

Can Interpretations of Self-Compassion Influence Expressions of Self-Compassion?

by

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Abstract

Self-compassion is approaching one's own difficult situations with kindness, mindfulness, and common humanity. Although defined without references to behaviours, self-compassion has been linked to many positive health behaviours. However, when people try to enact self-compassion, it is unclear if this is the definition they use. It is also unknown whether or how their personal interpretations of self-compassion or self-care affect their behaviours. In Study 1, I surveyed 219 university students online, asking them to first reflect on a difficult experience and report their state self-compassion, and then to indicate eating behaviours they considered as self-compassionate and self-caring from a list of both adaptive and maladaptive behaviours. The eating behaviours participants labeled as self-compassionate and self-caring were mostly adaptive. Participants who were higher in state self-compassion also associated more adaptive behaviours with self-compassion and self-care. In Study 2, after inducing state self-compassion in half of 219 participants, I observed their eating behaviours in a bogus taste test, in which they were provided with both healthy and unhealthy foods to freely eat for 10 minutes. I found that participants interpreted self-compassion as eating more healthy foods than unhealthy foods. The results also showed that participants' own self-compassion interpretations and food preferences, but not their state self-compassion, predicted their eating behaviours in this situation. Altogether, the results suggest four main conclusions about the relationship between self-compassion and eating: (1) Self-compassionate feelings do not correlate with maladaptive eating or interpretations; (2) They do lead to eating more of what one likes (which tends to be healthy and adaptive choices); (3) These feelings might instill motivations and subsequent actions to be self-caring rather than self-compassionate; and (4) A person's state self-compassion is highly

insufficient to predict their actions, without also taking into account their behavioural interpretations of self-compassion and self-care.

Keywords: self-compassion, eating behaviours, adaptive eating, maladaptive eating, self-care

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Table of Contents

Abstract	ii
Acknowledgments.....	iii
List of Tables	vii
List of Figures	viii
Can Interpretations of Self-Compassion Influence Expressions of Self-Compassion?	1
Self-Compassion	2
Definitions of Self-Compassion.....	2
Benefits of Self-Compassion	5
Self-Compassion and Eating Behaviours.....	7
Self-Compassion Interpretations.....	10
Distinguishing Self-Compassion from Self-Care	15
The Current Research	16
Study 1.....	17
Method	17
Participants.....	18
Procedure	21
Measures	21
Physical Activity.....	21
Adaptive Eating	22
Maladaptive Eating.....	23
Writing Prompt	24
State Self-Compassion.....	25
Eating Behaviours When Practicing Self-Compassion and Self-Care	26
Results.....	29
Self-Compassion Behavioural Interpretations	29
Self-Compassion, Self-Compassion Interpretations, and Eating Behaviours.....	34
Discussion	35
Study 2.....	38
Method	38
Participants.....	39

Procedure	42
Measures	43
Screening	43
Instruction Compliance and Hunger	43
Physical Activity, Adaptive and Maladaptive Eating	43
Self-Compassion Condition and Control Condition	44
State Self-Compassion Scale-Short Form	45
Bogus Taste Test	46
Results	48
Self-Compassion Behavioural Interpretations	49
Self-Compassion, Self-Compassion Interpretations, and Eating Behaviours	51
Self-Compassion, Food Preferences, and Eating Behaviours	53
Discussion	55
General Discussion	57
Interpretations of Eating Behaviours as Expressions of Self-Compassion	58
Effects of Interpretations on Eating Behaviours	60
Limitations and Future Directions	62
Conclusion	64
References	65
Appendices	82
Appendix A: Lay Statement	85
Appendix B: Study 1 – Consent Form	86
Appendix C: International Physical Activity Questionnaire	89
Appendix D: Intuitive Eating Scale-2	90
Appendix F: Three-Factor Eating Questionnaire-R18	92
Appendix E: Study 1 - Writing Task	94
Appendix G: State Self-Compassion Scale-Long form	95
Appendix H: Eating Behaviours When Practicing Self-Compassion and Self-Care	98
Appendix I: Study 2 - Pre-Session Instruction and Reminder	99
Appendix J: Study 2 - Consent Form	100
Appendix K: Study 2 - Writing Tasks	103

Appendix L: State Self-Compassion Scale-Short form	106
Appendix M: Food Rating Sheet	107
Appendix N: Procedure Script.....	109

List of Tables

Table 1. Study 1: Participants' Sociodemographic Characteristics	20
Table 2. Adaptive and maladaptive behaviour items for each eating constructs	28
Table 3. Cross-tabulations of behavioural interpretation frequency for each eating behaviour ...	31
Table 4. Study 1: Descriptive Statistics and Correlation Coefficients for Study Variables.....	33
Table 5. Regression Models Predicting Adaptive and Maladaptive Eating Tendencies	35
Table 6. Study 2: Participants' Sociodemographic Characteristics by Condition	41
Table 7. Study 2: Descriptive Statistics and Correlation Coefficients for Study Variables.....	50
Table 8. Moderation Models Predicting Food Consumption from Condition and Self- Compassion Interpretations	51
Table 9. Moderation Models Predicting Food Consumption from Condition and Food Preferences	54

List of Figures

Figure 1. Self-Compassion Interpretations and Food Consumption by Condition.....52

Figure 2. Food Preferences and Food Consumption by Condition.....55

Can Interpretations of Self-Compassion Influence Expressions of Self-Compassion?

In a comic posted in April 2018, the Tumblr user ‘pocketss’ described an interaction between them, depicted as a character snuggling in bed, and a friend. The friend asked them if they were okay since they had been staying in bed for 17 hours. In response, the character declared they were “Having A Self-Care Day” and demanded 12 more pillows and a chocolate croissant. Later in December of that year, the user posted another comic, also about an exchange between them and a friend. This time the character is making chocolate croissants and the friend asked if they were okay because they had not taken “a self-care day” in a while. They responded: “So it turns out staying in bed for days wasn’t actually self-care” but a sign of depression. The user ‘pocketss’ realized that staying in bed all day was not taking care of or being compassionate to themselves, but how do others understand the same distinction? Is eating a tub of ice cream to cope with bad news self-compassion? Is drinking a whole bottle of wine to wind down self-care?

Neff (2003a) defined self-compassion as a way to approach one’s own difficult situations without judgment, with kindness, and with the awareness that suffering is part of the human experience. Since its conception, self-compassion has consistently demonstrated positive effects on psychological well-being (Zessin et al., 2015). Self-compassion also benefits physical health (Phillips & Hine, 2021) through promoting and maintaining health behaviours (Biber & Ellis, 2019; Sirois et al., 2015). As a result, the concept of self-compassion has permeated the general public, through therapy (Wilson et al., 2019), self-help books (Neff, 2011), and social media (Seekis & Kennedy, 2023), as a self-care practice or predisposition. But not everyone who knows and uses the term conceptualizes self-compassion the way that researchers do. Many people view self-compassion as self-indulgence and selfishness (Dunkley-Smith et al., 2021) and equate self-compassion with maladaptive behaviours such as self-isolation and self-criticism

(Halamová et al., 2022). When it comes to eating, some consider indulging in alcohol and high-fat, sugary foods as self-compassion and self-kindness (Egan & Mantzios, 2018). It is possible that for those who associate maladaptive behaviours with self-compassion, inducing self-compassion might result in higher frequency of such behaviours, in line with previous findings of self-compassion's paradoxical effects (Ellingwood et al., 2018; Fan & Wang, 2022).

The present research has two main purposes. The first is to explore people's interpretations of eating behaviours as a means of expressing self-compassion and the overlap between such interpretations and researcher-defined self-compassion. Study 1, by collecting participants' responses in an online survey, and Study 2, by observing participants' behaviour in a laboratory setting, were designed to further the understanding of how the general public interprets self-compassion. The second purpose is to investigate the role of self-compassion interpretations in the relationship between self-compassionate feelings and eating behaviours. Study 1 used a regression approach to determine the predictive power of self-compassion vs. self-compassion interpretations on participants' self-reported adaptive and maladaptive behaviours in general. Study 2 experimentally induced feelings of self-compassion in half of the participants, and through a bogus taste test provided all participants with options of high- and low-calorie foods to measure their healthy and unhealthy food choices and consumption. Participants' interpretations of these foods as expressions of self-compassion were also assessed during the taste test. Together, these studies aimed to contribute to the knowledge of the link between self-compassion and health behaviours by shedding light on what drives eating behaviours: self-compassion interpretations or the actual state of self-compassion.

Self-Compassion

Definitions of Self-Compassion

The most popular definition and measurement of self-compassion in psychology was proposed by Kristin Neff (2003a, b) more than 20 years ago. Inspired by Buddhist teachings, Neff defined self-compassion as a healthy attitude toward oneself amidst suffering. Self-compassion is signified by high compassionate (self-kindness, common humanity, and mindfulness) and low uncompassionate (self-judgment, isolation, and over-identification) responding to one's personal difficulties. Self-kindness is treating oneself with understanding and support, much like one would treat a friend in times of need. The opposite, self-judgment is treating oneself with harshness and criticism. Common humanity is recognizing that mistakes and failures are part of the human experience, connecting oneself to others. The opposite, isolation is feeling that one's mistakes and failures separate and cut one off from others. Mindfulness is acknowledging one's present suffering with perspective and balance. The opposite, over-identification is losing perspective on one's suffering and fixating on one's mistakes. These six components interact with and affect one another, creating a system of self-responding that can be characterized as more compassionate or uncompassionate overall.

After the concept of self-compassion was introduced and inspired more and more research (Neff, 2023), some researchers argued that the six-component model of self-compassion and Self-Compassion Scale should be separated into self-compassion (positive subscales—self-kindness, common humanity, mindfulness) and self-coldness (negative subscales—self-judgment, isolation, and over-identification; Gilbert et al., 2011; López et al., 2015). Some even said the negative subscales should be taken out all together since they resemble neuroticism (Pfattheicher et al., 2017) or psychopathology (Muris et al., 2016, 2020). Based on the fact that negative subscales predict psychopathology more strongly than positive subscales, Muris et al. (2016, 2020) also suggested that the negative subscales inflate the link between self-compassion

and psychopathology. Hence to truly understand self-compassion's protective effects, they urged researchers to examine the subscales independently rather than as a total score. In response to these criticisms, Neff (2016a; Neff et al., 2018) conducted studies to show that the bifactor model, which models six factors and one general factor simultaneously, demonstrated the best fit across multiple samples. Neff (2016b, 2020) also pointed out that while the uncompassionate subscales correlate highly with neuroticism and psychopathology, the correlation is not perfect thus demonstrating divergent validity. Furthermore, when Dreisoerner et al. (2021) attempted to induce positive components of self-compassion separately, they found that conditions spillover and improved unexpected components of self-compassion (e.g., self-kindness condition reduced over-identification, mindfulness condition increased self-kindness and reduced isolation). It is clear that while investigating the subscales separately might uncover the specific mechanisms of self-compassion, the six interrelated components still make up the general factor that is self-compassion.

Other than Neff's definition and scale, there are other research-based conceptualizations of self-compassion, namely by Gilbert et al. (2017), Strauss et al. (2016), and Falconer et al. (2015). Gilbert et al. (2017) defined self-compassion as "sensitivity to suffering in self with a commitment to try to alleviate and prevent it." With this definition, they identified and measured competencies required for two processes: compassion engagement (sensitivity, distress tolerance, sympathy, empathy, non-judgment, care for well-being) and compassion actions (attending, thinking/reasoning, behaving, emotion/feeling). Strauss et al.'s (2016) definition of self-compassion instead consists of five elements: (1) recognizing suffering; (2) understanding the universality of suffering; (3) feeling moved by suffering; (4) tolerating uncomfortable feelings aroused due to suffering; (5) acting or being motivated to alleviate suffering. Based on this

conceptualization, Gu et al. (2020) developed the Sussex-Oxford Compassion Scales, which managed to detect compassionate responding but failed to identify uncompassionate responding (Muris et al., 2022). Interestingly, Falconer et al. (2015) viewed self-compassion and self-criticism as too complex of a cognitive, affective, and behavioural response to measure with statements and opted for asking participants about how they would react to themselves in response to eight self-threatening scenarios. However, the vast majority of self-compassion research, including research on self-compassion's beneficial effects, still use Neff's (2003a, b) definition and scale (Muris & Petrocchi, 2017).

In spite of the ongoing debate about the operationalization of self-compassion, there is no debate on how it can operate as both a trait—a stable and enduring characteristic, and a state—a dynamic and changing condition. Experience sampling studies showed that 23% to 37% of the variance of self-compassion is at the within-person level (Breines et al., 2014; Kelly & Stephen, 2016; Li et al., 2020). Li et al. (2020) found that both trait and state self-compassion have similar impact on eating behaviours through decreasing perceived stress. On the other hand, Kelly and Stephen (2016) found that controlling for self-esteem, state self-compassion was a better predictor of intuitive and restrained eating but a worse predictor of body and body areas satisfaction than trait self-compassion. As the effects of state and trait self-compassion can diverge, I chose to focus on examining self-compassion as a state for this research.

Benefits of Self-Compassion

In recent years, many researchers have synthesized different aspects of the vast research on self-compassion's benefits. They concluded that self-compassion has positive effects on both mental health and physical health. Self-compassion is highly correlated with reduced psychopathology like depression, anxiety, and stress in both clinical and non-clinical samples

(MacBeth & Bluth, 2012). Investigating the more positive aspects of well-being and mental health, Zessin et al. (2015) found a strong correlational and causal relationship between self-compassion and well-being, but most of the samples examined were non-clinical. Wilson et al. (2019) later addressed this issue by conducting a systematic review and meta-analysis on the effects of self-compassion related therapies in clinical and subclinical populations. They observed that self-compassion related therapies perform as well as other therapies in reducing anxiety and depressive symptoms. Corroborating these findings, Ferrari et al. (2019) reported that self-compassion interventions improve not only depression and anxiety but also rumination, stress, self-criticism, and low mindfulness. Along with intrapersonal outcomes mentioned, self-compassion also correlates with better interpersonal relationship between family members, romantic partners, and friends, indicated by more positive relationship markers like conflict resolution and secure attachment (Lathren et al., 2021).

