassion whilst actively trying to lose weight in non-clinical settings could help researchers and clinicians in their design and delivery of new psychological approaches to weight management.

Strengths of the study included the exploratory nature of the research, integration of different literatures, a high quality IPA design, and service-user involvement. Limitations included limited generisability of the study and large variability in participants' age and dieting history.

Future research would be beneficial in order to explore experiences of barriers to self-compassion in overweight participants who are male, who are diagnosed with an eating disorder, and who use weight-loss interventions in clinical settings.

Chapter 4. Integration, Impact, and Dissemination

Integration.

Both systematic review (SR) and empirical paper (EP) suggested that self-compassion may act as a booster against negative outcomes associated with being overweight such as low self-worth, vicious circle of food deprivation and overeating, and weight-related negative affect. Despite this integration, both studies differed in significant ways. The SR was secondary research whereas the EP was primary research. Also, SR focused on the role of self-compassion in women with problematic eating patters from the general population, whereas the EP explored the perceptions of self-compassion in overweight women who were actively trying to lose weight by using community-based approaches. Findings of the EP suggested that, due to a number of internal and external processes, participants often felt unable to cultivate compassion

for self. This finding seemed to extend the results of the SR suggesting that some women, when experiencing eating-related problems, may have difficulties with developing a self-compassionate stance.

Impact.

It was hoped that this thesis would contribute to further research and development of efficacious compassion-based weight-loss interventions and that healthcare professionals and policy makers would ensure that overweight women have access to resources promoting self-compassion such as self-compassion psychoeducation booklets, online programmes, or group-based interventions.

Dissemination.

Dissemination of the thesis findings included: presenting locally to staff and students at Royal Holloway, presenting at the Division of Health Psychology Annual Conference 2019; writing manuscripts for academic journals in order to publish both the systematic review and empirical paper; and talking directly to service users and facilitators from local community-based weight-loss programmes.

2. The Role of Self-Compassion in Women Experiencing Problematic Weight Regulation

Abstract

The construct of self-compassion has been studied in relation to psychological wellbeing as well as weight management, and numerous explanations have been suggested as to the role of self-compassion in weight regulation. However, there is uncertainty around which components may be more helpful or need more emphasis when developing compassion-based weight management programmes. The current review aimed to synthesise and critically evaluate the available research investigating the role of self-compassion in problematic weight regulation. Studies were accessed through electronic databases, PsycINFO and PubMed. Inclusion criteria required publications to: be peer-reviewed and published in English between years 2008 and 2018, have female participants from a non-clinical sample, include empirical data collection, report quantitative process, and use the Self-Compassion Scale. 524 papers were identified through the initial search; 19 papers including 21 studies met inclusion criteria. Two independent reviewers read the papers in full and assessed the eligibility of the retrieved articles. The 21 studies included a total of 6296 participants. Self-compassion was significantly associated with healthy weight management patterns, healthy BMI scores, improved body image outcomes, and positive early experiences. These patterns were consistent across general population and student samples. The main limitation of the review was that the included studies had large variability and used correlational data, limiting interpretations of the results. The findings provided evidence that self-compassion may have a protective role in women with problematic weight difficulties and therefore compassion-based weight loss interventions could be one of the treatment options for women who experience problems with weight management.

Introduction

In the last 15 years there has been a growth of research into the nature and functions of compassion for self. Over the years, two theoretical models of self-compassion have been proposed in literature. The models are considered complimentary yet emphasise different aspects of self-compassion (Inwood & Ferrari, 2018). The first model conceptualises self-compassion as a mindful awareness of oneself, which involves treating oneself kindly at all times including any challenging situations. The model posits that an individual is able to achieve this when one realises that suffering is a common human experience; by using the three core components of relating to one's self: self-kindness vs harsh criticism, common humanity vs isolation and disconnection, and mindfulness vs over-identification with suffering (Neff, 2003). Based on this conceptualisation, a self-reported measure of self-compassion trait, the Self-Compassion Scale (SCS), has been developed and commonly used in research. Subsequently, also a short version of the tool was developed (Raes, Pommier, Neff, & Van Gucht, 2011).

The second theoretical model is based on evolutionary approach and affective neuroscience; it proposes that self-compassion is a form of self-kindness, self-acceptance, and courage (Gilbert, 2014). The model is also considered as an effective way to understand and regulate emotions as it suggests three complimentary systems of emotion regulation: the threat system, the drive system, and the safeness system. 'The three circles model of emotion' has been theorised to help develop self-compassion as a way to validate, soothe, and find helpful ways of working with various experiences including suffering (Kolts, 2016; Gilbert, 2014). Research has showed preliminary findings that the ability to activate the three types of emotion-regulation system may be related to being raised in a safe and supportive environment (Gilbert,

2014) and that early experiences of this system may play a protective role in individuals' adult lives (Ferreira, Oliveira, & Mendes, 2017). The above three circles model is complex and dynamic and can produce blended affects combining valence (positive-neutral-negative) and arousal (activation-inhibition), which are currently being investigated. Individual difference, mental states such as anxiety, self-reflection might also influence the response of the regulation system (Richardson, McEwan, Maratos, & Sheffield, 2016).

Despite the increased interest and attention, self-compassion is a complex and multifaceted construct. There is currently lack of consensus on the definition of self-compassion and there are controversies over its definition and nature (e.g. a feeling state vs motivational state; Gilbert et al., 2017). This is also reflected in the measures that have been developed to assess self-compassion and there is currently a number of instruments that assess self-compassion in a different way (Elices et al., 2017). For example, Neff's SCS (2003), as described above, uses three factors of compassion and their respective opposite constructs, whilst Gilbert et al.'s Compassionate Engagement and Action Scales for Self and Others (2017) assess competencies that facilitate engaging in suffering and actions that alleviate and prevent suffering.

Self-Compassion as a Protective Factor

There is a growing body of research that asserts a protective role of self-compassion in adults' psychological wellbeing. For example, a recent review found numerous evidence for a positive relationship between self-compassion and positive affect, coping strategies, and self-reported life satisfaction, and a negative relationship between self-compassion and negative affect, rumination, and maladaptive perfectionism (Barnard & Curry, 2011). Furthermore, lower levels of self-compassion were consistently found to be correlated with symptoms of low self-esteem (Leary,

Tate, Adams, Allen, & Hancock, 2007) as well as anxiety, depression, and stress (MacBeth & Gumley, 2012).

The construct of self-compassion has also been studied in relation to psychological wellbeing as well as health behaviours such as eating patterns and weight regulation (Mantzios & Egan, 2017). Recently, there has been an interest in developing compassionate-based weight loss programmes which produced promising results. For example, a five-week self-compassionate intervention helped military employees lose more weight than a control group (Mantzios & Wilson, 2015). In another study, participants who were encouraged to complete mindfulness and self-compassion exercises during meal times reported a significant weight loss and delayed weight regain compared to a control group (Mantzios & Wilson, 2014). Finally, a compassion-based weight loss group intervention (BEfree) was designed in order to help obese women reduce binge eating. The programme was found to reduce symptoms of binge eating as well levels of weight-related shame, self-criticism, and negative affect (Pinto-Gouveia et al., 2017).

Following a number of successful compassion-based weight loss interventions, numerous explanations have been suggested as to the role of self-compassion in weight regulation. For example, it has been shown that increased levels of self-compassion may be beneficial in overcoming disinhibition among highly restrictive eaters (Adams & Leary, 2007). In addition, research on disordered eating suggested that women who were able to act in accordance with self-compassionate attributes, were less susceptible to adopt disordered eating attitudes and behaviours (Carvalho Barreto, Ferreira, Marta-Simões, & Mendes, 2018). Furthermore, a positive association was found between self-compassion and intentions to engage in health-promoting eating behaviours suggested by a self-regulating resource model (Sirois, 2015). The model proposed that the above

association was promoted by three different self-regulation resources: high levels of positive affect, low levels of negative affect, and high levels of health self-efficacy (Sirois, 2015). Finally, Webb & Forman (2013) found that self-compassion was positively related to unconditional self-acceptance and negatively associated with emotional intolerance, which indirectly impacted on severity of binge eating symptoms.

Furthermore, literature has shown that compassion for self may act as a booster against weight-related distressful thoughts and feelings. In fact, Manztios and Wilson (2014) suggested that a self-compassionate stance may result in blocking out the critical and intolerable self-talk that usually comes with dieting. Moreover, research has identified the indirect effects of self-compassion on intuitive eating through the mechanisms of distress tolerance (Schoenefeld & Webb, 2013). In addition, self-compassion was found to moderate the positive relationship between negative affect and restrictive eating in undergraduate female students (Beekman, Stock, & Howe, 2017).

The protective role of self-compassion has also been identified in relation to body image acceptance in people with problematic weight regulation. First, compassion for self in women has been linked to appearance processing (comprising of self-objectification, social comparison, and thin-ideal internalisation), which in turn was linked to higher levels of body appreciation (Andrew, Tiggemann, & Clark, 2016). Furthermore, research on body compassion (a construct consisting of evaluative, cognitive, and behavioural components of body-image and self-compassion) has found that women high in this trait were more likely to favourably evaluate their physical appearance, fitness levels, and general health (Altman, Linfield, Salmon, & Beacham, 2017). The protective role of self-compassion has been also found in females with body dissatisfaction, social physique anxiety, and drive for thinness (Thogersen-

Ntoumani, Dodos, Chatzisarantis, & Ntoumanis, 2017). Finally, studies on overweight women indicated that a lower ability to deal with one's negative body image in a kind and accepting manner may significantly increase the impact of body satisfaction on one's quality of life (Ferreira, Fortunato, Marta-Simões, & Trindade, 2016).

Self-Compassion and Weight Regulation in Females

There is some evidence suggesting that the experiences of self-compassion in relation to weight may be different between males and females. For example, a recent study investigated the protective role of self-compassion identified in individuals with body image concerns. The findings suggested that dimensions of self-compassion in females were positively associated with appearance esteem and negatively associated with perceived overweight status and appearance comparison; however the relationship was somewhat different among males (Rodgers et al., 2017). The authors suggested that cultivating self-compassion may protect against negative self-image among both genders, albeit through different pathways.

Although these study used a sample of young adults, there is some evidence to suggest that similar gender differences may exist among older adults too. For example, a study investigated the association between body image, body composition constructs such as body dissatisfaction, and sexual satisfaction among adult participants. The results suggested a complex pattern of relationships which were different for men and women (Milhausen, Buchholz, Opperman, & Benson, 2015). Furthermore, research examining body satisfaction in women and men suggested that appearance norms encountered by women were different to those for men (Buote, Wilson, Strahan, Gazzola, & Papps, 2011). The study found that media images of the rigid ideal were more homogenous for women than men. Also, idealised images and media messages

about ways to control or alter weight and appearance were encountered more frequently by women than men.

Self-Compassion in Non-Clinical Female Population

The role of self-compassion in females' weight management has often been examined by using non-clinical samples. For example, in a recent study using a sample from the Portuguese general population, researchers investigated the safeguarding properties of 'body compassion' (Altman et al., 2017) and found that the results confirmed that the accumulation of life events of negative appraisal were positively associated binge eating patterns in participants. The findings also corroborated a moderating effect of body compassion on the above link (Barata-Santos, Marta-Simões, & Ferreira, 2018). Another example of a study using a non-clinical sample also came from Portugal. This time, the authors investigated the link between self-compassion and disordered eating attitudes and behaviours in females. The results showed that there was a negative relationship between self-compassion and levels of pathological eating attitudes and behaviours. In addition, the authors found that self-compassionate actions partially mediated the positive link between self-compassionate attributes and body compassion (Carvalho Barreto et al., 2018).

Rationale for the Current Review

Despite the encouraging findings, self-compassion in relation to weight regulation would benefit from further research. The protective role of self-compassion in eating related problems, such as binge eating, has only recently been examined (Barata-Santos et al., 2018) and there is uncertainty around which components may be more helpful or need more emphasis when developing weight management programmes (Mantzios & Egan, 2017). In addition, existing reviews of the functions of self-compassion (MacBeth & Gumley, 2012; Inwood & Ferrari, 2018) focused on

general mental health or resilience rather than eating behaviours. Also, given that there are ongoing systematic reviews on the role of self-compassion in the treatment of eating disorders (PROSPERO, 2019), it was felt that focusing on women from the general population would be an important next step in summarising existing research.

Therefore, the current review aimed to synthesise and critically evaluate the available research investigating the role of self-compassion in problematic weight regulation. It was hoped that a number of direct and indirect influences of self-compassion on eating patterns and weight-related variables in community-based females would be investigated. The amalgamation of quantitative correlational data enabled synthesis of a large number of participant variables, with the view to produce generalizable results. Understanding the precise relationship between self-compassion and various components of weight management may provide direction for new research and assist in the development of new interventions designed for both clinical and non-clinical populations experiencing weight management difficulties.

Methodology

To ensure transparency and clarity of the paper, the PRISMA (Liberati et al., 2009) recommendations were used when developing a protocol for this review. Furthermore, a Senior Psychology Lecturer and a Royal Holloway Library Information Consultant, both experienced in completing systematic reviews, provided further guidance on various stages of this review.

Inclusion and Exclusion Criteria

The review considered studies which were published in a peer-reviewed journal between years 2008 and 2018. This was to capture most recent research in the area, in publications whose quality was determined in a peer-review process. Studies were

included if participants of the included studies were adult females, recruited from a non-clinical sample (e.g. general population or students). To synthesise the data and add to understanding of the literature, only studies were included if they employed empirical data collection and reported quantitative process. Given the established nature of the Self-Compassion Scale in the literature, and its confirmed rates of internal validity and reliability, it was agreed that only studies with this self-compassion tool (Neff, 2003), or its shortened version (Raes et al., 2011), were included. Furthermore, the review considered any variables statistically analysed in relation to self-compassion. These may be more defined as demographic, behavioural, or psychological variables. To explore the relationship between self-compassion and weigh-related variables, only studies employing cross-sectional correlational design were accepted.

Studies were excluded if the paper was: a review, case study or case series, comment, book chapter, conference abstract; or no abstract was available. Additionally, studies which reported qualitative data were not accepted. Studies including clinical samples (e.g. an Eating Disorder diagnosis) or mixed gender samples were excluded. Finally, studies reported in non-English or with non-human samples were also excluded.

Search Strategy and Selection Criteria

Studies were accessed through electronic databases, PsycINFO and PubMed. Searches were completed on 3rd January 2019. Boolean search was employed as the main search strategy.

The key search terms used for both databases were:

- Compassion, self-compassion, "self compassion", kindness, "compassion based", compassion-based, "compassion focused therapy", CFT, "third wave CBT approach*"
- Weight, "weight problems", "weight difficult*", overweight, obes*, eating, "eating difficult*", "healthy eating", “weight regulation”

BOOLEAN operators such as ‘AND’ and ‘OR’ combined search terms. Also other modifiers such as quotes and the truncation were used. All terms were searched for as keywords within the “title”, “abstract”, and “subject” of the paper.

Data Collection

The author completed the searches for the identification of relevant papers, using the pre-specified selection criteria outlined above. Next, using Mendeley software, all duplicates between databases were removed. Titles and abstracts of articles were then screened for eligibility by the author. Papers considered appropriate were retrieved in full text. Two reviewers (the author and an undergraduate psychology student) read the papers in full and independently assessed the eligibility of the retrieved articles. Any exclusions were recorded and reasons provided (see Figure 1 for PRISMA diagram). Any discrepancies were discussed until an agreement was reached in all cases. A final group of studies for analysis was then concluded.

Data Abstraction

For each eligible study the following information was extracted:

- Study information: authors, year of publication, location, study aim, design, and sample characteristics (sample size and origin, age, BMI, ethnicity), and variables measured.
- Rating given from the quality assessment process.

- Main findings. See Table 1 for details.

Quality Assessment

Based on scoping searches it was anticipated that the included studies would be exploratory and non-experimental. Therefore, the quality assessment of accepted studies was completed by using a 12 checklist developed by the Critical Appraisal Skills Programme for a Cohort Study (CASP, 2018). This was carried out by the author. An independent reviewer (an undergraduate psychology student) assessed a random sample of 25% of eligible studies. No discrepancies were found and agreement was reached for all cases. Overall, 19 studies were rated as 'Good' and 2 studies as 'Medium' quality (see Table 1). To prevent over-exclusion of studies which could threat the validity of the results, no studies were excluded based on quality assessment (Meline, 2006).

Planned Data Synthesis

All selected studies used the Self-Compassion Scale (SCS; Neff, 2003) which comprised of 26 items with six subscales (self-kindness vs self-judgment, common humanity vs isolation, and mindfulness vs over-identification). Therefore, the focus of planned data synthesis was to examine the relationships between the variables from the SCS and any weight-related variables. However, given the variety of methods that were used to measure different variables, the extracted data were examined without a statistical analysis such as meta-synthesis or meta-analysis (Popay et al., 2006). The writer therefore followed the guidelines of a narrative synthesis, which was in line with the existing literature on systematic reviews consisting of studies with a range of methodologies (Rodgers et al., 2009). To answer the key objectives of the review, the

main findings across the studies were compared and conclusions were drawn based on consistency of findings.

The PRISMA diagram

The databases searches generated a total of 524 articles. 81 of these were duplicates and were removed prior to screening, leaving a total of 443 papers. After the initial screening by title and abstract, 409 papers were removed. 34 articles were accessed and read in full and 19 were deemed eligible for the review. 19 papers reported single studies and 2 papers described two studies, which generated 21 studies in total. The PRISMA diagram in Figure 1 demonstrated the process of finalising the number of papers included in the review, including any reasons for exclusion.

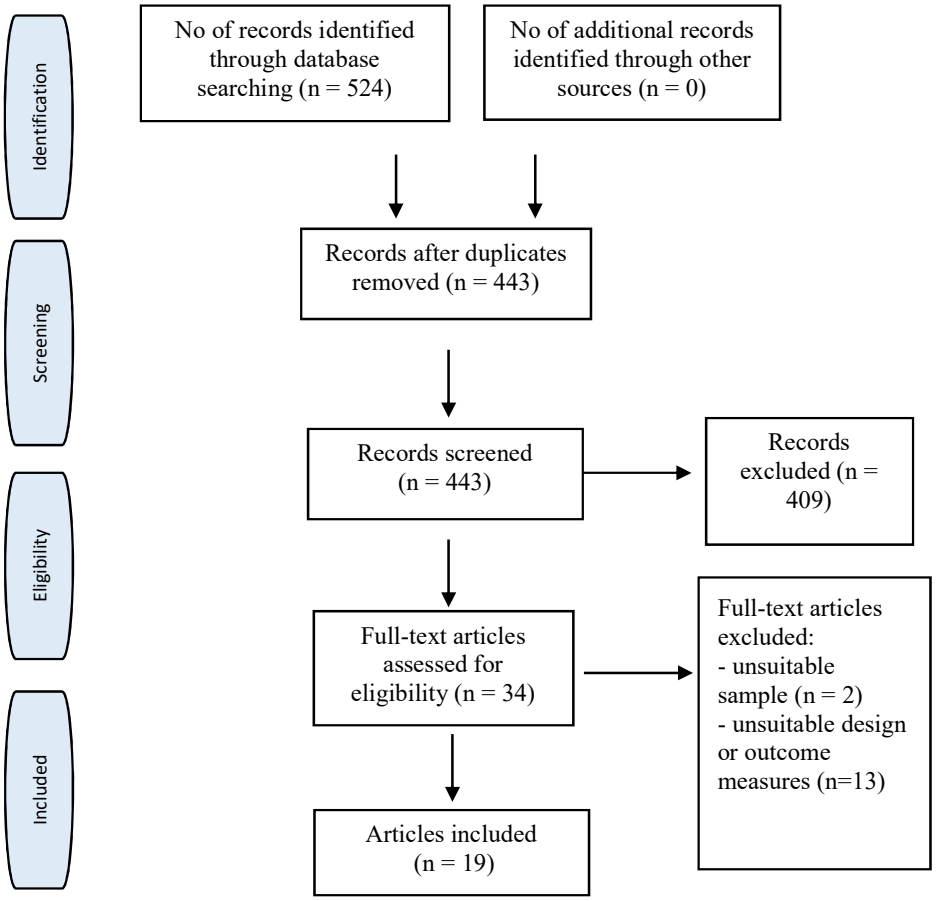

Figure 1. *PRISMA flow diagram*

Results

Of the 524 papers identified through the initial search, 19 papers including 21 studies met inclusion criteria for review (see Figure 1).

Study Characteristics

Study characteristics are described in Table 1. The 21 studies were conducted and published between 2013 and 2018. Two studies used the same dataset and 19 studies gathered individual datasets. The majority of studies were conducted in the USA (n=11), followed by Canada (n=7), and Portugal (n=3). All the studies used correlational cross-sectional design. 15 studies were completed online and the remaining 6 studies did not report the information on how the data was obtained.

The 21 studies included a total of 6296 participants who were recruited from the undergraduate student sample (n=14), or general population (n=7). The age range for the student population was 17-25 and the age range of participants from the general population was 18-76. All participants were female. Out of 21 studies, 15 studies recorded their participants' BMI, with the majority of samples falling into a normal BMI range (18.5-25.5). BMI was computed by using participants' self-reported height and weight (Kg/m2). 13 studies included information about participants' ethnicity and reported that the majority of participants were White Caucasian (between 48% and 87%), followed by Black Afro-Caribbean or Afro-American (between 3% and 20%), Asian (between 3% and 19%), and Other (typically less than 5%).

Measures Used

A variety of different self-report measures were used in the included 21 studies. All studies used the Self-Compassion Scale (SCS; Neff, 2003). The full version comprised of 26 items with six subscales to measure three facets of self-compassion: self-kindness vs self-judgment, common humanity vs isolation, and mindfulness vs

over-identification. Five studies used the short version of SCS comprising of 12 items (Raes et al., 2011). Other outcome measures included a wide range of self-report questionnaires. To capture body image concerns and behaviours, most studies employed: The Body Shape Questionnaire (Cooper, Taylor & Fairburn, 1987), Body Esteem Scale (Franzoi & Shields, 1984), the Body Appreciation Scale (Tylka & Wood-Barcalow, 2015), The Body Image-Acceptance and Action Questionnaire (Sandoz, Wilson, Merwin, & Kellum, 2013), and the Objectified Body Consciousness Scale (McKinley & Hyde, 1996). To measure disordered eating behaviour, the following were used in the majority of studies: The Eating Attitudes Test (Garner, Olmsted, Bohr, & Garfinkel, 1982), the Intuitive Eating Scale (Tylka & Kroon Van Diest, 2013), and Eating Disorder Examination Questionnaire (Fairburn & Beglin, 1994). To measure levels of depressive symptoms and other forms of distress the studies employed: The Beck Depression Inventory (Beck, Steer, Ball & Ranieri, 1996), the Center for Epidemiology Studies Depression Scale (Bourna, Ranchor, Sanderman, and van Sonderen, 1995), and the Positive and Negative Affect Schedule (Watson, Clark & Tellegen, 1988). Other examples of measures included: The Rosenberg Self-Esteem Scale (Rosenberg, 1965); Early Memories of Warmth and Safeness (Richter, Gilbert, & McEwan, 2009); and Extrinsic and Intrinsic Goals (Kasser & Ryan, 1996).

Results of Individual Studies

Weight management variables.

A number of weight management variables were significantly associated with self-compassion (n=12). Specifically, self-compassion was reported to negatively correlate with disordered eating symptomatology (Geller, Srikameswaran, & Zelichowska, 2015) and adherence to food rules (Brown, Parman, Rudat, & Craighead, 2012). Also, self-compassion was associated with both a positive and negative pathway

for eating regulation. In the positive pathway, having intrinsic weight-related goals was positively correlated with self-compassion and self-determined motivation for eating, which then led to healthy eating behaviours. Conversely, the negative pathway suggested that having extrinsic weight-related goals were positively associated with 'fat talk' and negatively associated with self-compassion, which led to unhealthy eating behaviours (Guertin, Barbeau, & Pelletier, 2018).

Further findings provided evidence that self-compassion was significantly correlated with intuitive eating (conceptualised as: eating when hungry, eating for physical rather than emotional reasons, and relying on internal satiety cues to determine when and how much to eat). The nature of this relationship was examined by measuring the indirect effects of self-compassion on intuitive eating through the pathways of distress tolerance and body image acceptance. The correlational analyses suggested that individual differences in body image acceptance but not distress tolerance helped explain the main relationship between self-compassion and intuitive eating (Schoenefeld & Webb, 2013). Self-compassion also significantly mediated the negative relationship between internalised judgmental weight beliefs and the likelihood of intuitive eating occurring (Webb and Hardin, 2016).

In addition, self-compassion was found to significantly moderate: the negative interaction between spending time with body-focused others and healthy eating patterns (Kelly, Miller, & Stephen, 2016), the negative association between media thinness-related pressure and disordered eating (Tylka, Russell, & Neal, 2015), and the positive correlation between BMI scores and eating psychopathology (Kelly, Vimalakanthan, & Miller, 2014). Self-compassion also significantly mediated the negative relationship between early positive experiences and disordered eating symptoms (Ferreira et al., 2017) whilst the Self-Judgement component of SCS strongly mediated the positive

correlation between external shame and overall levels of eating psychopathology (Oliveira, Ferreira, Mendes, & Marta-Simões, 2017), and between perfectionism and disordered eating patterns (Barnett & Sharp, 2016).

Two associations between weight management variables and self-compassion were found non-significant (n=2). Self-compassion did not mediate the relationship between maladaptive perfectionism and disordered eating (Barnett & Sharp, 2016) and did not mediate the association between body dissatisfaction and dietary restraint (Maraldo et al., 2016).

Body image variables.

Self-compassion was significantly associated with a number of variables related to body image (n=15). Specifically, self-compassion was reported to positively correlate with body appreciation (Kelly & Stephen, 2016; Homan and Tylka, 2015), and negatively correlate with body objectification (Liss & Erchull, 2015) and body preoccupation (related to fewer body shape concerns and increased body appreciation and body self-esteem; Wasylkiw, et al., 2012). Also, all three separate subscales of SCS (Self-Kindness, Self-Judgement, and Isolation) were significantly associated with shape and weight concerns (Geller et al., 2015).

In addition self-compassion significantly moderated: the relationship between body appreciation and time spent with body-focused others (Kelly, Miller, & Stephen, 2016); the association between body image flexibility and BMI scores (Kelly, Vimalakanthan, & Miller, 2014), and the link between recollections of caregiver eating messages and dimensions of objectified body consciousness, conceptualised as body surveillance (worrying about and scrutinising the way the body looks), body shame, and appearance control (Daye, Webb, & Jafari, 2014). The preliminary correlational results also suggested that the perceptions of excessive parental control and negative

opinions about food consumption may undermine the development of healthy relationship with one's body. Self-compassion may have a potential protective role in this function (Daye, Webb, & Jafari, 2014). Other findings also suggested that the inverse relationship between two body-related threats (body comparisons and appearance self-worth) and body appreciation were moderated by self-compassion. The results supported the hypothesis that self-compassion played a protective role in women who experienced low body appreciation associated with weight-related social comparisons and staking one's self-worth in appearance (Homan and Tylka, 2015). Furthermore, a negative association was found, via body shame, between anti-fat attitudes (dislike, fear of fat attitudes, and willpower beliefs) and the likelihood of engaging in fat talk. Also, higher levels of self-compassion moderated the strength of this relationships, confirming its potential protective role in women with weight concerns (Webb, Fiery, & Jafari, 2016). Finally, self-compassion moderated the link between media thinness-related pressure (pressure felt from media encounters) and thin-ideal internalisation (Tylka et al., 2015). Higher levels of self-compassion were also directly linked with fewer perceived thinness-related pressures and lower thin-ideal internalisation. Thus supporting the idea of the protective role of self-compassion in women at risk of developing disordered eating (Tylka et al., 2015).

Self-compassion also significantly mediated the link between recall of early memories of warmth and body appreciation (Marta-Simoes, & Ferreira, 2018). Also, the Self-Kindness and Self-Judgment components of SCS significantly mediated the relationship between body image satisfaction and perfectionism (Barnett & Sharp, 2016) and the Self-Judgement component of SCS and fears of receiving compassion mediated the positive correlation between external shame and overall levels of eating psychopathology (Oliveira et al., 2017). In addition, body image flexibility and, to a

lesser degree, self-compassion mediated the negative relationship between internalised judgmental weight beliefs and the likelihood of intuitive eating occurring (Webb and Hardin, 2016). Body image acceptance was also found to significantly mediate the positive relationship between self-compassion and intuitive eating (Schoenefeld & Webb, 2013) and the relationship between body preoccupation and depressive symptoms (Wasylkiw, MacKinnon, & MacLellan, 2012).