In addition to its benefits on mental health, self-compassion also plays a significant role in physical health aspects like functional immunity and sleep (Phillips & Hine, 2021). It has been suggested that self-compassion affects physical health through promoting health behaviours like smoking cessation, self-care, adaptive eating, and physical activity (Biber & Ellis, 2019). In their systematic review and meta-analysis, Wong et al. (2021) found that self-compassion shares a positive relationship with physical activity. However, Brenton-Peters et al. (2021) observed that self-compassion interventions often fail to maintain positive effects on physical activity at follow-up. Informed by the range of health behaviours on which self-compassion has a positive effect, many researchers have speculated that self-compassion might directly or indirectly affect some underlying mechanism common to these behaviours, such as self-regulation (Terry & Leary, 2011) or motivation to improve one's health and well-being.

Self-Compassion and Eating Behaviours

One of the most studied health behaviours is eating. However, its definition and operation are complex and its relationship to self-compassion seems to be complicated as well (Brenton-Peters et al., 2021). Eating is an umbrella term and encompasses a wide range of behaviours such as snacking, eating fast food, and eating out (Mesas et al., 2012). But much of the relevant psychological literature has focused on eating disorders and eating pathology, so eating behaviours are often mapped on an adaptive and maladaptive continuum. Adaptive eating refers to eating attitudes and behaviours that support well-being and associate with better health outcomes. In contrast, maladaptive eating refers to eating attitudes and behaviours that interfere with well-being and correlate with worse health outcomes (Johnson & Byrd-Bredbenner, 2023).

Exemplars of adaptive eating are intuitive eating and mindful eating. Intuitive eating is eating according to one's physiological hunger and fullness cues. Intuitive eaters also do not worry about dieting or judge what, when, and how much they eat (Tylka, 2006). Similarly, mindful eating includes acceptance of one's eating but also other facets of general mindfulness like awareness (i.e., being aware of rather than distracted from one's food and eating) and non-reactivity (i.e., being calm rather than irritated in response to one's hunger; Hubert-Williams et al., 2014). These adaptive eating styles prevent eating pathology and eating disorder but might not always contribute to healthy eating and weight management (Van Dyke & Drinkwater, 2014; Warren et al., 2017). In a North American context, healthy eating often involves appropriate, as opposed to excessive, amounts of food consumption and healthy food choices, such as increasing fruits, vegetables, and legumes and decreasing animal products, particularly red meat (Fanzo et al., 2020).

Maladaptive eating, in contrast, advances eating pathology and can lead to eating disorders and poor health. One example of maladaptive eating is emotional eating or eating to relieve negative emotions and affects (van Strien et al., 1986). Restrained eating—restricting unhealthy foods and following extreme diets—is also considered maladaptive eating since this eating style often causes overeating and bingeing afterwards (Polivy & Hermann, 1985). Another maladaptive eating behaviour is binge eating or disinhibition—the consumption of more foods than needed (Kerin et al., 2018)—which can be caused by other maladaptive eating like emotional and restrained eating. But similar to how adaptive eating does not always promote healthy eating (Van Dyke & Drinkwater, 2014; Warren et al., 2017), certain maladaptive eating patterns such as restrained eating can somewhat contribute to better diet quality (Jackson et al., 2022). Therefore, it is important to keep in mind that the categorization of adaptive and maladaptive eating is mainly in relation to eating pathology and disorders and is not the same as healthy and unhealthy eating.

As mentioned, the positive relationship between self-compassion and health-promoting behaviours in general is well-established (Biber & Ellis, 2019; Phillips & Hine, 2021; Sirois et al., 2015). The same goes for the link between self-compassion and eating, especially adaptive and maladaptive eating. In Turk and Waller's (2020) systematic review and meta-analysis, all 22 correlational and longitudinal studies found a negative correlation between self-compassion and eating pathology, or maladaptive eating attitudes and behaviours, for both clinical and non-clinical samples. Therefore, self-compassion has been used as an intervention or with other interventions to improve the eating pathology of people with eating disorders (Turk & Waller, 2020) and obesity (Braun et al., 2022; Brenton-Peters et al., 2021; Haley et al., 2022; Palmeira et al., 2019). In non-clinical populations, self-compassion interventions decrease maladaptive

eating, like emotional (Schnepper et al., 2020) and restrictive eating (Adams & Leary, 2007) as well as increase healthy eating (Stapleton et al., 2016) and adaptive eating, such as intuitive (Braun et al., 2022; Rogers et al., 2022) and mindful eating (Horan & Taylor, 2018). These self-compassion interventions often followed Neff's definition of self-compassion, thus illustrating how people will eat when they are placed into a researcher-defined self-compassionate mindstate. But how do people eat when they are trying to be self-compassionate according to their own definitions?

There are reasons to doubt that people who are trying to be self-compassionate will know what to do and do it accordingly. Self-compassion sometimes has not produced the established or expected effects: for example, not correlating with health-promoting behaviours (Aneca et al., 2021), not increasing physical activity (Dyer et al., 2020; Horan & Taylor, 2019; Trent et al., 2019), and not increasing flossing time and intentions (Friis et al., 2017). Self-compassion can also backfire: increasing risk-taking in potential problem gamblers (Bailis et al., 2023) and decreasing relationship problem-solving in men low in conscientiousness (Baker & McNulty, 2011).

Although self-compassion is quite effective at tackling eating pathology and preventing eating disorders (Rahimi-Ardabili et al., 2018; Turk & Waller, 2020), some studies have found that self-compassion was not associated with healthy eating (Aneca et al., 2021; Carels et al., 2021; Mantzios et al., 2018). Inductions and interventions aimed specifically at promoting self-compassion also occasionally failed to improve eating pathology (Kelly & Waring, 2018; Rahimi-Ardabili et al., 2020) and healthy eating (Barbeau et al., 2022; Brenton-Peters et al., 2023). Broader interventions with a self-compassion component often have no effects on healthy eating as well (Dyer et al., 2020; Horan & Taylor, 2018; Trent et al., 2019). When added to other

eating behaviour interventions, the self-compassion component did not boost the interventions' effects on both adaptive and maladaptive eating behaviours (Carels et al., 2021; Duarte et al., 2021).

Self-compassion even has paradoxical effects on eating sometimes. Ellingwood et al. (2018) found that college student drinkers have higher self-compassion, especially self-kindness, than nondrinkers. In Adams and Leary's (2007) study, after eating a donut—a "forbidden food" in this context—highly guilty eaters engaged in disinhibition and ate more candy if they experienced the self-compassion induction than those who did not. Similarly in Fan and Wang's (2020) study, when primed with economic abundance, participants in the self-compassion condition chose more high-calorie foods than the control group.

These unexpected effects might be explained by differing perceptions of self-compassion in the general public. Mantzios and Egan (2017) suggested that self-compassion is often conflated with or simplified to "being kind to yourself" or "treating yourself." Furthermore, "treating yourself" or "deservingness" is one of six common justifications to indulge (Taylor et al., 2014). Maybe highly guilty eaters in Adams and Leary's (2007) study considered indulging in candy to be following the experimenter's self-compassionate advice: "I hope you won't be hard on yourself" and "I don't think there's any reason to feel really bad about it." The idea that self-compassion is "treating yourself" with unhealthy foods might also explain why self-compassion interventions often fail to improve diet quality (Brenton-Peters et al., 2021). The link between self-compassion interventions and eating behaviours may depend on how one interprets self-compassion.

Self-Compassion Interpretations

As mentioned, most researchers studying self-compassion agree on and use Neff's (2003a, b) definition and scale. But the concept of self-compassion has become more popular outside of research in recent years through the help of therapy (Wilson et al., 2019), self-help books (Neff, 2011), and social media (Seekis & Kennedy, 2023). As a result, people's definitions of self-compassion may deviate from the definition used in research, despite Neff's (n.d.) effort in spreading the concept of and research about self-compassion through her website (selfcompassion.org).

Many qualitative studies have investigated self-compassion interpretations in different populations, from the general public with a wide age range (Halamová et al., 2022) to marginalized groups such as LGBTQ+ youths (Iacono et al., 2023) and refugees (Wilson et al., 2023). Although these qualitative studies highlight different ways that different groups viewed self-compassion, I first want to discuss certain similarities in self-compassion conceptualizations across these groups. For example, the majority saw self-compassion as beneficial to psychological well-being through its ability to manage distress (Campion & Glover, 2017; Iacono et al., 2023; Pauley & McPherson, 2010; Tiwari et al., 2020; Wiklund Gustin & Wagner, 2013; Zhao et al., 2021) and facilitate positive interpersonal relationships (Dunkley-Smith et al., 2021; Klingle & Van Vliet, 2019; Tiwari et al., 2020). Despite recognizing the benefits of self-compassion, many groups also found it difficult or even impossible to adopt self-compassion (Campion & Glover, 2017), especially those that have or are at risk of poor mental health such as people with depression and anxiety (Pauley & McPherson, 2010), adult children of parents with mental illness (Dunkley-Smith et al., 2021), LGBTQIA+ youths (Iacono et al., 2023), and refugees (Wilson et al., 2023).

Almost all groups described self-compassion, especially self-kindness, in terms of behaviours, most commonly that of doing things for themselves (Campion & Glover, 2017; Dunkley-Smith et al., 2021; Halamová et al., 2018, 2022; Iacono et al., 2023; Klinger & Van Vliet, 2019; Wilson et al., 2023; Zhao et al., 2021). This way of conceptualizing self-kindness is demonstrated further in Egan and Mantzios' (2018) qualitative study, in which participants associated self-kindness or "treating themselves" with eating unhealthy food and drinking alcohol, eating foods that take time and effort to prepare, eating with others, and taking time and doing things for themselves. Other behaviours deemed to be self-compassionate include spending time with others (Campion & Glover, 2017; Dunkley-Smith et al., 2021; Klinger & Van Vliet, 2019), accepting help from others (Campion & Glover, 2017; Wiklund Gustin & Wagner, 2013), and taking care of themselves (Halamová et al., 2018; Iacono et al., 2023; Klinger & Van Vliet, 2019).

In terms of sentiments, some but not all equated self-compassion with ideas that are close to Neff's definition. Being aware and accepting of one's values, thoughts, emotions, wants, and needs is certainly reminiscent of mindfulness and was mentioned by non-clinical participants (Campion & Glover, 2017; Halamová et al., 2018, 2022; Tiwari et al., 2020) and participants who were at risk of poor mental health (Dunkley-Smith et al., 2021; Iacono et al., 2023; Wiklund Gustin & Wagner, 2013; Wilson et al., 2021). Many also defined self-compassion as self-acceptance (Campion & Glover, 2017; Halamová et al., 2018; Klinger & Van Vliet, 2019; Pauley & McPherson, 2010; Tiwari et al., 2020; Wiklund Gustin & Wagner, 2013), positivity, and emotional stability (Iacono et al., 2023; Klinger & Van Vliet, 2019; Tiwari et al., 2020; Zhao et al., 2021), which are outcomes of self-compassion rather than self-compassion itself.

Young people like adolescents (Klingbe & Van Vliet, 2013) and university students (Halamová et al., 2018) often associated self-compassion with emotions but not always the same emotions. Klingbe and Van Vliet (2013) found that several adolescents used “self-compassion” and “happiness” interchangeably, suggesting that they equated self-compassion with positive emotions. Some university students in Halamová et al.’s (2018) study also associated the term self-compassion with positive emotional words such as “love” and “calmness” but even more so with negative emotional words such as “sadness,” “remorse,” “unhappiness,” and “anger,” which could be causes or occasions for self-compassion rather than self-compassion itself.

Other than the wider range of emotions being linked to self-compassion, the general public also seemed to have many distinct and interesting perceptions of self-compassion. Zhao et al. (2021) found that young adults in China saw both the good and the bad in almost every aspect of self-compassion: Self-kindness eased distress but could become self-pity; common humanity soothed negative experiences but could detract introspection; mindfulness regulated emotions but could suppress emotions; self-criticism elicited negative feelings but could assist in mistake correction; over-identification caused rumination but could benefit self-reflection. Surveying the general public in Slovakia, Halamová et al. (2022) also observed participants considering self-pity, self-isolation, and self-criticism as self-compassion. Furthermore, in both of Halamová et al.’s (2018, 2022) studies, participants had negative perceptions of self-compassion, finding self-compassion “pointless” and “misused” and mentioning that self-compassion made them feel that they “failed.” Some LGBTQIA+ youths echoed this sentiment, using words like “weak,” “passive,” and “apathetic” (Iacono et al., 2023). Self-compassion was also stated as synonymous with selfishness, self-absorption, and “letting yourself off the hook” by participants in Dunkley-

Smith et al.'s (2021) study. Such views are common myths about self-compassion and have been addressed empirically by Neff (2023) but seem to persist in the public's mind.

Focusing on specific populations, Pauley and McPherson (2010) were the first to examine the meaning of self-compassion for people diagnosed with depression and anxiety. The authors pointed out that participants seem to misunderstand mindfulness, considering it as an objective way to look at situations instead of an accepting and nonjudgmental way of approaching situations. Klinge and Van Vliet (2019), interviewing adolescents from an alternative high school program, also discovered another unique way of interpreting self-compassion: making yourself attractive to others. Adolescents also defined self-compassion as self-improvement and working on yourself whereas young adult children of parents with mental illness described self-compassion as a rejection of the expectation to self-improve (Dunkley-Smith et al., 2021). Marginalized group members such as Hazaras refugees brought interesting perspective into their definitions as well. They felt that self-compassion was only justified if it also helps others (Wilson et al., 2023), resembling the common saying "you have to take care of yourself so that you can take care of others."

Quantitative studies have also examined people's perceptions of self-compassion through scenarios. Participants were asked to put themselves in either a self-compassionate or self-critical scenario in response to negative events. Robinson et al. (2016) saw that regardless of trait self-compassion levels, people who imagined themselves in the self-compassionate scenarios saw themselves as more self-indulgent but also more pleasant/nice, confident, admirable, relaxed, happy, and having high self-esteem. These results were replicated and expanded by Schellenberg et al. (2021), who found that participants also imagined better outcomes (e.g., better goal

achievement and future performance) in the self-compassionate scenario than the self-critical scenario.

Through these studies, it is clear that people have very different, sometimes even contradictory, perspectives on what self-compassion is. Not only do the diverse variations of interpretations illustrate how people's perspectives deviate from researchers' but the similarities in interpretations do so as well. Researchers often define self-compassion as a state of mind and a way of relating to oneself internally, whereas the general public consistently defines self-compassion in terms of external behaviours, outcomes, and emotions surrounding experiences of self-compassion. These differences could result in different translations of self-compassion into adaptive behaviours.

Distinguishing Self-Compassion from Self-Care

As shown above, self-compassion is frequently considered as and sometimes used interchangeably with self-care by the public. Furthermore, Truscott et al. (2023) found that young people consider self-compassion as a main aspect of mental health self-care. Researchers also have touted self-compassion as a way to care for oneself (middle-range theory of self-care; Mills, 2021), despite not having a consensus on the definition of self-care (Godfrey et al., 2011; Truscott et al., 2023). One concept of self-care, mindful self-care—the repeated process of recognizing one's internal and external needs as well as fulfilling those needs to improve one's well-being—even incorporates self-compassion into its measurement (Cook-Cottone & Guyker, 2017). Indeed, self-compassion and self-care, broadly defined as self-initiated practices and behaviours that aim to better one's health and wellbeing (Sherman, 2004), share a strong relationship (Garcia et al., 2022). Moreover, Rogers et al.'s (2022) self-compassion intervention can even promote mindful self-care.

But unlike self-compassion, researchers and many others who are not researchers seem to have the same ideas of self-care practices. For example, medical, social work, and music therapy students and palliative care professionals agreed that self-care involves eating healthy, exercising regularly, and spending time with friends and family (Ayala et al., 2017; Mills et al., 2018; Moore et al., 2011; Wilhelm & Moore, 2023). However, most studies on self-care definitions examined the perspectives of helping professionals (Truscott et al., 2023), who already know how to take care of themselves because of their training. Most people, who do not have that formal training, might have less clear ideas on how to take care of themselves. Egan and Mantzios (2018) noticed that participants, despite identifying exercising as self-care, failed to consider self-kindness as self-care. During the COVID-19 pandemic, some LGBTQ+ adolescents reported “taking care” of themselves by turning to alcohol and drugs (O’Brien et al., 2021). Although there is more consensus on self-care than on self-compassion in the general public, little effort has been made to inspect perceptions of self-care practices among people who are not helping professionals. Also, no study to date has compared people’s behavioural interpretations of both self-compassion and self-care.

The Current Research

The first goal of the current research was to explore how people interpret eating behaviours as expressions of self-compassion and how well such interpretations align with (a) researchers’ understanding of self-compassion and (b) people’s interpretations of self-care. To reach this goal, Study 1 measured self-compassion interpretations by asking participants to indicate which adaptive and maladaptive eating behaviours they consider as expressions of self-compassion and self-care in an online survey. While Study 2 measured self-compassion

interpretations by asking participants to rate how much of the healthy and unhealthy foods provided they would eat to enact self-compassion in a laboratory setting.

The second goal was to examine the inter-relationships of state self-compassion, self-compassion interpretations, and eating behaviours. By assessing (Study 1) and manipulating (Study 2) state self-compassion, as well as measuring adaptive and maladaptive eating behaviours, I was able to examine how state self-compassion and self-compassion interpretations predict eating behaviours. Study 2 also extended current research by testing whether self-compassion interpretations could play a moderating role within the relationship between self-compassion and eating. My hypothesis was that self-compassion interpretations would moderate the connection between state self-compassion and eating. More specifically, adaptive self-compassion interpretations would lead participants in the self-compassion condition to make healthy and adaptive eating choices (i.e., eating more healthy and less unhealthy foods) while maladaptive self-compassion interpretations would lead them to make indulgent and maladaptive eating choices (i.e., eating less healthy and more unhealthy foods). This research aimed to develop the theoretical understanding of the decision-making mechanisms of self-compassion's influence on health and well-being, and the practical understanding of the implications of self-compassion's widespread promotion in society as a means of improving mental and physical health.

Study 1

Method

The aim of Study 1 was to explore how people conceptualize self-compassion and self-care in the context of eating, as well as to examine the relationship between self-compassion, eating behaviours, and interpretations of self-compassion and self-care. Therefore, this study

employed many widely used measures in self-compassion research and eating behaviours research. However, since there are no quantitative measures for self-compassion perceptions in relation to eating, I created a simple categorical measure based on commonly used scales for both adaptive and maladaptive eating styles. This measure allowed me to investigate the specific eating behaviours people associate with self-compassion and self-care.

Participants

In Study 1, I recruited 219 participants through the University of Manitoba's Psychology Research Participation Pool. Each participant received one research-participation credit in their Introduction to Psychology course for completing the online survey. As there were no exclusion criteria for this study, any student who attended the Introduction to Psychology course during the time of data collection was eligible. The study was approved by the University of Manitoba's research ethics board (HE2024-0246).

Out of 219 participants recruited, 11 participants answered "No" to the honesty check: "Please answer 'Yes' to this question if you believe the researchers should use your answers to this survey, or 'No' if you believe they should not" and thus was removed from the data. Another three participants were excluded because they skipped one of the behavioural interpretation questions. Finally, while checking the writing tasks responses for identifying information, I noticed that one participant failed to follow the writing task instruction and removed their data from the final analysis. The final sample consists of 204 participants, which achieved an 80% power to detect small effect sizes ($d = .20$) in paired sample t -test and small-to-medium effect sizes ($f^2 = .04$) for multiple regression at the 0.5 level of significance. This sample size also had 80% power to detect small-to-medium correlations ($r = .20$) at the .05 level of significance, according to power analysis conducted using G*Power (Faul et al., 2009).

Participants were on average 20.43 years old ($SD = 5.63$) and had high English proficiency ($M = 4.71$, $SD = 0.58$). As detailed in Table 1, the overwhelming majority of the participants identified as women. However, participants' ethnic and cultural background were quite diverse. 17.2% and 26.5% of the sample reported that they had been diagnosed with or thought they had, respectively, an eating disorder and a mental health disorder. Such prevalences are similar to what other studies have found on rates of eating disorder (Lipson & Sonnevile, 2017) and mental health disorder (Sheldon et al., 2021) in the undergraduate student population.

Table 1*Study 1: Participants' Sociodemographic Characteristics*

Characteristic	<i>n</i>	%
Gender		
Woman	168	82.4
Man	35	17.2
Genderfluid	1	0.5
Ethnicity/Cultural Background		
White/European	75	36.8
Southeast Asian	43	21.1
Black/African	36	17.6
South Asian	18	8.8
Indigenous	11	5.4
East Asian	7	3.4
South or Latin America	4	2.0
West Asian, Middle Eastern, or Arab	4	2.0
West Indian	3	1.5
Mixed/Other	3	1.5
Household Income		
\$0-\$5000	32	15.7
\$5001-\$10,000	13	6.4
\$10,001-\$20,000	13	6.4
\$20,001-\$30,000	16	7.8
\$30,001-\$75,000	43	21.1
\$75,001-\$100,000	37	18.1
Over \$100,001	44	21.6
Missing	6	2.9
Parents' Education Level		
Less than high school	7	3.4
High school graduate	26	12.7
Some college	35	17.2
2-year degree	10	4.9
4-year degree	65	31.9
Professional degree	49	24.0
Doctorate	12	5.9
Eating Disorder	35	17.2
Mental Health Disorder	54	26.5

Note. *N* = 204.

Procedure

The first page of the survey required participants to indicate their consent to participate or else they would not be able to move forward (see Appendix B). After some demographic questions (e.g., age, gender, ethnicity, etc.), participants were asked whether they had received a diagnosis or thought they had an eating disorder or a mental health disorder recently. Participants then answered a physical activity questionnaire and two eating behaviour frequency assessments—one for adaptive eating and one for maladaptive eating. The survey then instructed participants to recall and write about a time when they had academic troubles. This writing task not only established a common and relevant context for engaging in self-compassion and adaptive or maladaptive eating, but also disengaged participants from the eating behaviours assessments before indicating their self-compassionate or self-caring eating behaviours. Participants had to write for at least 3 minutes before being able to move on to the next section. Afterwards, the survey assessed participants' state self-compassion with the State Self-Compassion Scale-Long Form (Neff et al., 2021), asking how they feel toward themselves at that moment. Next, participants reported which eating behaviours they would do to practice self-compassion and what eating behaviours they would to practice self-care. Both questions were presented in a counterbalance order and with a multiple-choice list of both adaptive and maladaptive eating behaviours. When the survey is completed, participants saw a debriefing page that explained the study and its purposes as well as provided participants with mental health resources in case they feel distressed writing about their academic troubles.

Measures

Physical Activity. As eating behaviours can be affected by one's level of physical activity, I measured participants' physical activity as a control variable using the International

Physical Activity Questionnaire (Craig et al., 2003; see Appendix C). The questionnaire asked participants to report the number of days in the past week they spent doing vigorous (e.g., heavy lifting, digging, aerobics, or fast bicycling) and moderate physical activity (e.g., carrying light loads, bicycling at a regular pace, or doubles tennis) as well as walking. Participants then indicated how much time in hours and minutes they usually spent doing those activities on one of those days. The International Physical Activity Questionnaire has been validated in many countries including Canada, Japan, Portugal, and South Africa. It showed concurrent and criterion validity as well as good reliability (0.8 in most samples; Craig et al., 2003). As instructed in the questionnaire's data processing and analysis guidelines, I transformed the reported duration from hours and minutes to minutes and removed missing and "don't know" answers from analysis. In cases where participants seemed to misunderstand the question format (e.g., wrote "3" for the hours and then "180" for the minutes, reported that they do vigorous activity four hours per day), I recoded their answers (e.g., disregarded the minutes, divided the extremely high hours by seven assuming they meant hours per week). A total physical activity score in MET-minutes per week was computed for each participant using the following equation:

$$\begin{aligned} \text{Total MET-minutes/week} = & \text{Walking MET-minutes/week } (3.3 * \text{walking minutes} * \text{walking days}) + \\ & \text{Moderate MET-minutes/week } (4.0 * \text{moderate activity minutes} * \text{moderate activity days}) + \\ & \text{Vigorous MET-minutes/week } (8.0 * \text{vigorous activity minutes} * \text{vigorous activity days}) \end{aligned}$$

MET scores are multiples of the resting metabolic rate and MET-minute scores represent kilocalories burned by a 60kg person (Craig et al., 2003).

Adaptive Eating. I only measured intuitive eating, using the Intuitive Eating Scale-2 (Tylka & Kroon Van Diest, 2013), as a proxy for adaptive eating and not measured mindful eating due to the scales' similarity and time constraint. The Intuitive Eating Scale-2 (see

Appendix D) comprised four subscales, descriptively named after the principles they measure: Unconditional Permission to Eat (6 items; e.g., “If I am craving a certain food, I allow myself to have it”), Eating for Physical rather than Emotional Reasons (8 items; e.g., “When I am bored, I do NOT eat just for something to do”), Reliance on Hunger and Satiety Cues (6 items; e.g., “I trust my body to tell me when to eat”), Body-Food Choice Congruence (3 items; e.g., “I mostly eat foods that give my body energy and stamina”). Participants indicated how each of the 23 statements characterizes their attitudes and behaviours on a scale from 1 (*Strongly disagree*) to 5 (*Strongly agree*). The Intuitive Eating Scale-2 has been translated into many languages—Turkish, French Canadian, Brazilian Portuguese, Chinese, and Hungarian to name a few—and validated in samples speaking those languages (Bas et al., 2017; Carbonneau et al., 2016; da Silva et al., 2020; Ma et al., 2019; Román et al., 2021) as well as the English-speaking sample (Tylka & Kroon Van Diest, 2013). After reversing the scores as instructed for items like “I try to avoid certain foods high in fat, carbohydrates, or calories,” I computed the adaptive eating score for each participant by averaging their responses on all 23 items. The scale had a Cronbach’s alpha of .83, indicating good internal consistency.

Maladaptive Eating. Participants’ maladaptive eating behaviours were assessed by the Three-Factor Eating Questionnaire-R18 (Karlsson et al., 2000; see Appendix E), which measured Cognitive Restraint (6 items; e.g., “I consciously hold back at meals in order not to gain weight”), Uncontrolled Eating (9 items; e.g., “Sometimes when I start eating, I just can’t seem to stop”), and Emotional Eating (3 items; e.g., “When I feel blue, I often overeat”). For most of the items, responses ranged from 1 (*Definitely true*) to 4 (*Definitely false*). Other items were in question form and require different responses (e.g., “Do you go on eating binges though you are not hungry?” *Never/Rarely/Sometimes/At least once a week*). The Three-Factor Eating

Questionnaire-R18 is also a well-validated scale with good reliability for both the obese and non-obese population (de Lauzon et al., 2004) and has been translated into many languages including Arabic, Finnish, and Chinese (Alhebshi et al., 2023; Anglé et al., 2009; Chong et al., 2016).

However, I decided to change the wording for the item “When I smell a sizzling steak or a juicy piece of meat, I find it very difficult to keep from eating, even if I just finished a meal” to “When I smell a delicious and tempting dish, I find it very difficult to keep from eating, even if I just finished a meal” to accurately estimate this Uncontrolled Eating item score for participants who do not eat meat. To calculate participants’ maladaptive eating score, I first reversed the scores for items like “How likely are you to consciously eat less than you want?” where a lower score indicates less maladaptive eating. Then I transformed the 8-point scale—where 1 means *no restraint in eating (eating whatever you want, whenever you want it)* and 8 means *total restraint (constantly limiting food intake and never ‘giving in’)*—into a 4-point scale. Participants’ maladaptive eating scores were the mean of their responses on all 18 items, and a lower score suggests maladaptive eating. For ease of interpretations, I reversed participants’ mean scores so that a lower score now means less maladaptive eating and a higher score means maladaptive eating. The scale had acceptable internal consistency ($\alpha = .79$).

Writing Prompt. After completing the eating assessments, participants were presented with this prompt:

Please think about a situation related to your academic life that is painful or difficult for you right now. It could be some struggle in your academic life, or perhaps you are feeling inadequate in some way. Please don’t think of a situation in which you are upset with someone else, but instead think of an academic situation where you are feeling badly

about yourself or you are going through a hard time. Decide on a single situation that you will focus on throughout this study.