One study (n=1) reported findings that were not significant in relation to self-compassion and body image. Self-compassion was not found to mediate either the relationship between fear of negative evaluation and thin-ideal internalisation or the association between body dissatisfaction and dietary restraint (Maraldo et al., 2016).

Weight-related negative affect.

A significant relationship between self-compassion and weight-related affect were identified across four studies (n=4). Specifically, a protective role of self-compassion was shown in relation to mental health variables; the higher levels of self-compassion the women reported, the lower depression and body shame scores they had (Liss and Erchull, 2015).

Also, high scores on self-compassion predicted less eating guilt and mediated the relationship between body preoccupation and depressive symptoms (Wasylkiw et al., 2012). Furthermore, lack of self-compassion was found to be a vulnerability factor to disordered eating via body dissatisfaction and negative affect (Maraldo et al., 2016). Lastly, the SCS Mindfulness was also found to moderate the positive relation between distress and disordered eating (Geller et al., 2015).

BMI scores.

One study (n=1) found a significant relationship between self-compassion and women's BMI. Women's levels of self-compassion were found to moderate the positive

association between BMI scores and eating psychopathology and the negative association between BMI scores and body image flexibility. The findings supported the hypothesis that self-compassion may protect women against eating disturbances (usually coincided with a higher BMI) and enable them to develop a more positive body image. (Kelly, Vimalakanthan, & Miller, 2014).

Early experiences.

The relationship between early experiences and self-compassion was found to be significant in two studies (n=2). Specifically, the positive relationship between the recall of early memories of warmth and safeness with peers and body appreciation was mediated by self-compassion and social safeness. This mediating relationship was also positively associated with a lower tendency to display disordered eating patterns and attitudes (Marta-Simoes, & Ferreira, 2018).

Self-compassion was also found to attenuate the associations between pervasive recollections of restrictive/critical caregiver eating messages and both body surveillance and body shame. The preliminary correlational results also suggested that the perceptions of excessive parental control and negative opinions about food consumption may undermine the development of healthy relationship with one's body. Self-compassion was reported to have a potential protective role in this function (Daye et al., 2014).

Perfectionism.

Maladaptive perfectionism was also found to be significantly associated with self-compassion (n=3). Specifically, self-compassion significantly correlated with the rigid adherence to food rules, which mediated the positive correlation was found between perfectionism and eating pathology (Brown et al., 2012). Also, the Self-Judgment component of SCS mediated the association between perfectionism and

disordered eating (Barnett & Sharp, 2016) and both the Self-Kindness and Self-Judgment components of SCS mediated the association between maladaptive perfectionism and body image dissatisfaction (Barnett & Sharp, 2016).

Table 1.

Study characteristics

Study (country)	Quality assessment	Aim	Study design	Participants	Variables measured	Main findings
Barnett et al. 2016a (USA)	Good	To examine the relationship between maladaptive perfectionism, self-compassion, and body image satisfaction.	Cross-sectional correlational	580 female undergraduate students age 18–30 at a large public university.	Maladaptive perfectionism; Body image satisfaction; Self-compassion	Maladaptive perfectionism had an indirect effect on body image satisfaction through self-compassion (self-kindness and self-judgment).
Barnett et al. 2016b (USA)	Good	To replicate the findings of Barnett et al. (2016a) in a new sample and to explore whether the same pattern of prediction would be found with disordered eating behaviour.	Cross-sectional correlational	398 female undergraduate students age 18–30 at a large public university in the southern U.S.	Perfectionism; The Body Image Satisfaction; The Self-Compassion; Eating Attitudes	Maladaptive perfectionism did not have a significant indirect effect on body image satisfaction through self-kindness, but it did through self-judgment. Maladaptive perfectionism had an indirect effect

						on disordered eating behaviour through self-judgment.
Brown et al 2012 (USA)	Good	To test the properties of Food Rules Measure and explore the relationship between perfectionism, adherence to food rules, and disordered eating.	Cross-sectional correlational	48 undergraduate females Age: 18-35 (M=19.2, SD=2.5) Ethnicity: 66.7% Caucasian, 18.8% Asian, 8.3% Black or African-American, 4.2% Mixed Race or Other, 10.4% Hispanic or Latino.	Food rules; Perfectionism; Eating pathology; Eating-related cognitions; Intuitive eating; Body dissatisfaction; Depression; Self-esteem; Self-compassion and other-compassion	Adherence to food rules mediated the relationship between self-oriented perfectionism and three indices of eating pathology. A medium effect size correlation found between food rules outcomes (lower scores indicate greater adherence to food rules) and low levels of self-compassion.
Daye et al. 2014 (USA)	Good	To examine the associations between caregiver eating messages and dimensions of	Cross-sectional correlational	322 undergraduate females Age: 18–24years(M=	Caregiver eating messages; Objectified body consciousness; Self-compassion.	Self-compassion attenuated the links between more pervasive recollections of

		objectified body consciousness and explore whether self-compassion moderate these links.		19.48, SD = 1.46) Ethnicity: White or European American(65.3%), African American (20.4%), 10% others BMI: 14% underweight, 62%normalweight, 16%overweight, and 8%obese.		restrictive/critical care-giver eating messages and both body surveillance and body shame.
Geller et al. 2015 (Canada)	Good	To examine the relation between SCS subscales and measures of shape and weight concerns and disordered eating.	Cross-sectional correlational	131 females from a large city responded to an online survey. Age: M = 28.76 years (SD = 8.45). Ethnicity: 72% Caucasian, BMI: M = 24.04 (SD = 4.74)	Self-compassion; Depression; Symptom Inventory; Weight Bias; Body Shape; Body Esteem; Eating Attitudes; Disordered eating	SCS Self-Kindness, Self-Judgement and Isolation subscales negatively correlated with shape and weight concern measures, while the SCS Over-Identification subscale positively correlated with disordered eating. The SCS Mindfulness

						subscale moderated the relation between distress and disordered eating.
Ferreira et al. 2017 (Portugal)	Good	To test the impact of early memories of warmth and safeness on eating psychopathology, and whether self-compassion and body appreciation play a significant role on this association.	Cross-sectional correlational	490 women the Portuguese general population. Age: 18 to 54 years old (M = 24.76; SD = 7.66). BMI: 53 (10.82%) underweight, 349 (71.22%) normal weight, and 88 (17.96%) were overweight	BMI; Early positive affiliate; experiences; Self-compassion; Body Appreciation; Disordered eating	Early positive experiences were positively associated with self-compassion, and negatively correlated with eating psychopathology's severity. Early positive memories had a positive direct effect on body appreciation, and an indirect effect, mediated by increased self-compassion.
Guertin et al. 2018 (Canada)	Good	To examine whether pursuing different goals for	Cross-sectional correlational	485 female undergraduate students.	Body mass index; Extrinsic and	In the positive pathway, intrinsic goals

		weight management was associated with distinct motivational processes in eating regulation and whether self-compassion influenced on these.		Age: between 16 and 48 (M = 19.63; SD = 3.42) Ethnicity: European-American (53.6%); Black, Afro-Caribbean, or Afro-American (10.8%); East-Asian or Asian-American (8.3%); Middle-Eastern or Arab-American (7.9%); South-Asian or Indian-American (6.6%); other (12.8%).	intrinsic goals; Contextual non-self-determined and self-determined motivation for eating; Fat talk (The Negative Body Talk scale); Self-compassion; Unhealthy and healthy eating behaviours	were positively associated with self-compassion, which was positively associated with self-determined motivation for healthy eating. In the negative pathway, extrinsic goals were negatively correlated with self-compassion, which was correlated with unhealthy eating.
Homan et al. 2015 (USA)	Good	To investigate whether body comparison and appearance contingent self-worth were more weakly related to body appreciation when self-compassion was high.	Cross-sectional correlational	263 females (221 online and 42 undergraduate students) Age: 19-76 (M= 35.26years, SD = 12.42). BMI: M = 26.23, SD = 6.45 3.4% underweight; 54.6% normal	Self-compassion; Body comparison; Body appreciation; Appearance self-worth.	Self-compassion moderated the inverse relationships between body related threats and body appreciation.

				weight, 20.5% over-weight, and 25.5% obese. Ethnicity: White (77.9%), African American (10.6%), Asian American (5.3%), Latin American (4.6%), 7% others		
Kelly et al. 2014 (Canada)	Good	To examine whether self-compassion would attenuate the positive relationship between BMI and eating disorder pathology, and the negative relationship between BMI and body image flexibility.	Cross-sectional	153 undergraduate females Age: M=20.2 years (SD = 3.49) Ethnicity: 48.3% Caucasian; 19.4% South Asian; 12.9% East Asian; 6.5% Southeast Asian; 3.2% Black African; others 10%	Self-compassion Self-esteem Eating disorder pathology Body image acceptance	Self-compassion was positively related to body image flexibility and negatively related to all forms of eating disorder pathology.
Kelly et al. 2016a (Canada)	Good	To investigate the unique contributions of within-person variability in self-	Cross sectional	92 undergraduate females Age: M=19.7, SD = 1.93 Ethnicity: 50%	BMI Self-compassion Self-esteem Intuitive eating Dietary restraint	Within-persons, day-to-day fluctuations in self-compassion contributed to

		compassion, and between-persons differences in self-compassion, to body image and eating behaviour.		Caucasian, 21% East Asian, 1.6% Southeast Asian, 4.8% Black/African, 9.7% South Asian, 12.5% others	Body appreciation Body areas satisfaction State body image	day-to-day fluctuations in body image and eating. Between-persons, participants' average levels of self-compassion across days contributed to their average levels of body image and eating over the week.
Kelly et al. 2016b (Canada)	Good	To examine whether a woman's level of self-compassion on a given day and over a week influenced her eating, body image, and affect in the face of interactions with body-focused others.	Cross sectional	92 undergraduate females Age: M = 19.7, SD = 1.93 Ethnicity: 50% Caucasian, 21% East Asian, 1.6% Southeast Asian, 4.8% Black/African, 9.7% South Asian, 12.5% others	Interactions with body-focused others. Self-compassion. Intuitive eating. Body appreciation. Body image concerns. Negative affect.	On days when women were less self-compassionate than usual, frequent interactions with body-focused others were associated with more body image concerns and negative affect, and less body

						appreciation and intuitive eating. Self-compassion played a similar buffering role at the between-persons level.
Liss et al. 2015 (USA)	Good	To investigate whether self-compassion moderated the pathway in which body surveillance positively relates to body shame which, in turn, relates to higher levels of depression and negative eating attitudes.	Cross sectional	210 general psychology female students Age: 18-25years (M=19.23, SD=1.85) Ethnicity: White Caucasian 87%, Black/African American 3%, 11% others	BMI; Objectified Body Consciousness; Self-Compassion; Negative eating attitudes; The experience of depressive symptoms	Participants reporting high levels of self-compassion had lower levels of body surveillance, body shame, negative eating attitudes, and depression as compared to the participants reporting low levels of self-compassion.
Maraldo et al. 2015 (USA)	Good	To replicate and extend the dual pathway model of bulimic symptoms.	Cross-sectional	609 community and student females	The eating disorder presence; Positive and negative affect;	Fear of negative evaluation was positively associated with thin-ideal

				Age: M = 34.74, SD = 11.36 (community sample) and M = 19.44, SD = 1.75 (student sample) BMI: M = 27.73, SD = 8.28 (community sample) and M = 23.25, SD = 4.37 (student sample)	Eating behaviour; Body dissatisfaction,	internalisation and negative affect. This effect was mediated by self-compassion. Self-compassion was found to predict body dissatisfaction and negative affect. Self-compassion was not found to mediate the relationship between body dissatisfaction and dietary restraint.
Marta Simoes et al. 2018 (Portugal)	Good	To test the impact of early memories of warmth and safeness with peers, self-compassion, and social safeness, in body appreciation and in disordered eating attitudes and behaviours.	Cross-sectional	387 females from university and general population Age: 18-25 years old (M = 21.64; SD = 1.70) BMI: M = 21.58, SD = 3.26	BMI Early Memories of Warmth and Safeness; Self-Compassion; Social Safeness and Pleasure; Body Appreciation; Disordered eating	Early memories of warmth and safeness with peers associated with higher self-compassion and feelings of social safeness, which were both positively linked to body appreciation.

Oliveira et al. 2017 (Portugal)	Good	To examine the mechanisms of self-judgment and fears of receiving compassion from others in the association between external shame and disordered eating, while controlling for BMI.	Cross-sectional correlational	400 females from a community sample Age: 18 to 55 years (M = 30.55; SD = 11.04) BMI: 15.2 - 38.06 (M = 23.16)	BMI View of others as shamer; Self-Compassion; Fears of Compassion; Disordered eating	Higher levels of a judgmental inner relationship were associated with the fear of receiving others' care and compassion. Similarly, these emotion processes were positively linked to a higher engagement in maladaptive body and eating-related attitudes and behaviours.
Schoenefeld et al. 2013 (USA)	Good	To investigate the relationship between self-compassion and intuitive eating	Cross-sectional correlational	322 female undergraduate students Age: 18–24 years (M = 19.48, SD = 1.46) BMI: M = 23.55 (SD = 5.11) Ethnicity: European American	Self-compassion; Distress Tolerance; Body Image-Acceptance and Action; Intuitive Eating; Self-Esteem	Body image flexibility helps account for the strong positive link observed between self-compassion and intuitive eating.

				(67.4%), African American (21.1%), Latina (5.8%), Asian (3.2%), 2.5% others		
Tylka et al. 2015 (USA)	Medium	To explore self-compassion's associations with threats involving thinness-related pressures (from friends, family, partners, and media), thin-ideal internalization, and disordered eating.	Cross-sectional	435 community women Age: range 18–40; M = 28.14; SD = 5.45; Ethnicity: White (73.3%), Asian American (8.7%), African American (8.5%), Latina (4.8%), or multiracial (4.6%). BMI: M = 24.81; SD= 5.31	Perceived Sociocultural Pressures; Self-compassion; Sociocultural Attitudes towards Appearance; Eating Attitudes.	Self-compassion buffered the links from media thinness-related pressure to disordered eating and thin-ideal internalization. Higher self-compassion was directly associated with fewer perceived thinness-related pressures, lower thin-ideal internalization, and lower disordered eating.
Wasylkiw et al. 2015a (Canada)	Good	To provide evidence of the	Cross-sectional	142 female undergraduate	Self-Esteem; Self-compassion;	Increased self-compassion was

		relationship between women's body image and self-compassion when controlling for self-esteem.		students Age: range 17 - 22 years; M = 19 years (SD = 1.13) Ethnicity: primarily Caucasian	Body image; Body Appreciation	associated with less body preoccupation, fewer concerns about weight, and greater appreciation towards one's body.
Wasylkiw et al. 2015b (Canada)	Good	To further explore the nature of the relationship between self-compassion and women's body image.	Cross-sectional	187 female undergraduate students Age: range 17 - 24 years (M = 18.41, SD = 1.04)	Self-Esteem Self-Compassion Body preoccupation Restrained eating	Self-judgment component of self-compassion uniquely predicted body preoccupation. High scores on self-compassion predicted less eating guilt. Self-compassion was shown to partially mediate the relationship between body preoccupation and depressive symptoms.
Webb et al. 2016a (USA)	Medium	To examine the relationship	Cross-sectional	333 female undergraduate	BMI Internalized	Body image flexibility and, to

		between internalized weight bias and intuitive eating, via body shape, body image flexibility, and self-compassion mediators.		students Age: M = 19.4 years; SD = 1.53 BMI: 8.5% underweight, 64.7% normal weight (18.5-24.9), 17.9% overweight (25.0-29.9), and 8.8% obese (M = 23.45; SD = 4.90)	weight bias Body shame Body image flexibility Self-compassion Intuitive eating	a lesser degree, self-compassion mediated the relationship between internalized weight bias and intuitive eating.
Webb et al. 2016b (USA)	Good	To test if body shame moderated the predicted positive associations between weight bias (anti-fat attitudes) To evaluate if self-compassion served as a protective factor.	Cross-sectional	309 undergraduate women Age: M = 19.5 years (SD = 1.48) BMI: M= 23.3 (SD = 4.97); Ethnicity: 19.4% Black, 66.7% White, 5.8% Hispanic or Latina American, 8% Others.	BMI Anti-fat attitudes. Fat self-talk. Body shame. Self-compassion.	The indirect effect of anti-fat attitudes on fat talk via body shame declined with increasing levels of self-compassion. Self-compassion weakened the relationship between body shame and fat talk.

Synthesis of Results

All 21 studies included in the review used correlational cross-sectional design, which precluded inferences of causality. Despite this, all studies reported a range of significant influences on the relationships between self-compassion and various weight-related variables across both college and general population samples.

Quantitative findings were extracted from the studies and grouped into two higher-order domains: undergraduate students and the general population. Across these two categories three significant types of findings emerged and suggested that self-compassion could have the following levels of influence on a range of weight-related variables: direct, mediating, or moderating.

Undergraduate students sample.

14 studies (n=14) reported a range of significant results across female undergraduate students. Three studies found a negative relationship between self-compassion and weight related variables: body objectification (comprising of body surveillance and negative eating attitudes), body shame, depression (Liss & Erchull, 2015), body preoccupation (comprising of body shape concerns, body appreciation, and body self-esteem (Wasylkiw et al., 2012), and eating guilt (Wasylkiw et al., 2012). In three other studies, a positive relationship was found between self-compassion and: body appreciation and healthy eating patterns (Kelly & Stephen, 2016), intuitive eating (Schoenefeld & Webb, 2013) and rigid food rules adherence (Brown et al., 2012).

The mediating influence of self-compassion on other variables was found in four studies (n=4). The Self-Kindness and Self-Judgment components of self-compassion significantly mediated the relationship between maladaptive perfectionism and body image satisfaction (Barnett & Sharp, 2016) and the relationship between maladaptive perfectionism and disordered eating behaviours (Barnett & Sharp, 2016).

Furthermore, self-compassion was found to mediate the positive association between intrinsic weight-related goals and healthy eating, and the negative association between extrinsic weight goals and unhealthy eating (Guertin et al., 2018). Finally, self-compassion was found to marginally mediate the negative link between internalised negative weight beliefs and the likelihood of intuitive eating (Webb & Hardin, 2016).

The moderating influence of self-compassion on other variables was found in four studies (n=4). First, self-compassion was found to significantly moderate the positive association between recollection of negative caregiver eating messages and body consciousness (comprised of body surveillance, body shame, and appearance control; Daye et al., 2014). Also, self-compassion had the moderating effect on the negative link between time spent with body-focused others and both healthy eating and body appreciation (Kelly et al., 2016). Furthermore, self-compassion moderated the positive relationship between BMI scores and eating psychopathology and the negative relationship between BMI scores and body image flexibility (Kelly et al., 2014). Finally, self-compassion was found to moderate the link between anti-fat attitudes in women and engaging, via body shame, in fat talk (Webb et al., 2016).

The general population sample.

Seven studies (n=7) included in this review were carried out using community-based samples. Two studies reported a direct relationship between self-compassion and other health-related variables. Self-compassion was found to be positively correlated with body appreciation (Homan & Tylka, 2015), and negatively correlated with: shape and weight concerns, disordered eating (Geller et al., 2015), thinness-related pressures and thin-related internalisation (Tylka et al., 2015).

The mediating effect of self-compassion was examined in four studies (n=4). First, self-compassion mediated the negative association between early positive

experiences and disordered eating symptoms (Ferreira et al., 2017). Furthermore, self-compassion mediated the positive link between fear of negative evaluation and negative affect (Maraldo et al., 2016).

Also, self-compassion was found to mediate the positive relationship between recall of early memories of warmth and safeness with peers and body appreciation (Marta-Simões et al., 2018). Finally, the Self-Judgment component of self-compassion as well as fear of receiving compassion from others were reported to have significant mediating effects on the association between external shame and eating psychopathology (Oliveira et al., 2017). Contrary to Maraldo et al.'s (2016) prediction, self-compassion did not mediate the positive correlation between body dissatisfaction and dietary restraint(Maraldo et al., 2016).

In the general population, self-compassion was found to have the moderating influence on the negative relationship between body comparisons and body appreciation and between appearance self-worth and body appreciation (Homan & Tylka, 2015). Furthermore, the Mindfulness component of self-compassion was found to moderate the positive association between emotional distress and disordered eating (Geller et al., 2015). Finally, self-compassion significantly moderated the positive relationship between media thinness-related pressure and both disordered eating and thin-ideal internalisation

(Tylka et al., 2015).

Discussion

Summary of the Main Findings

The aim of this systematic review was to summarise and synthesise the available evidence on the role of self-compassion in community-based women experiencing

problematic weight regulation. In line with the criteria set for the review, all the studies conceptualised and measured self-compassion in the identical way and used a frequently used self-compassion measurement (Neff, 2003). The 21 included studies identified a number of meaningful relationships between self-compassion and weight-related variables in women. The findings consistently suggested that higher levels of self-compassion were associated with higher levels of body appreciation, healthy eating patterns, and intuitive eating. A number of studies concluded that self-compassion might also predict lower levels of: rigid food rules adherence, body objectification, body preoccupation, eating guilt, shape and weight concerns, disordered eating behaviours, and thinness-related pressures. In addition, the findings revealed that self-compassion might have the important mediating and moderating influence on a number of positive and negative associations between weight regulation and psychological variables. The reported associations provided additional support for the protective role of self-compassion in community-based women with problematic weight regulation. This was in line with existing theoretical models of self-compassion that suggest self-compassion might act as a buffer against eating psychopathology (Thogersen-Ntouman et al., 2017) and body image related concerns (Wasylkiw et al., 2012).

Importantly, self-compassion was found to influence the relationship between weight and mood variables in women. First, high levels of self-compassion were negatively correlated with low levels of depression. Furthermore, self-compassion mediated the positive association between body preoccupation and depressive symptoms, and between fear of negative evaluation and negative affect. These findings seemed to provide additional support for health behaviour models such as the self-regulating resource model (SRRM; Sirois, 2015). SRRM postulates that high levels of

positive affect and low levels of negative affect boost self-regulation resources needed to successfully engage in health promoting behaviours.

Furthermore, the review found that self-compassion consistently related to a range of pathways leading women to both successful and unsuccessful weight regulation behaviours. For example, self-compassion boosted the relationship between intrinsic health-related weight loss goals, and healthy eating and it attenuated the relationship between extrinsic appearance-related goals and unhealthy eating. Although marginally, self-compassion was also found to mediate the inverse relationship between having negative weight beliefs and the likelihood of intuitive eating. These findings provided additional support for the importance of and potential influences of self-compassion on theoretical models such as thin-ideal internalisation (Stice, 2001) and self-determination theory (Ryan & Deci, 2017). The theories postulate that individuals' goals, attitudes and motivation may determine behaviours involved in women's weight regulation.

In addition, the review summarised the evidence that self-compassion influenced the associations between early experiences and weight-related psychopathology. This was observed in three studies in the review. First, self-compassion was found to moderate the positive link between recollection of early negative eating messages from a caregiver and body consciousness. Self-compassion was also found to mediate the relationship between early positive experiences and both disordered eating symptoms and body appreciation in adulthood. These findings suggested the importance of a self-soothing system, responsible for adaptive emotion regulation in healthy eating, and how it may be developed in childhood as a result of both positive and negative experiences from caregivers (Gilbert, 2014). Furthermore,

the findings suggested the impacts of negative early experiences may be recovered to some extent in adulthood by practicing self-compassion.

Finally, three different studies in this review provided additional support for the protective role of self-compassion in women with eating difficulties and who displayed traits of perfectionism. First, self-kindness and self-judgement were found to mediate the negative association between maladaptive perfectionism and body image satisfaction. Also, self-judgement mediated the positive relationship between perfectionism and disordered eating behaviours. Finally, high levels of self-compassion correlated with low levels of rigid food adherence that was the mediating factor in the relationship between perfectionism and eating psychopathology. These findings were in line with previous research which showed that self-compassion might help activate the soothing system, as suggested by Gilbert & Procter (2006). The soothing system is part of 'the three circles model of emotion' (the other two being the drive and the threat systems) hat has been theorised to help develop self-compassion as a way to validate, soothe, and find helpful ways of working with various experiences including suffering (Kolts, 2016). The authors suggested that when individuals experienced high levels of perfectionism and self-criticism, self-compassion reduced their sense of threat and increased their sense of safeness, enabling them to engage with negative cognitive material. Increased self-kindness and decreased self-judgement components of self-compassion may also increase feelings of self-worth in these individuals (Neff, 2011).

Strengths, Limitations, and Suggestions for Future Research

This review had a number of strengths. First, a comprehensive literature review was performed which secured a robust number of eligible studies. Also, to ensure transparency and clarity of the paper, a protocol for this review followed the PRISMA recommendations (Liberati et al., 2009) and provided clear inclusion and exclusion

criteria. Furthermore, to ensure that consistency in conceptualisation of self-compassion was preserved, the review included the studies which exclusively employed the most common measure of self-compassion, Self-Compassion Scale (SCS; Neff, 2003). In addition, to ensure a good level of quality and academic scrutiny, only peer-reviewed articles were selected, which were then quality assessed by two independent reviewers. Finally, given the variability of analyses used in the included studies, the appropriate methods of narrative data synthesis were followed (Ryan, 2013).

The review had also a number of limitations. First, there was a large variability in the outcome measures analysed in the 21 included studies. Furthermore, some studies examined a direct relationship between self-compassion and weight-related variables whereas others focused on the mediating or moderating influences of self-compassion on a number of positive and negative associations between weight-related constructs. This inconsistency made synthesis of results and interpretation of the relationship between variables difficult. However, given that this was the first systematic review examining the role of self-compassion in women from the general population, conclusions drawn from a number of significant relationships between variables made an important contribution to the literature in this area.

Another limitation related to the fact that the studies in the review used only correlational cross-sectional design and therefore causality between self-compassion and weight-related psychological variables could not be inferred from the results. Higher levels of self-compassion may facilitate improved weight-related wellbeing in women but equally, lower levels of weigh-related problems may enable women to be more self-compassionate. Also, including only correlational designs meant that the review excluded studies with experimental designs which could have provided

additional evidence and allowed for more conclusions of causal nature of self-compassion and eating management.

Moreover, only two studies included in this review (Kelly & Stephen, 2016; Kelly et al., 2016) examined changes in self-compassion over time (one week) and therefore more longitudinal studies would be beneficial. Also, all correlational analyses were carried out on data obtained from self-report measures, which required high levels of honesty and self-awareness. There may have also been a risk of social desirability among the participants.

Furthermore, the review focused on women from community-based sample. Although significant findings across undergraduate student and general populations examined in this review suggested that self-compassion may be a protective factor in women experiencing weight difficulties, future research will benefit from focusing on the role of self-compassion in women from clinical samples (e.g. those with a diagnosed eating disorder) and male samples. The current review could be used as the first step in developing the understanding in this area.

Another limitation of the studies included in this review was that some studies reported the total score of SCS rather than specific subscales. SCS' total score is derived from three components acting as positive-negative opposing pairs: self-kindness vs self-judgement, common humanity vs isolation, and mindfulness vs over-identification. Although the current review identified a number of associations between self-compassion and improved weight-related psychological wellbeing, some studies reported the total score rather than specific subscales of SCS. Therefore, it was not possible to deconstruct these relationships to identify which positive or negative components of SCS contributed to any changes that were found (MacBeth & Gumley, 2012). Examining the influence of individual components of SCS would be an

important next step in designing future research on the protective role of self-compassion.

Additionally, this review included studies that only used Self-Compassion Scale (Neff, 2003) to measure levels of self-compassion. Although this step ensured the consistency in conceptualisation of self-compassion and the use of a self-compassion measure with good validity and reliability, there was a risk of excluding significant studies that used measures such as Compassion Engagement and Action Scales for Self and Others (Gilbert et al., 2017) or Body Compassion Scale (Altman et al., 2017). Studies with the most up-to-date measures could provide additional evidence for the role of self-compassion and it may therefore be important to include them in future research.

All studies included in this review were published in peer-reviewed journals. Although this strengthened the quality of the review, there was a risk of publication bias due to the fact that such studies may be more likely to present positive results (Rose, Thornicroft, & Slade, 2006) and exclude studies with non-significant findings which are commonly difficult to publish but could further inform the role of self-compassion in the examined population. Also, the majority of studies were carried out in the USA and Canada. Given that these countries are identified as individualist in their approach to health, perceptions and experiences of self-compassion may be different in countries of a more collectivist nature. In addition, all included studies in this review were published in English between 2008 and 2018, which may have excluded any older findings or papers written in non-English speaking countries. Therefore, the findings may be culturally biased and limit their generalisability.