This prompt was taken from the beginning of Neff et al.'s (2021) Self-Compassion Mindstate Induction, with a few words added to instruct participants to think specifically about academic troubles. Considering the undergraduate sample, I assumed that academic troubles would be common and easy to recall. Participants then rated how difficult the situation was for them personally on a scale from 1 (*Not at all difficult*) to 5 (*Extremely difficult*) and wrote about the situation "as descriptive as possible." Furthermore, the instructions ensured participants that their responses would be kept anonymous and confidential so that they felt free to write about their experiences (see Appendix F). Although the task is not often done online, evidence shows that people can write as emotionally online as in person (Sharp & Hargrove, 2004). Ultimately, this writing exercise placed participants' minds into a personally difficult situation, where self-compassion was relevant.

State Self-Compassion. Next, participants reported their self-compassion level at that moment, or state self-compassion, with the widely used State Self-Compassion Scale-Long Form (see Appendix G) developed by Neff et al. (2021). The State Self-Compassion Scale, reflecting the components of self-compassion, consisted of six components as well: self-kindness (3 items; e.g., "I'm being kind to myself"), self-judgment (3 items; e.g., "I'm being pretty tough on myself"), common humanity (3 items; e.g., "I'm remembering that there are lots of others in the world feeling like I am"), isolation (3 items; e.g., "I feel like I'm struggling more than others right now"), mindfulness (3 items; e.g., "I'm keeping my emotions in balanced perspective"), and over-identification (3 items; e.g., "I'm obsessing and fixating on everything that's wrong"). These 18 items were rated on a scale from 1 (*Not at all true for me*) to 5 (*Very true for me*). The

state self-compassion scale has been translated to Japanese, Spanish, and Turkish and has demonstrated its reliability (e.g., internal reliability, test-retest reliability) and validity (e.g., factor structure, criterion validity, predictive validity) in these samples (Chishima et al., 2022; Galiana et al., 2022; Ümmet et al., 2023) and the English-speaking sample (Neff et al., 2021). After reversing the scores for the items belonging to uncompassionate components, I computed the mean for all 18 items to be participants' state self-compassion scores. The scale had good internal consistency with a Cronbach's alpha of .89.

Eating Behaviours When Practicing Self-Compassion and Self-Care. Then, participants were presented with the instruction for the behavioural interpretation measure:

When facing difficult situations like the one you described, people exhibit different eating behaviours with certain goals. We would like you to think of the goal: [being compassionate to yourself/taking care of yourself]. With this goal in mind, please select all eating behaviours in the following list you would be likely to do.

The list (see Appendix H) consisted of both adaptive (11 items; e.g., “Relying on my body for what, when, and how much to eat”) and maladaptive eating behaviours (11 items; e.g., “NOT trusting my body to tell me when to stop eating”). The measure was intended to have 12 adaptive and 12 maladaptive behaviours but due to an error made when creating the survey, one adaptive (“Eating as normal after eating too much the previous day”) and one maladaptive behaviour (“Eating more than usual when I see others eating”) were not included in the list.

I compiled this list based on Kerin et al.'s (2019) study that aimed to find the core components of adaptive and maladaptive eating by analyzing the responses to the Intuitive Eating Scale (Tylka, 2006), the Mindful Eating Scale (Hubert-Williams et al., 2014), the Overeating Regulation Scale (Kerin et al., 2018), and the Dutch Eating Behaviour Questionnaire

(van Strien et al., 1986). Kerin et al. (2019) found that all 15 subscales of these four common eating assessments mapped onto four principal components: Attuned Eating (i.e., the ability to be aware and be free of distraction when you are eating), Unrestrained Eating (i.e., the ability to be flexible, non-rigid, and non-judgmental about what and when you eat), Eating and Hunger Awareness (i.e., the ability to notice the properties of foods as well as your own physical level of hunger and satiety), and Casual Eating Attitudes (i.e., the ability to refrain from eating automatically or becoming irritable when hungry).

Looking at these four principal components and the 15 subscales that loaded onto them, I found that many subscales are measuring the same construct. Emotional Eating, for instance, is measured in the Intuitive Eating Scale (Tylka, 2006), the Dutch Eating Behaviour Questionnaire (van Strien et al., 1986), and the Overeating Regulation Scale (Kerin et al., 2018). Combining subscales and items that are similar, I ended up with 11 constructs, each represented with an adaptive and a maladaptive eating behaviour (Table 2). I also added one adaptive (“Eating food that I planned for or took time to prepare”) and one maladaptive eating behaviour (“Treating myself with alcohol”) that were found in Egan and Mantzios’ (2018) qualitative study but are not in any of the four eating measures. The wide variety of eating behaviours with known adaptive and maladaptive characteristics allowed me to examine whether participants associated self-compassion and self-care with adaptive or maladaptive eating styles.

Table 2*Adaptive and maladaptive behaviour items for each eating constructs*

Principal component and construct	Adaptive	Maladaptive
Attuned eating		
Emotional eating	Finding other ways to cope with negative emotions without turning to food for comfort	Eating while I'm emotional (e.g., lonely, depressed, bored, irritated, stressed, etc.) even when I'm not hungry
Being present when eating	Being aware of my food while eating	Eating while multitasking or distracted
External eating	Eating the usual amount I eat when eating with others	Eating more than usual when I see others eating*
Eating according to availability	Resisting eating too much when there are delicious or high-calorie foods available	Eating more delicious or high-calorie food when they are available
Unrestrained eating		
Unconditional permission to eat	Allowing myself to eat food that I crave	NOT allowing myself to eat forbidden foods
Non-judgmental eating	NOT evaluating whether my eating is right or wrong	Criticizing myself for what and how much I eat
Restrictive eating	Eating as normal after eating too much the previous day*	Taking into account my weight when eating
Eating and hunger awareness		
Eating according to hunger cues	Relying on my body for what, where, and when to eating	NOT trusting my body to tell me when to stop eating
Eating with awareness	Noticing appearances, aromas, flavours, and textures of food	Eating to fuel up only
Casual eating attitudes		
Non-reactive to hunger	Being able to tolerate being hungry for a while	Eating like clockwork
Flexible eating	Eating different things everyday	Having a routine for what and when I eat

*Not in the survey due to coding mistake.

To do so, I used Signal Detection Theory (Green & Swets, 1966) as a statistical framework. Signal Detection Theory posits that there are two core factors underlying a judgment

with two choices—sensitivity and threshold. Sensitivity refers to one’s ability to make correct judgments whereas threshold refers to one’s tendency to favour one choice over the other. Since selecting a behaviour in the categorical measure is a judgment with two choices (i.e., selecting or not selecting), a participant’s sensitivity score can show how adaptive they considered self-compassion and self-care. Similarly, a participant’s threshold score can show whether they considered every behaviour to be self-compassion or self-care. Both scores are based on each participant’s number of adaptive judgment (i.e., hit—identifying adaptive behaviours as self-compassion and self-care) and maladaptive judgment (i.e., false alarm—identifying maladaptive behaviours as self-compassion and self-care). Based on this framework, I calculated participants’ sensitivity scores, or adaptive interpretations in this case, using the formula below:

$$\text{Sensitivity } d' = z(\text{Hit}) - z(\text{False alarm})$$

and participants’ threshold scores, or bias in this case, using the formula below:

$$\text{Threshold } C = -\frac{z(\text{Hit}) + z(\text{False alarm})}{2}$$

Results

Self-Compassion Behavioural Interpretations

Using cross-tabulations, I examined the frequency of each eating behaviour being identified as expressions of self-compassion, self-care, both self-compassion and self-care, or neither self-compassion nor self-care (see Table 3). Participants on average identified 7.26 ($SD = 3.41$) and 7.49 ($SD = 3.47$) behaviours as self-compassion and self-care, respectively. All observed frequencies differed from an equal distribution, evident by the significant chi-square statistics (all p -values $< .001$). Of note, almost all adaptive behaviours (except for “Resisting eating too much when there are delicious or high-calorie foods available” and “NOT evaluating whether my eating is right or wrong”) were considered as self-compassion, self-care, or both by

more than half of participants. Compared to adaptive behaviours, only one maladaptive behaviour (i.e., “Having a routine for what and when I eat”) was considered as such by more than half of the participants.

I further explored how adaptively participants viewed self-compassion and self-care by comparing the number of adaptive behaviours and maladaptive behaviours selected by each participant. On average, participants selected 4.82 ($SD = 2.51$) adaptive and 2.44 ($SD = 1.77$) maladaptive behaviours for self-compassion; and 4.86 ($SD = 2.54$) adaptive and 2.63 ($SD = 1.73$) maladaptive behaviours for self-care. Wilcoxon signed-rank tests revealed that the number of adaptive behaviours selected was significantly higher than the number of maladaptive behaviours selected for both self-compassion ($z = -9.65, p < .001$) and self-care ($z = -9.47, p < .001$). However, participants still identified many maladaptive behaviours as self-compassion and/or self-care. For example, approximately 30% thought of “Criticizing myself for what and how much I eat” and 44% thought of “Eating more delicious or high-calorie food when they are available” as self-compassion and self-care.

Finally, I would like to point out a theme I noticed when contrasting participants’ behavioural interpretations of self-compassion and self-care. Regardless of adaptiveness, behaviours that were more often considered as self-compassion than self-care seemed to involve indulging and eating more (e.g., “Allowing myself to eat food that I crave,” “Eating more delicious or high-calorie food when they are available,” and “Treating myself with alcohol”). But behaviours that were more often considered as self-care than self-compassion seemed to involve restricting and eating less (e.g., “Resisting eating too much when there are delicious or high-calorie foods available,” “Being able to tolerate being hungry for a while,” and “Taking into account my weight when eating”).

Table 3*Cross-tabulations of behavioural interpretation frequency for each eating behaviour*

Eating behaviour	Behavioural interpretation								
	Both self-compassion and self-care		Self-compassion but not self-care		Self-care but not self-compassion		Neither self-compassion nor self-care		χ^2
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	
Adaptive behaviour									
Finding other ways to cope with negative emotions without turning to food for comfort ^b	83	40.69	19	9.31	29	14.22	73	35.78	59.13*
Being aware of my food while eating ^b	71	34.80	26	12.75	37	18.14	70	34.31	31.02*
Eating the usual amount I eat when eating with others ^a	58	28.43	30	14.71	24	11.76	92	45.10	56.86*
Resisting eating too much when there are delicious or high-calorie foods available ^b	33	16.18	12	5.88	32	15.69	127	62.25	156.61*
Allowing myself to eat food that I crave ^a	78	38.23	50	24.51	28	13.73	48	23.53	24.86*
NOT evaluating whether my eating is right or wrong ^a	30	14.71	35	17.16	28	13.73	111	54.41	94.63*
Relying on my body for what, where, and when to eat ^a	63	30.88	33	16.18	19	9.31	89	43.63	57.57*
Noticing appearances, aromas, flavours, and textures of food ^a	58	28.43	29	14.22	20	9.80	97	47.55	70.78*
Being able to tolerate being hungry for a while ^b	53	25.98	24	11.76	44	21.57	83	40.69	35.41*
Eating different things everyday ^a	60	29.41	36	17.65	28	13.73	80	39.22	32.86*
Eating food that I planned for or took time to prepare ^b	84	41.18	18	8.82	32	15.69	70	34.31	56.86*

Eating behaviour	Both self-compassion and self-care		Self-compassion but not self-care		Self-care but not self-compassion		Neither self-compassion nor self-care		χ^2
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	
Maladaptive behaviour									
Eating while I'm emotional (e.g., lonely, depressed, bored, irritated, stressed, etc.) even when I'm not hungry ^a	19	9.31	20	9.80	14	6.86	151	74.02	261.84*
Eating while multitasking or distracted ^a	30	14.71	29	14.22	24	11.76	121	59.31	128.51*
Eating more delicious or high-calorie food when they are available ^a	25	12.25	41	20.10	23	11.27	115	56.37	110.90*
NOT allowing myself to eat forbidden foods ^b	17	8.33	10	4.90	25	12.25	152	74.51	268.90*
Criticizing myself for what and how much I eat ^b	18	8.82	17	8.33	27	13.24	142	69.61	217.69*
Taking into account my weight when eating ^b	37	18.14	20	9.80	36	17.65	111	54.41	97.69*
NOT trusting my body to tell me when to stop eating ^b	8	3.92	11	5.39	13	6.37	172	84.31	383.02*
Eating to fuel up only ^b	44	21.57	15	7.35	36	17.65	109	53.43	96.74*
Eating like clockwork ^b	12	5.88	11	5.39	13	6.37	168	82.35	357.92*
Having a routine for what and when I eat ^b	51	25.00	31	15.20	43	21.08	79	38.73	24.47*
Treating myself with alcohol ^a	16	7.84	16	7.84	6	2.94	166	81.37	347.06*

^a Behaviours more often considered as self-compassion than self-care.

^b Behaviours more often considered as self-care than self-compassion.

* $p < .001$

Table 4*Study 1: Descriptive Statistics and Correlation Coefficients for Study Variables*

Variable	<i>M</i>	<i>SD</i>	1	2	3	4	5	6	7	8
1. State SC	3.03	0.68	—							
2. Adaptive Eating Tendency	3.43	0.54	.32***	—						
3. Maladaptive Eating Tendency	1.26	0.41	-.15*	-.56***	—					
4. Physical Activity ^a	3634	2683	-.06	-.02	.03	—				
5. Adaptive Interpretations of SC (<i>d'</i>)	0.00	1.23	.15*	.08	-.17*	-.09	—			
6. Bias for SC (<i>C</i>)	0.00	0.79	-.02	.07	-.03	-.17*	.00	—		
7. Adaptive Interpretations of Self-care (<i>d'</i>)	0.00	1.18	.21**	.34***	-.29***	-.03	.37***	-.13	—	
8. Bias for Self-care (<i>C</i>)	0.00	0.80	-.02	.12	-.06	-.24**	-.17*	.66***	.00	—

Note. *N* = 204. SC = Self-compassion.^a In MET-minutes. *N* = 148.**p* < .05. ***p* < .01. ****p* < .001

Self-Compassion, Self-Compassion Interpretations, and Eating Behaviours

To investigate the bivariate relationships among the study variables, I performed correlational analysis for state self-compassion, eating behaviours, physical activity levels, adaptive interpretations of and bias for self-compassion and self-care (i.e., sensitivity and threshold scores). As shown in Table 4, well-known correlations between self-compassion and adaptive eating as well as maladaptive eating were re-established. Of particular interest, state self-compassion was positively related to both adaptive interpretations of self-compassion and of self-care, suggesting that people higher in self-compassion are more likely to associate adaptive behaviours with self-compassion and self-care. However, state self-compassion was not related to bias for self-compassion and self-care, or the extent to which a participant considers every behaviour as self-compassion and self-care. These results indicate that regardless of self-compassion tendency, participants did not differ in their bias towards self-compassion and self-care. But participants' bias towards self-compassion was highly associated with bias towards self-care. Adaptive interpretations of self-compassion and of self-care were also positively and moderately correlated with each other. Regarding eating behaviours, maladaptive eating was negatively related to both adaptive interpretations of self-compassion and self-care. Unlike maladaptive eating, adaptive eating was only related to adaptive interpretations of self-care but not to adaptive interpretations of self-compassion. Unexpectedly, physical activity level was not related to any main variables of interest, thus was not taken into account in later analyses.

To further examine the relationship between self-compassion, self-compassion interpretations, and eating behaviours, I ran multiple regression models for adaptive and maladaptive eating separately, with state self-compassion, adaptive interpretations of self-compassion and self-care as predictors (see Table 5). None of the assumptions for multiple

regression analysis (e.g., multicollinearity, homoscedasticity) were seriously violated. Both models were statistically significant (adaptive eating: $R^2 = .18$, $F(3, 200) = 15.01$, $p < .001$; maladaptive eating: $R^2 = .09$, $F(3, 200) = 6.99$, $p < .001$). For adaptive eating, self-compassion and adaptive interpretations of self-care were significant predictors but adaptive interpretations of self-compassion were not. Adaptive interpretations of self-care were also a significant predictor for maladaptive eating while self-compassion and adaptive interpretations of self-compassion were not¹.

Table 5

Regression Models Predicting Adaptive and Maladaptive Eating Tendencies

Predictor	<i>b</i>	<i>SE</i>	<i>t</i>	<i>p</i>
Adaptive Eating				
Intercept	2.78	0.16	17.05	< .001
State Self-Compassion	0.27	0.05	4.09	< .001
Adaptive Interpretations of Self-Compassion	-0.07	0.03	-1.03	.306
Adaptive Interpretations of Self-Care	0.31	0.03	4.40	< .001
Maladaptive Eating				
Intercept	1.42	0.13	10.79	< .001
State Self-Compassion	-0.09	0.04	-1.26	.208
Adaptive Interpretations of Self-Compassion	-0.07	0.02	-.96	.340
Adaptive Interpretations of Self-Care	-0.24	0.03	-3.31	.001

Note. $N = 204$.

Discussion

The purpose of Study 1 was to examine lay conceptualizations of self-compassion and self-care in the context of eating and to relate these conceptualizations to self-compassionate feelings and eating behaviours. The results showed that participants associated self-compassion

¹ When participants who indicated that they had been diagnosed with or thought that they had an eating and/or mental health disorder were removed, correlational and regression analyses produced similar results

and self-care with more adaptive eating behaviours than maladaptive ones, indicating that in general, people have adaptive interpretations of self-compassion and self-care. Such interpretations also positively correlated with state self-compassion, meaning self-compassionate individuals were more likely to have adaptive interpretations of the two concepts.

Although people seem to view self-compassion and self-care as adaptive overall, it is hard to ignore the substantial number of participants who considered maladaptive behaviours like “Taking into account my weight when eating” as self-compassion and self-care. These quantitative findings reflected and expanded on the qualitative findings on self-compassion and self-care interpretations. As mentioned, qualitative studies demonstrated that people have mixed perceptions of self-compassion and self-care: Some considered adaptive behaviours like accepting others’ help as self-compassion (Campion & Glover, 2017) and exercising as self-care (Egan & Mantzios, 2018); Some considered maladaptive behaviours like isolating oneself as self-compassion (Halamová et al., 2022) and using substances as self-care (O’Brien et al., 2021). But Study 1 showed that people did not consider both adaptive and maladaptive behaviours as equally representative of self-compassion and self-care. Rather, adaptive eating behaviours made up the largest part, but not all, of what most people consider to be self-compassionate and self-caring.

Another interesting finding is that self-compassion was more often affiliated with indulgent eating behaviours while self-care was more often affiliated with restrictive eating behaviours, suggesting a distinction between the two concepts. Furthermore, only adaptive interpretations of self-care predicted adaptive and maladaptive eating, whereas adaptive interpretations of self-compassion did not. These results echoed participants’ view of self-compassion and self-care in Egan and Mantzios’ (2018) qualitative study, as expressed in one

participant's statement: "I think there's a difference between being kind to yourself and looking after yourself" (p. 7). But the moderate correlation between adaptive interpretations of self-compassion and self-care, together with the strong correlation in biased interpretations (i.e., one's likelihood of judging all eating behaviours as self-compassion and self-care), imply that people view the two concepts as somewhat overlapping.

Correlational analysis also showed that state self-compassion was related to adaptive interpretations of self-compassion and self-care. State self-compassion was also not related to bias towards or viewing all behaviours as self-compassion and self-care, meaning people feeling self-compassionate seem to have better discrimination between adaptive and maladaptive eating behaviours in their interpretations of self-compassion and self-care. It is possible that participants' reported state self-compassion in response to an academic struggle stemmed from their (unmeasured) trait self-compassion and that one's trait self-compassion ultimately explains the observed association between state self-compassion, associates with more adaptive interpretations. Many participants in qualitative studies believed that self-compassion is "letting yourself off the hook" (Dunkley-Smith et al., 2021) and makes people "passive" and "weak" (Iacono et al., 2023), but these results showed that people letting themselves feel self-compassion do not self-license and ascribe maladaptive behaviours to self-compassion and self-care.

Among all three variables, adaptive interpretations of self-care was the strongest predictor for both adaptive and maladaptive eating. In other words, participants seemed to act according to the behaviours they associated with self-care, similar to the Tumblr user described in the beginning of this thesis. However, the regression results showed that the influences of state self-compassion and interpretations of self-care on adaptive eating tendencies were independent and about equal in importance, meaning the person most likely to eat adaptively is one who is

high in state self-compassion and who associates adaptive eating behaviours with their concept of self-care. Moreover, compassion—be it for others or for oneself—is intrinsically imbued with care and caring behaviours (Neff, 2003a). As such, what could be happening is that state self-compassion, instead of encouraging people to eat according to their interpretations of self-compassion and maintain their self-compassionate state, actually encouraged people to take care of themselves and eat according to their interpretations of self-care. Nevertheless, it seems that the motivation and the knowledge structure are both important for eating adaptively, and promoting one without the other as many interventions did (Barbeau et al., 2022; Brenton-Peters et al., 2023; Kelly & Waring, 2018; Rahimi-Ardabili et al., 2020) might not be enough to cause behaviour change.

The results of Study 1 expanded previous findings about people's definitions of self-compassion and self-care: Participants associated self-compassion and self-care mostly with adaptive behaviours but also partly with maladaptive behaviours. Further, the results showed that participants have distinct but somewhat overlapping definitions of self-compassion and self-care. Study 1 also revealed the effect of self-compassion and interpretations of self-care on adaptive eating behaviours as well as the effect of interpretations of self-care on maladaptive eating behaviours. However, due to Study 1's correlational nature, it is impossible to conclude whether self-compassion and different interpretations of self-compassion lead to different eating behaviours. Thus, the aim of Study 2 was to observe participants' eating behaviours and capture their interpretations after instilling self-compassion experimentally.

Study 2

Method

Study 2 experimentally examined the moderating role of self-compassion interpretations in the relationship between self-compassion and eating behaviours. Self-compassion was manipulated using a brief but effective self-compassion induction (Neff et al., 2021). Eating behaviours were then assessed by a bogus taste test—a food choosing task in actuality. Finally, participants' interpretations of self-compassion as food choice and consumption were measured discreetly during the bogus taste test.

Participants

Study 2 recruited 219 participants from University of Manitoba's Psychology Research Participation Pool, who were compensated with research participation credits for the Introduction to Psychology course. Since participants must be able to sample the four foods provided in the study, people who have allergies or intolerances towards any of the four foods were not eligible. Participants who reported that they have previously been diagnosed with any medical conditions such as diabetes that prevent them from freely eating the food provided were excluded as well. Participants were informed about these eligibility criteria via the recruitment material, the consent form, and the reminder emails. The experimenter also screened participants for the eligibility criteria when they arrived at their sessions. Data collection started after the University of Manitoba's Research Ethics Board approved the procedures for this study (HE2024-0262).

One participant with severe peanut allergy was given participation credit and turned away since I could not guarantee that the foods did not contain trace amount of peanut. To clean the data, I first removed six participants' data because they skipped either parts of the writing task or questions in the food rating sheet. Eight participants failed the writing task's compliance check but only one was determined by two raters to be non-compliant with the instructions and thus removed from the final analysis. Another two were excluded because their writing showed

failure to follow the writing task instructions. Finally, I excluded one participant who, during the taste test, put all of the food provided into their container brought from home. The final sample comprised 208 participants, which had 80% power to detect small-to-medium effect sizes ($f^2 = .04$) in moderation analysis at the .05 significance level. The same sample size can identify small-to-medium correlations ($r = .20$) with 80% power at the .05 significance level (G*Power; Faul et al., 2009).

Similar to Study 1, participants were young ($M = 19.23$, $SD = 2.71$), had high English proficiency ($M = 4.76$, $SD = 0.51$), and came from diverse ethnic and cultural background. The majority of the sample identified as women (see Table 6). Study 1 and Study 2 had similar number of participants reporting that they have been diagnosed with or thought they had a mental health disorder (Study 1: 26.5%; Study 2: 25%), inline with prevalences found in other studies (Sheldon et al., 2021). As expected for a study involving an in-person taste test, there were less participants who reported to have been diagnosed with or thought they had an eating disorder (10.6%) in Study 2 compared to Study 1 (17.2%). Shown in Table 6, the two conditions were also similar in sociodemographic characteristics.

Table 6*Study 2: Participants' Sociodemographic Characteristics by Condition*

Characteristic	Self-Compassion Condition		Control Condition		Total	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
Gender						
Woman	71	34.3	61	30.9	135	65.2
Man	31	15.0	39	18.8	70	33.8
Gender Nonconforming	1	0.5	1	0.5	2	1.0
Ethnicity/Cultural Background						
White/European	35	16.9	33	15.9	68	32.9
Black/African	21	10.1	23	11.1	44	21.3
Southeast Asian	18	8.7	17	8.2	35	16.9
South Asian	7	3.4	10	4.8	17	8.2
Indigenous	8	3.9	3	1.4	11	5.3
East Asian	5	2.4	5	2.4	10	4.8
South or Latin America	4	1.9	4	1.9	8	3.9
West Asian, Middle Eastern, or Arab	0	0	5	2.4	5	2.4
West Indian	3	1.4	0	0	3	1.4
Mixed/Other	2	1.0	4	1.9	6	2.9
Household Income						
\$0-\$5000	13	6.4	11	5.4	24	11.8
\$5001-\$10,000	6	3.0	5	2.5	11	5.4
\$10,001-\$20,000	4	2.0	5	2.5	9	4.4
\$20,001-\$30,000	7	3.4	6	3.0	13	6.4
\$30,001-\$75,000	28	13.8	26	12.8	54	26.6
\$75,001-\$100,000	18	8.9	21	10.3	39	19.2
Over \$100,001	25	12.3	28	13.8	53	26.1
Parents' Education Level						
Less than high school	4	1.9	2	1.0	6	2.9
High school graduate	7	3.4	11	5.3	18	8.7
Some college	13	6.3	22	10.7	35	17
2-year degree	5	2.4	6	2.9	11	5.3
4-year degree	34	16.5	26	12.6	60	29.1
Professional degree	33	16.0	33	16.0	66	32.0
Doctorate	7	3.4	3	1.5	10	4.9
Eating Disorder	11	5.3	11	5.3	22	10.6
Mental Health Disorder	32	15.5	20	9.7	52	25.1

Note. $N = 208$.

Procedure

Participants were told that the study examined how current experiences affect taste perceptions. To control for hunger, I instructed participants to eat something two hours before their session. The instruction was emailed to participants twice, a day before and again about two to four hours before their respective sessions, to remind and give them enough time to follow the instruction (see Appendix I). After reading the consent form with clearly outlined eligibility criteria (see Appendix J) and providing their written consent, participants were screened for the exclusion criteria and asked about their instruction compliance and hunger level.

Participants then completed the demographics, physical activity questionnaire, eating behaviours assessments, the writing task, and the follow-up on a computer. The demographic questions, the physical activity questionnaire, and the eating assessments were the same as Study 1. The writing task, randomly assigned to be either the Self-Compassion Mindstate Induction writing task or the control writing task, lasted for at least 6 minutes. A follow-up State Self-Compassion Scale (Neff et al., 2021) was administered afterwards to check if the manipulation increased self-compassion. While participants were completing the computer survey, the experimenter prepared for the bogus taste test, weighing and portioning the foods on four identical serving bowls using a food scale. After completing the follow-up and notifying the experimenter, participants were presented with four equally filled bowls of four foods: green seedless grapes (low calorie, sweet); hummus with baby carrots (low calorie, savoury); jujubes candy (high calorie, sweet); potato chips (high calorie, savoury). The experimenter instructed participants to taste each food and rate the food on a rating sheet. The experimenter also told participants to eat as much as they want after completing the task since the leftover foods would

be thrown away for sanitation purposes. The rating sheet asked participants to indicate their preference for the food, the taste of the food, and how much of the food would they eat if they wanted to practice self-compassion. The experimenter then left the room and came back after 10 minutes to debrief the participant, informing them about the study's deception and true purpose. Lastly, the experimenter weighed the left-over foods before discarding them.

Measures

Screening. After providing their written consent, participants were screened for relevant food allergies or intolerances and for medical conditions that might prevent them from eating freely. Participants who did not pass the screening were turned away but still received participation credit. Participants who passed the screening continued with the study (see procedure script in Appendix N).

Instruction Compliance and Hunger. The experimenter then asked participants questions about the study's instruction: "Did you follow the study's instruction to eat something two hours before your session?" and "When was the last time you ate something?" To measure participants' hunger, the experimenter also asked when they last ate something and how hungry they were on a scale from 1 (*Not hungry at all*) to 5 (*Extremely hungry*; Hussain et al., 2021).