Finally, the review did not include grey literature which could have provided a variety of findings that were unpublished or published in non-commercial form such as

conference proceedings and theses. Findings from such sources could have provided evidence for any causal links between self-compassion and problematic eating regulation. Grey literature could have also provided details of any studies that produced non-significant results, which can often be missed in peer-reviewed journals.

Conclusion

This review aimed to provide a synthesis of the literature on the role of self-compassion in women experiencing eating difficulties in community-based population. The findings suggested that self-compassion may play a protective role in women experiencing low levels of body appreciation and high levels of shape concerns, eating guilt, body shame, and thin-related pressures. In addition, self-compassion mediated the relationship between perfectionism and disordered eating behaviours, and it moderated the associations between a number of weight-related variables such as BMI, anti-fat attitudes, negative body comparisons and eating psychopathology. Further research needs to focus on identifying which components of self-compassion contribute to improved psychological weight-related outcomes. Also, more longitudinal studies, including clinical samples with women diagnosed with eating disorders, are required in order to examine any changes in self-compassion over time.

3. The Lived Experience of Barriers to Self-Compassion in Women Experiencing Weight Difficulties

Abstract

There is an increased interest in developing innovative compassion-focused approaches to weight management for women. Despite promising results, some women find it difficult to engage in self-compassionate activities. This study aimed to explore experiences of barriers to self-compassion in women who, following a number of previous weight loss attempts, were actively trying to manage their weight by using community-based approaches. A qualitative study was employed using an interpretive approach. Using semi-structured research methods, 10 women were recruited through community-based weight loss clubs, using purposive sampling. Interpretative phenomenological analysis was conducted to analyse the data. Ten sub-ordinate themes within three super-ordinate themes suggest that women who actively try to lose weight using community-based approaches experience a number of internal and external barriers to cultivating self-compassion. Women report a number of factors that affect their ability to cultivate self-compassion on a daily basis: prioritising other needs and other people over self-compassionate activities, feeling guilty when practising self-care, novelty of the experience, lack of experience in childhood, unconscious barriers, perfectionism, judgement from self and others, unfavourable comparisons with others, and negative perceptions of self-compassion. To ensure that women are able to fully utilise compassionate-based interventions to weight loss, it is important that we explore how women attempting to manage their weight understand self-compassion and what stands in the way of cultivating self-care. Further research is needed to inform interventions supporting women's weight loss and support evidence-based clinical practice.

Introduction

Overweight is on the rise due to complex biological, psycho-social, and environmental factors. Additionally, much clinical evidence suggests that traditional approaches to weight loss such as restrictive eating and excessive exercise are not sustainable as they cause rapid re-gain of weight (Pietiläinen, Saarni, Kaprio, & Rissanen, 2012). Therefore, health professionals have become particularly concerned about how to tackle this international problem (Swinburn et al., 2011). Among researchers, there has been an increasingly urgent interest in helping people focus on person-centred dietary, lifestyle, and other solutions to losing weight (Gilbert et al., 2014). Based on the protective role of self-compassion found in the research (as discussed below), innovative psychological compassion-focused interventions have been developed for individuals with weight difficulties (e.g. Macpherson-Sánchez, 2015).

The Protective Role of Self-Compassion

Derived from evolutionary science, attachment theory, and cognitive neuroscience, self-compassion is a form of self-kindness, self-acceptance, and courage. It involves self-warmth, non-judgemental concern for one's well-being, and acceptance of one's distress (Gilbert, 2014).

The second model conceptualises self-compassion as a healthy way of relating to self by involving three core dimensions. The three core components of relating to one's self include: (1) treating oneself with self-kindness versus harsh criticism; (2) acknowledging that suffering is part of common humanity versus isolation and disconnection, and (3) mindfulness, accepting suffering and holding it in awareness versus over-identification with suffering (Neff, 2003).

An emerging body of research points to self-compassion as promoting resilience in psychological wellbeing (MacBeth & Gumley, 2012). For example, self-compassion has been linked to health-promoting behaviours and helpful reactions to illness (e.g. Terry, Leary, Mehta, & Henderson, 2013; Leary, Tate, Adams, Allen, & Hancock, 2007). Furthermore, self-compassion can increase individuals' ability to self-soothe following distress (Gilbert & Procter, 2006).

Reviews of research on self-compassion also revealed that self-kindness and courage could also directly and indirectly affect problematic eating patterns and other factors related to being overweight. For example, a recent study showed that being self-compassionate mediated the relationships between Body Mass Index (BMI) and symptoms of pathological eating (Kelly, Vimalakanthan, & Miller 2014). In addition, some investigators have suggested that higher levels of acceptance and self-compassion may be linked to positive body image (Ferreira, Pinto-Gouveia, & Duarte, 2011), increased body compassion (Palmeira, Pinto-Gouveia, & Cunha, 2017a) and improved intrinsic motivation to exercise (Magnus, Kowalski, & McHugh, 2010). Further findings suggested that self-compassion may also contribute to a decrease in negative attitudes towards overeating following an unsuccessful diet plan (Adams & Leary, 2007) and mediating weight stigma (Hilbert et al., 2015). Self-compassion has also been shown to be negatively correlated to binge eating severity with emotional tolerance and unconditional self-acceptance mediating this interaction (Webb & Forman, 2013). However, most of these studies used cross-sectional correlational design (e.g. Adams & Leary, 2007), employed self-report measures (e.g. Hilbert et al., 2015) and recruited community based samples such as undergraduate students (e.g. Webb & Forman, 2015). Therefore, it was impossible to infer causality from the findings and also generalisability and validity of the results were somewhat compromised. Also, most

studies were quantitative, suggesting a need for qualitative research in this area, which could provide a rich and detailed picture of self-compassion in overweight people.

Studies on compassion-based interventions contributed to further understanding of the role of self-compassion in weight management. For example, a compassion-based intervention was developed in Portugal. A weight management programme (BEfree), with elements of psychoeducation, mindfulness, and compassion, was designed for women with binge eating and obesity (Pinto-Gouveia et al. 2017). BEfree was a 12-session group interventions delivered by a cognitive-behavioural clinical psychologist. Compared to wait-list control, BEFree was found efficacious in reducing binge eating symptomatology as well as shame, self-criticism, and negative internal states related to obesity.

Another compassionate-based group intervention (Kg-Free) was developed for women experiencing weight difficulties (Palmeira et al., 2017b). The authors completed two efficacy studies which suggested that Kg-Free significantly improved participants' quality of life, physical exercise, and self-compassion skills (Palmeira et al., 2017a; Palmeira et al., 2017b). Kg-Free significantly reduced women's problematic eating patterns, their BMI, and weight-related self-stigma and self-criticism. Results were sustained at 3-month follow-up though the effect size was small.

Further developments of interventions using a self-compassionate approach were designed for people with problematic eating behaviour in the Netherlands. One intervention was specifically developed to help overweight individuals complaining about food cravings. When presented with food cues, participants who attended the course complained less of losing control over food. They also reported to be less preoccupied with eating. The authors concluded success of the acceptance approach may have been related to mechanisms of disengagement from obsessive thinking as

well as prevention of goal frustration and automatic responses to urges (Alberts, Mulkens, Smeets, & Thewissen 2010). Another 8-week intervention was found to be efficacious in reducing food cravings, concerns about body shape and weight (body dissatisfaction), and emotional eating (Alberts, Thewissen, & Raes, 2012). The authors concluded the intervention helped individuals accept emotionally painful experiences and not act upon then, which prevented them from impulsive reactions (Fetterman, Robinson, Ode, Gordon, 2010).

These findings provided evidence emphasising the importance of self-compassion in women experiencing overweight. However, most researchers failed to demonstrate benefits gained during interventions were sustainable at post intervention (e.g. Palmeira et al., 2017a) as a proportion of individuals did not seem to respond to self-compassion techniques or found them difficult to implement (e.g. Palmeira et al., 2017b).

Authors of the above studies speculated about the nature of problems individuals may encounter when engaging with compassionate-focused interventions. Alberts et al. (2010) hypothesised lack of face-to-face contact between trained professionals and participants meant some individuals may have not fully understood and, therefore committed to, the principles of the intervention. In the BEFree study (Pinto-Gouveia et al., 2017), differences between the intervention and control group were only found post-intervention. Authors concluded that a self-compassionate mind frame may not materialise immediately and that some women required time to develop relevant skills in and reflect on self-compassion exercises to fully benefit from intervention. Similar conclusions were drawn by authors of the Kg-Free intervention (Palmeira, et al., 2017b) who speculated that for women with an underdeveloped soothing system, more time for practising self-compassion was required. Furthermore,

authors of other studies suggested some participants may have viewed the programme exercises as a means to lose weight rather than an advancing lifestyle change and they therefore stopped cultivating self-compassion once the study ended (Mantzios & Wilson, 2015). Participants also reported to face judgment from others when practicing elements of the intervention (Mantzios & Wilson, 2015), as well as weight self-stigma (Lillis, Hayes, Bunting, & Masuda, 2009), which may have hindered the maintenance of the intervention.

Barriers to Experiencing Self-Compassion

Given the difficulties some people have when utilising compassion-based approaches, some investigators have attempted to explore and understand potential barriers to self-compassion. For example, when people with depression were asked about potential obstacles, they reported perceiving compassion as meaningful and useful, however they found implementing it difficult. Some participants found the concept of compassion too challenging and unfamiliar to enact. Others' experience was that depression prevented them from feeling self-compassion (Pauley & McPherson, 2010).

Fear of positive affect has been suggested as another barrier to experiencing compassion. For example, Gilbert and colleagues surveyed a clinical sample of individuals with depression (Gilbert et al., 2012) and a non-clinical population of undergraduate students (Gilbert, McEwan, Matos, & Rivis, 2011). Findings suggested a strong association between fears of self-compassion for self and alexithymia, self-coldness, self-criticism, insecure attachment, depression, anxiety, and stress. Fear of self-compassion was also linked to fear of compassion from others.

Further findings came from a study which was conducted in a group setting where a 12-week compassion mind training was delivered to five individuals

experiencing chronic psychological difficulties. Findings suggested reasons for experiencing fear of compassion included: perception of receiving it as a sign of weakness, painful memories of not receiving it when needed, and feeling unworthy of it (Gilbert & Procter, 2006).

Finally, when Gilbert and his team (Gilbert, Baldwin, Irons, Baccus, & Palmer, 2006) introduced compassion-based techniques to undergraduate psychology students and found some individuals may feel overwhelmed by sadness and grief when experiencing warmth and kindness through imagery.

Thus far, few studies have explicitly focused on barriers to compassion in population experiencing difficulties with weight regulation. For example, one recent study revealed high levels of fear of self-compassion in individuals with a diagnosis of eating disorder may hinder intervention (Kelly, Carter, Zuroff, & Borairi, 2013). This study however included individuals who were both under- and overweight (BMI ranged from 12.5 to 35) and authors did not specify whether there was a difference in fear of compassion between individuals who were under- and overweight (BMI >25). Furthermore, Palmeira et al. (2017b) found that participants' inability to cultivate self-compassion mediated the positive relationship between self-disgust and problematic eating symptoms. Finally, Gilbert et al. (2014) designed and conducted the first qualitative study that explicitly focused on experiences of compassion in people with obesity from a clinical population. Authors completed semi-structured interviews in which they asked participants about their lived experience and meaning of self-compassion. Findings suggested overweight individuals who broke diet regimes faced high levels of self-hate and self-disgust, which seemed to impact on their ability to be self-compassionate.

Given researchers have identified numerous obstacles to cultivating self-compassion and current research lacks studies focusing on obese population, it is paramount to explore what barriers may have the biggest impact on the effectiveness of compassionate-based weight loss interventions.

Gender Differences in Self-compassion

Additionally, research on self-compassion suggests there may be gender differences in being self-kind and courageous. Firstly, it has been suggested that self-compassion trait may be less present in females than males (Neff, Hsieh, & Dejitterat, 2005). Neff (2011) argued that this was due because women were more self-critical and ruminate on their self-image in a more negative way than males. Another study, investigating the protective role of self-compassion in young people with body image concerns, found developing self-compassion protected against negative self-image among both gender through different pathways (Rodgers et al., 2017). Palmeira et al. (2017b) also suggested that females may report lower levels of self-compassion and higher levels of self-disgust and eating psycho-pathology than males. Given the above examples, it is important that in early stages of this research area, the experiences of self-compassion in women are studied separately from men.

Rationale for the Current Study

Although a considerable number of studies on self-compassion and obesity have recently been undertaken in Portugal and Spain, there is little research on perceptions of compassion and being overweight in the UK. Given the UK is identified as an individualist country, whereas Portugal and Spain are more collectivist (Yoon, 2010), there may be differences in perceptions and experiences of compassion to and from others. Also, Grabe and Hyde's (2006) meta-analysis suggested white women may be

more dissatisfied with their bodies than females from Hispanic backgrounds, which also could impact on experiences of compassion related to weight.

Furthermore, self-compassion and weight management in women have largely been studied by using quantitative designs (e.g. Kelly et al., 2014; Kelly et al., 2016). For example, a number of findings from cross-sectional studies consistently suggested that higher levels of self-compassion were linked to higher levels of healthy eating behaviours and body appreciation. Self-compassion has also been found to predict lower levels of shape and weight concerns and thinness-related pressures (for more details see Chapter 2). While quantitative studies point to some interesting considerations, they fail to capture the complexity of people's experiences of self-compassion when attempting to lose weight.

Some attempts have been made to explore the experiences of obesity in females in more depth (Brown & Gould, 2013). For example, qualitative studies found that women were aware that the mainstream weight loss approaches such as short-term restrictive eating and excessive exercise were not sustainable and caused them to immediately gain back any weight loss they succeeded (Diaz, Mainous, & Pope, 2007; Chang, Chang, & Cheah, 2009). Furthermore, experiences of developing excess weight were found to be very complex and often related to emotional eating (Holland, Dallos, & Olver, 2012) and food addiction (Cullen et al., 2017). Women who did not have any emotional regulation strategies ended up using food to cope with challenges such as family conflicts, carrying responsibilities for others, and weight-stigma. In addition, qualitative studies showed that excess weight limited women's freedom and affected their social relationships (Alqout & Reynolds, 2014). Stigmatising attitudes directed towards obese patients in the healthcare settings (Malterud & Ulriksen, 2011) and

experiences of different types of stigma among obese individuals (Lewis et al., 2011) were also frequent themes.

Given the complexities that women's experiences of weight loss and a self-compassionate stance involve, it is necessary that research adopts more explorative approach to these issues. Due to limited qualitative research focusing on the phenomenological experiences of self-compassion in overweight women, more in-depth accounts of these experiences are required. Research (Gilbrt et al., 2014) exploring self-compassion in overweight clinical sample suggested that, to provide a broader picture of the barriers to self-compassion in people who are overweight, specific demographic populations such as individuals attending weight loss clubs should be studied. The author was not aware of any current research exploring how overweight women describe the problems involved in becoming self-compassionate whilst managing their excess weight by using community-based approaches.

Research Questions and Aims

The current study aimed to explore the lived experiences of self-compassion in females who were overweight and, following a number of previous weight loss attempts, were actively trying to lose weight. It was anticipated that the data collected would add to the understanding in this under-researched area, allowing researchers and health professionals to better design compassionate-based weight loss interventions. The study also hoped to add to the existing literature and encourage others to complete further research in this area.

The main research questions for the current study were:

- What are the lived experiences of barriers to self-compassion in overweight women who, following a number of previous dietary attempts, have actively been trying to lose weight?
- What are women's descriptions of the problems involved in becoming self-compassionate whilst managing their excess weight?
- How do overweight women make sense of their experiences of self-compassion and what is the personal meaning of being self-compassionate whilst being overweight and trying to lose excess weight?

The general aims for the current study were:

- To establish whether the findings of the study could help identify females who may be unable to utilise compassionate-based weight loss interventions.
- To establish whether the findings of the study could have an influence on policy and practice in this area.

Methodology

Participants

Participants were recruited using purposive sampling, which was consistent with the qualitative paradigm and IPA approach (Smith, Flowers, & Larkin, 2009). To retain an idiographic focus, IPA studies have small sample sizes and numbers of interviews of between 4 and 10 are adopted in professional doctorates (Smith et al., 2009). Other researchers suggested 12 interviews in qualitative studies if the group is relatively homogeneous (Guest, Bunce, & Johnson, 2006). However, IPA experts refrain from suggesting an exact number of participants due to various factors which may impact on sample size (e.g. the quality and depth of interviews). Therefore, this study aimed to recruit between 8 and 10 individuals.

Inclusion and Exclusion Criteria

To ensure a purposive and homogenous sample, recommended for projects employing IPA, the researcher followed examples in the relevant literature and decided on a number of inclusion and exclusion criteria for the study. The inclusion criteria for participants included: being over 18 years old female, having a Body Mass Index (BMI) over 25kg/m2 (BMI > 25), managing excess weight by using a community-based intervention, and having a history of dieting (at least 2 previous dietary attempts).

The age and BMI criteria were set so that the study could focus on a population relevant to existing self-compassion research (e.g. Gilbert et al., 2014; Pauley & McPherson, 2010)).

To reflect homogeneity of the study sample, it was decided only females would be recruited. This was in line with recent research findings which suggested females may report lower levels of self-compassion than males (Palmeira et al., 2017b) and that appearance norms encountered by females are more rigid and pervasive than those experienced by males (Buote et al., 2011).

The study employed a community sample to reflect a number of recent studies on problematic weight regulation suggesting many people experiencing weight difficulties come from non-clinical samples. For example, Barnes and colleagues (2010) accessed over 300 community participants who experienced problematic eating symptoms; and Hilbert and colleagues surveyed over 1100 overweight community individuals with weight-related self-stigma (Hilbert et al., 2015).

Participants' history of dieting was included in the criteria as the study aimed to explore experiences of self-compassion in individuals who had been attempting to change their overweight condition but had previously failed. Existing research on weight regulation suggests that bouts of restrictive eating in obese individuals may

trigger preoccupation with food which then can lead to patterns of overeating and weight gain (Pietiläinen et al., 2012).

Furthermore, it was agreed that the study would exclude females with a confirmed diagnosis of an eating disorder (any type). This was due to the fact that the researcher was particularly interested in self-compassion associated with weight loss and if other mental health conditions were present, it would be difficult to ascertain if the compassion was related to weight or other issues.

The researcher also decided to exclude females whose level of English was not sufficiently fluent to ensure rich and detailed accounts of participants' experiences.

Recruitment

Participants were primarily recruited through local weight loss groups such as Weight Watchers and Slimming World. Access to London groups was discussed with individual group facilitators. Once the agreement was obtained, the study was advertised verbally among attendees. Visits to a number of London groups were arranged to establish relationships with potential interviewees. Participants were given a study leaflet (see Appendix 2) and were able to opt into the study by verbally agreeing to take part or emailing the researcher at a later stage. Prospective participants were also able to express their interest in the study by phoning the University research line. The researcher also distributed a study leaflet at her local university and advertised the study on social media such as Facebook.

Once participants agreed to take part, they were invited to attend a semi-structured interview and a location convenient to them was agreed. Most participants met the researcher on premises of University of London.

Monetary incentives were introduced in the form of £10 Marks & Spencer vouchers. Participants received them in person after completing the interview.

Overall, 10 women met study criteria and agreed to be interviewed. Table 2 summarises demographic information. To protect interviewees' anonymity, names were changed and only general criteria of ethnicity, education level, and employment were provided.

Table 2.

Participants' demographics.

Participant number	Pseudonym	Age range	Ethnicity	Education level	In employment?
1	Brenda	55-74	White British	A Levels	No
2	Clarissa	35-54	Other	Degree	Yes
3	Sandra	18-34	White British	A Levels	Yes
4	Victoria	18-34	Other	Degree	Yes
5	Lorraine	18-34	White British	Degree	Yes
6	Suzie	18-34	Other	Degree	Yes
7	Yvonne	55-74	White British	A-Levels	No
8	Patricia	18-34	White British	Degree	Yes
9	Tracey	18-34	White British	A-levels	Yes
10	Roxanna	18-34	Other	Degree	No

Ethical Considerations

The study was fully approved by the Royal Holloway Research Ethics Committee (see Appendix 3). To ensure participants' confidentiality, anonymity, and voluntary nature of participation, the Code of Ethics (British Psychological Society; BPS, 2009) and institutional ethical guidelines were adhered to at all times.

Participants were provided with a standardised information sheet (Appendix 4) and research consent form (Appendix 5) which had to be read in full and signed prior to the interview. Voluntary participation and the right to withdraw at any time were explained both verbally and in a written format. Participants were encouraged to ask any questions before signing the form.

Semi-structured interviews involved questions of sensitive nature that could cause distress to participants and therefore a sensitive approach during data collection was ensured at all times. Although it was not anticipated that the study would cause any significant distress, if participants mentioned or showed any sign of distress, they were signposted to places of support (e.g. Mind Infoline). Additionally, there was a University research phone number provided that participants could call if they had any questions following the interview.

Following interview, participants were debriefed and encouraged to ask any questions about the study. If they expressed an interest in reading the final report, a verbal agreement was made to contact them in the future.

During interviews, in line with Camden & Islington lone worker policy the following guidelines were adhered to: keeping another professional or supervisor apprised of the visit; arranging a check-in and check-out time; carrying a working mobile phone; considering the use of techniques from a breakaway training if necessary.

Procedure

The core components of a semi-structured interview were developed by drawing on existing compassion research (e.g. Gilbert et al., 2014; Pauley & McPherson, 2010). These components were used to form specific questions which were discussed with two Weight Watchers facilitators and two volunteers who were not invited to interview. Their feedback informed the final set of questions in terms of relevance and the ability to elicit the experiences of participants. Table 3 includes a sample of the interview schedule (for a full copy of the interview schedule see Appendix 6).

Table 3.

Examples of the interview questions.

What is your experience of being your current weight?
What were your experiences of compassion and self-compassion when you were growing up?
What could facilitate more self-compassion in your life?
Can you describe the process of deciding to go on a diet vs ending it?

Broad interview questions such as those suggested in this study are commonly used in IPA research as they encourage the understanding of individuals' experiences with phenomena rather than making specific predictions about what will be said (Smith et al., 2009). When participants shared their understanding of self-compassion, the researcher defined it as the ability to be kind and courageous towards oneself and others (Gilbert, 2014). More guidance on this was also given to participants throughout the interview.

Interviews were conducted between July and December 2018, lasted between 37 and 97 minutes and were audio recorded and transcribed verbatim within 2-4 weeks. The researcher always ensured the room where interviews took place allowed for confidentiality and undisturbed conversation.

To capture and reflect on the researcher's own perspectives that arose during the study and contributed to the research process, a reflective document was kept throughout the data collection process.

Study Design

Epistemological and ontological position.

To employ an appropriate methodology in the current study, considerations were made about epistemological and ontological questions regarding how reality is seen, understood and explored (Guba & Lincoln, 1994).

Epistemology is concerned with the nature of knowledge (Braun & Clarke, 2013). Depending on its methods, validity, and scope, there are different types of knowledge one is able to develop, which influence the researcher's decisions about data collection and analysis (Willig, 2013). The epistemological position for the current study used an interpretivist approach which appreciates lived experiences of people who interact in social contexts (Schwandt, 2007). The phenomenological approach states that experience is constructed through the process of interpretation and is therefore flexible rather than determined or fixed (Willig, 2013). It therefore employs qualitative methodology in research (Robson, 2014).

Ontology refers to the nature of reality and how that reality can be tested. Ontological assumptions range from relativism (which assumes that we can only learn what reality is through human interpretation and therefore there is no one 'true' reality) to realism (which states reality can be tested in an objective way and therefore there is 'true' reality). The current study used the position between relativism and realism, the concept referred to as critical realism, which postulates that a 'true' reality does exist but access to it is limited due to social influences such as language, culture, and history (Braun & Clarke, 2013). What that meant for the current study was that knowledge obtained by the researcher was influenced both by the participants and researcher herself, and was therefore subjective.

Existing research on self-compassion and eating regulation has typically used quantitative methods to explore the role of self-compassion on women's weight management (e.g. Daye et al., 2014) or has examined barriers to self-compassion in women experiencing eating disorders (e.g. Kelly et al.,2013). However, thus far research has not looked into women's experiences of the process of engaging in self-compassion and overcoming any obstacles standing in the way of cultivating it. A particularly suitable method to understand the 'lived experience' of a participant is interpretative phenomenological analysis (IPA; Smith, 2011), which attempts to perceive and interpret the individuals' view of the world.

Interpretive phenomenological analysis.

IPA is a qualitative research approach developed by psychologists in order to examine personal lived experiences (Smith, 2011). It is considered to be a whole qualitative approach, as opposed to data analysis method, with its own theoretical underpinnings (Braun & Clarke, 2013).

The three primary principles that guide IPA include: phenomenology, hermeneutics, and idiography (Smith, 2017). Phenomenology has its roots in the works of philosophers such as Husserl, Heidegger, and Sartre and offers a unique way of studying a human experience. It suggests that we can only understand other people's relationship to the world by focusing on their attempts to make meanings out of their experiences and therefore this process will always be interpretative in its nature (Smith et al. 2009).

Hermeneutics is concerned with the process of interpretation on the part of both researcher and research participant (Smith, 2017). One of the primary ideas within hermeneutic theory is referred to as the 'hermeneutic circle', which looks at the dynamic relationship between the part and the whole (Smith et al., 2009). Most

hermeneutic writers stated that interpretation is more of a dynamic rather than linear style of thinking and, therefore, to understand any given part, you need to look at the whole, and to understand the whole, you need to look at the parts (Smith et al., 2009).

The other fundamental concept involved in an interpretative process is a 'double hermeneutics'. Given that the researcher is trying to make sense of the participant, who is trying to make sense of their world, IPA operates with a 'double hermeneutics' (Smith & Osborn, 2015). In this way the process of the participant's meaning-making is first-order while the process of the researcher's sense-making is second-order (Smith et al. 2009).

Third and final theoretical underpinning of IPA, idiography, is concerned with how particular phenomena (e.g. an event, process, or relationship) have been understood from the perspective of particular individuals, in a particular context (Smith et al. 2009). It is therefore believed that an IPA study should demonstrate idiographic commitment to a thorough and systematic case-by-case analysis. Following this, the particular experience of each participant is captured and both convergence and divergence within the study sample is clearly articulated (Smith, 2017).

Rationale for choosing IPA.

IPA is a recommended qualitative methodology for examining complex and ambiguous topics within psychology and obtaining a detailed account of each participant's experience (Smith & Osborn, 2015). Self-compassion and overweight were examples of such complex issues, as they can be difficult to conceptualise and discuss. For example, excess weight can be understood as a socially constructed phenomenon (Hermiston, 2010) and weight-related shame as an experience within a social realm (Lindsay-Hartz, de Rivera, & Mascolo, 1995). Also, it has been argued that compassion can be constructed through people's actions, perceptions, and

presentations of themselves (Blackstone, 2009). Therefore, the idiographic commitment of IPA allowed to understand how a particular phenomenon (the experience of self-compassion) was understood by particular people (overweight females), in a particular context (active attempt to lose weight in the community), which helped connect the findings of this study to the existing nomothetic research. Finally, IPA is viewed as a way of giving voice to people experiencing the phenomena the researcher is interested in (Willig, 2013). Therefore, given all the above considerations, IPA was viewed as the most appropriate methodology for the current study.

IPA vs other qualitative methods.

Several other well-established approaches to qualitative research were considered when designing the current study. However, given all the considerations presented above, it was felt that IPA would best suit the purpose of the current study within the time and resource constrain of a clinical doctorate.

Grounded theory methods (GT) are concerned with individual processes in the context of social structures and they aim to generate theory from data (Smith, Harre & Langenhove, 1995). IPA however was designed to gain insight into individual participants' accounts of phenomena, which fit the purpose of the current study.

Thematic analysis (TA) focuses on organising and reporting themes within data that can be collected and analysed in a flexible manner (Braun & Clarke, 2006; Smith et al. 2009). Although IPA and TA share some similarities such as identifying themes, IPA was chosen due to its interpretative nature, philosophical underpinnings, and sampling strategy. Also, the idiographic aspect of IPA highlights characteristics of individuals as well as patterns across the sample, while TA describes patterns across the sample only.

Content Analysis (CA) is a systematic way of coding and categorising data in order to determine trends, patterns, and frequencies of phrases used within text's content and characteristics. It is a recommended method technique to explore relatively new research topics (Vaismoradi, Turunen, & Bondas, 2013). Although the current study explored new phenomena, its aim was to go beyond simple reporting of common phrases mentioned in the data and therefore IPA was preferred over CA.

Data Analysis

Data was collected from ten in-depth semi-structured interviews and analysed using an IPA approach as suggested in Smith et al. (2009). All interviews were transcribed verbatim by the researcher who then followed a set of common processes and principles, applied flexibly throughout the analysis stage (Smith et al. 2009). Firstly, the researcher immersed herself in the data by reading and re-reading the original transcripts ensuring an active phase of engagement with the data. This stage focused on descriptive comments (the content of the participant's answer), linguistic comments (e.g. pauses, laughter etc.), and conceptual comments (focusing on a more abstract level and using tentative interpretations). The three types of comments included summarising, making any connections between what was said, noticing, any contradictions in what the participant said and interpreting what it could have meant for the interviewee). Following this, the researcher kept an open mind and started making notes of anything that was of interest within the text. That stage of analysis involved exploring participants' language and the context of their experiences as well as identifying more abstract concepts around the patterns of meaning. The next step of analysis focused on developing emerging themes and the authors created a table where she wrote any emerging themes next to the text lines. This stage was more interpretative in nature as it reflected the participant's original phrases and also the researcher's

interpretation (see Appendix 7 for an extract of initial noting and emerging themes), and generated a large number of emerging themes. The fourth step in the analysis involved generating connections between emerging themes, grouping similar ones together, and discarding irrelevant ones. Given the nature of rich data in qualitative studies, the author followed the suggestions of Smith et al. (2009) and only kept the emerging themes that were closely related to the research question. Following the grouping stage, the researcher used post-it notes, wrote the initial emerging theme clusters and placed them on the floor to help gain a better overview of the themes. The researcher looked at how the emerging themes fit together to create a structure that would point to the most interesting and important aspects of the participant's account (Smith et al., 2009, p. 96). The final two stages of analysis focused on repeating the aforementioned steps with the remaining participants' accounts and looking for patterns across cases, which led to forming subordinate and super-ordinate themes (see Results). Extracts from transcripts were used to support each theme that emerged during the analysis. The researcher ensured that examples included both similarities but also the uniqueness in individual experiences.

Quality in IPA.

Four general principles were consulted to guide the current study: sensitivity to context, commitment and rigour, transparency and coherence, and impact and importance (Yardley, 2008).

Sensitivity to context was demonstrated in various stages of the study. For example, a purposive sample of participants who shared a particular lived experience was employed. Also, this principle required the researcher to constantly use their empathic engagement skills and be highly attuned to what was being said in the interview. This helped the researcher to be appropriately probed into asking further

questions and discovering new and important aspects (Smith & Osborn, 2015). This was drawn on the researcher's trainee clinical psychologist skill set.

To ensure commitment and rigour of an IPA study, measure of prevalence for a theme was provided. A recent literature review of IPA studies suggested that for studies employing over eight participants, at least three to four extracts from participants should be selected in order to support the theme and show its breath and depth (Smith, 2011).

To maintain coherence and transparency, the researcher: provided a clear description of all stages of the study (see previous sections), arranged frequent consultations with supervisors, and looked jointly at transcripts and emerging themes, used extracts from transcripts to support themes, and used a reflective journal to keep track of own perspectives and contributions to the process.

Finally, to ensure the final core principle of quality in the current study, impact and importance, the researcher sought to address an important question in clinical psychology. By exploring the experiences of self-compassion in females with weight management difficulties, the researcher hoped to further the understanding of this growing research area.

Results

Interpretative Phenomenological Analysis revealed that participants' lived experiences of trying to lose weight whilst remaining self-compassionate were significantly influenced by various obstacles. Interviewees encountered a number of barriers to self-compassion at the time of growing up as well as at present when they were focusing on weight loss. Data analysis revealed 10 sub-ordinate themes, which were grouped into three super-ordinate themes. The nature of each super-ordinate theme was summarised by a number of subthemes and each subtheme was supported by a selection of the most representative quotes coming from the majority of

participants (Smith et al., 2009). Table 4 demonstrates how the themes were represented. For more comprehensive table of all the themes with additional supportive citations from interviewees see Appendix 8.

Some quotes had to be edited to ensure participants' anonymity. Also, to maintain transparency of the themes, less relevant parts of the quotations were removed and this was indicated by '[…]'. Occasionally, the researcher added exploratory material and this was marked as [text].

Table 4.

Master table of themes

Super-ordinate theme	Sub-ordinate theme	No of participants
"I don't think I really consider myself enough"	Prioritising other needs over self-compassion	6
	Prioritising other people over self-compassion	7
	Feeling guilty of prioritising self-compassion	6
Re-learning a new way of life	"It's a very new thing, it's odd"	8
	The impact of growing up	8
	Unconscious barriers to self-compassion	5
"I have very high standards for myself"	Striving for perfection	6
	Judgement from self and from others	10
	Comparing yourself to others	8
	Negative perceptions of self-compassion	5

Super-Ordinate theme one: "I don't think I really consider myself enough".

The first super-ordinate theme revealed that, whilst attempting to lose weight, the majority of participants prioritised a number of other responsibilities over being self-compassionate. The reasons for this were multi-fold and therefore this super-ordinate theme was divided into three subthemes: 'Prioritising other needs over self-

compassion', 'Prioritising other people over self-compassion', and 'Feeling guilty over prioritising self-compassion'.

Sub-Ordinate theme one: Prioritising other needs over self-compassion.

All participants reported being self-compassionate meant losing weight by eating healthily and having some form of exercise routine. However, they were also aware that a number of their other day-to-day responsibilities stood in the way of achieving this. Important in participants' lived experiences were daily commitments such as holding a stressful job, working irregular hours when studying for a degree, or looking after the house.

"I think my biggest problem is just life getting in the way and I just prioritise everything over that. […] I always find that at the beginning of the week I've got this motivation and I'm like 'it's a new week, I'm going to plan all my lunches, plan my dinners, go to the gym', and I may get it on Monday and Tuesday and then I'll be tired, there'll be work to do, clean the house, see friends, whatever, things will pop up and then that is the first thing that drops off (Participant 9)

"…just trying to find some time so I can fit in meal prep and going to the gym during the day. I don't eat as healthily as I think I could and when time's getting a bit stressful, that's the first thing to go, like, 'I'm just going to get a takeaway' or 'I just put something in the oven rather than cook from scratch' (Participant 4)

One participant specifically talked about life getting in the way of not just losing weight but also maintaining her new weight:

"… you may lose a stone or a stone and a half […] and you feel good but then just life, you put on [weight], and children, grabbing things to eat on the way, yeah, I think life generally" (Participant 7)

Sub-Ordinate theme two: Prioritising other people over self-compassion.

The tendency to prioritise daily commitments over self-compassionate attitude to weight loss, seemed to coincide with prioritising other people's needs. The majority of participants seemed to feel a lot of pressure to take care of their loved ones such as friends and family. That meant they did not have time to rest, focus on their nutritional needs or attend exercise classes. Some also felt they were unable to afford time or finances to meet their health needs.

"I don't think I really consider myself enough and I think my husband would agree, like I put him and my daughter first all the time, um, every day, you know it's, I ask them what they need, what they want. […] if I want to do something, I put myself at the bottom of the list every time […] (Participant 3)

"…I prioritise that [friends' events] and then in day to day situation I don't do nice things [e.g. yoga class]. Because I wouldn't be able to save up for big things" (Participant 6)

"I never had the time to spend it on me. I always gave so much to other people. I really didn't focus on myself" (Participant 10)

It seemed that participants' motivation to prioritise others' needs over their own was difficult to explain, which was expressed by Participant 3:

"I'm just like a robot and I just […] do things but, I suppose, people do need to do things for themselves and I don't do enough at all for myself, in any way" (Participants 3)

Sub-ordinate theme three: Feeling guilty of prioritising self-compassion.

The majority of participants spoke about a sense of guilt they felt when attempting to focus on their weight loss in a compassionate way. The guilt was usually represented by negative thoughts stating that they should be doing something else than looking after themselves.

"Sometimes, if I want to go and do something to feel better, I feel like I've got to be doing something somewhere else or that I'm leaving them [family] in a lurch, this is how I feel" (Participant 3)

"… not feeling guilty about that after you've done that so, kind of, giving yourself permission to do it rather than feeling that you're procrastinating" (Participant 4)

Participants also talked about self-blame and lack of forgiveness when they were unable to follow their eating routines. It seemed that it was difficult for them to access self-compassion even though the reasons for a slip-up included exhaustion or a diet plan that was too difficult to follow.

"I had quite a stressful day and I was like "can't be bothered to cook", […] I was like 'oh, I'm just going to get a pizza' and then I felt awful afterwards 'why did I do that on a Monday? The rest of the week is off now' (Participant 9)

"And then [after eating less healthy food] the guilt and the shame come in so it stays in the negative all the time so the compassion doesn't, it's trying to peek in, but you're just like 'pff, I'm going to carry on what I am doing" (Participant 8)

Some participants were able to challenge the negative thoughts which generated the guilt, by focusing on a kind-self talk or healthy lifestyle.

"… to justify in my head that I'm not being cruel or unkind and I'm just meeting my needs. And in the same way, I'd like to meet their needs but sometimes I'm just not able to and that's ok" (Participant 2)

"[Currently] There's no diet, no meal plans, no texting people, no justifying what you've eaten that day, no guilt or shame or anything like that, which is huge when you look at dieting "(Participant 8)

Super-ordinate theme two: Re-learning a new way of life

This super-ordinate theme comprised of three subordinate themes: "It's a very new thing, it's odd", 'The impact of growing up', and 'Unconscious barriers to self-compassion'. Each subtheme related to a different aspect of difficulties with cultivating self-compassionate approach to weight loss, ranging from the novelty of experiences to

participants' perspectives on their past and reflections on less accessible (unconscious) material.

Sub-ordinate theme one: "It's a very new thing, it's odd".

Most of the participants had practiced being more self-compassionate at some point in their lives. However, they reported that facilitating self-compassion whilst trying to lose weight involved learning a new skill and took time and practice.

"… it's a very new thing, it's odd, that what I say to myself […] it's learning a new way of life, it's interesting […]it is odd because it's out of my comfort zone and I've lived a certain way for so long, now I'm changing it" (Participant 8)

"… a part of my learning journey, it's been trying to remind myself in these moments when it's difficult 'this is something that you have to practice like everything else' (Participant 2)

"… my voice of compassion has been in development from when it was almost non-existent" (Participant 4)

"[name] did like a self-compassionate meditation with me, but even that I found very hard, it's just, it felt like, I didn't feel comfortable because I'm not used to being self-compassionate" (Participant 9)

Some participants spoke about the fact that being self-compassionate meant that compared to restrictive dieting the process of slimming down could take time and be gradual but that it also involved more self-awareness.

"… back then [when crash dieting] it was very much all or nothing, either you're hitting the numbers or you're not, but equally then you're not being able to be very self-aware, not noticing the progress, […] whereas now being more compassionate, just being a bit more self-aware" (Participant 4)

"[…] now I understand, genuinely only lose a pound a week but I know it's such a long-term thing, I'm not looking for a quick fix this time for all the right reasons. It's a long-term thing" (Participant 5)

"So it's gradual, I'm trying not to focus on the weight loss if there is any (Participant 8)

Despite the difficulties with cultivating more self-compassion, some participants were able to reflect on occasions when they were able to change their attitudes to dieting, which helped them be kinder to themselves.

"… giving myself permission to take my time and having a few goals set but if I meet them then I meet them if I don't, it's not the end of the world and I think maybe placing a little bit less importance on weight" (Participant 4)

"… big big part of it for me is accepting the fact that people like and love me for me. They don't care how much I weigh; they don't care what clothes I'm wearing" (Participant 8)

"I'm definitely seeing things in a different light, like I'm not just doing it for a weight loss or whatever. It's more about feeling comfortable with myself. Yeah, I don't know if some of that comes with age, just being a bit like 'I am who I am' (Participant 9)

Sub-ordinate theme two: The impact of growing up.

All participants reflected on how early experiences may have impacted on their current ability to be self-compassionate in relation to weight management. Some of the women described difficult memories such as experiences of emotional and physical abuse, or bullying at school.

"I had quite a traumatic childhood and I think that may have been the part of me, developing it [being overweight], because of the stress, and the stuff I underwent, I think. And I think this was also what made me comfort eat, maybe, and becoming this shape" (Participant 1)

"…sometimes you get a few comments when you're at school, when you're a bit younger people are a bit nasty […] I was a bit too young […] to really understand what the process was to not be the big one all the time" (Participant 5)

"I was bullied when I was a kid and, um, for various things, weight was one of them so I think when you're constantly dug out" (Participant 8)

"I was always taller than everyone else and I was always bigger than everyone else and I think that's when I really became aware of it, almost because of the bullying, […] that then made me more aware of myself and how I was different (Participant 9)

For some women, the difficulty with practicing aspects of self-compassion such as the kind voice stemmed from lack of role modelling in the family home.

"I think it was probably hard to model or to be self-compassionate without really having that model. I think people were quick to say when something was wrong and to call it out and criticise than saying when something was going right and saying 'well done for trying'. And maybe that was something I, kind of, randomly picked up, that, that self-criticism to improve yourself rather than acknowledging the good and the bad" (Participant 4)

"I suppose compassion to me is not something that has ever really been thought about, myself being compassionate to me […], you just got on with it really" (Participant 7)

Sub-ordinate theme three: Unconscious barriers to self-compassion.

Some participants reflected on the fact that they had not previously thought about self-compassion and what may have contributed to not practicing it. For some women the prospect of discussing self-compassion in the interview was novel, which may have impacted on their ability to reflect on it.

"I just can't work out what the block is, which is really difficult because it's not something I've ever thought about" (Participant 3)

"I don't think I was really aware of things like that. I don't think I was very aware of the whole 'kind voice' thing until this year. I don't think I paid too much attention to it or really thought about it" (Participant 6)

"I suppose compassion to me is not something that has ever really been thought about, myself being compassionate to me, wasn't something that, you just got on with it really" (Participant 7)

Super-ordinate theme three: "I have very high standards for myself".

The third super-ordinate theme revealed the impact that high standards had on participants' lives and the way they managed their weight, which seemed to have come internally from the self and externally from others. It comprised of four sub-ordinate themes: 'Striving for perfection', 'Judgment from self and from others', 'Comparing yourself to others', and 'Negative perceptions of self-compassion'.

Sub-ordinate theme one: Striving for perfection.

This subtheme focused on the impact that perfectionism had on the interviewed women. Unrelenting standards seemed to dominate how some women perceived themselves and how they maintained their desires to have perfect eating patters which would help them become slim.

"…my desire was just to be slim and to be this person that I had envisaged in my head, that I'd never been before. […] It's an obsession. It doesn't ever stop, it's 'what can I do to improve myself' whether it would be a diet or whether it'd be a gym, it's 'how can I change myself to make myself better', and not in a good way. So it's just a sheer

drive to achieve this perfection but you've no idea what this perfection is" (Participant 8)

"I have very high standards for myself, I don't have the same standards for other people, but for myself it's crazy high, when you look at them they're ridiculous, they're not reachable often, so I'm often falling short, so that'll often be a spiral, like a negative space because it'll be about totality of my being" (Participant 2)

"… when […] I had a bad dinner or something, in those moments I […] say […] 'oh well it's all out the window, you've failed' (Participant 9)

"… I need to work on everything, including my weight, including my wellbeing, including my studies, friends, everything. So I need to be working on everything" (Participant 10)

Some participants with perfectionist traits felt that they need to earn self-compassion somehow and that they had to earn of self-kindness.

"… especially in the beginning, if you don't think you're worthy of something, you're not going to do it very much. Or you're going to need such a good reason to be compassionate to yourself that it's going to be "if you do this, you deserve it" (Participant 2)

"[asking herself] … do you deserve it? What have you done to deserve that? Why are you being compassionate to yourself, have you earned it? I think that's kind of where it sits, I think because you're so used to be in the negative" (Participant 8)

"If I see that […] I've lost weight, I look great, […] I will maybe be a bit more nice to myself, but not now, not yet" (Participant 10)

Sub-ordinate theme two: Judgment from self and from others.

The majority of women reflected that the high standards they had for themselves also contributed to judgement received both from self and others. The internal critical voice would comment on their appearance and weight. It would become even stronger if they felt they had failed at losing weight.

"…I've definitely yo-yoed a lot in the last 10 years, definitely. […] If I feel like my clothes are getting a bit tighter, […] I could have put 4, 5, 6 pounds and I'm like 'oh my God, this is awful, what are you doing, you're so fat, come on!' (Participant 5)

"…you restrict restrict restrict to get, to achieve what you want and then afterwards you start eating and then […], you're eating for the sake of eating because you've deprived yourself for so long but the cycle starts, putting on weight, you feel crap, you don't want to leave the house, your clothes don't fit, you weigh more, and it's 'oh my God', I've got to go on a diet again" (Participant 8)

"… if I get changed in the morning and I get a glance of myself and I'm like 'oh God, that's awful' and then I may feel quite rubbish for the rest of the morning' (Participant 9)

As a result of frequent self-criticisms of self-image, some women reported avoiding certain places or individuals and they concealed dieting habits from others.

"I like swimming but I would never do it now because I'm too body conscious. Things like wearing a sleeveless top, I would never do it now because I'm body conscious about my arms" (Participant 2)

"… [dieting] it's something that sometimes I'd rather keep to myself" (Participant 7)

"I was like 'I don't want to go' because I know people are going to be like 'God how much weight she's put on?' and I was like 'I just can't go' and I ended up not going so that was quite big" (Participant 9)

The lived experiences of feeling judged by others related to direct comments the women received from their families, friends, or weight loss group facilitators.

"… people comment on it [weight] a lot so it further makes me uncomfortable going out, going to occasions such as weddings and things like that because I know there will be comments about it" (Participant 2)

"… the numbers on the scale were so negative and the woman's reaction [in a weight loss club], I don't think I'll ever be able to forget it, 'oh, were you expecting that?' I was like 'yeah, wow, thanks'. Everyone's here to improve and to feel better and you've got a 'judgy' attitude when taking someone's weight" (Participant 8)

"… family members, I mean in the past, they were telling me 'you need to lose some weight' (Participant 10)

Additionally, some women, despite trying to have a healthy lifestyle, felt under pressure to fit with peers as they feared they would be judged otherwise.

"… it's difficult when you on maternity leave, someone says 'let's go for a coffee' and everyone's having a cake and […] and you feel obliged in the society to participate in these things and that definitely had an impact" (Participant 3)

"… if someone's like "oh, come on, everyone's having a pudding" I don't really want one but I don't want to be the odd one out who is not partaking in something" (Participant 7)

Sub-ordinate theme three: Comparing yourself to others.

Part of participants' unrelenting standards was reflected in the way they compared themselves unfavourably with their siblings, friends, and peers.

"… as far as I'm aware my two sisters are normal but I'm not (laughs), to be this [points at her breasts] is over the top" (Participant 1)

"I've always known, always been bigger than my friends so even when I was in school I was always taller than everyone else and larger than everyone else, […] it was always like I'm the big one" (Participant 5)

"I was always aware that I was bigger than my friends because a lot of my friends are […] so petite. So so slim" (Participant 6)

Some women spoke about appearance and weight comparisons they made with people on social media or in press.

"I think that's why you end up torturing yourself a little bit because you always aspire to being like that, to fit into that category, or the images they're portraying of people in the media […]" (Participant 7)

"You couldn't tell me anything. I had one single minded focus and that was to lose weight and to look thin on Instagram and, yeah, no, I can categorically say that compassion did not enter into it one bit" (Participant 8)

"… there's a lot of people out there, especially on social media, […] like super skinny, […] and I think it definitely affects how I see myself, I always compare myself to other people" (Participant 9)

Sub-ordinate theme four: Negative perceptions of self-compassion.

Finally, some participants reflected on the fact that if they were to facilitate more self-compassion whilst attempting to lose weight, that would mean they were too lazy or soft. A number of women had concerns that experiencing more self-compassion would mean they were not motivated enough to fulfil their weight loss plans or that they were selfish.

"… in some situations, if I gave myself any more self-compassion, I would just lie down. I'm not sure if it would mean that I'm going to be too soft" (Participant 3)

"… self-kindness would have been mistaken with complacency, actually, and if you're accepting yourself where you are now you're not striving for where you should be or it was a sign that if you failed you weren't able to keep up so you were, kind of, admitting defeat" (Participant 4)

"… it almost makes me feel like I'm being a bit obnoxious or a bit vain, that's really what I guess it makes me feel, you know, egotistical, am I being unnecessarily praiseworthy to myself, I think that what it boils down to" (Participant 8)

One participant was concerned that having more self-compassion would mean that she would feel she could eat anything she wanted, which she feared would lead to weight gain.

"I think if I had more self-compassion, I'd probably let myself off more […] I think I would end up being very, very large and probably very miserable because I was large. So if I had that self-compassion I'd be 'oh, actually, that's fine' (Participant 7)

Discussion

The current study set out to explore experiences of barriers to self-compassion in overweight women who, following a number of previous dietary attempts, were actively trying to lose weight by using community-based approaches. Data analysis revealed 10 super-ordinate themes that consisted of 10 sub-ordinate themes. The first super-ordinate theme, "I don't think I really consider myself enough", revealed that the majority of participants prioritised a number of other responsibilities over being self-compassionate whilst attempting to lose weight. The reasons were manifold and included factors reflected in three subthemes: 'Prioritising other needs over self-compassion', 'Prioritising other people over self-compassion', and 'Feeling guilty over prioritising self-compassion'. The second super-ordinate theme, "Re-learning a new way of life" revealed why cultivating self-compassion may take time and comprised of three subordinate themes: "It's a very new thing, it's odd", 'The impact of growing up', and 'Unconscious barriers to self-compassion'. The third and final super-ordinate theme, "I have very high standards for myself", revealed the impact that high standards had on participants' lives and the way they managed their weight and comprised of four sub-ordinate themes: 'Striving for perfection', 'Judgment from self and from others', 'Comparing yourself to others', and 'Negative perceptions of self-compassion'.

Some participants, who reported prior experiences of compassion for self, had the understanding that cultivating self-compassion had a significant positive effect on their weight management. The women talked about feeling happier and more optimistic

about losing weight. They were also aware that although weight loss was not as rapid as during traditional restrictive approaches, it meant that it could be more sustainable. The women also perceived that self-compassion could help them to be less focused on food related thoughts, to better plan their meals, and break away from the vicious circle of restricting their food intake and overeating. The interviewees also thought self-compassion helped them reduce self-criticism and negative affect related to being overweight. For example, they talked about some days when they were able to engage with kind self-talk and have less weight-related self-judgment. The above accounts seemed to mirror previous findings from the general population where higher levels of self-compassion were positively correlated with body appreciation (Homan & Tylka, 2015), a happier and more optimistic mindset and the ability to better understand oneself and others (Neff, Rude, & Kirkpatrick, 2007), and negatively correlated with shape and weight concerns (Geller et al., 2015). In addition, the current findings seemed to support recently found negative association between self-compassion and body shame and depression (Liss & Erchull, 2015).

However, one of the key findings in the first super-ordinate theme was the conflict between practising self-compassion and fulfilling other responsibilities. When talking about the need to look after themselves, e.g. by cooking healthy meals or exercising regularly, participants described how daily commitments such as work and studies led to a decrease in self-care activities and a possible increase in weight. This mostly stemmed from prioritising other needs over compassion for self. Similarly, the need to cultivate self-care was compromised when they felt responsible for other people. Participants described looking after their children and partners as one of the key barriers to enacting self-compassionate behaviours on a regular basis. They also reported they would feel guilty if they focused on self-care activities. This may be

linked to challenges that some women still face in the Western society such as being responsible for meeting other's needs and feeling unable to negotiate others' demands (Scott & Clery, 2013). To the best knowledge of the author, this was the first exploratory study to find that prioritising other needs may be an external barrier to developing a self-compassionate stance whilst trying to lose weight.

The second super-ordinate theme suggested that the majority of women found that developing a new more self-compassionate stance towards themselves required time and effort. The lived experiences of some interviewed women was that although they were willing to develop a more self-compassionate stance, they felt it was a time-consuming and taxing process. The women spoke about needing to change habitual behaviours, which meant that occasional 'successes' were intertwined with times with little or no compassion. They also described oscillating between habitual hostile self-judgements and new more self-accepting thoughts. This finding seemed to be line with previous qualitative research that suggested that people who have struggled to control their eating may experience longstanding weight-related self-hatred and difficulties with emotional coping, which then may slow down the process of developing self-compassion (Gilbert et al., 2014).

When participants were asked about their experiences of self-compassion whilst growing up, the majority of interviewees shared memories of emotional abuse. The most common recollections were those of emotional neglect and weight-related bullying. The women reflected that these traumatic experiences may have impacted on their ability to be self-compassionate. This is in line with empirical evidence which suggests that experiences of abuse in childhood and adolescence may have detrimental effect on cultivating self-compassion. Survivors of physical and emotional maltreatment and emotional neglect report lower levels of self-compassion compared

to those with no abuse history (Tanaka, Wekerle, Schmuck, & Paglia-Boak, 2011). In addition, this population can be prone to experiencing fear of self-compassion (Miron, Seligowski, Boykin, & Orcutt, 2016). Based on previous findings, the current study supported the view that women who were bullied at school had difficulties with maintaining positive schematic beliefs about the self and the world (Littleton & Grills-Taquechel, 2011). Also, difficulty cultivating self-compassion in women may be related to the characteristic inconsistency in abusive environments (e.g. exposure to warmth as well as abuse) experienced in home or school setting, this may lead to the desire for compassion being associated with vulnerability and danger (Gilbert et al., 2012).

An interesting finding was that a number of the descriptions in the second super-ordinate theme seemed to suggest there may have been some unconscious mechanisms at play, which prevented the women from fully engaging in discussions on self-compassion. For example, some participants reported they were unable to access their cognitions when barriers to self-compassion were discussed. One woman described having a 'mental block' when thinking about possible barriers to self-compassion. A possible explanation for the inability to access cognitions is that some individuals who repress or avoid their negative emotions may have a limited ability to accurately capture emotional experiences, since repression is not a conscious process (Neff, 2003). In addition, individuals who struggle with weight-related shame and self-criticism may have limited access to their internal experiences (Kolts, 2016) and be unable to identify and overcome barriers to self-compassion. Another possibility is that participants may have needed more time to reflect on and develop language and skills in their self-compassionate practice, which seemed to be reflected in some of the women's comments and in recent literature. For example, one woman described how attending

psychological therapy and was able to overcome some of barriers to self-compassion (e.g. perfectionism) by using appropriate techniques (e.g. post-it note reminders on the mirror). Also, a recent efficacy study of a compassion-based weight loss intervention found that participants were better at cultivating self-compassion at 3- and 6-month follow-up than during the intervention (Pinto-Gouveia et al., 2017) This suggested that some people may initially lack skills, including problem solving skills, in overcoming any barriers to self-compassion, which can be addressed by a regular practice.

Also, different interview questions or descriptions of compassion could have helped the women when reflecting on compassion. However, no definite conclusions could be drawn and future research may help to further investigate compassion-related unconscious mechanisms.

Another relevant finding was that the third super-ordinate theme revealed that the lived experience of interviewed women was that they had very high standards for themselves in regards to their weight and self-image. Some of the women talked about striving for perfection when they started a new food or exercise plan and how they felt that any lapse meant they had failed. This quite rigid, 'all-or-nothing' approach prevented the women from being self-kind and cultivating self-care. The inverse effect between maladaptive perfectionism and self-compassion has been documented before (Barnett & Sharp, 2016). In this study, the women who reported previous successes in cultivating self-compassion, recognised that through self-compassion their idealised self-image or weight loss target had changed and become more realistic. These findings supported previous conclusions that perfectionism is negatively linked to women's body image satisfaction, which is mediated by self-compassion (Wasylkiw et al., 2012).