Physical Activity, Adaptive and Maladaptive Eating. On a computer, participants completed the same measures for physical activity (International Physical Activity Questionnaire; Craig et al., 2003), adaptive (Intuitive Eating Scale-2; Tylka & Kroon Van Diest, 2013) and maladaptive eating (Three-Factor Eating Questionnaire-R18; Karlsson et al., 2000) as Study 1 (see Appendix C, D, and E). Like Study 1, both the Intuitive Eating Scale-2 ($\alpha = .83$) and the Three-Factor Eating Questionnaire-R18 ($\alpha = .74$) showed acceptable internal consistency.

Self-Compassion Condition and Control Condition. Afterwards, all participants saw the same prompt in Study 1, instructing them to think of an academically difficult situation. For participants who were randomly assigned to the self-compassion condition, they were guided to write about the situation with mindfulness (“As you write and notice your feelings, see if you can validate your experience with an attitude of acceptance and non-judgment”), common humanity (“Please write about how other people may share similar feelings when encountering situations like this”), and self-kindness (“Please write any words of support, encouragement and kindness to yourself that would be helpful to hear right now”), respectively. For participants who were randomly assigned to the control condition, they were instructed to describe their difficult situation (“Please write about what exactly is occurring in this difficult situation”), the people involved (“Please describe the people involved with as much detail as possible, even if you are the only one involved - in this case describe yourself”), and words spoken in the situation (“Please write any words that have been spoken in the situation, either what you have said to yourself, what other people have said to you, or what you have said to other people”), respectively. Essentially, the control writing prompts paralleled the self-compassion writing prompts but without the self-compassion perspective. All participants also saw examples for each writing prompt and reminders that their responses would be anonymous and confidential to facilitate emotional writing (Neff et al., 2021; see Appendix K).

The writing task was set up so that participants could only progress to the next task after six minutes. Participants who finished writing in less than six minutes were instructed to wait or write more if they wanted. Then, a compliance check required all participants to indicate what they were just asked to do among three options: (a) “Write about your feelings in an accepting and validating way, consider how going through difficult situations is part of being human, write

to yourself like a supportive friend;” (b) “Write about the situation and try to figure out how to solve the problem;” (c) “Write the details of the situation, who is involved, and what was said with as much detail as possible.” Participants in the experimental condition passed the check if they chose (a) and participants in the control condition passed if they chose (c) (Neff et al., 2021).

Neff et al. (2021) have shown that the Self-Compassion Mindstate Induction can effectively increase self-compassion in the experimental group relative to the control group. Tracking pre and post state self-compassion, the Self-Compassion Mindstate Induction produced similar effect sizes when using both the State Self-Compassion Scale-Long Form ($\hat{\eta}_p^2 = 0.43$) and the State Self-Compassion Scale-Short Form ($\hat{\eta}_p^2 = 0.40$). Again, the large effect size was replicated when the State Self-Compassion Scale-Short Form was used by itself ($\hat{\eta}_p^2 = 0.59$; Neff et al., 2021). Although the self-compassion writing task is not commonly done on the computer, similar self-compassion writing tasks have successfully increased self-compassion in several online studies (Bailey et al., 2022; Huellemann et al., 2023).

State Self-Compassion Scale-Short Form. As a manipulation check, participants completed the State Self-Compassion Scale-Short Form (Neff et al., 2021; see Appendix L) following the writing task. This scale contains six items, one highest factor loading item for each component of self-compassion, on a 5-point Likert scale ranging from *Not at all true for me* to *Very true for me*. Like the long version, the short version of State Self-Compassion Scale has been translated to Turkish and illustrated its reliability and validity in the Turkish sample (Ümmet et al., 2023) and the English-speaking samples in Neff et al.’s (2021) studies. After participants submitted the follow-up, the computer survey instructed them to notify the experimenter for the final task. To calculate participants’ state self-compassion, I first reversed

the scores for the three uncompassionate items and then averaged the scores for all six items. The scale had acceptable internal consistency ($\alpha = .70$).

Bogus Taste Test. Participants' final task was a food choosing task, disguised as a taste test. The experimenter provided participants with a glass of water and equally filled bowls of four sweet and savoury foods:

- green seedless grapes (75g–95g portion, approximately 60kcal–76kcal);
- hummus with baby carrots (20g–35g portion of hummus, approximately 40kcal–70kcal; 50g–65g portion of carrots, approximately 21kcal–27kcal);
- jujubes candy (50g–65g portion, approximately 163kcal–212kcal);
- potato chips (15g–25g portion, approximately 84kcal–140kcal).

The foods were all vegan and gluten-friendly to accommodate as many diets as possible. The experimenter counterbalanced the presentation order of the bowls across participants and always wore gloves while handling the food (i.e., portioning and weighing the food). Participants were then told:

Please have at least a taste of each item so that you can rate them on the page for that food. Here's some water for you to cleanse your palate between each item. Please make sure to rate the item you just ate before moving on to the next. You are welcome to have as much of each food as you want in order to answer the questions on the form. It is important that you answer the questions on the form as accurately as you can, so if you need more food to answer the questions, please let me know, I'm just right next door. And if you finish early, feel free to eat as much as you want. For sanitation purposes, we have to throw it away after you go anyway. We're giving everyone the same amount of

time for this task, so I'll check back in on you after 10 minutes (adapted from M. Gerend, personal communication, May 2, 2024).

Participants were then left alone to rate the foods and eat as much as they liked for 10 minutes. The rating sheet (see Appendix M) asked participants to rate the food in terms of preference ("How much do you like this food?") and taste ("How sweet/savoury is this food?") to mimic a taste test (Robinson et al., 2017). Participants were also asked about their self-compassion interpretations of each food (i.e., how much of each food they would eat if they wanted to practice self-compassion) on a scale from 1 (*None*) to 5 (*A lot*). After 10 minutes, the experimenter returned to the room to debrief the participants. Finally, the experimenter weighed and disposed of the left-over foods. Meta-analysis of 31 studies that used the bogus taste test have shown that the bogus taste test in a laboratory setting is valid and sensitive to experimental manipulation (Robinson et al., 2017).

Participants' consumption of each food in grams was converted into kcal using nutritional information provided by the manufacturer and the USDA's database (<https://fdc.nal.usda.gov/>). To investigate low-calorie and high-calorie foods separately and to avoid conducting multiple analyses for four foods, I created several composite scores: Participants' healthy food consumption was the sum of their caloric intake of the low-calorie foods—grapes and hummus and carrots; Participants' unhealthy food consumption was the sum of their caloric intake of the high-calorie foods—jubes candy and potato chips. Responses to the self-compassion interpretation questions for the low-calorie foods were summed to create the healthy interpretations of self-compassion variable. Similarly, responses to the interpretation questions for the high-calorie foods were summed to create the unhealthy interpretations of self-compassion variable. Since participants' preferences can play a large role in their food

consumption (Robinson et al., 2017), I computed composite scores for preferences to use as controlling variables. Preference for healthy foods is the sum of preferences for grapes and hummus and carrots. Preference for unhealthy foods is the sum of preferences for jujubes candies and potato chips. For both self-compassion interpretations and food preferences, the lowest possible score was two and the highest possible score was ten.

Results

In general, participants' hunger was controlled. Out of 208 participants, only seven admitted that they did not follow the study's instructions to eat something two hours before their session. On average, participants reported to have eaten about 140 minutes ($SD = 2.31$) before their session and most participants (77.9%) said they were either slightly hungry or moderately hungry. Only 14.4% reported being not hungry at all and 7.7% reported being very or extremely hungry. To check if the self-compassion manipulation worked, I used an independent sample t -test to compare the state self-compassion levels of participants in self-compassion condition and the control condition. Participants in the self-compassion condition ($M = 3.44$, $SD = 0.69$) indeed had higher state self-compassion than participants in the control condition ($M = 3.13$, $SD = 0.72$), $t(206) = 3.19$, $p = .002$, $d = 0.44$, 95% CI [0.17, 0.72]. Independent sample t -tests also showed that the two conditions did not significantly differ in hunger levels, physical activity levels, adaptive and maladaptive eating, perceived difficulty of personal struggle, as well as healthy and unhealthy interpretations of self-compassion (all p -values $> .1$). Although the self-compassion manipulation was successful, participants in the self-compassion condition ($M = 77.36$, $SD = 44.62$) did not differ in caloric consumption of healthy foods compared to participants in the control condition ($M = 78.26$, $SD = 41.33$), $t(206) = -0.15$, $p = .880$, $d = -0.02$, 95% CI [-0.29, 0.25]. Participants in the self-compassion condition ($M = 114.84$, $SD = 71.24$) also did not differ

in caloric consumption of unhealthy foods compared to participants in the control condition ($M = 109.35$, $SD = 62.73$), $t(206) = 0.59$, $p = .556$, $d = 0.08$, 95% CI $[-0.19, 0.35]$.

Self-Compassion Behavioural Interpretations

Exploring the healthy-unhealthy aspect of participants' interpretations of self-compassion, I conducted paired sample t-test comparing the amount of low-calorie and high-calorie foods which participants said they would eat when being self-compassionate. Like Study 1 participants who associated self-compassion with more adaptive behaviours than maladaptive ones, Study 2 participants said they would eat more healthy foods ($M = 7.10$, $SD = 1.76$) than unhealthy foods ($M = 5.69$, $SD = 1.73$) if they wanted to be self-compassionate, $t(207) = 8.08$, $p < .001$, $d = 0.56$, 95% CI $[0.41, 0.71]$. Paired sample t-test also revealed that participants preferred healthy foods ($M = 7.53$, $SD = 1.53$) to unhealthy foods ($M = 6.67$, $SD = 1.52$), $t(207) = 5.70$, $p < .001$, $d = 0.39$, 95% CI $[0.25, 0.54]$.

Table 7*Study 2: Descriptive Statistics and Correlation Coefficients for Study Variables*

Variable	1	2	3	4	5	6	7	8	9	10	11
1. State SC	—										
2. Hunger	-.08	—									
3. Adaptive Eating Tendency	.25**	-.03	—								
4. Maladaptive Eating Tendency	-.17*	.13	-.57**	—							
5. Physical Activity ^a	.06	.01	.06	-.09	—						
6. Healthy Interpretations of SC	.04	-.02	.06	.02	-.07	—					
7. Unhealthy Interpretations of SC	-.07	.02	.03	.09	-.06	-.04	—				
8. Preference for Healthy Foods	.15*	.05	.04	-.02	.07	.65**	.01	—			
9. Preference for Unhealthy Foods	-.01	.06	.03	.04	.13	-.15*	.62**	-.02	—		
10. Healthy Food Consumption (kCal)	.08	.16*	.03	.02	.02	.26**	-.06	.30**	-.04	—	
11. Unhealthy Food Consumption (kCal)	-.05	.10	.06	-.02	.07	-.02	.26**	.02	.32**	.53**	—
<i>M</i>	3.29	2.40	3.57	2.19	3693	7.10	5.87	7.53	6.67	77.81	112.09
<i>SD</i>	0.72	0.84	0.51	0.37	2575	1.76	1.73	1.53	1.52	42.90	67.01

Note. $N = 208$. SC = Self-compassion.^a In MET-minutes. $N = 169$.* $p < .05$. ** $p < .00$

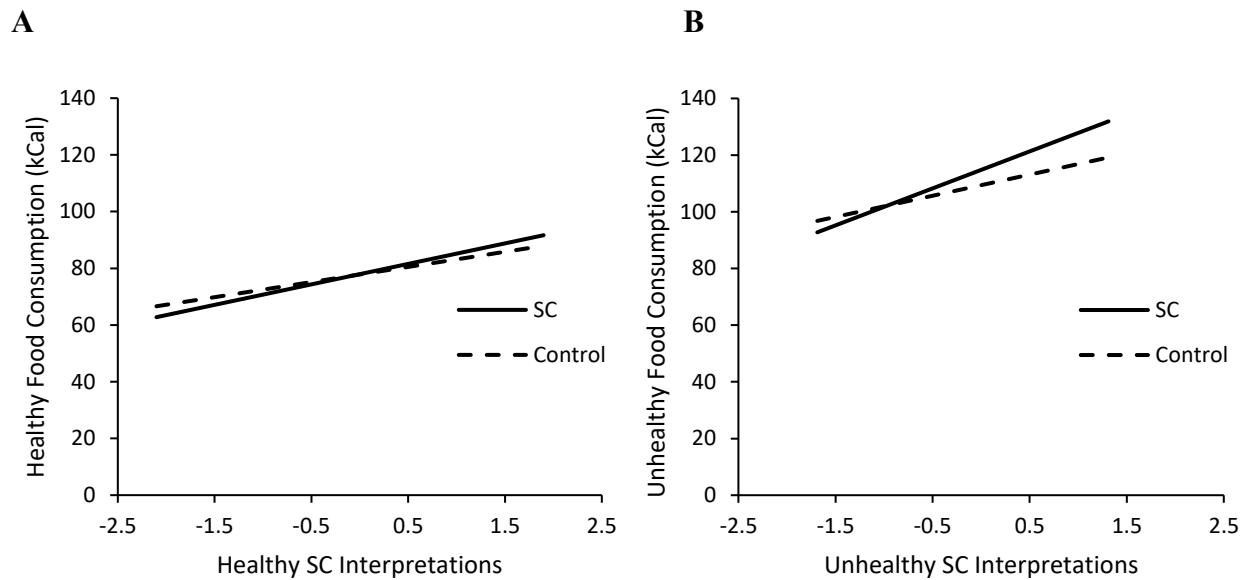
Self-Compassion, Self-Compassion Interpretations, and Eating Behaviours

Like Study 1, correlational analysis of study variables (see Table 7) again confirmed the known relationships between self-compassion and adaptive eating as well as maladaptive eating. However, state self-compassion was only weakly related to preference for healthy foods and was not related to consumption of healthy and unhealthy foods. The variables that did correlate with healthy and unhealthy food consumption were the corresponding predictors: healthy interpretations and preferences for healthy foods for healthy consumption; and unhealthy interpretations and preferences for unhealthy foods for unhealthy consumption. Surprisingly, adaptive and maladaptive eating tendencies only correlated with each other and no other study variables, including healthy and unhealthy food consumption. Interestingly, self-compassion interpretations of and preferences for healthy and unhealthy foods were positively and highly correlated, indicating a strong overlap.