Following on from previous studies (Diaz et al., 2007; Chang et al., 2009), the majority of interviewed women mentioned former failed dietary attempts. They

described the lived experience of developing restrictive eating patterns and excessive exercise regimes that lacked self-compassion. The women talked about trying a number of different 'crash diets', which were related to extrinsic goals such as attending a wedding or going on holiday. The women reflected on the fact that these diets were not sustainable and eventually led to overeating, which then caused a quick weight gain and reinforced the sense of failure. Some women disclosed that they had gone through multiple failed attempts before they realised they were stuck in a vicious circle of intentional rapid weight loss and weight gain, which seemed to mirror previous findings (Pietiläinen et al., 2012). The above vicious cycle may be related to the negative pathway of eating regulation suggested by Guertin et al. (2018). The authors found that having extrinsic weight-related goals (e.g. wanting to be beautiful) were positively associated with 'fat talk' (e.g. body concerns and body comparisons) and negatively associated with self-compassion, which led to unhealthy eating behaviours. In addition, previous studies showed that individuals who pursued appearance goals were more likely to have binge eating episodes (Schelling, Munsch, Meyer, & Margraf, 2011). Self-compassion was found to attenuate the tendency of increased eating in those who were trying to restrain their food intake (Adams & Leary, 2007), which seemed to suggest that, following a strict diet, the women low in self-compassion were at risk of overeating and gaining more weight.

It was apparent throughout the transcripts that the women's lived experiences of self-compassion were compromised in the context of frequent judgement from self and from other people. As seen in Gilbert et al. (2014), some of the women spoke about being hostile towards their self-image when they tried to confront their weight difficulties and struggled to lose weight or gained weight. People who try to lose weight may be particularly prone to weight self-stigma due to frequent feelings of inferiority,

failure, and self-criticism (Adams & Leary, 2007; Gilbert et al., 2014). There is also increasing evidence that people who evaluate their physical appearance, fitness levels and general health in a negative way, may lack in body compassion. Body compassion is a relatively new construct that encapsulates evaluative, cognitive, and behavioural components of body-image and self-compassion (Altman et al., 2017). The results of the current study suggested that females who experienced weight difficulties were prone to low body compassion. This vulnerability also seemed to be increased by negative weight-related comments made by those who were considered as a support network (e.g. family members or facilitators of weight loss clubs). Negative and shaming weight-focused evaluations that fail to fit with what others perceive as attractive has been documented before (Duarte, Pinto-Gouveia, Ferreira, & Batista, 2015).

Although the interviewed women were aware of the negative impact of comparing their weight and appearance with friends, family, or on social media, they seemed unable to cease this behaviour. One explanation for this could be that women low in self-compassion had also difficulties with their self-esteem. A strong positive link has been found between low-esteem and being overweight (Pila, Sabiston, Brunet, Castonguay, & O'Loughlin, 2015). Literature suggests that people low in self-esteem may engage in unhelpful behaviours such as downward social comparisons in order to increase their levels of self-worth (Crocker & Park, 2004). The motivation to protect a fragile self-image can lead to a rigid and negative mind-set that is unable to tolerate alternative viewpoints (Jost, Glaser, Kruglanski, & Sulloway, 2003). For this reason, people high in self-compassion would have less need to defend their self-esteem and be able to maintain their self-image. This would occur through emotional resilience and

greater self-concept accuracy. On the contrary, people who struggle with cultivating self-compassion may be trapped in negative evaluations (Neff & Vonk, 2009).

Interestingly, a few participants felt that if they allowed more self-compassion whilst trying to slim down their bodies, this would imply they did not work on themselves hard enough. This common confusion between self-compassion and self-indulgence was noted by Neff (2011) who in her extensive research became aware of people making conclusions that loving self would mean leading idle life or eating unhealthy food. However, researchers argue that people who choose not to notice their weight difficulties may lack an insight into the need to look after their health. Also, it may be a form of denial or self-neglect (Gilbert et al., 2014).

Strengths and Limitations

The main strength of this research was addressing the absence of qualitative research providing a rich and detailed picture of self-compassion in overweight women by integrating different literatures and using an exploratory approach. The interview schedule informed by service user involvement as well as the researcher's curious stance contributed to creating a lot of genuine and meaningful discussions with the interviewed women.

Furthermore, the study built on suggestions from previous research relating to the recruitment (Gilbert et al., 2014). This ensured homogeneity of the sample: all participants were female, had BMI over 25, and attempted to lose weight on at least three different occasions by using community-based approaches. Although some variability of the sample was inevitable, all females reported to have used local weight loss clubs and occasional 'crash diets'. Therefore, the relative homogeneity of the sample strengthens credibility of the findings and increases the likelihood that they could be applied to the local population.

In addition, the study benefited from service user involvement regarding the interview questions and recruitment strategies. This ensured the interview schedule was designed in a collaborative and sensitive way and generated a lot of rich data. Further considerations of service user involvement were described in the Integration, Impact, and Dissemination chapter.

The final strength of the current study related to high quality of IPA design. Validity of the results were maintained by credibility checks, as reported in the Methodology section (Yardley, 2008). Cross validation with a supervisor ensured that the themes were coherent and grounded in the data. Each super- and subordinate theme was supported by at least three to four extracts from participants, as recommended by the guidelines (Smith, 2011). Also, a reflective journal, which captured a number of assumptions held by the researcher, helped reduce biases during the analysis.

The study had also a number of limitations. First, given the purposive nature of the sample in the study, findings of this exploratory research may be specific to this context and not representative of the broader population of people experiencing weight difficulties. In addition, although the sample was relatively homogenous, interviewees' age range of participants was large (18-74) and the older participants reported lack of familiarity with the concept of self-compassion. Although this was managed by explaining self-compassion in jargon free terms such as 'self-kindness', 'courage', and 'looking after self/health', the researcher was aware that different understandings of self-compassion exist (as explained in the Introduction). Also, the design of the study did not have a top cut-off point for the number of dietary attempts. That meant that some participants reported dieting on an on-and-off basis for a number of years. Due to lack of contemporary literature on differences between females who attempted to lose weight a few times as opposed to those who report to diet on-and-off throughout their

adult life, it was difficult to conclude whether this factor impacted on the results of the study.

Furthermore, despite confidentiality and anonymity were assured throughout the study, it was possible that some participants felt unable to disclose negative views or feelings, for fear of experiencing emotional pain or being judged.

Clinical Implications

The high levels of overweight rates in the UK as well as the lack of evidence for existing approaches to weight loss (Pietiläinen et al., 2012) point to a need to find new ways of helping people sustainably lose excess weight. Further developments of the innovative interventions would be crucial in addressing the international pandemic of obesity (Swinburn et al., 2011). Compassion-based weight loss programmes can be of clinical importance if their effectiveness is well explored and improved. In line with evidence of the importance of such interventions, a better understanding of the experiences of self-compassion and barriers to cultivating this important trait, could aid in the further development of effective programmes. For example, new community-based interventions for women could include information about the importance of prioritising one's health needs, viewing a self-compassionate mind-set as an advancing lifestyle change practice, and tackling maladaptive weight-related shame, rigid thinking, and perfectionism. In addition, the improved understanding of self-compassion could be extended to help women tolerate and deal with weight-related distress and stigma (Mantzios & Egan, 2017).

A self-compassionate stance could be promoted in some commonly used weight management practices such as GPs' advice to restrain food intake and exercise; also cognitive-behavioural therapy for binge eating, or the theory of planned behaviour that promotes weight loss. Overweight individuals could benefit from learning about the

role of self-compassion in weight management. Also, those who are actively trying to lose weight by using a self-compassionate approach could be assisted with information on barriers to self-compassion. For example, they could be taught what a 'subjugation of needs' schema is (Young & Klosko, 1993) and how it might cause them to suppress their own weight-related preferences, decisions, and desires. They could also learn about their weight-related core beliefs and their impact on self-judgment, perfectionism, and unfavourable comparisons with others, and given tools to tackle these. Finally, they could benefit from learning they may lack some skills due to lack of modelling in childhood, but they can develop them through regular practice in day-to-day activities.

Finally, this study could potentially have important implications for weight loss clubs. Currently, women who attends local schemes are asked to weigh themselves in front of the group facilitator. Then their weekly weight is publicly shared, which potentially can contribute to increased levels of shame (particularly when there has been weight gain or 'small weight loss'). It would therefore be important to inform group facilitators of possible detrimental effects of such practice and the importance of a self-compassionate stance (e.g. a non-judgmental, kind, encouraging approach) in weight management.

Recommendations for Further Research

Future research is required in order to explore experiences of self-compassion in male participants who are overweight and have a history of dieting. This would allow investigation of similarities and differences that may exist in how both genders experience self-compassion (Neff et al., 2005). Also, given that females diagnosed with eating disorders (e.g. binge eating) may experience additional mental health difficulties, it would be useful to complete further exploratory studies on experiences of self-

compassion in women using weight management interventions in healthcare settings. Finally, to reduce the effect of maladaptive perfectionism on self-compassion (as seen in Discussion) another avenue of research could explore the lived experiences of self-compassion in females who try to lose weight and show significant perfectionist traits.

Conclusions

The current study offered a new insight into the experiences and meaning of self-compassion in overweight women who, following a number of previous attempts at slimming down, were actively trying to lose weight by using community-based approaches. This study suggested a number of internal and external barriers to self-compassion including prioritising other needs over self-care, difficulties with practicing self-compassionate stance in day-to-day life, and having unrelenting standards. It was hoped that the findings could inform policy and practice in designing and delivering well-informed compassionate-based weight management programmes for overweight women.

4. Integration, Impact, and Dissemination

This chapter aims to critically review: (a) my experiences of planning and carrying out the research, including the synergy achieved between the systematic review and empirical paper; (b) the potential academic impact of the work undertaken and any real world implications my research might have; and (c) the steps taken to maximise dissemination of the findings. The experiences of the research process are described and evaluated in the chronological order.

Integration

Identifying the research topic.

My interest in self-compassion developed during early stages of the clinical psychology doctorate training when Compassionate-Focused Therapy (CFT; Gilbert, 2014) became one of my preferred psychological approaches to conceptualising and working with human distress. I found that theoretical underpinnings of CFT (including evolutionary, attachment theory, affective neuroscience, and Buddhist principles) were very much aligned with my personal values. I was also aware that CFT was specifically designed for people experiencing high levels of shame and self-criticism who often found the more traditional cognitive-behavioural therapy ineffective in addressing their complaints (Kolts, 2016). When I studied CFT in more detail, I also became aware that overweight women with problematic weight regulation may also experience high levels of self-hatred (Adams & Leary, 2007) and that self-compassion may act as a booster against negative self-loathing thoughts. Having experienced difficulties with weight reduction myself, I became interested in investigating whether overweight women practice self-compassion and, if so, what impact it may have on their experiences of trying to lose weight. After I carried out a preliminary literature search, it became

apparent that the majority of studies in this area were quantitative and offered a limited understanding of the issues. Although I appreciated the findings and suggestions that self-compassion may have a protective role in overweight women, I had the desire to study the experiences of compassion for self in more depth. I was also struck by the fact that both correlational studies (e.g. Geller et al., 2015) and randomised trials (e.g. Palmeira et al., 2017a) only showed small to medium effects and I wondered whether some women may have difficulties with cultivating self-compassion. I was therefore motivated to find out what may stand in the way of becoming self-compassionate whilst attempting to slim down. I then came across the first qualitative paper looking at experiences of self-compassion in overweight women (Gilbert et al., 2014), which confirmed my desire to design and conduct research in this area.

Ontological and epistemological position.

As a trainee clinical psychologist I am drawn to the epistemological position of an interpretivist research approach that focuses on how the social world is interpreted by individuals who constantly construct and make sense of it (Robson, 2014). In particular, as a believer in the ontological stance of relativism, I agree with central tenets of phenomenology that posit that individuals' perceptions of their inner worlds are based on subjective experiences and perceived meanings and therefore multiple valid perspectives are possible (Barker, Pistrang, & Elliott, 2016). In addition, given that we witness experiences after the event, pure experience is never fully accessible and it can only be understood via an examination of the meanings which people impress upon it (Smith et al., 2009). When conducting my research, I was therefore aware of a 'double hermeneutic' (Smith & Osborn, 2015) suggesting that I, the researcher, was making sense of the participant, who was making sense of the phenomenon. Consequently, using the reflective journal, described in more detail below, I

consistently attempted to bring my presumptions to the awareness and set them aside by using a 'bracketing' technique (Smith et al., 2009).

Service-User involvement.

Given the well-known benefits of service-user involvement (Trivedi & Wykes, 2002), I planned to engage service-users in early stages of my research. After receiving the approval from the Royal Holloway Research Committee, I initiated a meeting with two Weight Watchers' facilitators in London. I presented my preliminary interview schedule to them and asked for advice on speaking to their group attendees whom they saw on a weekly basis. I was also able to involve two overweight women who were interested in taking part in my study but did not meet the full recruitment criteria. Overall, four people provided me with invaluable feedback on my research design. It was recommended that I changed some of the interview questions and the order I was planning to use them. For example, due to sensitivity of the topic, I was guided to first build the rapport with the participant by asking them more general questions and then to move to exploring more in-depth aspects of their journey. I was also advised that in order to remain as neutral as possible it was best to avoid the words such as 'overweight' or 'obese' as they could imply that I was judgemental.

Furthermore, after completing each interview I asked the participants for feedback. Given the novelty of the phrase 'self-compassion', the first interviewee recommended to me that I explained the term in jargon free terms and use alternative terms such as 'looking after self', 'self-kindness', and 'meeting your own needs'. Also, the service-users pointed out that, given the stigma around overweight women, my language should remain as neutral and non-blaming as possible throughout the interview.

Recruitment and data collection.

To ensure collecting rich data in my project I employed purposive sampling and therefore all participants had to meet a set of criteria (being a female over 18 years old, being on a diet using community-based approach, having had at least two other dietary attempts). Whilst some of the criteria could be based on existing literature (e.g. gender and the dieting status), the other criteria required additional considerations. For example, I contemplated whether I should have an upper age limit or whether I should interview women with a set number of previous dietary attempts. Whilst I was aware that as my qualitative research would benefit from as homogenous sample as possible, I was also mindful of the fact that too strict eligibility criteria may delay or restrict the recruitment process. I then consulted the literature in this area and chose not to have an age or diet number limit.

Another difficulty with recruitment related to establishing a number of participants. Literature on interpretative phenomenological analysis (IPA) does not give a definite answer as to what number constitutes a good enough sample (Smith et al., 2009). However, after reading some studies that employed IPA approach (e.g. Borkoles, Nicholls, Bell, Butterly, & Polman, 2008) and consulting academic staff who were experienced in this form of research methods I chose to recruit between 8 and 10 participants.

When planning recruitment an additional consideration was given to the possibility of introducing monetary incentives to encourage participation. Although research suggests that monetary incentives may have a positive impact on the response rate, the motives around why some people become participants in qualitative studies and others decline remain unclear (Head, 2009). After further consideration and reading

some literature in this area, I decided to introduce Marks & Spencer vouchers and I told participants it was in gratitude for the time they had given to my study.

The recruitment process was challenging but rewarding. Initially, I felt nervous about going to Weight Watchers groups and advertising the study. However, everyone seemed very friendly, approachable, and fairly interested in the study. After agreeing to meet, a number of potential participants cancelled their appointments or did not attend their interviews, which can be difficult for any researcher. It also contributed to me feeling worried about my recruitment timeframe. Nonetheless, I was able to find 10 participants and finish my recruitment on time. I was grateful for this as I was aware that data analysis in qualitative research was time consuming.

Overall, I enjoyed conducting the interviews. Although I felt nervous before I started each interview, I found that once I built the rapport with the interviewees, the conversation flowed and I was able to find out interesting things about them. One of the difficulties that I encountered whilst interviewing some women was when the time to talk was restricted by their commitments or room availability during out of office hours. Although I advertised my study as lasting up to an hour, when I was given 45 minutes to complete the whole interview, I felt the impact of being aware of a possibility of running out of time. I also found myself not fully concentrating on what I was hearing and I was concerned that the interviewee would feel rushed in the process. Fortunately, the aforementioned difficulty occurred only twice.

In interviews, I also drew on my skills as a trainee clinical psychologist. Whilst I felt this helped me make participants relatively relaxed in the room, I also found myself wanting to switch to a more ‘therapy mode’ when the topic of the conversation became somewhat emotive. For example, the majority of participants disclosed experiences of past trauma such as bullying and physical abuse, which made me feel

empathic and wanting to comfort my interviewees. I then reminded myself about my role as a researcher and I balanced myself between being appropriately sensitive yet professional.

Transcribing and data analysis.

Although transcribing the interviews felt somewhat arduous and time-consuming, it gave me the opportunity to immerse myself in the data. The transcripts provided a large amount of raw data, however following the steps outlined by Smith et al. (2009) helped me feel contained and become creative (e.g. I used post-it notes and kept re-arranging them on the floor). Also, having my analysis audited not only increased the study's credibility but also motivated me to remain scrupulous throughout the coding stage and reassured me that there was a high level of agreement between my codes and those of the independent researcher.

Throughout the data analysis stage, supervision proved an important forum to organise my thinking processes and reflections and compare them to alternative interpretations of the data. Following the extensive data analysis, I found writing up the results section very rewarding. It was satisfying to be able to present tangible evidence after the many hours of organising, conducting, and transcribing the interviews.

Keeping a reflective journal.

To capture any assumptions and biases I had during various stages of the study, I kept a reflective journal throughout the whole research process. This helped me to record observations about the experiences of planning and conducting the research, which contributed to many of the discussion points in this chapter. The journal was especially helpful with noting down reflections following each interview. I was aware that when I strongly disagreed with my participants, this could influence my interpretation of the data. Equally, when some aspects of interview resonated with me,

I did not want this to bias the process of coding the transcripts. Therefore, I carefully studied my journal entries before attempting to code each transcript and when writing up the results and discussion sections of the study.

Reflections on the systematic review.

When conducting preliminary literature searches for my main research project it became apparent that there was a plethora of studies investigating various relationships between self-compassion and a number of psychological variables in people with disordered eating. Given that my empirical study focused on women experiencing difficulties with their weight and attempting to resolve it by attending community-based weight loss interventions, selecting the topic of the role of self-compassion in women with problematic weight management seemed the most relevant choice. I felt this topic would sufficiently relate to my empirical paper and have the potential to add to the existing research pool. Also, given that there is an ongoing systematic reviews on the role of self-compassion in the treatment of eating disorders, I felt that focusing on women from the general population would give me a novel angle.

During preliminary searches it became apparent that qualitative research on self-compassion in overweight people is scarce. The majority of empirical papers, I initially identified, employed quantitative methodology and cross-sectional designs. Although I was aware that a quantitative approach was not in line with my empirical study I chose to continue with the topic of self-compassion in women with weight difficulties as I felt it could add to the interpretation of my study's findings.

The database searches generated a large number of studies, which seemed unfeasible for a doctoral-level novice researcher with time and resources constraints. I therefore consulted a professional librarian who was experienced in conducting systematic reviews. I was advised to narrow the inclusion criteria, for example by only

selecting studies that used a particular outcome measure. I then became aware that the most common self-compassion measure was a self-report questionnaire developed by Neff (2003). The measure had good validity and reliability and I therefore concluded that narrowing studies down to only those that used Neff's measure would be a good next step.

Once I selected the final 19 papers with 21 studies, I felt more contained. I found the quality assessment process quite arduous, however completing it helped me to have a better understanding of the studies. I was also satisfied to hear there were no major discrepancies between the results of my quality assessment and those from an independent second reviewer. I was reassured that the selected studies had an overall good quality and therefore the conclusions of the systematic review would be more valid.

Although I felt that my systematic review added to the current literature on the mechanisms involved in self-compassion and eating regulation, I found synthesis of the results quite challenging for two reasons. Firstly, all selected studies were correlational and therefore causality between the variables could not be inferred. Secondly, some studies examined a direct relationship between self-compassion and weight-related variables whereas others focused on the mediating or moderating influences of self-compassion on a number of positive and negative associations between weight-related constructs. This inconsistency made synthesis of results and interpretation of the relationship between variables difficult.

Integration of the findings of the systematic review and empirical paper.

Both the systematic review (Chapter 2) and empirical paper (Chapter 3) focused on the notion of self-compassion in women experiencing difficulties with weight regulation. By highlighting the protective role of self-compassion in women struggling

with weight difficulties and suggesting that, despite that role, not all women have the ability to practice self-compassion, the systematic review lays the foundations for the empirical paper's findings suggesting a number of internal and external barriers to cultivating compassion for self. Both papers suggested that self-compassion can boost against negative outcomes associated with being overweight such as low self-worth, vicious circle of food deprivation and overeating, and weight-related negative affect. The findings of both papers also implied that the protective role can take place through a number of mechanisms such as reversing the impact of childhood trauma or reducing perfectionist trait in women who deal with problematic eating patterns and dieting.

Despite this integration, both studies differed in significant ways. Firstly, the systematic review drew on the conclusions of other studies, whereas the empirical paper was primary research. Furthermore, the systematic review focused on the role of self-compassion in women with problematic eating patters from the general population, whereas the empirical paper explored the perceptions of self-compassion in overweight women who were actively trying to lose weight by using community-based approaches. Although there might have been some overlap in the samples, the systematic review drew conclusions from a population including under- and overweight women and those within normal weight range, whereas the empirical paper had a much more homogenous group of only overweight participants. Also importantly, the review used cross-sectional correlational studies that point out some interesting associations between self-compassion and other psychological weigh-related variables, whereas the empirical study provides direct evidence of the lived experiences of self-compassion in relation to weight problems in women. Nevertheless, due to the nature of design of both correlational studies and qualitative IPA study, generisability of both papers is somewhat limited.

In summary, the findings of the study suggested that, despite some clear benefits of self-compassion in women with weight difficulties, participants often felt unable to cultivate it for a number of reasons and reflected that developing more self-compassion is a long-term process. This finding seems to extend the findings of the review that showed that self-compassion plays the protective role in women. Small and medium effect sizes suggested that not all women could become self-compassion when experiencing eating-related problems and the empirical study offers some explanations to these findings.

Impact

It is hoped that this thesis will contribute to further research and development of efficacious compassion-based weight-loss interventions for women. The empirical paper has demonstrated that overweight women experiencing difficulties with weight management can benefit from a self-compassionate stance towards their weight, however developing such a self-caring attitude can be prevented by a number of internal and external obstacles women can face on a daily basis. This outcome may encourage researchers and clinicians to take the notion of barriers to self-compassion into account when designing and delivering weight-loss programmes such as Kg-Free (Palmeira, Cunha, et al., 2017) or BEfree (Pinto-Gouveia et al., 2017). For example, new community-based interventions for women could include information about the importance of prioritising one's health needs, viewing a self-compassionate mind-set as an advancing lifestyle change practice, and tackling maladaptive weight-related rigid thinking and perfectionism.

Furthermore, it is hoped that additional evidence for the protective role of self-compassion in women experiencing difficulties with negative eating- and weight-

related thinking and emotional patterns, as suggested in the systematic review, will encourage healthcare professionals and policy makers to ensure that overweight and obese women have access to self-compassion weight-loss interventions. This could include creating self-compassion psychoeducation booklets, online programmes, or group-based interventions to reach broader audience. In addition, healthcare professionals, who work with obese individuals in clinics such as bariatric surgeries or weight management centres, could introduce the principles of CFT (Gilbert, 2014) into a standard individual treatment programme.

The outcome of the review, which to the best of my knowledge is the first to investigate the role of self-compassion in women with problematic eating patterns from the general population, suggests which psychological outcomes seem to particularly benefit from a self-caring stance. Hopefully this knowledge will also help researchers and clinicians to understand and explore the literature and be informative for further synthesis of information. It is therefore hoped that women from the general population will also have access to self-compassion material through weight-loss community-based loss programmes and general practitioners (GPs). This could be achieved through directing the above stakeholders to the relevant literature where this research will be published or through sending a summary in the form of poster that will be presented at a conference.

Obesity in on the rise and extensive research has suggested that traditional approaches to weight reduction such as restrictive eating and/or excessive exercise regimen not only lack efficiency but they also cause re-gain of weight (Pietiläinen et al., 2012). Dieting and exercise are particularly promoted by the mainstream media including television, press, and social media. Therefore, it is hoped that the findings of both the systematic review and empirical paper reach broader audience and initiate a

shift in the general public's idea on the current status of evidence base for weight loss. This could be achieved by presenting the findings online on websites such as the NHS' 'Obesity Health News' or The Compassionate Mind Foundation. Another route to public engagement could involve presenting the findings at various conferences. For example, I have been accepted to present a poster with a summary of my empirical paper at Division of Health Psychology Annual Conference 2019 run by the British Psychological Society. It is hoped that the findings will reach broad and diverse audience.

Finally, by ensuring this research is disseminated to service users it is hoped that the findings will be known by people directly affected by the problem of overweight. This will be achieved through writing an article for academic journals specialising in health and obesity and also through disseminating the findings directly to service users and facilitators from local community-based weight-loss programmes. It is anticipated that this will increase service users' awareness which hopefully will result in more appropriate support to gain tools in order to sustainably lose and manage weight.

Despite being aware of some clear benefits of the impact of this research and outlining its potential beneficiaries such as service users, healthcare organisations, and policy makers, there may be some barriers to implementing recommendations arising from the findings. Raising funds for changes such as implementing CFT in individual standardised programmes, creating online resources, and delivering group interventions could be challenging in the current financial climate. However, services could start by introducing small changes. For example, they could develop informational leaflets on the benefits of practising self-compassion, including the protective role of self-compassion in weigh-related self-image and negative affect and tips on how to cultivate

compassion for self when facing any potential obstacles. This could also be facilitated by low-cost online video medium. If relevant outcome measures could then show that service users benefit from these small developments, policy makers would be more likely to view such innovative approaches to weight loss as feasible and affordable and invest in them.

Dissemination

The findings of the empirical paper have already been disseminated locally to staff and students at Royal Holloway, at a Research Presentations event held annually by the Doctorate in Clinical Psychology department.

Furthermore, one of the primary places where this research will be disseminated is back to participants who expressed their interest in the outcomes of the study and requested to receive them via email. Sharing the findings of one's study is not only a form of expressing the researcher's gratitude towards the participants but also an ethical duty (Fernandez, Kodish, & Weijer, 2003) in order to complete the process of participation and increase participants' sense of value, which may contribute to future interest in other studies (Shalowitz & Miller, 2005). Another way of disseminating the findings to service users will be through an accessible document summarising the most important suggestions from the systematic review and empirical paper that will be created and sent to Weight Watchers facilitators who enabled recruitment of participants for the qualitative study. If possible, a consultation with one of facilitators will be held to ensure the document is structured in a sensitive and user friendly manner.

Furthermore, the summary of my empirical study will be disseminated at the Division of Health Psychology Annual Conference 2019 run by the British Psychological Society. A place to present a poster has been confirmed for the 11th of

July 2019 in Manchester. The conference will provide me with a good opportunity to disseminate my research findings to a range of academics, researchers, and practitioners from around the UK.

To seek further dissemination, manuscripts of both empirical study and systematic review will be submitted to, in order of preference: Journal of Compassionate Health Care, International Journal of Qualitative Studies on Health and Well-being, and Health and Social Care in the Community All three above journals publish a range of qualitative studies and have previously published research on self-compassion. In addition, a manuscript of the empirical study will be submitted to The PsyPAG Quarterly which is a national organisation representing Postgraduate Psychology students across the UK. Given that articles submitted to the Quarterly are not subject to an exclusive copyright, the manuscript will be submitted alongside one of the aforementioned academic journals.

Finally, I will also approach teams responsible for uploading research news on health-related websites such as Obesity Health News on the NHS website and on The Compassionate Mind Foundation website, and seek disseminating the findings from both systematic review and empirical paper.

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Appendices

Appendix 1: Critical Appraisal Skills Programme (CASP) checklist

www.casp-uk.net
info@casp-uk.net
Summertown Pavilion, Middle Way Oxford OX2 7LG

CASP Checklist: 12 questions to help you make sense of a Cohort Study

How to use this appraisal tool: Three broad issues need to be considered when appraising a cohort study:

- Are the results of the study valid? (Section A)
- What are the results? (Section B)
- Will the results help locally? (Section C)

The 12 questions on the following pages are designed to help you think about these issues systematically. The first two questions are screening questions and can be answered quickly. If the answer to both is "yes", it is worth proceeding with the remaining questions. There is some degree of overlap between the questions, you are asked to record a "yes", "no" or "can't tell" to most of the questions. A number of italicised prompts are given after each question. These are designed to remind you why the question is important. Record your reasons for your answers in the spaces provided.

About: These checklists were designed to be used as educational pedagogic tools, as part of a workshop setting, therefore we do not suggest a scoring system. The core CASP checklists (randomised controlled trial & systematic review) were based on JAMA 'Users' guides to the medical literature 1994 (adapted from Guyatt GH, Sackett DL, and Cook DJ), and piloted with health care practitioners.

For each new checklist, a group of experts were assembled to develop and pilot the checklist and the workshop format with which it would be used. Over the years overall adjustments have been made to the format, but a recent survey of checklist users reiterated that the basic format continues to be useful and appropriate.

Referencing: we recommend using the Harvard style citation, i.e.: *Critical Appraisal Skills Programme (2018). CASP (insert name of checklist i.e. Cohort Study) Checklist. [online] Available at: URL. Accessed: Date Accessed.*

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Critical Appraisal Skills Programme

Paper for appraisal and reference:.....

Section A: Are the results of the study valid?

1. Did the study address a clearly focused issue?

Yes ☐
Can't Tell ☐
No ☐

HINT: A question can be 'focused' in terms of
- the population studied
- the risk factors studied
- is it clear whether the study tried to detect a beneficial or harmful effect
- the outcomes considered

Comments:

2. Was the cohort recruited in an acceptable way?

Yes ☐
Can't Tell ☐
No ☐

HINT: Look for selection bias which might compromise the generalisability of the findings:
- was the cohort representative of a defined population
- was there something special about the cohort
- was everybody included who should have been

Comments:

Is it worth continuing?

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3. Was the exposure accurately measured to minimise bias?

Yes ☐
Can't Tell ☐
No ☐

HINT: Look for measurement or classification bias:
- did they use subjective or objective measurements
- do the measurements truly reflect what you want them to (have they been validated)
- were all the subjects classified into exposure groups using the same procedure

Comments:

4. Was the outcome accurately measured to minimise bias?

Yes ☐
Can't Tell ☐
No ☐

HINT: Look for measurement or classification bias:
- did they use subjective or objective measurements
- do the measurements truly reflect what you want them to (have they been validated)
- has a reliable system been established for detecting all the cases (for measuring disease occurrence)
- were the measurement methods similar in the different groups
- were the subjects and/or the outcome assessor blinded to exposure (does this matter)

Comments:

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5. (a) Have the authors identified all important confounding factors?

Yes ☐
Can't Tell ☐
No ☐

HINT:
- list the ones you think might be important, and ones the author missed

Comments:

5. (b) Have they taken account of the confounding factors in the design and/or analysis?

Yes ☐
Can't Tell ☐
No ☐

HINT:
- look for restriction in design, and techniques e.g. modelling, stratified-, regression-, or sensitivity analysis to correct, control or adjust for confounding factors

Comments:

6. (a) Was the follow up of subjects complete enough?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- the good or bad effects should have had long enough to reveal themselves
- the persons that are lost to follow-up may have different outcomes than those available for assessment
- in an open or dynamic cohort, was there anything special about the outcome of the people leaving, or the exposure of the people entering the cohort

6. (b) Was the follow up of subjects long enough?

Yes ☐
Can't Tell ☐
No ☐

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Comments:

Section B: What are the results?

7. What are the results of this study?

HINT: Consider
- what are the bottom line results
- have they reported the rate or the proportion between the exposed/unexposed, the ratio/rate difference
- how strong is the association between exposure and outcome (RR)
- what is the absolute risk reduction (ARR)

Comments:

8. How precise are the results?

HINT:
- look for the range of the confidence intervals, if given

Comments:

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9. Do you believe the results?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- big effect is hard to ignore
- can it be due to bias, chance or confounding
- are the design and methods of this study sufficiently flawed to make the results unreliable
- Bradford Hills criteria (e.g. time sequence, dose-response gradient, biological plausibility, consistency)

Comments:

Section C: Will the results help locally?

10. Can the results be applied to the local population?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider whether
- a cohort study was the appropriate method to answer this question
- the subjects covered in this study could be sufficiently different from your population to cause concern
- your local setting is likely to differ much from that of the study
- you can quantify the local benefits and harms

Comments:

11. Do the results of this study fit with other available evidence?

Yes ☐
Can't Tell ☐
No ☐

Comments:

CASP
Critical Appraisal Skills Programme

12. What are the implications of this study for practice?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- one observational study rarely provides sufficiently robust evidence to recommend changes to clinical practice or within health policy decision making
- for certain questions, observational studies provide the only evidence
- recommendations from observational studies are always stronger when supported by other evidence

Comments:

Appendix 2: Research poster

Would you like to take part in a research study?

The aim of the study

We appreciate that trying to lose weight may be both a challenging and rewarding experience. We would therefore like to hear from females who have been trying to lose weight on a number of occasions in the past. The study will involve a one-off one-to-one interview about your experiences (will last up to an hour).

As a way of appreciation, we would like to offer you a £10 gift voucher.

My details

Anna Jeziorek-Wozny

Tel.: 078 5661 6759 or 01784 414012

Email: anna.jeziorek-wozny.2016@live.rhul.ac.uk

Interested?

Please contact me and I will send you full information about the project. Once you receive the details about the study, you can then make the decision to participate or not.

Appendix 3: RHUL Ethics Approval

ROYAL HOLLOWAY UNIVERSITY OF LONDON

Ethics Review Details

You have chosen to submit your project to the REC for review.	
Name:	Jeziorek-Wozny, Anna (2016)
Email:	NDJT026@live.rhul.ac.uk
Title of research project or grant:	The experience and meaning of compassion for individuals with eating difficulties
Project type:	Royal Holloway postgraduate research project/grant
Department:	Psychology
Academic supervisor:	Dr Afsane Riazi
Email address of Academic Supervisor:	afsane.riazi@rhul.ac.uk
Funding Body Category:	No external funder
Funding Body:	
Start date:	09/04/2018
End date:	09/06/2019

Research question summary:

A number of compassion and mindfulness based interventions have recently been suggested for individuals experiencing overweight and obesity. Efficiency studies have confirmed that these innovative approaches can be efficient in reducing binge eating symptomatology as well as and negative internal states related to obesity. Nevertheless, despite a number of advantages of compassion-based approaches being established, some individuals may feel unable to utilise such interventions. Quantitative studies suggest that factors such as fear of compassion and high levels of self-criticism may impact on one's ability to experience compassion. Also, a link has been found between low levels of self-compassion and self-disgust experienced when overweight people break diet regimes. Whilst some aspects of difficulties in compassion-based approaches have been found, more detailed accounts of individuals' perceptions and understandings of this phenomenon remain unknown. The current study hopes to gain insight into the understanding and experiences of compassion in people who are overweight and actively trying to lose weight.

Research Questions

How do overweight people think about the experience of compassion?

How do people with problematic eating perceive difficulties in experiencing compassion?

Research method summary:

The current study will employ a community sample and participants will be recruited by using a purposive sampling process.

The inclusion criteria for participants will include: being over 18 years old; having a Body Mass Index (BMI) > 25; being a female; and having a history of dieting (at least 3 episodes of dieting).

Participants will be recruited through local weight loss groups such as Weight Watchers(WW). The researcher will personally attend a number of London based WW meetings and advertise the study. Also a written advert (see attached) will be left with WW facilitators and attendees. Anyone willing to take part in the study will be then provided with an Information Sheet and asked to sign a Consent form. This could be handed back to the researcher in person or by email. Following this a face-to-face interview will be scheduled at RHUL (Egham or Central London).

In-depth semi-structured interviews will be used. Interpretative Phenomenological Analysis (IPA) is a recommended qualitative methodology for examining complex and ambiguous topics and obtaining a detailed account of each participant's experience (Smith & Osborn, 2015). The experience of compassion and being overweight is an example of a complex issue and can be a difficult subject to discuss. IPA is therefore viewed as the most appropriate methodology for the current study as it will allow for exploring the experience and meaning of compassion for individuals with weight difficulties. The data will be transcribed verbatim on a computer. Guidelines on data storage will be adhered to at all times. There will be a number of stages involved in the data analysis process. To follow standardised phases of the analysis, guidelines as outlined by Smith et al.

Risks to participants

Does your research involve any of the below?
Children (under the age of 16),
No

Participants with cognitive or physical impairment that may render them unable to give informed consent,
No

Participants who may be vulnerable for personal, emotional, psychological or other reasons,
Yes

Participants who may become vulnerable as a result of the conduct of the study (e.g. because it raises sensitive issues) or as a result of what is revealed in the study (e.g. criminal behaviour, or behaviour which is culturally or socially questionable),
Yes

Participants in unequal power relations (e.g. groups that you teach or work with, in which participants may feel coerced or unable to withdraw),
No

Participants who are likely to suffer negative consequences if identified (e.g. professional censure, exposure to stigma or abuse, damage to professional or social standing),
No

Details,
Semi-structured interviews may involve questions of sensitive nature (weight difficulties and dieting) that can cause distress to participants. Therefore a sensitive approach during data collection will be ensured at all times. Although it is not anticipated that the study will cause any significant distress, if participants mention or show any sign of distress, they will be signposted to places of support (e.g. Mind Infoline 0300 123 3393). Additionally, there will be a phone number provided (RHUL on 01784 414012) that the participants can call if they have any questions regarding the study.

Also, following the interview process, there will be debriefing whereby participants will have a chance to ask further questions about the study, give their feedback, and be directed to further support if necessary.

Furthermore, participants will be offered a meeting following data analysis when they can view the results and raise any questions.

Design and Data

Does your study include any of the following?

Will it be necessary for participants to take part in the study without their knowledge and/or informed consent at the time?,
No

Is there a risk that participants may be or become identifiable?,
Yes

Is pain or discomfort likely to result from the study?,
No

Could the study induce psychological stress or anxiety, or cause harm or negative consequences beyond the risks encountered in normal life?,
No

Does this research require approval from the NHS?,
No

If so what is the NHS Approval number,

Are drugs, placebos or other substances to be administered to the study participants, or will the study involve invasive, intrusive or potentially harmful procedures of any kind?,
No

Will human tissue including blood, saliva, urine, faeces, sperm or eggs be collected or used in the project?,
No

Will the research involve the use of administrative or secure data that requires permission from the appropriate authorities before use?,
No

Will financial inducements (other than reasonable expenses and compensation for time) be offered to participants?,
No

Is there a risk that any of the material, data, or outcomes to be used in this study has been derived from ethically-unsound procedures?,
No

Details,
Confidentiality and data protection will be ensured at all times. Participants will be informed about the safe storage of their personal details as well as the contents of the interviews and questionnaires. Voluntary participation and the right to withdraw at any time will be explained both verbally and in a written format of informed consent. Informed consent will be provided and participants will be encouraged to ask any questions before signing the form.

Risks to the Environment / Society

Will the conduct of the research pose risks to the environment, site, society, or artifacts?,
No

Will the research be undertaken on private or government property without permission?,
No

Will geological or sedimentological samples be removed without permission?,
No

Will cultural or archaeological artifacts be removed without permission?,
No

Details,

Risks to Researchers/Institution

Does your research present any of the following risks to researchers or to the institution?

Is there a possibility that the researcher could be placed in a vulnerable situation either emotionally or physically (e.g. by being alone with vulnerable, or potentially aggressive participants, by entering an unsafe environment, or by working in countries in which there is unrest)?,
No

Is the topic of the research sensitive or controversial such that the researcher could be ethically or legally compromised (e.g. as a result of disclosures made during the research)?,
No

Will the research involve the investigation or observation of illegal practices, or the participation in illegal practices?,
No

Could any aspects of the research mean that the University has failed in its duty to care for researchers, participants, or the environment / society?,
No

Is there any reputational risk concerning the source of your funding?,
No

Is there any other ethical issue that may arise during the conduct of this study that could bring the institution into disrepute?,
No

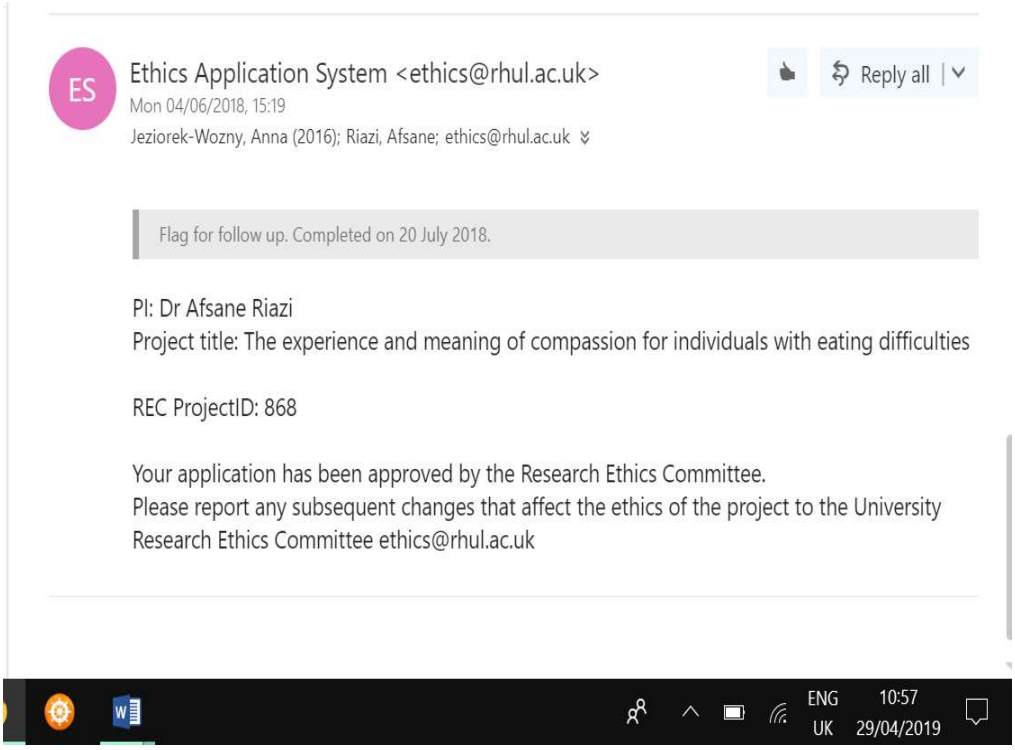
Details,

Declaration

By submitting this form, I declare that the questions above have been answered truthfully and to the best of my knowledge and belief, and that I take full responsibility for these responses. I undertake to observe ethical principles throughout the research project and to report any changes that affect the ethics of the project to the University Research Ethics Committee for review.

Certificate produced for user ID, NDJT026

Date:	30/04/2018 19:04
Signed by:	Jezlorek-Wozny, Anna (2016)
Digital Signature:	Jezlorek-Wozny
Certificate dated:	4/30/2018 8:00:36 PM
Files uploaded:	Full-Review-868-2018-04-06-11-13-NDJT026.pdf Consent Form template.doc Participant Information Sheet template.doc Full-Review-868-2018-04-11-16-32-NDJT026.pdf Participant Information Sheet.doc Full-Review-868-2018-04-19-12-10-NDJT026.pdf Consent Form updated 20.04.doc Participant Information Sheet updated 20.04.doc Full-Review-868-2018-04-20-12-52-NDJT026.pdf Study advert April 2018.doc


ES
Ethics Application System <ethics@rhul.ac.uk>
Mon 04/06/2018, 15:19
Jeziorek-Wozny, Anna (2016); Riazi, Afsane; ethics@rhul.ac.uk
Reply all
Flag for follow up. Completed on 20 July 2018.
PI: Dr Afsane Riazi
Project title: The experience and meaning of compassion for individuals with eating difficulties
REC ProjectID: 868
Your application has been approved by the Research Ethics Committee.
Please report any subsequent changes that affect the ethics of the project to the University Research Ethics Committee ethics@rhul.ac.uk
ENG
UK
10:57
29/04/2019

Appendix 4: Information Sheet

PARTICIPANT INFORMATION SHEET

TITLE: The lived experience of barriers to self-compassion in women experiencing weight difficulties

Invitation

You are being invited to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish, including friends, relatives and your GP. If there is anything you do not understand, or if you would like more information, please ask. Thank you for reading this.

Part 1 of this Information Sheet contains details of the study and what it will involve if you decide to take part. Part 2 contains more information about the conduct of the study, issues of confidentiality, and whom to contact if there are any problems.

Please read both parts fully and take time before deciding whether or not you wish to take part.

PART 1

What is the purpose of the study?

The study aims to explore the experience and meaning of compassion for individuals who are actively trying to lose weight. It will examine people's understanding of being compassionate to oneself and any potential difficulties around doing this.

Who is eligible to take part?

Women over 18 years old are eligible to take part in this study provided that they have attempted to lose weight at least on three occasions. Any disclosures will be treated in the strictest confidence.

Do I have to take part?

No. It is up to you to decide whether or not to take part. If you decide to take part, you would be given this Information Sheet to keep and be asked to sign a Consent Form.

What will happen to me if I take part?

If you decide to take part in the study, we will ask you to provide us with your telephone number and email address to be able to contact you and check your eligibility. If you are suitable and willing to proceed, you will be asked to read and sign the Consent Form and return it to us. If you decide to participate, you will be asked to engage in tape-recorded interview discussion. In the interview, you will be asked to discuss your experiences. This should last approximately 45-60 minutes.

Please note that:

You can decide to stop the study session at any time.

You need not answer questions that you do not wish to.

Your name will be removed from the information gathered in the study and it will not be possible to identify anyone from our reports on the study.

After the interview you will have a chance to ask further questions about the study and give your feedback.

Expenses and payments

As a way of gratitude, we would like to offer you a £10 gift voucher.

What are the possible disadvantages and risks of taking part?

There are no anticipated risks associated with your participation in this study. We know, however, that trying to lose weight or being overweight can sometimes be stressful. In any case you feel discomfort or distressed during the interview, you can access support services available at Mind Infoline 0300 123 3393. Additionally, you can phone me on 01784 414012 if you have any questions regarding the study.

What are the benefits of taking part?

Apart from a small financial gratitude, there is no direct benefit for you. However, it is hoped that the information we gather will help us develop our understanding of the experiences of people who try to lose weight. This may then inform new and innovative weight management interventions available for people in the future.

Would my taking part in this study be kept confidential?

Yes, we will follow ethical and legal practice regarding confidentiality and all information about you will be handled in confidence. The specific steps taken to assure confidentiality are outlined in Part 2 of this Information Sheet.

PART 2

What if I do not wish to continue with the study?

You are free to withdraw from the study at any time without giving a reason. If you wish to withdraw from the study after the data has been collected, you may do so up to three months after taking part.

What if there is a problem?

If you have a concern or complaint about any aspect of the way you have been treated during the course of this study, you may contact the project Supervisor, Dr Afsane Riazi, on Afsane.Riazi@rhul.ac.uk. You may also contact the Research Ethics Secretary via ethics@rhul.ac.uk.

Would my taking part in this study be kept confidential?

All the information about your participation in this study will be kept confidential. Your results will be coded with a participant number and no personal information will be attached to the data. Data will be stored on a personal computer (electronic password file) while personal details will be stored separately in a locked filing cabinet. We are obliged to keep all research data for a period of 10 years. After this time, it will be destroyed. Only the named researchers will have access to this data. The only circumstances in which confidentiality would be breached would be in the rare situation in which it was judged that you or someone else was at risk of serious harm or if a court applied for the information. In these circumstances we would endeavour to discuss the matter with you and would disclose only information of immediate relevance.

What will happen to the results of the research?

This study is being carried out as part of the course requirements for a postgraduate degree. It is also hoped that the results will eventually be published in an academic journal. The results of the study will be anonymous and any research publication (if relevant) will not identify you individually.

Who is organising and funding the research?

The research is being carried out by Anna Jeziorek-Wozny as part of a qualification of degree, under the supervision of Dr Afsane Riazi. The study is neither funded nor sponsored by any company or organisation.

This research has been reviewed by Royal Holloway Research Ethics Committee in order to protect your safety, rights, wellbeing and dignity and has been given favourable opinion (study approval ref: 868).

Contact for further information.

If you would like more information or have any further questions about any aspect of this study please do contact Anna Jeziorek-Wozny either by telephone on 01784 414012 or e-mail Anna.Jeziorek-Wozny2016@live.rhul.ac.uk or Dr Afsane Riazi Afsane.Riazi@rhul.ac.uk

Thank you for taking the time to read this information sheet and considering whether to take part in this research. You will be given a copy of this Information Sheet and a signed Consent Form to keep if you do take part.

Appendix 5: Consent Form

CONSENT TO RESEARCH FORM

TITLE: The lived experience of barriers to self-compassion in women experiencing weight difficulties

INVESTIGATORS: Anna Jeziorek-Wozny and Dr Afsane Riazi

Signing this form does not commit you to completing this study; you remain free to leave the study at any time and without having to give any reason for doing so.

	Please initial
I have read the Information Sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	☐
I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason.	☐
I understand that data collected during the study may be looked at by the study team from Royal Holloway, University of London.	☐

I agree to take part in the study. ☐

Name of Participant Date Signature

Name of Researcher Date Signature

Appendix 6: Interview Schedule

Interview schedule

1. What is your experience of being your current weight?
2. How do you feel about your self-image? Do you think your weight has any impact on your self-image?
3. What is your perception of your body image?
4. How do you feel about any lifestyle choices which may have impact on your weight?
5. What do you know and understand about self-compassion (self-kindness, courage to meet your own needs, pursuing goals despite difficulties)?
6. Is it something you think about day to day/in relation to yourself?
7. What were your experiences of self-compassion whilst you were growing up?

7a. How about compassion towards others/from others?

8. What have been your experiences of self-compassion more recently?

8a. How about compassion towards others/from others?

9. Do you perceive yourself to experience any barriers to self-compassion? What do you think may be most contributing to these?

9a. How do you feel about these barriers?

9b. Do you think barriers to self-compassion may be related to your wellbeing?

9c. What would it mean to have fewer barriers to compassion in the future?

10. How do you experience self-compassion whilst dieting? Is it similar to whilst you're not on a diet?

11. What is your experience of deciding to go on another diet after you completed one?

11a. Can you talk me through the process?

11b. Are you conscious of that is impacting it on your health?

11c. How are you taking care of yourself on a day to day?

Appendix 7: Extract of coded transcripts

	RT: Yes, absolutely. Ok, brilliant, and if we look at self-compassion in your earlier years. I was just wondering, if it's ok for you to share or think about it out loud, what was your experience of self-compassion when you were growing up? And, again, if we think about both kindness but also looking after yourself, you know meeting needs and things like that. Lorraine: I think I've always known, always been bigger than my friends so even when I was in school I was always taller than everyone else and	
Comparison with others	larger than everyone else, I was always, like, not that I stood out but it was always like I'm the big one, all aspects of being big… RT: I get that, I was there myself (both laugh).	not that I stood out I'm the big one, all aspects of being big
Early experiences	Lorraine: …so sometimes you get a few comments when you're at school, when you're a bit younger people are a bit nasty so some things were a bit "not really sure about", but at that age I wasn't "I want to diet", I think I was a bit too young and, naïve is not the right word but, uneducated, I guess, to really understand what the process was to not be the big one all the time. And then, probably since I was 18 and above, that's when I started thinking "oh, I could lose weight" and I started hearing about things like Weight Watchers and stuff like that and I started going to the gym a bit more because I knew it could help me lose weight, that sort of thing. I think it was then that I had my eyes open a bit more to "oh, you may not be quite as happy as you could be, maybe you could love yourself a bit more". One thing worth mentioning, actually, my husband	when you're a bit younger people are a bit nasty too young, naïve, uneducated I started hearing about things you may not be quite as happy as you could be
Support from others	now, we've been together since school, I've always had a supportive partner, I've never had to go out to a club and look for a boy so I've never been knocked back from weight, you know, I've never had that "oh I can't get anyone because I'm too fat", do you know what I mean? I've never had any of that. RT: Yeah, yeah, which possibly many young people experience. Lorraine: Exactly, so touch wood I'm very lucky, I've never had that because I've always had my other half. But it's definitely been quite easy for me to see that I'm the one who easily sticks out quite often, but again,	a supportive partner never been knocked back from weight – <u>contradiction to when she was saying she was the biggest one?</u>
Comparison with others	not really in a bad way, I'd spend a lot of my time being "yes, I'm a lot bigger than a lot of my friends, or taller than a lot of my friends therefore	the one who easily sticks out

Being critical of herself Comparing herself to others via social media Comparing herself with her boyfriend Fear of rejection Impact of comparisons on social media	RT: Ok. And, again, you've kind of touched on some of the things, but if we were to focus to on perception of self, so to speak, would you add anything to that, how you feel about your self-image. Tracey: Yeah, um, I've never been happy with my self-image. I think that's just been with me since, I don't know, probably, high school. And I think it comes back to that comparing with friends or, I don't know, social media, all of that massively impacts on how we all see ourselves. And I think as well, I maybe have mentioned it earlier, my partner being quite tall and skinny, he's very health conscious, very sporty and often I'll feel a bit of pressure in that sense of "oh, I should be a bit skinnier" or "will he still want to be with me if I'm think kind of shape or size or whatever". Yeah, I'm not sure if I've answered your question there. RT: Yeah, absolutely, there's no set questions, is just about understanding but, absolutely I've heard from a lot of women that I've spoken to that the idea of comparing yourself to others, that kind of, um, harsh reality, that stigma around women in the society. Tracey: Yeah, massively. RT: Does that resonate with you? Tracey: Yeah, hugely, and I think what I find frustrating is that there's a lot of people out there, especially on social media, trying to go against that, like "you know it's not about being skinny, it's about being strong lalala" but you're still promoting pictures of yourself, like super skinny, (inaudible) abs, it's still going to get to people and I think it definitely affects how I see myself, I always compare myself to other people, even my friends, I'll think "oh God this is so nice but I would never wear that because of my size". And I don't know but I'll often, if I buy some clothes online and I'm trying them on and I'm like "oh this is awful, on someone skinnier	I've never been happy with my self-image that's just been with me comparing with friends social media I'll feel a bit of pressure will he still want to be with me? it definitely affects how I see myself on someone skinnier that would look amazing

	Tracey: Yeah. RT: So is there anything else, I mean you've obviously said about a few things, but anything else about body perception that we've been talking about?	
Critical voice What is the priority? Avoidance Fear of being judged	Tracey: Um (pause), I don't think so. The only other thing is if I get changed in the morning and I get a glance of myself and I'm like "oh God, that's awful" and then I may feel quite rubbish for the rest of the morning being like "I really need to do something about that" but there are so many other things I need to do as well. But I think it's one of these things with me that it's pigs and troths so if I know that I've got an event coming up or something then I'll be really conscious of it and I'll be going in my mind "do I have to go to this thing really?" and I think there was an instance, when was it, a few years ago, we had a uni reunion, and I think at that point I was probably at my heaviest and I was like "I don't want to go" because I know people are going to be like "God how much weight she's put on?!" and I was like "I just can't go" and I ended up not going so that was quite big, for me, that kind of answers that it had a huge impact on how I perceived myself or how I think other people would perceive me. But looking back now I think I should have gone because "so what that people think that anyway?" but also they would want to see me for me and not what size and shape I am. But, yeah, I think it does have a big impact, definitely. RT: Mmm, yeah, I can definitely relate to that. So actually it reminds me of someone else talking to me about seeing themselves in a photograph, that just reminded me of that, you know people knowing you from that time and that you look different and how much impact this may have. Tracey: Oh, yes, definitely, and I've got a picture that I saw a couple of weeks ago, you reminded me of it, and I was like "oh my God, I	I get a glance of myself oh God, that's awful feel quite rubbish for the rest of the morning I really need to do something about that there are so many other things I need to do as well do I have to go to this thing really? I just can't go

Prioritising other needs Emotional/ comfort eating Emotional impact High expectations All or nothing thinking Constant battle Self-care Difficult to let go of weight aspect	drops off and it's always been that way, it feels like the easiest thing to let go off in a way, with like the gym but then with food, I think I've noticed more in the last year that I'm definitely an emotional eater so I'll comfort myself with food and that's what I'm really trying to focus on at the moment but that is quite difficult as well because if I'm, I was thinking about it, what was it, Monday or Tuesday last week, I had quite a stressful day and I was like "can't be bothered to cook", my boyfriend was away and I was like "oh, I'm just going to get a pizza" and then I felt awful afterwards "why did I do that on a Monday? The rest of the week is off now" and so then the cycle starts again next Monday. So God, even talking about makes you realise how much of a minefield it is, you're just like constantly battling with yourself. And I think a big part for me is that I feel like I've no, what's the word, no determination, well I guess it is determination, like self-control in a way. Because I could control this but I will always find an excuse in a way so I'll always be like "oh, I'm too tired" or "I had a really bad day" so yeah. It's really interesting talking about it! (laughs) and realising these things, actually. But having said that, um, going to the gym, I've been trying to focus more not doing it for the benefit of getting in shape but more for just that stress relief and generally having some headspace as well so, in a way, that is maybe shifting slightly but there will always be that "but it may help me lose weight" underneath it (laughs) so, yeah. RT: And so you said, um, just trying to get my head around that and understand it, so you've got various things going on in a week and then for whatever reason, being conscious of what you eat or how many times you go to the gym and it goes out of the window first if there are other things going on, do you know what may contribute to that, if you're able to share.	that is the first thing that drops off the easiest thing to let go off I'm definitely an emotional eater I'll comfort myself with food quite difficult I felt awful afterwards The rest of the week is off now minefield constantly battling with yourself I've (…) no determination, (…) self-control I will always find an excuse stress relief and generally having some headspace there will always be that "but it may help me lose weight" underneath it