Table 8*Moderation Models Predicting Food Consumption from Condition and Self-Compassion**Interpretations*

Predictor	<i>b</i>	<i>SE</i>	<i>t</i>	<i>p</i>
Healthy Food Consumption				
Intercept	77.88	2.89	26.94	< .001
Condition (SC vs. Control)	−0.04	1.93	−0.02	.982
Healthy SC Interpretations (mean-centered)	6.28	1.66	3.78	< .001
Condition x Healthy SC Interpretations	−0.63	1.11	−0.57	.569
Unhealthy Food Consumption				
Intercept	112.08	4.50	24.93	< .001
Condition (SC vs. Control)	−1.80	2.99	−0.60	.549
Unhealthy SC Interpretations (mean-centered)	10.26	2.60	3.94	< .001
Condition x Unhealthy SC Interpretations	−1.86	1.73	−1.07	.284

Note. SC = Self-compassion. *N* = 208.

Figure 1*Self-Compassion Interpretations and Food Consumption by Condition*

Note. SC = Self-Compassion. Panel A: Healthy food consumption as predicted by healthy self-compassion interpretations and condition (Self-compassion vs. Control). Panel B: Unhealthy food consumption as predicted by unhealthy self-compassion interpretations and condition (Self-compassion vs. Control). In both models, only self-compassion interpretations significantly predicted food consumption.

To explore the role of self-compassion interpretations in the relationship between self-compassion and eating, I ran moderation models predicting healthy and unhealthy food consumption with condition as the independent variable and self-compassion interpretations as the moderator. Testing showed that assumptions like homoscedacity and multicollinearity were not violated. Both models were significant (healthy consumption: $R^2 = .07$, $F(3, 204) = 5.21$, $p = .002$; unhealthy consumption: $R^2 = .08$, $F(3, 204) = 5.68$, $p < .001$). In both models, only self-compassion interpretations had an effect on food consumption while the condition and the interaction between self-compassion interpretations and condition did not significantly affect

food consumption (see Table 8 and Figure 1)². As such, my hypothesis that self-compassion interpretations would moderate the relationship between state self-compassion and eating was not supported.

Self-Compassion, Food Preferences, and Eating Behaviours

In theory, participants should only eat more of the foods they consider as expressions of self-compassion when they feel self-compassionate. But the moderation models revealed that participants in both high and low self-compassion condition ate more if they viewed it as self-compassionate. As shown previously, self-compassion interpretations of and preferences for low-calorie and high-calorie foods were highly correlated. Moreover, food consumption correlated more strongly with the preferences for those foods than the self-compassionate interpretations of such foods. I therefore suspected that the effect of self-compassion interpretations on food consumption was somewhat driven by participants' food preferences.

Consequently, I conducted moderation analyses for food consumption with condition as the predictor and preferences as the moderator after making sure that none of the assumptions (e.g., homoscedacity, multicollinearity) was violated. Again, both models were significant (healthy consumption: $R^2 = .09$, $F(3, 204) = 7.10$, $p < .001$; unhealthy consumption: $R^2 = .14$, $F(3, 204) = 10.98$, $p < .001$). Shown in Table 9, preferences had significant effects while condition had no effect on both healthy and unhealthy food consumption. However, while preference for healthy food did not moderate the relationship between condition and food consumption, preference for unhealthy food did. Specifically, participants in the self-compassion condition ate less unhealthy foods they disliked but ate more unhealthy foods they liked than participants in

² Models with self-compassion interpretations as moderators and standardized food consumption in grams as the outcome variable produced the same results as models with food consumption in calories as the outcome variable.

the control condition (see Figure 2)³. Johnson-Neyman intervals showed that the caloric intake between the two groups significantly differed when preference for unhealthy foods was less than 1.78 *SD* under the mean ($b = 8.83$, $SE = 4.48$, 95% CI [0, 17.66], $p = .05$) and more than 1.10 *SD* over the mean ($b = -7.05$, $SE = 3.57$, 95% CI [-14.10, 0], $p = .05$).

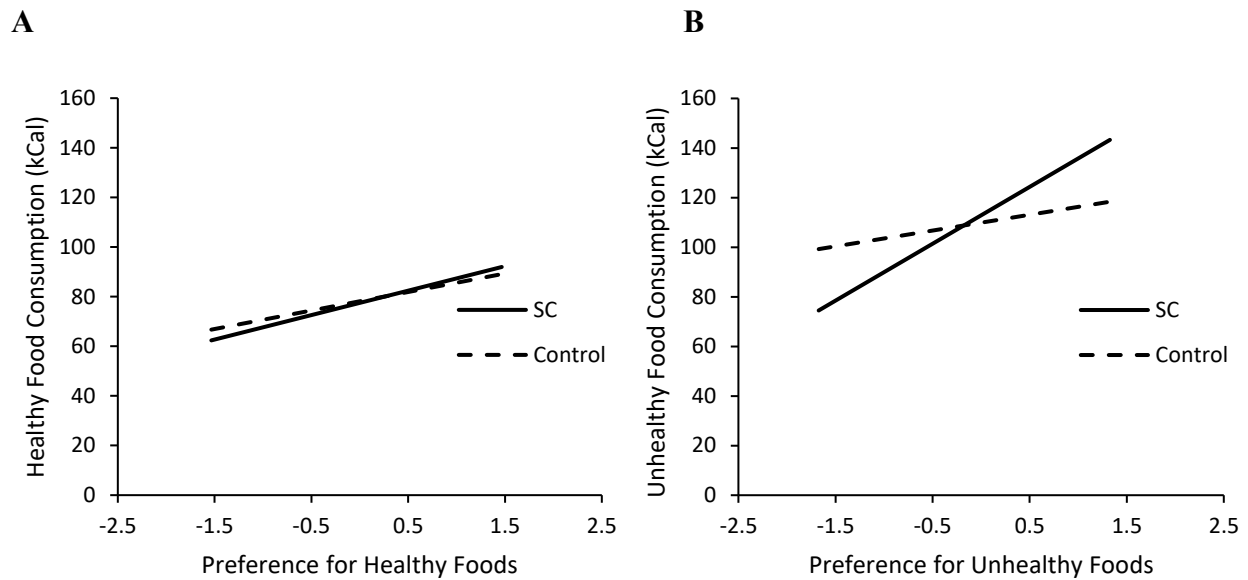
Table 9

Moderation Models Predicting Food Consumption from Condition and Food Preferences

Predictor	<i>b</i>	<i>SE</i>	<i>t</i>	<i>p</i>
Healthy Food Consumption				
Intercept	77.82	2.85	27.29	< .001
Condition (SC vs. Control)	0.22	1.90	0.11	.909
Preference for Healthy Foods (mean-centered)	8.66	1.88	4.61	< .001
Condition x Preference for Healthy Foods	-0.80	1.25	-0.64	.523
Unhealthy Food Consumption				
Intercept	111.38	4.35	25.60	< .001
Condition (SC vs. Control)	-0.98	2.90	-0.34	.734
Preference for Unhealthy Foods (mean-centered)	14.65	2.87	5.10	< .001
Condition x Preference for Unhealthy Foods	-5.52	1.91	-2.88	.004

Note. SC = Self-compassion. $N = 208$.

³ Models with food preferences as moderators and standardized food consumption in grams as the outcome variable produced the same results as models with food consumption in calories as the outcome variable.

Figure 2*Food Preferences and Food Consumption by Condition*

Note. SC = Self-Compassion. Panel A: Healthy food consumption as predicted by preference for healthy foods and condition (Self-compassion vs. Control), only preference for healthy foods significantly predicted food consumption. Panel B: Unhealthy food consumption as predicted by preference for unhealthy foods and condition (Self-compassion vs. Control), preference for unhealthy foods moderated the effect of condition on unhealthy food consumption.

Discussion

The purpose of Study 2 was to further investigate interpretations of self-compassion in terms of food choice and consumption as well as the role such interpretations may play in the link between state self-compassion and eating. Similar to Study 1's results regarding adaptiveness, participants associated self-compassion with eating more of low-calorie or healthy foods than high-calorie or unhealthy foods. Although the self-compassion manipulation successfully increased participants' state self-compassion, it did not affect participants' food

consumption. What did have an effect were participants' self-compassion interpretations and food preferences.

Corroborating and supplementing Study 1's findings, Study 2 showed that participants viewed self-compassion as eating more healthy foods than unhealthy foods but still allowing themselves to eat a small amount of unhealthy foods. This eating attitude is in line with adaptive eating, particularly intuitive eating. Intuitive eating involves trusting your body to know what and when to eat, including letting yourself eat what you crave and not barring yourself from unhealthy foods (Tylka & Kroon Van Diest, 2013). Together, the results from both studies suggest that people generally associate self-compassion with healthy and adaptive eating.

However, across conditions in Study 2, the more participants said they would eat a food to practice self-compassion, the more of that food they ate in the taste test, no matter whether it was a healthy or unhealthy choice to do so. A potential explanation for this phenomenon is food preferences, which were strongly related to self-compassion interpretations and food consumption in Study 2 (see also Robinson et al., 2017). Participants' preferences for unhealthy food also moderated the relationship between their assigned condition and unhealthy food consumption. Specifically, participants in the self-compassion condition ate less of the unhealthy foods they disliked but more of the unhealthy foods they liked, as compared to participants in the control condition. The combination of these trends resulted in similar caloric intake in both conditions, mirroring other studies in which self-compassion interventions failed to promote healthy eating (Barbeau et al., 2022; Brenton-Peters et al., 2023). In other words, the self-compassion induction encouraged participants to consume more of the treat foods they liked—something “unhealthy” and “naughty in the food department” (Egan & Mantzios, 2018). Self-compassion might have such effect on food consumption through indulgent interpretations that

were expressed by Study 1's participants (e.g., "Allowing myself to eat food that I crave," "Eating more of delicious and high-calorie food when they are available").

Building on the results of Study 1, Study 2 employed a different methodology—inducing state self-compassion and observing subsequent food choice and consumption instead of measuring state self-compassion and general eating tendencies—to examine the effects of self-compassion interpretations on eating. As Study 2 found no relationship between eating tendencies and food consumption in the laboratory setting, I treated these outcomes as separate aspects of eating behaviour: adaptive and maladaptive eating tendencies as general eating; food choices and consumption in the bogus taste test as episodic eating. Although self-compassion interpretations did not influence general eating in Study 1, it became all that mattered when predicting episodic eating in Study 2. Induced state self-compassion, vice versa, had no impact on food choices and consumption in Study 2 although state self-compassion after recalling an academic struggle predicted general eating patterns in Study 1. Study 2 also found that food preferences functioned similarly to adaptive self-compassion interpretations in predicting eating behaviours, making it hard to distinguish self-compassion interpretations and simple food preferences. Still, it is undeniable that participants' food choices and consumption were guided by their own unique self-compassion interpretations and food preferences, and not by their state self-compassion levels at the time of such consumption.

General Discussion

As self-compassion gains more and more popularity, it is imperative to understand how lay people interpret the concept and how their views of self-compassion affect their behaviours. Building on qualitative studies about people's perceptions of self-compassion, the present research quantitatively examined people's interpretations of eating behaviours as expressions of

self-compassion: Study 1 asked participants which adaptive and maladaptive behaviours they would do to enact self-compassion; Study 2 asked participants which and how much of healthy and unhealthy foods they would eat to practice self-compassion. Both Study 1 and 2 found that people had a mostly adaptive and healthy interpretations of self-compassion, balanced with a tinge of indulgence, as explained in detail subsequently. Furthermore, this research also investigated the effects of such interpretations on food choice and consumption: Study 1 did so by measuring general eating tendencies and Study 2 did so by directly observing food choice and consumption in a laboratory setting. Both studies showed that interpretations of self-compassion and self-care mattered distinctly from state self-compassion in predicting eating behaviours.

Interpretations of Eating Behaviours as Expressions of Self-Compassion

Despite being measured in two different ways in Study 1 and 2, participants' interpretations of self-compassion exhibited a constant through line: mostly adaptive and erring on the side of indulgence. In Study 1, participants identified more adaptive behaviours than maladaptive behaviours as self-compassionate. But many also identified indulgent behaviours, both adaptive (e.g., "Allowing myself to eat food that I crave") and maladaptive (e.g., "Eating more delicious or high-calorie food when they are available"), as more self-compassionate than self-caring. In Study 2, participants said they would eat more low-calorie foods than high-calorie foods, while still permitting themselves some high-calorie foods, in order to be self-compassionate. Nurturing oneself while occasionally letting oneself indulge is generally understood to be an adaptive eating pattern.

Although Neff (2023) has fervently argued that self-compassion is not and does not lead to self-indulgence, this perception seems to persist in the public zeitgeist and was demonstrated by the responses of Study 1's participants and the indulgent behaviours of Study 2's participants,

specifically in the self-compassion condition. Self-compassion researchers often regard self-indulgence as problematic (e.g., Neff, 2023; Egan & Mantzios, 2018), but in the context of research on eating, restrictive eating (i.e., following extreme dieting rules and forbidding unhealthy foods) is ultimately more problematic, causing binge eating and worse health outcomes (Polivy & Hermann, 1985). In contrast, intuitive eating (i.e., letting oneself satisfy cravings and not moralizing eating behaviours) is adaptive and preventative of eating disorders (Tylka & Kroon Van Diest, 2016), and seemed to be associated in both of the present studies with participants' state self-compassion and interpretations of self-compassion.

An unexpected finding in Study 2 was that of the strong association between participants' interpretations of a food as self-compassion and their preferences for that food. This finding suggests that a popular lay interpretation of self-compassion is simply letting oneself eat what one likes, aligning with what Egan and Mantzios (2018) had found. Although simplified, such an interpretation can be reconciled with Neff's (2003) description of self-compassion—treating oneself like a supportive friend. If you want to comfort your friend during a difficult time, I imagine you would make or buy them their favourite foods and not force them to eat something they hate. Contemplating the results of both studies, I concluded that lay interpretations of eating behaviours as expressions of self-compassion, even at their most indulgent, are not far from the ideas researchers have about self-compassion.

Both studies also examined the relationship between state self-compassion and self-compassion interpretations. Study 1 found that state self-compassion correlated positively with adaptive interpretations of self-compassion. Though it is unknown whether participants' state self-compassion after recalling an academic struggle were specific to that experience or may have stemmed from their trait self-compassion, what can be said is that participants who

responded more self-compassionately in this context also had more adaptive interpretations of self-compassion. However, when state self-compassion was manipulated in Study 2, participants in the self-compassion condition did not have more healthy nor less unhealthy interpretations of self-compassion than those in the control condition, suggesting that the association between self-compassion and interpretations of self-compassion in Study 1 might be the result of trait self-compassion. Combined, these results imply that one's self-compassion interpretations are linked to trait self-compassion and are stable, thus unaffected by state self-compassion induction. Nevertheless, since Study 1 did not include a measure of trait self-compassion, this speculation needs to be confirmed in future studies.