Ongoing journey Anxiety provoking	*Patricia: And it changes I think as you go through this journey, it's never just one set path, that's good, it's exciting but it's also nerve wrecking at the same time.* *RT: And I mean, again, yeah, we don't have to go there in detail but I just wonder if I ask let's say how you feel about your self-image, would that automatically be related to your body or other things as well?* *Patricia: Yeah, I think it all comes under one bubble for me unfortunately. I've always taken pride in my appearance, that's come up from my upbringing so no matter if I feel like awful, the worst I've felt in a long time, I don't go out looking like a scrag (laughs), I just don't. Mum has always, it's still in me, "if your hair and your shoes are ok, no one will notice what goes on", like in between. And I enjoy taking care of myself, which is indirect contradiction, I know it sounds ridiculous but, no, self-image is, I know what suits me, I know what I'm comfortable in, I just roll with it (laughs).* *RT: Yeah? (laughs). And in terms of, um, kind of thinking about what your programme looks like now, would you be able just to say a little bit about how your current lifestyle choices look like* *Patricia: Like food?* *RT: Yes, food but also other choice that sometimes people relate to weight.*	Journey it's never just one set path that's good, it's exciting but it's also nerve wrecking I've always taken pride in my appearance that's come up from my upbringing I enjoy taking care of myself
Listening to own body Better understanding	*Patricia: Um, so I'm listening to my body a lot more so I've actually come to conclusion that I actually need to cut out dairy completely because it's slowly, cos my boyfriend is vegan/vegetarian so on plan based things now, this is relevant I promise, so taking the dairy out makes me feel better anyway, not on a diet front but how it makes my body feel, that's how I pay attention to it. Food choices, now, I try to prep my food where possible, I do have a thing about not knowing what ingredients are in certain foods when you buy them from the shop, I've always had that, I don't eat ready meals because of the content in those sort of things so on a nutrition basis there's a lot of knowledge in there although my choices are just random (laughs). So I try to do meal prep as much as possible, I*	I'm listening to my body a lot more how it makes my body feel, that's how I pay attention to it I try to prep my food I don't eat ready meals on a nutrition basis there's a lot of knowledge in there

	spinach and then again you may mix that up with some salmon, it the evening it was like a shake. It was horrific. I can't even, can you imagine? *RT: Yeah….* *Patricia: I did that for (pause) three months, that's what you can define restrictive because I had nothing else, there was no deviation from that programme at all.* *RT: Mhm, and you mentioned body building so was that combined with*	
Slow process	*exercising regime or…?* *Patricia: So it wasn't body building as such, it was, the diet was there to get me lean, so to drop off the fat that needed to be dropped off but I was in the gym 4-5 times a week, like two hours at a time. And I'll be honest,*	
Gradual process	*I've been back a couple of times but I haven't been back because I still haven't got around, the um, connection of the food and the gym so "I've eaten this much so I need to go this amount of time to burn this much off because I need to get rid of it". So it's like baby steps, and it's about going back to it and enjoying it and actually go to exercise for health reasons rather than weight loss reasons, if that makes sense.* *RT: I see, yeah, yeah.* *Patricia: So it all ties in gradually.* *RT: So does that mean that now you possibly try to avoid gyms, so to*	baby steps exercise for health reasons rather than weight loss reasons it all ties in gradually
Stressful process	*speak, and then take it slow and then…* *Patricia: Yeah, I mean I've been a couple times, I have a gym membership and I swim when I want to, I pop to a spa, and when I go to a PT, those*	
Rigid thinking	*kind of things, it's very sporadic now whereas it was very rigid and then I tend to panic when I don't get things fit in, so I panic around food, I panic if the meals weren't done, those kind of things. It's terrifying, honestly, it's like, these periods and events in my life and how they affected the food and how it affected me going into adulthood, it is stressful.* *RT: Yeah, I can imagine. And, um, part of, as you may have read in the information sheet, an aspect of journeys with dieting that we're interested in is, sort of, aspect of self-compassion…* *Patricia: Ah (sighs)*	it's very sporadic now It's terrifying it affected me going into adulthood it is stressful

	RT: (Smiles) so before we go anywhere there I just wonder if first of all, so we're on the same lines, to see how you understand this word self-compassion, are you able to say what your understanding of this word is first. *Patricia: It's just being kind to yourself, in the very basic of forms. It's not derogatory, no looking in the mirror and picking out the negatives, just "it's ok today".* *RT: Mmm, yeah.* *Patricia: "Is it ok how you're feeling today?"* *RT: Absolutely. And very similarly, just to check that we're on the same page, so we look at self-compassion as having two components, one is being kind to yourself, like you said, accepting yourself as you are but there is also maybe a more active component, as I call it, because it is being aware of your needs and meeting your needs, even when maybe there are difficulties around just focusing on "ok I want to take care of myself, my needs are important, as much as anyone else's". so it's like those two components…* *Patricia: Mhm* *RT: …for us. So thinking about that, if that's ok for a moment, of those two components, would you say is it something you're aware of these days or…*	
Learning process	*Patricia: (laughs) I'm aware of it but putting it into practice is another story. It is something that I'm learning, it's something I'm reminded of every time I speak to my sponsor, and there's a saying "you're finding your own progress, not perfection" and you can apply it to lot of different things but it's one of the main foundations but the idea of this is that I'm perfectionist by heart and if it's not everything I'm so vile to myself, it's like, if anyone else is in my head, they'll in the corner rocking and crying, that's how vile it can be. It doesn't come out that way because it's not my nature but then why would I do it to myself, that's the fascinating bit for me. Do I practice it? Nowhere near to as much as I should, no. I'm trying.*	I'm aware of it but putting it into practice is another story It is something that I'm learning
Perfectionism		something I'm reminded of you're finding your own progress, not perfection I'm perfectionist by heart if anyone else is in my head, they'll in the corner rocking and crying, that's how vile it can be it's not my nature but then why would I do it to myself? Do I practice it? Nowhere near to as much as I should, no. I'm trying.
Critical internal voice	*RT: Are you able to say a bit more about that how you're trying?*	

Appendix 8: Extract of final themes

Super-ordinate themes	Sub-ordinate themes	Supporting quotes
"I don't consider myself enough"	Prioritising other needs over self-compassion	*PT3* *I'm just like a robot and I just, kind of, do things but, I suppose, people do need to do things for themselves and I don't do enough at all for myself, in any way.* *(...) when there's only one body around the house doing everything, I'm working full-time, so I tend to snack more. I eat leftovers for breakfast. Or you're constantly stuffing your mouth, or eating late at night, therefore your digestive system is not working the way it should.* *PT4* *(...) just trying to find some time so I can fit in meal prep and going to the gym during the day.* *I don't eat as healthily as I think I could and when time's getting a bit stressful, that's the first thing to go, like "I'm just going to get a takeaway" or I just put something in the oven rather than cook from scratch so I definitely can see this has an impact on my weight. And then the next thing that goes is I don't go the gym so I'm not active and that's having an impact on my weight as well.* *(...) definitely if I'm stressed, the first thing that will go will be meal prep probably. And then the more stressed I get the more, just kind of, I'm just existing as opposed to planning.*

		In terms of, kind of, giving yourself a break and being able to relax, I think that's something that developed quite late in my teens, just because I felt that if I was doing that, everything else had to suffer a little bit. *I think it's very difficult to have a good wellbeing if you're not recognising or paying attention to your own needs, so if these barriers are there, that's definitely an issue.* *PT6* *(...) that idea of going into work every day. Having some normality, and order, and schedule back into my life will really help, because I'm really bad at doing it for myself. And that kind voice will then definitely be there.* *PT7* *you may lose a stone or a stone and a half, a couple of stones sometimes maybe and you feel good but then just life, you put on, and children, grabbing things to eat on the way, yeah, I think life generally.* *PT8* *I think you just lose sight of it, don't you? You go through your day to day routine and you go through everything else and you're battling away and you do everything else, you forget about you because you're the one taking yourself through life, aren't you?* *PT9* *I think my biggest problem is just life getting in the way and I just prioritise everything over that.* *I always find that at the beginning of the week I've got this motivation and I'm like it's a new week, I'm going to plan all my lunches, plan my dinners, go to the gym, and I may get it on Monday and Tuesday and then I'll be*

		tired, there'll be work to do, clean the house, see friends, whatever things will pop up and then that is the first thing that drops off and it's always been that way, it feels like the easiest thing to let go off in a way. *It feels like it's the easiest thing not to do in a way because I'm like "oh, I don't need to do it today, I can do it tomorrow" or "oh, I'll start again next week", it's almost one of the things you feel like you can put off but then if I think about it, it's the same like with cleaning the house, like why should that be any different?* *I think time as well, especially with [name of the job] being so demanding, it's really hard to find time to look after yourself, which sounds awful but you're constantly looking for those quick options.* *(...) checking in with my needs as well, I don't know if I really ever do that, actually, so it's not something I'm probably doing or, but I should be doing.* *(...) life gets in the way for sure. I don't know, I think sometimes it's difficult to just be attuned with yourself in that sense because sometimes I'm like "oh God is there going to be more than I can handle right now?, in term of emotions, um, I think, yeah, life, not having time.*
	Prioritising others over self-compassion	*PT1* *Being the eldest, I just felt sometimes, if the younger ones were a bit naughty, I felt I was responsible for them being naughty. But obviously I wasn't because it wasn't my job to, sort of, really look after them.*

		PT2 *(…) it's been about subjugating your own needs, because you're not really being used to verbalise what you need, for other people's needs.* *I think I will always automatically think of someone else first so the journey for me is not feeling guilty for putting myself first.* *I would be obsessed with making sure they wouldn't do anything, because I had this idea of you know, very stressful life etc, so I wanted them to feel relaxed. But what that did was I was never relaxed, I was exhausted.* *PT3* *I don't think I really consider myself enough and I think my husband would agree, like I put him and my daughter first all the time, um, every day, you know it's, I ask them what they need, what they want. (…) if I want to do something, I put myself at the bottom of the list every time, (…) but I don't even think about it, I just do it.* *(…) when doing things or being in places, I always put others ahead of myself. Always, actually, always everyone else.* *I still don't think I'm that nice to myself, to be honest, my husband is constantly telling me I'm thinking about everyone else and that I should do something for myself. And I don't. I am distracted and (…) I'll do something for (…) a friend, you know, I still don't put myself in that first place. Just my mind set doesn't want to sit there.* *(…) he reminds me I can do those things whereas I think my block doesn't see that. I can't do them because I have other responsibilities, maybe?*

		PT6 *I feel really guilty about people making changes of plans for me. So a lot of the time (...) I just say something like "I'm sorry I can't afford it". That's easier for them to understand rather than to understand all the things I'm thinking.* *(...) you don't want to be offensive. But this is the thing, (...) what's wrong with saying "I need to eat at one of these places. I would like to come so could we go to one of these?"". I just feel (...) I do feel like I'm holding people back. I feel so bad for my boyfriend.* *(...) my friends are getting married all the time. And it's so expensive to travel around the world. And it's not that I don't want to be there, I obviously do, but I prioritise that and then in day to day situation I don't do nice things. Because I wouldn't be able to save up for big things. So there are all sort of things.* *PT7* *I worked full-time, cooking family meals, after school clubs so there was always something that was happening and you'd be just "oh quick, I'll have something quick". Now, before I go here or before you come here, it'd be something quick and then bed time so it was always, I suppose, everything was a bit rushed.* *I suppose if you didn't have children you'd have more time on your hands.* *PT8* *I find it easier to be compassionate to other people. If someone picks up the phone and tells me to be there, I'll drive up there and be there, it doesn't*

		even factor in my brain that it's a problem but for myself "I must do it alone; I must work on it myself. *PT10* *I never had the time to spend it on me. I always gave so much to other people. I really didn't focus on myself.* *In other years I tried to be very helpful to other people but now, I mean I'm helpful to others if they ask, but I used to just offer myself to other people, you know, "do you need help? Do you need that?". (...) I don't know, just treating yourself as a priority, that's what changed. It never was like that before.* *I was always there for other people, in terms of, physically there for them, if someone needed to see me, I'd be there. (...) I wasn't focusing on working on myself, I think that touches on the needs, I didn't really work on that. I was trying to keep myself happy outside but I wasn't really happy.*
	Guilt	*PT2* *Feeling ok to put me first, feeling I'm worth putting first, that's also an important one. Not feeling I'll cause a fuss. All these things that are in my head that people have all sorts of stresses and strains that pull on them and thinking am I creating another one. And also because traditionally in my family I am the person who gets everyone together, the person who keeps people in mind, the person who's there if people need stuff.* *(...) to justify in my head that I'm not being cruel or unkind and I'm just meeting my needs. And in the same way I'd like to meet their need but*

		sometimes I'm just not able to and that's ok. So that's been part of the journey. *(…) whilst you may lose weight and it may feel great on the scale, you're going to gorge again.* *I get to my target weight, I'm so excited, I will congratulate myself by having a massive meal and so what would happen is, because I was on juice diet for two weeks, my stomach is in so much pain because now it has to digest all this complex meat and what, and it's bloated and it's in pain so I would be on the floor rubbing my stomach because I so overdone it.* *PT3* *Sometimes if I want to go and do something to feel better, I feel like I've got to be doing something somewhere else or that I'm leaving them in a lurch, this is how I feel.* *I feel bad already that I should be back home, cooking dinner or running around or thinking about school uniform or what the next play day is* *PT4* *not feeling guilty about that after you've done that so, kind of, giving yourself permission to do it rather than feeling that you're procrastinating.* *PT6* *Even if you stop and watch TV for 5 minutes, you feel really guilty. That guilt is constantly there, it's ridiculous. I tell this to my friends all the time "you need to take a break, everybody needs a break, you can't work constantly, that's silly" but the guilt is always there.*

		And then you start feeling guilty "oh, I shouldn't have come out for dinner because now I'm eating really badly. If I had stayed home, I could've had salad". *I think I am more conscious of what I eat, partly because of the weight, because I feel guilty if I eat something bad.* *it does make you feel guilty about what you're eating and makes you really think about it and it does work because sometimes I'm like I'm going out for dinner, I'll do a bit of extra exercise and I'll burn extra 500 kcal today so I feel less guilty about the fact that I'm going for dinner, and I'm probably going to eat four times that, so it does work but at the same time I find it so restrictive (...)* *I feel really guilty about people making changes of plans for me. So a lot of the time (...) I just say something like "I'm sorry I can't afford it". That's easier for them to understand rather than to understand all the things I'm thinking.* *So I can do that when it's not affecting anybody else but when it does start to impact other people's lives, especially when it impacts my partner's life, then it's really hard not to feel guilty.* *PT8* *No more guilt in her new way of eating: There's no diet, no meal plans, no texting people, no justifying what you've eaten that day, no guilt or shame or anything like that, which is huge when you look at dieting.* *(...) you need to keep going, you're going to do whatever it takes to get it. And then the guilt and the shame come in so it stays in the negative all the*

		time so the compassion doesn't, it's trying to peek in, but you're just like "pff, I'm going to carry on what I am doing". *The girl with shame comes in because you want to have a choice to not do it and to be kind to yourself and to be willing to just come down and to just be normal if you like. But it didn't matter what was said and what happened and if I was in that state of mind you couldn't really get hold of me.* *PT9* *I had quite a stressful day and I was like "can't be bothered to cook", (...) I was like "oh, I'm just going to get a pizza" and then I felt awful afterwards "why did I do that on a Monday? The rest of the week is off now" and so then the cycle starts again next Monday.* *talking about it makes you realise how much of a minefield it is, you're just like constantly battling with yourself. And I think a big part for me is that I feel like I've no, what's the word, no determination, well I guess it is determination, like self-control in a way. Because I could control this but I will always find an excuse in a way so I'll always be like "oh, I'm too tired" or "I had a really bad day".*
"Learning a new way of life"	"It's a very new thing, it's odd"	*PT2* *I've got to a point where I'm aware of what I should do. And it's about, on one level I know what I need to do, and on the other level there's a voice inside of me saying "you've deserved this" or "you should have this".* *I realised on a cognitive level, of course "don't be ridiculous", but on an emotional level, it doesn't always tally with what I know.*

		(...) a part of my learning journey, it's been trying to remind myself in these moments when it's difficult "this is something that you have to practice like everything else". *keep things around me to keep this on my mind, which is why they're around me and they're on my mirror when I get up in the morning and when I brush my teeth. And sometimes I just ignore it and sometimes I just catch eyes with it and go "yeah".* *(...) it's been a journey and I'm always aware that sometimes it's going really well, sometimes it's really difficult, and sometimes when something happens to knock me off that progression.* *PT4* *it's slipping back to old habits and wanting to be better. And the way I want to be better is to say what I'm doing is not good enough, as opposed to acknowledging both sides, but then I've been noticing, and again more recently, that this is not having a good effect on my mood and is making me more anxious, so I'm trying to figure out how to be better without, kind of, beating myself up for it.* *the recent episode of trying to lose weight started in January this year, and the once before last year, and so my voice of compassion has been in development from when it was almost non-existent.* *(...) a part of me equally wonders if it's taking me longer because I've been more self-compassionate but if it takes me 12 months to get there rather than 6 and I feel better for the end of it emotionally maybe that's just as much a good sacrifice.*

		(...) back then it was very much all or nothing, either you're hitting the numbers or you're not, but equally then you're not being able to be very self-aware, not noticing the progress, so maybe not losing weight but also developing muscle and being physically slimmer, but just not being able to recognise that as that whereas now being more compassionate, just being a bit more self-aware. *PT5* *(...) now I understand, genuinely only lose a pound a week but I know it's such a long-term thing, I'm not looking for a quick fix this time for all the right reasons. It's a long-term thing. Even when I get to my target weight, I can't go and have a massive binge or something, I just have to carry on to maintain it.* *PT8* *So it's gradual, I'm trying not to focus on the weight loss if there is any. Even when people complement it when they notice it I just have to forget about it.* *it's actually listening to when I'm hungry, which is a new thing cos I can't remember, for years, I've just not felt hungry, it's just never occurred. Um, eating nutritious food if possible, I don't deprive myself because that encourages binges so if I want to eat a croissant I will so it's having a balance and not freaking out and analysing what's going in and that is a direct product of what's going on in diet clubs.* *You're judging yourself enough as it is. You've got your goals set so high as to where you want to go, how many times you're going to go to the gym,*

		inches, and all that kind of stuff, and someone else to shoot you back down again it's like a double whammy. *It's something that I'm working on. It's never going to go away and I focus on the ability not to put myself on a downward spiral so I really have to work hard and I need to use tools that I was given to not focus on it so much.* *it changes I think as you go through this journey, it's never just one set path, that's good, it's exciting but it's also nerve wrecking at the same time. I'm aware of it but putting it into practice is another story. It is something that I'm learning, it's something I'm reminded of every time I speak to [name], and there's a saying "you're finding your own progress, not perfection" and you can apply it to lot of different things but it's one of the main foundations (...). Do I practice it? Nowhere near to as much as I should, no. I'm trying.* *(...) self-compassion, I think comes in, in, in pieces in the programme, it's not something you can work on in one go.* *it's a very new thing, it's odd (laughs), that what I say to myself (inaudible), I have to do it a lot and be grateful for things, and it's, um, learning a new way of life, it's interesting.* *it is odd because it's out of my comfort zone and I've lived a certain way for so long, now I'm changing it, (pause), it feels odd, it's new experience, it's alien, and it's exciting because I quite like change but, yeah, that's probably why I would call it odd because it's not the norm.* *I think it's a key part of people's personalities but it's about developing it and nurturing it, I guess, but you have to learn to nurture it for yourself.*

		I think it's just going to be day by day process. I need to re-learn who I am, my self-worth (pause), that there's more to life than weight, image, perception, life. You only get one life and you really really should live it and I think that's what this is teaching me because being stuck in the black hole, really, of negativity and dieting, and how I felt, I couldn't see any light at the end of the tunnel and now I can. So I think it's (pause), I can't really explain it because it's coming along naturally rather than something that I'm actually mentally aware of. *PT9* *I think there's an awareness of it but whether I'm putting it into practice sometimes, I think I'll probably could do more.* *(...) maybe not feeling like I could do it properly as well, you know. I just feel like "do I really know how to be compassionate towards myself?" or "what does that look like?"* *It's a weird one, isn't it, for me what would self-compassion look like, would it be more on a practical level so like I said going to the gym and stuff like that but for me I think it's a deeper level than that, it's a bit more about, like you said, being accepting of yourself, it sounds really weird to say that but I don't know how to be accepting of myself, if that makes sense, because I think I've always been not accepting of myself. (...) So, yeah, I do think it's about 'how', how do we do that?* *[Name] did like a self-compassionate meditation with me, but even that I found very hard, it's just, it felt like, I didn't feel comfortable because I'm not used to being self-compassionate. But I would love to be able to get to that place, just being accepting of who I am and then being more in tuned in what I need, just being kinder to myself.*

		What has helped to cultivate self-compassion so far *PT1* *This is one of the reasons why, with all the slimming, I just have to keep going. I simply must keep going, I have to get my weight down and hopefully reverse my type 2 diabetes.* *PT4* *I'm kind of trying to come to terms with the fact that I may never look how I envision myself looking in my head but that's ok because to look like that I'd have to lose something I don't want to lose.* *recognising that needing to stop or needing to have a break wasn't a weakness, that it was just a norm, and also just being nice to yourself and not having to beat yourself up all the time.* *if I have a period of stress where I'm run down and (inaudible) and I notice that may become ill where I wasn't feeling ill before and maybe that's a sign that it's not that would have affected you normally but just the lack of sleep and lack of self-care so that you're at risk of becoming ill.* *(...) giving myself permission to take my time and having a few goals set but if I meet them then I meet them if I don't, it's not the end of the world and I think maybe placing a little bit less importance on weight. and, actually that's going to be worse often, in a long run, so may as well just stop and have a good night's sleep now rather than paying for it down the line.*

		PT7 *I'm aware now that as you get older that you have to take more care about yourself and if you don't use it, you lose it basically. And you see I see some people and think "my goodness, I don't want to end up not being to do those sort of things".* *PT8* *I have a support network who I can speak to, that all thinks the same, whether they are from one end of the spectrum, anorexics, to the other end of the spectrum. But it's incredible, by doing it they help me because they get it, they get it here (points to her heart).* *I don't feel I'm on a diet, I don't feel I'm restricting, I don't feel like I'm depriving myself, it just allows me to have the headspace to not think about food because when I was dieting it was a constant thing of "I've eaten this, what am I going to eat next, can I have a snack" and it's that thing 24/7. So you can imagine how exhausting it is.* *(...) big big part of it for me is accepting the fact that people like and love me for me. They don't care how much I weigh; they don't care what clothes I'm wearing.* *That's been a huge lesson and it still will continue to be a huge lesson because even with friends, family, loved ones you still think that they are wanting you to look better or lose some weight or be healthier or, that's what my head tells me.* *I had no issues with food, I wasn't negative, I wasn't unhappy, and that's my mecca if you like, a bliss, my head was in peace the whole time I was travelling.*

		There will be good days and bad days and that's what I'm learning. It's ok to have a bad day, if you relapse, you relapse, you just get back on it, you move through it. *I had no stress, I had no outside factors of negativity. Everybody I met, all ages, lot of uni leavers with no idea what they wanted to do with their lives, literally just winging it and I was like "there's so much to learn from you lot, so so much, I'm so bogged down from adulthood, like, working, commuting, all that kind of stuff that I need to get involved with and actually it's kind of going to be there if you like it or not so do you get bogged down by it or do you just go with it?"* *PT9* *I'm definitely seeing things in a different light, like I'm not just doing it for a weight loss or whatever. It's more about feeling comfortable with myself. Yeah, I don't know if some of that comes with age, just being a bit like "I am who I am".* *PT10* *what really made a difference was my, again, giving yourself more, starting to really focus on yourself, realising that you need to look after yourself, not like in egocentric way, but you need to be kind to yourself. And then if you're kind to yourself, you can be kind to others.* *then just realising that everyone has their own life, everyone has their own priorities and, I don't know, I just assumed that "look after yourself" because they're so busy, they don't have time for me so I should get busy with myself then and, you know, work on myself.*

		I think having other people, that really drives me, that motivates me so much, (inaudible) that's one of the biggest things *… I used to do the things I didn't like, definitely, so maybe wrong diets, going to extremes sometimes and that didn't work so I obviously went back to eating everything.*
	The impact of growing up	*PT1* *I had quite a traumatic childhood and I think that may have been the part of me, developing it, because of the stress, and the stuff I underwent, I think. And I think this was also what made me comfort eat, maybe, and becoming this shape.* *I've never had or been encouraged to have an active childhood.* *I remember my dad actually give me a whack that I didn't want to eat or I felt I didn't need to. Anyway, after that I just, every time I saw my dad at the table and I was eating, and I just wonder if that was part of it as well* *I came from a generation where if you got knocked down, you've just got to get up, sort of thing* *(…) my dad didn't talk to me about what I wanted to do in my life.* *I had to start doing household when I was 11. I cooked my own breakfast every morning.* *I could have wanted a lot of things but I knew I wouldn't get them.* *I think I've had too much too much structure when I was young, I was told too much about what I was going to be doing, school, work, that's all structure, you know?* *I think when you're a kid, you're spending your life with your family and you've just got to do things, you're trained in some way, aren't you? I think, my childhood may have been a bit too structured. And of course*

		when that went, I was left high and dry, literally, because I couldn't manage the freedom of having to think for myself, really. *If I fell down, I had to stand up, I couldn't wait down there for someone to pick me up.* *PT2* *I don't think I ever even considered keeping me in mind, I thought it was something out there that people did to me, I think. And that's become much more of an issues when I became an adult and became autonomous. And how do you learn something that you've never done for yourself, when those people are away? And that's been a big thing for me.* *(...) that's more something I've become more aware of as an adult. I don't think I was in any way taught to be compassionate to myself when I was a child.* *I wasn't even aware of what my needs were, I don't think. I can't remember of consciously thinking "I need this" or "I would like to have this", it was, sort of, done for me.* *PT3* *I don't even remember being aware of my needs and, regarding my mother, she wasn't very aware of my needs as a child either.* *I don't think anyone saw my needs and my own innocence as well so I was just, kind of, blazé about what I needed or what I wanted.* *PT4* *I don't know if we were, kind of, encouraged to be self-kind.*

		I think it was probably hard to model or to be self-compassionate without really having that model. And I think people were quick to say when something was wrong and to call it out and criticise than saying when something was going right and saying "well done for trying". And maybe that was something I, kind of, randomly picked up, that, that self-criticism to improve yourself rather than acknowledging the good and the bad. *I think the main things is having it not modelled, not necessarily experiencing something as being compassionate or not even seeing other people being compassionate towards themselves and then it all becomes a bit of a cycle, really, yeah. And then asking yourself if you've fallen into a group you're in, because you will all share that tendency and that's actually something you have in common (laughs) and then it perpetuates it even more.* *PT5* *sometimes you get a few comments when you're at school, when you're a bit younger people are a bit nasty so some things were a bit "not really sure about", but at that age I wasn't "I want to diet", I think I was a bit too young and, naïve is not the right word but, uneducated, I guess, to really understand what the process was to not be the big one all the time.* *PT8* *I was bullied when I was a kid and, um, for various things, weight was one of them so I think when you're constantly dug out or you (sighs) compare yourself to people on social media for example, or peer pressure.*

		PT9 *I'm not really sure about that, and I'm not sure if I was aware of my needs growing up, in that sense, in terms of self-compassion, I don't think so. I imagine not.* *I had my parents who, kind of, almost looked out for my needs in a way so I'm not sure how aware I would've been, what my own needs were.* *I feel like maybe I didn't. I think maybe that's why I'm struggling with it now because I wasn't really aware of that.* *I think that age, you know, you just hit puberty and everyone is at different stages and that was my first real experience of like bullying and I just remember, I was always taller than everyone else and I was always bigger than everyone else and I think that's when I really became aware of it, almost because of the bulling, and I don't think the bullying was about my shape or my weight or anything, maybe it was, but I didn't realise but I don't know if that then made me more aware of myself and how I was different.* *PT10* *My parents could have pushed me a bit into getting involved more. They did tell me but there could have been more persistence so I wasn't burning off that energy and I was negative most of the time so that really reflected on my emotions and my relationships with my family members and other people.* *I didn't know what I wanted, my opinions were not strong in many things, I could be influenced, I still had my opinion of course but not so strong. I wasn't a leader and I always wanted to be one*

	Unconscious barriers	*PT1* *I suppose what I was told as a child, I may subconsciously, I'm still doing them now.* *PT3* *I don't know if it goes way back. Being one of five and that there wasn't maybe an opportunity all the time to do things that way or, I honestly have no idea.* *(...) because I don't know what they are, I don't know how to work on them.* *I'm not really sure what my needs are rather than, you know, my basic functioning and my main job. (...) I don't have any, kind of, needs or too many wants.* *I just can't work out what the block is, which is really difficult because it's not something I've ever thought about.* *PT6* *I don't think I was really aware of things like that. I don't think I was very aware of the whole kind voice thing until this year. I don't think I paid too much attention to it or really thought about it.* *I can't think of anything (...). I was quite young. I don't think I was thinking about those sort of things. I just think of (pauses) thinking in that way or having any of those sorts of thoughts.* *I don't think it was until this year that I realised how I spoke to myself. I can't think of any times growing up where this would have been even in my consciousness at all.*

		PT7 *I suppose compassion to me is not something that has ever really been thought about, myself being compassionate to me, wasn't something that, you just got on with it really.* *PT9* *I don't know, I'm really stuck on that as well, if I'm honest, and I think that's quite interesting because it ties with that how to be more self-compassionate and I don't really know because I feel it is quite a block. I think you just made me aware that I'm not self-compassionate, which is really interesting because, not made me aware because I was aware recently but it made me realise that it's not just at work that I'm not self-compassionate, it's also outside, in my relationship to how I look and food and diet and exercise.*
Unachievable ideals of self	Striving for perfection	*PT2* *(…) not being able to be in touch with my physical needs, what my body was saying it wanted, and what was needed within me. And when it was happening, I wasn't in touch with it until either exhaustion or illness or something and then it was looking back and there were quite a lot of signs of "take a rest now" or "stop now" or "maybe you should take a day off and rest".* *(…) my size, my weigh, whatever, those things have been quite difficult to work through, because if you're not good enough, you're not worthy of compassion, or if you haven't reached a goal you should have.* *I have a low self-esteem but it was masked because I used to work really hard and do lot of things, and it wasn't fake but people would be "oh my*

		god, you're doing so well, you're amazing", but I was coming from a place of not being good enough, "I'll work hard and show them how good I am" but actually now I've realised that because of putting my boundaries my big fear was "people will get angry at me" and me being around people was about doing lot of things for them. *I have very high standards for myself, I don't have the same standards for other people, but for myself it's crazy high, when you look at them they're ridiculous, they're not reachable often, so I'm often falling short, so that'll often be a spiral, like a negative space because it'll be about totality of my being, it's not like that anymore, but it's very much located in the thing I'm doing and also what else is happening around me.* *(...) there've been a lot of times in my life where I've done something and I've pushed myself to the unreasonable and I located that in my lack of self-worth. But it's work in progress. And I realised that I not only push myself to incredible limits, I also judge myself incredibly harshly not on a fair play field.* *(...) what you're doing is sending your body into shock because you've gone from gorging on cakes to as if you cut your throat waiting for nothing. And whilst you may lose weight and it may feel great on the scale, you're going to gorge again.* *When you're just emotionally drained or you were ill, or physically, or whatever it was, your body went "no, enough is enough" and not being able to push yourself out of that, and that feeling of being really frustrated because your body was almost against you having to think back and reflect on "what can I do to so I don't get to this point.*

		"is that your body saying if you don't stop, I'll stop you" *(...) there's more of a target and if I reach that target and the reaction I have, as opposed to when I don't reach that target. Having that target there in the first place can be a bit of a barrier.* *PT4* *(...) when I was younger I was very self-critical, very harsh on myself, I had very high expectations. Not necessarily in regards to just weight but I guess also academic achievement in particular.* *PT8* *my desire was just to be slim and to be this person that I had envisaged in my head, that I'd never been before, that I thought I'd be happy, I thought I'd be better, I'd be more attractive to my partner, etc, etc, and things like that. It's an obsession. It doesn't ever stop, it's "what can I do to improve myself whether it would be a diet or whether it'd be a gym, it's "how can I change myself to make myself better", and not in a good way. So it's just a sheer drive to achieve this perfection but you've no idea what this perfection is.* *(...) there was never enough, it was never perfect enough.* *So I've reached the goal, I've got slim, and I guess I'm happy but I'm still picking myself apart and I still won't be happy.* *(...) it was very rigid and then I tend to panic when I don't get things fit in, so I panic around food, I panic if the meals weren't done, those kind of things. It's terrifying, honestly, it's like, these periods and events in my life and how they affected the food and how it affected me going into adulthood, it is stressful.*

		I'm perfectionist by heart and if it's not everything I'm so vile to myself, it's like, if anyone else is in my head, they'll in the corner rocking and crying, that's how vile it can be. It doesn't come out that way because it's not my nature but then why would I do it to myself, that's the fascinating bit for me. *was easier to be vile and pick out thoughts than to be accepting because I guess there's always something to perfect.* *PT9* *I think that's something that I really struggle with. I think thinking about what I need and being kind to myself, across all areas of my life, is something that I've always found difficult. And it probably ties a bit into perfectionism, kind of style, whatever I do is never as good as it could be in a way.* *I think I just reached that point, almost like, not breaking point but like "I'm so tired, I need to look after myself because if I don't I'm going to burn out". And I think that's probably when I started probably being aware of "ok, I need to take some time off at the weekend".* *I could probably spend my whole life, nor my whole life but majority of it, constantly "I need to be this, I need to be that" and never actually be happy with what shape or weight I was so I don't know if that's just something that is going to carry on even if I do hit a goal, I don't know, um, yeah, it's a weird concept to think about.* *(...) when I think about my typical cycle of like Monday it's great and then it all ends because I had a "bad dinner" or something, in those moments*

		could I be a bit more self-compassionate and kind of say "ok, it was a bad blip, that's fine, everyone is going to have these blips along their journey" and just start fresh tomorrow rather than being "oh well it's all out the window, you've failed" *PT10* *I just want to be happy, truly happy, in every aspect, so I need to work on everything, including my weight, including my wellbeing, including my studies, friends, everything. So I need to be working on everything.* Deserving self-compassion *PT2* *(...) especially in the beginning, if you don't think you're worthy of something, you're not going to do it very much. Or you're going to need such a good reason to be compassionate to yourself that it's going to be "if you do this, you deserve it"* *I'm worthy of compassion, I know it sounds ridiculous, because I can see that everybody outwardly in my family, friends, (...), I can see they're worthy of compassion but I've realised (...) that I don't believe I am, for whatever reason.* *PT8* *(...) do you deserve it? What have you done to deserve that? Why are you being compassionate to yourself, have you earned it? I think that's kind of where it sits, I think because you're so used to be in the negative.*

		Earning self-compassion *PT5* *self-image is definitely getting better as the weight goes down* *I don't really let my weight get me down as such in a massive way but it's so much nicer seeing scales going down. It gives me positive reinforcement in my head, like one "you should be really proud of yourself because you're doing really well".* *PT10* *Being worthy, I really want to be worthy and I know I can and I just have to work on it, always. And I know I can do it, it just was never the focus of my life.* *If I see that I've achieved something, maybe I have a degree or I've lost weight, I look great, I have a career, I don't know, I have some aims in life, I will maybe be a bit more nice to myself, but not now, not yet.*
	Judgement from self	*PT1* *I quite resent having to be on a diet, to be honest.* *PT2* *I've got a big inner critic, which I've always had since being a little child so I think that's been hard in terms of being self-compassionate towards myself these days.* *(...) it used to be a very negative voice, which is "oh my god, you're ridiculous; you're so fat, you're so gross, you're so disgusting". That was talking in my head.*

		Historically, I would've been very harsh on myself, very harsh and I would castigate myself eating calories. So I would have a diet plan and eating anything out of this plan would be on my mind and I would be in bad mood. I was about "look what a failure you are, you have to do this again, haven't you done this before, why are you so disgusting? How did you get to get to this size again?"(...) *(...) whilst you may lose weight and it may feel great on the scale, you're going to gorge again.* *(...) when I get to my target weight, I'm so excited, I will congratulate myself by having a massive meal and so what would happen is, because I was on juice diet for two weeks, my stomach is in so much pain because now it has to digest all this complex meat and what, and it's bloated and it's in pain so I would be on the floor rubbing my stomach because I so overdone it.* *PT4* *(...) when I was younger I was very self-critical, very harsh on myself, I had very high expectations. Not necessarily in regards to weight but I guess also academic achievement in particular.* *I've shyed away from having goals to do with my weight in the past when I've set them I haven't met them I think I kind of beat myself up about that. I think that critical voice is definitely a barrier to be self-compassionate. if you have barriers to self-compassion, you'll become more unhappy about your weight because you become more self-critical and your self-image becomes more negative.* *I think if you're critical, for me anyway, I start doubting and second guessing myself when actually I know things. And then you start labelling*

		yourself as being incompetent because you think you don't know things but, actually you do. *If I wasn't critical, I'd be more likely to be like "oh, that was a bad week, never mind, you know what you did, let's try again next week" and then having these positive experiencing "oh I've lost some weight, that's good, let's carry on, well done".* *PT5* *I don't really let my weight get me down as such in a massive way but it's so much nicer seeing scales going down. It gives me positive reinforcement in my head, like one "you should be really proud of yourself because you're doing really well". (...) if I started going the other way and I started putting on weight, absolutely that's be a factor and my little voice in my mind would be going "you need to do something about that".* *I've definitely yo-yoed a lot in the last 10 years, definitely. and I tried to deny it a little bit. If I feel like my clothes are getting a bit tighter, I'll be like "oh it's fine, just cut down a little bit", and I don't lose weight by cutting down a little bit, and then I have to buy the bullet and be like "go on scales and see what's going on" and sometimes it's the realisation then, I could have put 4, 5, 6 pounds and I'm like "oh my god, this is awful, what are you doing, you're so fat, come on!". But to be honest those sort of feelings are quite short term for me, it'll soon turn into like "do something about it "rather than feeling sorry for myself, I won't get into a slump and just go down and down.* *it is taking me such a long time to see it in myself with [CLUB'S NAME] because it's a longer period and you only lose a little bit here and little bit there so I think it's always more difficult to notice it in yourself when you*

		lose weight than for someone else to notice it so the kind voice may take a little longer to react maybe. *PT6* *I just feel like I'm pregnant, especially after I've eaten something that is not good for me, I bloat so badly, I genuinely look like a pregnant woman.* *I'm still really bad at being kind to myself, really really bad, and I am still very critical of myself, more critical that I would ever be if it wasn't me in the exactly the same situation. And I definitely talk to myself in a completely different way as I would talk to any of my friends.* *PT7* *It's not other people accepting it, it's you accepting it yourself really. But then you'll be going out somewhere to a nice event and then can't find something nice to wear or everything you put on doesn't fit properly.* *it would be harsh. For me it wouldn't be a compassionate "you need to look after yourself". It'll be "you need to do something now!"* *PT8* *I think it depended on times and circumstances of what else was going on in one's life, I'd say it was dependent on that. I guess it's always a pattern, for me it would be a pattern of losing lots of weight and then, as science will tell you, you lose it and you put in back on as quickly and then you put on more, which I do believe it's true because you restrict restrict restrict to get, to achieve what you want and then afterwards you start eating and then you're eating and you know you're doing, not wrong, that's really bad but I guess that's where my head went, you're not eating intuitively, you're eating for the sake of eating because you've deprived yourself for so long but the cycle starts, putting on weight, you feel crap, you don't want to leave the house, your clothes don't fit, you weigh more, and it's "oh my God, I've got to go on a diet again". So it's genuinely is the cycle of you*

		eating well and then "that's enough now, it's all right". But you haven't got the skills or the knowledge or even the will to maintain it. *There was no self-compassion because it was just constant negativity, picking yourself apart, freaking out about what people thought, just everything, all negative behaviours that can come with my life really. It just applied to everything. I didn't matter, it wasn't necessarily just food, it was the whole mentality of it.* *PT9* *I don't think I'll ever be happy with the way that I look and I don't know if that's my shape, I don't know. Right now I'm definitely not where I want to be and I think I'm always, it's always in the back of my mind, I'm not looking for a quick fix but I want things happen quickly, I want to see a change.* *if I get changed in the morning and I get a glance of myself and I'm like "oh God, that's awful" and then I may feel quite rubbish for the rest of the morning being like "I really need to do something about that".* *I think we can have quite distorted perceptions of ourselves in terms of our size and shape, so it's easy for me to say to my sister, for example, "you're in great shape" but she's like "no, I'm not" and it's the same for me, if I say to my boyfriend "oh, I really need to lose some weight" and he'll be like "no, you don't, you're great as you are" but I'd be like "but I look like a whale in that picture" and I would genuinely feel that I was that kind of shape or size but for him that's really distorted.* *I've been trying to focus more not doing it for the benefit of getting in shape but more for just that stress relief and generally having some*

		headspace as well so, in a way, that is maybe shifting slightly but there will always be that "but it may help me lose weight" underneath it. *I might be feeling "oh, I'm not seeing any results" or I feel crap so what's the point of doing this? I think if it's like "oh feel crap, what's the point doing it?"* *I usually be so frustrated that it hasn't worked and I'm like "nothing is going to work" and I'd just be, yeah, frustrated and feeling, like, lacking motivation, so it's usually more than a month.* *PT10* *My weight really counts for a lot of negativity I used to have because I'm quite a sociable and happy person but sometimes when I look at myself I'm like "you should look a bit better because you're so much better inside so you need to reflect it on the outside" so you need to work on it.* *To be fully happy you need to be happy in all aspects and if you're not happy with your weight, with your looks, I mean you can work on it.* *I'm quite critical of myself. So sometimes I actually criticise myself too much and possibly I shouldn't be doing that. That's what my family always tells me like "you should be less critical of yourself". And sometimes I can even hurt myself that way, you know. I just overanalyse, overthink, and it's not the best thing. But I always think that if I criticise myself I will work on it, if I don't criticise myself I will leave it.* *(...) that's why I'm trying to achieve something that I will be really proud of myself so then maybe I can be more self-compassionate.*

		Self-criticising a lot can be hurting sometimes but makes me work though. And it sometimes doesn't lead to negative feelings so I try to balance it, I don't do it too much. *(...) to really lose weight you need to be accepting your current weight, your appearance right now, and I was kind of avoiding that.* Shame *PT2* *I try not to look in the mirrors, I tend to walk past the full length mirror in my hallway.* *I like swimming but I would never do it now because I'm too body conscious. Things like wearing a sleeveless top, I would never do it now because I'm body conscious about my arms.* *I also eat a meal before I go out. So I'm not really eating an adult portion, I'm eating food but that's not a portion an adult would eat.* *(...) getting out of water in a very strategic way, getting the towel and wrapping it round again and putting the leggings on.* *PT7* *then they'll be saying to you "oh I thought you were trying to lose weight. Why are you having that bit of chocolate?". So people are actually monitoring you then that is irritating so yeah, it's something that sometimes I'd rather keep to myself.* *PT9*

		with certain events I'd be like "oh no, I don't feel comfortable going to that" because I don't know, I wouldn't want to be in a swimming costume around other people or something like that. *if I know that I've got an event coming up or something then I'll be really conscious of it and I'll be going in my mind "do I have to go to this thing really?"* *I think at that point I was probably at my heaviest and I was like "I don't want to go" because I know people are going to be like "God how much weight she's put on?!" and I was like "I just can't go" and I ended up not going so that was quite big.* *I didn't go back to it. So at that point maybe I was aware of that stuff but not that self-compassion but definitely my shape and size. Yeah, I always regret that, just thinking back now, it's so silly but at that time it was a really really big thing.*
	Judgement from others	*PT1* *When someone was telling me what to do, that was ok, but I think, once that finished, I was left on my own and I wasn't able to manage the unstructuring of my life, do you know what I mean? and I think this is the part of carrying on with the diet.* *PT2*

		(...) people comment on it a lot so it further makes me uncomfortable going out, going to occasions such as weddings and things like that because I know there will be comments about it. *(...) it would be actually comments from other people that would upset me. And I think it was because I was used to having comments so that's the way I judged myself, so when I said I wasn't really in touch with myself, I would use other people's judgement to see if I looked nice.* *(...) comments from people who I know and who are very close to me, particularly comments about my weight, my size, and how it's going to impact on me health wise, those sorts of things. So it's always on my mind. I don't expect people to be on the same page as me, because another thing that I've learned is that people don't move with you sometimes, because you're the person doing all the work on yourself, you're the person who knows what your goals are, people around you are not necessarily going to shift just because you do or have a realisation, but that's ok. As long as I can explain to them in a rational way, and that's the big thing about self-compassion, is boundaries. I've had to really learn about boundaries in order to be compassionate towards myself.* *(...) there's a thing in my family about (...) me and my sister's sizes, it's always has been, and that is very prominent. So people would say "do you need to take another one?" or "don't you think you've had enough?" or "I don't think your face can take it anymore". So those comments are coming. (...) they haven't really understood that, they understood it as rejection of them or rejection of their child but I've grown to say "they're adults, they know what they're doing".*

		(...) there's that idea in the society and in magazines, and increasingly now on Facebook and other social media, TV, reality TV, that women are certain way and if you're not that, there's something wrong with you or you don't somehow aspire to be attractive. *PT3* *(...) it's difficult when you on maternity leave, someone says "let's go for a coffee" and everyone's having a cake and (inaudible) and you feel obliged in the society to participate in these things and that definitely had an impact.* *(...) definitely for me it's these social things, when I think about it, it's definitely got an impact on it, how it all kind of spirals.* *PT4* *I was always worrying about others, whether that was family or friends but it wasn't necessarily the compassion to myself, like at all.* *(...) it's becoming easier to get along with it because that's what everyone else is doing or everybody you know is doing so you think that's what's out there.* *PT5* *the thought "I'm doing this for myself", most of the time, but at the same time I would love, my husband has zero issues with my waist whatsoever and never has done, but I'd just love for him to look at me and be like "you've done so well".* *I get why people would hate themselves, especially with society as it is and especially with social media side of things. Obviously trolls putting bad messages.*

		PT6 *People can be really judgemental so I couldn't do with that amount of guilt. I know it for myself, I don't need you telling me this. So you have other friends on there and they're like "oh congratulations for burning 400 kcal by cycling" and you're like "all right, calm down".* *I hate when people start making decisions for me cos I get really stressed about it. It's really hard, when other people are involved, to have a kind voice. And I get angry because of the repetition of the situation, yeah, I don't like it, so the kind voice just leaves.* *it happens so often, "we're going to get this but why don't you order that?". "why I don't get to decide what I order?". I don't know why people know better than me, it really frustrates me. So, yeah, the kind voice disappears.* *PT7* *I wouldn't want people to think "crikey, she's eaten a lot today, she's just finished that, I wanted to have a bit more of that" so I'd probably hold back.* *then they'll be saying to you "oh I thought you were trying to lose weight. Why are you having that bit of chocolate?". So people are actually monitoring you then that is irritating so yeah, it's something that sometimes I'd rather keep to myself.* *portrayed in the press, you know you see some of these lovely young girls who are being vilified for putting on a few pounds.* *I wouldn't want people to say "oh my word, she's fat"*

		I think sometimes people can trigger something in you which makes you feel bad about yourself and then you might be, I might think "oh well what's the point?", sometimes. *if somebody's out and is almost encouraging you "oh go on, it'll be fine", some people just try to sabotage you "you'll be fine, you can have that, that's no problem" and sometimes you think "oh, ok then, I don't want to be a party pooper" so, yeah, you go along with it and then that just throws you out of kilter.* *because of the experience I've had of people actually monitoring of what you're supposed to be eating, I'd rather not tell people so I wouldn't necessarily say to somebody "well, I'm not going to have that because I'm trying to lose some weight". I would just choose something now that would fit my lifestyle. But if someone's like "oh, come on, everyone's having a pudding" I don't really want one but I don't want to be the odd one out who is not partaking in something that, yeah.* *PT8* *the numbers on the scale were so negative and the woman's reaction, I don't think I'll ever be able to forget it, "oh, were you expecting that?". I was like "yeah, wow, thanks". Everyone's here to improve and to feel better and you've got a 'judgy' attitude when taking someone's weight". I think it's worse now for generation that is growing up, I think that had a lot to do with pretty girls at school "oh why can't I be that skinny, why have they got, why, why, why, why", and you were like "oh just get on with it". And I think when you are growing up, I think as you become older it's in the back of your head but it's not so, I guess it's not so important to impress people, but when you're growing up you want to have all the*

		friends and you want to be in the right groups and you want to get to the parties and it's all about just being known and involved and liked and wanted and needed. *PT9* *for me, that kind of answers that it had a huge impact on how I perceived myself or how I think other people would perceive me.* *it's sadly kids, isn't it and I think school can be quite a cruel place and sometimes, I think, you do hold on to that, yeah. But I think then it definitely makes you more aware of your differences* *PT10* *If I lose weight I'll be confident in expressing myself a bit more, or people will take me more seriously I guess, so it's working on myself inside that will help me. So I don't care that much about any judgement. Only if it's like family members or really close people.* *There are so many people around you, I wouldn't, I can't care about every single opinion but family members, I mean in the past, they were telling me "you need to lose some weight".* *I just want them to be proud of me, you know? Inside and outside.* *I never had the time to spend it on me. I always gave so much to other people. I really didn't focus on myself.* *(...) being disappointed by people I guess and thinking "are they really worth it?", I mean, "you should be more worth it than other people because you are you are in charge of yourself so I think all the*

		disappointments, maybe people leaving, I don't know, I think that definitely change me *I think I just really realised that when I was there for others I wasn't happy. I was giving more to other people and then they didn't appreciate it.* *I just did it because, yeah, I had to do it. I actually felt pressured to do it, as a teenager to lose weight. Especially by my family and everyone else because, I was never actually called fat, I think just once when I was in primary school, but yeah I was quite pressured by other people*
	Comparing yourself to others	*PT1* *(…) as far as I'm aware my two sisters are normal but I'm not (laughs), to be this (points at her breast) is over the top.* *PT4* *there's a lot of pressure to be at the smaller end of the spectrum and actually what the reality is that, I think for a dress size it's like 16, or 14-16 in this country, but I think for some reason women of my age or a little bit older think it's a lot smaller. I would think people think it's like a size 8 or 10 is average but actually it isn't and so you're comparing yourself to something smaller than average rather than comparing yourself to the mid-point and that's not making you feel any good.* *PT5* *I've always known, always been bigger than my friends so even when I was in school I was always taller than everyone else and larger than everyone else, I was always, like, not that I stood out but it was always like I'm the big one, all aspects of being big…*

		(…) with my wedding day, I know it sounds really silly but I always said "I don't want to be the fat bride so you're going to do something about it". *PT6* *my friend who is getting married, is half Chinese and is so thin. And so is her twin sister. Even if she's just had a baby, she'll be thinner than me, definitely, and all her friends are so petite so I'm just like "oh I can't just wait to lie down next to you on the beach"* *I was always aware that I was bigger than my friends because a lot of my friends are Asian and they are so petite. So so slim.* *PT7* *I think that's why you end up torturing yourself a little bit because you always aspire to being like that, to fit into that category, or the images they're portraying of people in the media, which aren't always true anyway, are they?* *you see a photograph and you're standing next to a few friends and you think "Oh, gosh I'm the fat one". And that's for me, that's what's sort of motivates me sometimes, um, yeah, I don't want, I don't want to be the fat one.* *It's all these little boxes (BMI) they want to fit you into. Some people just don't, I suppose they can physically fit them, but it's almost like torturous to remain there. Because you're constantly monitoring everything that you eat and I don't want to be that person.* *PT8*

		I think it's worse now for generation that is growing up, I think that had a lot to do with pretty girls at school "oh why can't I be that skinny, why have they got, why, why, why, why", and you were like "oh just get on with it". And I think when you are growing up, I think as you become older it's in the back of your head but it's not so, I guess it's not so important to impress people, but when you're growing up you want to have all the friends and you want to be in the right groups and you want to get to the parties and it's all about just being known and involved and liked and wanted and needed. *You couldn't tell me anything. I had one single minded focus and that was to lose weight and to look thin on Instagram and, yeah, no, I can categorically say that compassion did not enter into it one bit.* *PT9* *growing up I was always the bigger one compared to my friends and that has probably always stuck with me as well. Even my friends now, they're all just naturally very slim, petite, and I've never been that way.* *I think that's always, especially with girls, that's always a tricky one, comparing yourself to other people all the time.* *I think that's just been with me since, I don't know, probably, high school. And I think it comes back to that comparing with friends or, I don't know, social media, all of that massively impacts on how we all see ourselves. And I think as well, (...) my partner being quite tall and skinny, he's very health conscious, very sporty and often I'll feel a bit of pressure in that sense of "oh, I should be a bit skinnier" or "will he still want to be with me if I'm think kind of shape or size or whatever".*

		there's a lot of people out there, especially on social media, trying to go against that, like "you know it's not about being skinny, it's about being strong lalala" but you're still promoting pictures of yourself, like super skinny, (...) abs, it's still going to get to people and I think it definitely affects how I see myself, I always compare myself to other people, even my friends, I'll think "oh God this is so nice but I would never wear that because of my size". *I don't think I've ever been very compassionate towards myself, um (long pause) because I think I've always been stuck in that cycle of comparing myself to other people so I think, yeah, that's where it is tricky to be kind to yourself when you're constantly putting yourself down, comparing yourself to other people. I think that's just how I grew up, I spent the whole time like "I'm not as good as them, I'm not as thin as them".* *(...) at the peak of your puberty there and everyone's like, some people are still very small and petite and others are, you know, it was a weird time, because you're finding your own style as well at that age and "oh so what clothes are we going to wear to this party" and like, I don't know, there was one girl in a really nice dress and I was like "oh, I could never wear that.* *I was tallest and had broadest shoulders, I maybe in my mind I distorted that thought that I was bigger than everyone else was, maybe. Because when I look back at pictures I wouldn't have said I was overweight or anything but at the time I definitely felt like "I'm the big one".* *PT10* *I'm around people that definitely have lower weight than me and, of course, I may want to fit in as well. Not that I'm extremely overweight but I*

		think I should weigh less, you know, maybe when being social with people and considering that that's not a norm to be as overweight as I am.
	Negative perception of self-compassion	*PT3* *(...) in some situations, if I gave myself any more self-compassion, I would just lie down.* *I'm not sure if it would mean that I'm going to be too soft.* *(...) if I was to be too compassionate I could come across as soft.* *PT4* *(...) self-kindness would have been mistaken with complacency, actually, and if you're accepting yourself where you are now you're not striving for where you should be or it was a sign that if you failed you weren't able to keep up so you were, kind of, admitting defeat.* *PT7* *its' almost like a negative thing because you're then thinking about yourself in terms of treating yourself as opposed to continuing on a line, so I suppose self-compassion for me, if I was to give myself a break, I'd be thinking of it along the lines "oh perhaps I actually need something nice" and giving myself a break in those sort of terms as opposed to thinking "oh actually I look quite nice", that's me giving myself a break.* *And it's about whether or not you can let it go for a short period of time and then get back on track again. And I suppose if you were being compassionate with yourself, if you say "actually, that's fine, just have that and then give yourself a break for a week and then go back and, but there's*

		always that anguish, I suppose that perhaps you might start slipping off the slope again. *I think if I had more self-compassion, I'd probably let myself off more, so probably no, it wouldn't necessarily work for me. I'd be "hey, I'm fine". I don't think I'd enjoy myself as much long-term. As I said I admire people who are quite happy with themselves in their own skins and they're quite happy with their clothing and whatever else but for me it would be a hindrance, um, long-term.* *I think I would end up being very, very large and probably very miserable because I was large. So if I had that self-compassion I'd be "oh, actually, that's fine".* *PT8* *It's something that I really struggle with, self-compassion, I think it doesn't come easy, it almost makes me feel like I'm being a bit obnoxious or a bit vain, that's really what I guess it makes me feel, you know, egotistical, am I being unnecessarily praiseworthy to myself, I think that what it boils down to.* *PT10* *I know I can do it; it just was never the focus of my life. Again, that sounds very egocentric.*