Effects of Interpretations on Eating Behaviours

Both studies showed that interpretations of self-compassion or self-care can influence eating behaviours. In Study 1, interpretations of self-care predicted general eating tendencies along with state self-compassion after recalling a personal struggle. In Study 2, interpretations of self-compassion predicted episodic eating behaviours while induced state self-compassion did not. In other words, the desire or motivation to be kind to oneself, indicated by high state self-compassion, does not automatically yield the corresponding eating behaviour, and participants' interpretations of behaviours as expressions of self-compassion or self-care can substantially add to or detract from the level of adaptive eating that would be expected from their state self-compassion.

Study 1 found that even though self-compassion interpretations did not predict adaptive and maladaptive eating, interpretations of self-care did. There are two potential explanations: (1) the popularity of self-care practices; and/or (2) the translation of state self-compassion into self-care practices. Although people are becoming increasingly aware of self-compassion, they are

more familiar with self-care, so much so that they often used self-care and taking care of oneself to describe self-compassion (Iacono et al., 2023). People also want to practice self-care more, especially after the COVID-19 pandemic (Jonas, 2020). I believe that because people are more aware of self-care and its practices, their interpretations of self-care might be more likely to translate to behaviours. For example, if one believes that exercising is self-care and also tries to practice self-care, they may be more likely to exercise. Even when one believes that exercising is self-compassion, if they do not strive to practice self-compassion, their interpretations may not result in actual behaviours. State self-compassion itself, due to its connection to care and caring behaviours, might also have inspired behaviours according to interpretations of self-care instead of interpretations of self-compassion, as implied by the regression analysis in Study 1. Either separately or combined, these reasons might explain the influence of self-care interpretations on eating behaviours and future studies should investigate them further.

Study 2 also found a significant overlap between self-compassion interpretations and food preferences, suggesting that lay people's working definition of self-compassion, at least in the context of moment-to-moment eating, is eating more of what one likes and less of what one does not like. Such interpretations of self-compassion seemed to guide participants' episodic eating during the bogus taste test. Although it seems worrying, being self-compassionate and allowing oneself to eat what one likes and thinks of as self-compassionate closely resemble components of adaptive eating, particularly unrestrained eating. When participants were eating more of whatever they prefer, regardless of its health properties, they were practically enacting the statements "I allow myself to eat what food I desire at the moment" and "If I am craving a certain food, I allow myself to have it" (Intuitive Eating Scale-2; Tylka & Kroon Van Diest, 2016). This eating behaviour also indicated that they did not "criticize myself for the way I eat"

and “evaluate whether my eating is right or wrong” (Mindful Eating Scale; Hubert-Williams et al., 2014). Participants were also eating more of what they deemed as self-compassionate, and as shown in Study 2, what they often deemed as self-compassionate were low-calorie foods. Study 2 also showed that people higher in self-compassion seemed to prefer healthy foods.

Over time, if participants continued to be self-compassionate and eat without judgment (i.e., non-judgmental eating), eat what they like (i.e., unconditional permission to eat), and eat what they think as self-compassionate (i.e., usually healthy foods), they would be considered to have adaptive eating tendencies. Indeed, both Study 1 and 2, as well as many other studies on self-compassion and eating, found that self-compassion is positively correlated with adaptive eating and negatively correlated with maladaptive eating (Rahimi-Ardabili et al., 2018). However, adaptive eating tendencies do not always equal healthy eating and better diet quality. Unconditional permission to eat, in particular, was associated with worse diet quality (Jackson et al., 2022). Therefore, I suspect that self-compassion and adaptive interpretations of self-compassion may reduce eating pathology and prevent eating disorders but may not always improve diet quality and foster healthy eating (Brenton-Peters et al., 2021). Unfortunately, because Study 1 was cross-sectional and Study 2 was only looking at one eating instance, I can only speculate on this development of adaptive eating pattern. To fully understand how self-compassion and self-compassion interpretations affect eating behaviours and diet quality over time, more than one eating instance should be observed.

Limitations and Future Directions

Since the present research and other quantitative studies on self-compassion interpretations (Robinson et al., 2016; Schellenberg et al., 2021) suffered from the same limitation: college student sample (Peterson, 2001), other populations, especially ones that have

a high degree of fear of self-compassion, should have their self-compassion interpretations and its effects examined quantitatively. According to Gilbert et al. (2011), many people harbour a fear of self-compassion, believing that they do not deserve it or will be made complacent and weak by it, which prevents them from being compassionate to themselves. It is likely that fear of self-compassion and maladaptive interpretations of self-compassion are intricately linked, informing one another or creating a feedback loop. But to properly study this relationship, a more concrete measure of self-compassion interpretations first needs to be constructed, replacing the rudimentary ways that it was measured in this research.

In hindsight, it is clear that certain design choices created limitations in both studies. As Study 1 mainly focused on general eating patterns, including both trait and state self-compassion measures would have allowed further investigation of stable and unstable factors affecting these patterns. By including a measure of self-care interpretations in Study 2, considering its significant effect on adaptive and maladaptive eating in Study 1, I could have provided further evidence of the role of self-care interpretations in making immediate food choices. Future research should strive to integrate both trait and state self-compassion as well as self-compassion and self-care to better discern their divergence and convergence.

Finally, the differing influences of self-compassion and self-compassion interpretations on episodic and general eating urge further exploration into the short-term and long-term effects of self-compassion and its interpretations on behaviours. Many studies have breached this topic using experience sampling, examining adaptive and maladaptive eating, coping, and exercising (Fraser et al., 2025). However, no study has examined self-compassion's long-term and short-term effects on behaviours that have complicated relationships with either state or trait self-compassion such as healthy eating, flossing, and alcohol drinking. Understanding how trait and

state self-compassion as well as self-compassion interpretations influence behaviours long- and short-term can better inform future research on and interventions involving self-compassion.

Conclusion

This thesis' aim was to explore how the public interprets self-compassion and self-care, as well as how their interpretations affect their behaviours, particularly eating behaviours. The results showed that people generally and mostly associate self-compassion and self-care with adaptive eating behaviours and healthy food choices, aligning with researchers' ideas of self-compassionate and self-caring behaviours. The results also showed that people think of self-compassion and self-care as similar but not the same, with self-care being more restrictive than self-compassion. The current research also contributed to the understanding of the link between self-compassion and eating. Specifically, state self-compassion might facilitate desires and actions to be self-caring according to ones' adaptive interpretations of self-care, which predicts more adaptive eating and less maladaptive eating. State self-compassion can also lead people to eat more of what one likes and less of what one dislikes as well as to eat what they consider self-compassionate (i.e., mostly low-calorie foods) in their moment-to-moment eating, which over time might evolve into adaptive eating tendencies. In conclusion, behavioural interpretations of self-compassion and self-care significantly influenced eating behaviours along with self-compassion and should be further investigated and taken into account in future research.

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Appendix A

Lay Statement

Self-compassion is a healthy way to treat yourself. It is being kind to and not judging yourself. It is also knowing that everyone, like you, makes mistakes. Self-compassion is good for mental health, so it has been promoted through social media posts and self-help books. Self-compassion also helps people eat better. But some people who try to practice self-compassion might not know what to do or how to eat. Some think indulging is self-compassion. Some think eating healthy is self-compassion. This research concerns how people think about self-compassion and if that affects how they show compassion to themselves. In Study 1, I asked 219 university students how they eat to be self-compassionate and self-caring in an online survey. They chose from a list of both good and bad eating attitudes and behaviours. Participants considered self-compassion and self-care as mostly good eating attitudes. Participants who were higher in self-compassion also associated self-compassion and self-care with more good eating behaviours. But only participants' concepts of self-care, and not of self-compassion, was relevant to reported eating behaviours. In Study 2, I gave 219 university students a writing task to increase their state self-compassion. I then gave them both healthy foods and unhealthy foods. While eating, they also reported how much of a food they would eat if they were trying to have compassion for themselves. Participants said that self-compassion is eating more healthy foods than unhealthy foods. People in both conditions tended to eat more of the foods they considered to be self-compassionate. Also, participants whose self-compassion was induced ate less unhealthy foods they disliked but ate more unhealthy foods they liked. These studies showed that the public think of self-compassion as good and healthy and that their beliefs affect how they eat when they try to be kind to themselves.

Appendix B

Study 1 - Consent Form

Study Name: Personality and Eating Behaviours**Student Principal Investigators:** Natalia Nguyen, Master's Student, Department of Psychology**Student Advisor:** Dan Bailis, Professor, Department of Psychology

This consent form, a copy of which you can download or print, is only part of the process of informed consent. If you would like more detail about something mentioned here, or information not included here, feel free to ask any of the people named above. Please take the time to read this document and any accompanying information carefully. It is very important that you understand:

- what is being asked of you,
- what the risks and benefits of participation are, and
- how the information you provide will be used and stored.

Purpose of the Study

I am doing this research for my Master's thesis under the supervision of Dr. Dan Bailis. The present study aims to learn about your personality and your eating behaviours, including what you eat, your circumstances for eating, and how you perceive different eating behaviours. You are being asked to volunteer for this research. It is up to you whether you choose to participate or not.

Study Procedures

If you agree to participate in this study, you will first be asked some questions about yourself and your everyday eating behaviours. You will then be asked to write for several minutes about a personal situation that is difficult for you. Finally, you will answer some further questions about your personality and eating behaviours. The entire study will take about **30 minutes** of your time. All information will be collected via your responses on this online survey, and no other information about you will be collected or included in this research.

Study Risks

All potential risks associated with this study are minimal. The questionnaires and writing tasks are previously published and widely used by other researchers. You may **skip** any questions you prefer not to answer, and you can also withdraw from the study at any time by exiting the survey. If you withdraw from the study part-way through, your consent is assumed to be withdrawn, and your answers to previous questions will not be used. You can also withdraw your data after you participate, by contacting the researchers prior to January 2025. After that date, SONA identifiers will be deleted from the data file, and we will not be able to selectively remove your data.

Study Benefits

By participating, you will be contributing to the knowledge of personality and eating behaviours.

Compensation

To thank you for your participation, you will receive 1 research-participation credit in your PSYC 1200 Introduction to Psychology course. You will still receive this credit for your participation even if you skip questions on the survey or withdraw from the study part-way through.

Storage and Use of Data

Information collected in this survey will never be associated with your name or shared in any format that permits the information to be traced back to any individual. Your numerical SONA identifier will be recorded automatically and used to provide your research-participation credit in PSYC 1200. Once the credits have been assigned to all participants, the SONA identifiers will be deleted entirely and permanently from our records. Any identifying information disclosed in the free text responses and the writing task will also be redacted. Only Natalia Nguyen and Dr. Dan Bailis have access to your response. These individuals have completed research ethics training and signed an Oath of Confidentiality.

Your data will be transmitted to us online using the Qualtrics platform. Although no guarantees can be made regarding possible third-party interception of data sent via the Internet, Qualtrics complies with all applicable Canadian privacy laws and standards, and the servers hosting our data are geographically located in Canada. After data collection is complete, the raw survey data will be removed from Qualtrics servers, anonymized, and stored electronically in a password-protected file on a university network drive. The data will be stored indefinitely in this anonymized electronic format. The data, including the anonymized free text response and writing task, may be shared with other interested researchers (e.g., by uploading the anonymized file to an online data repository) for purposes of archiving, verifying, collaborating on, and extending this research. **An aggregate summary of the results from all participants will be posted on the Action and Identity Laboratory website (<https://actionandidentitylab.weebly.com>) no later than May 2025.** The aggregate results will also be used in my Master's thesis and potentially in future journal publications and conference presentations. In the unlikely event that we wish to quote a participant's response, for the sake of illustration, we will refer to them simply as "a participant" and will not include any information that could potentially identify a participant as the source.

Questions or Concerns

A designated University of Manitoba auditor may check that this study is being done safely and properly. To do this, they may visit the study site or review the research records.

This study has been reviewed and approved by the Research Ethics Board at the University of Manitoba, Fort Garry campus. However, this does not mean that participation is risk-free. If you have any questions, concerns, or complaints about this study, you may contact any members of the research team listed on the first page or the Office of Human Research Ethics at humanethics@umanitoba.ca or (204) 474-7122.

Consent

By clicking "Yes" at the bottom of this form, I have read the above information and have had the opportunity to ask and have answered any questions I may have.

I understand that:

- I will be taking part in a research study.
- I may freely leave the research study activities at any time.
- I do not waive my legal rights by participating in the study.

I agree to participate in this study.

- ☐ Yes
☐ No

Appendix C

International Physical Activity Questionnaire

We are interested in the time you spent being physically active in the **last 7 days**. Please answer each question even if you do not consider yourself to be an active person. Please think about the activities you do at work, as part of your house and yard work, to get from place to place, and in your spare time for recreation, exercise or sport.

Think about all the **vigorous** activities that you did in the **last 7 days**. **Vigorous** physical activities refer to activities that take hard physical effort and make you breathe much harder than normal. Think only about those physical activities that you did for at least 10 minutes at a time.

During the **last 7 days**, on how many days did you do **vigorous** physical activities like heavy lifting, digging, aerobics, or fast bicycling?

- ☐ _____ days per week
- ☐ No vigorous physical activity [Skip the next question if participant chose this option]

How much time did you usually spend doing **vigorous** physical activities on one of those days?

- ☐ _____ hours per day
- ☐ _____ minutes per day
- ☐ Don't know/Not sure

During the **last 7 days**, on how many days did you do **moderate** physical activities like carrying light loads, bicycling at a regular pace, or doubles tennis? Do not include walking.

- ☐ _____ days per week
- ☐ No moderate physical activity [Skip the next question if participant chose this option]

How much time did you usually spend doing **moderate** physical activities on one of those days?

- ☐ _____ hours per day
- ☐ _____ minutes per day
- ☐ Don't know/Not sure

Think about the time you spent **walking** in the **last 7 days**. This includes at work and at home, walking to travel from place to place, and any other walking that you have done solely for recreation, sport, exercise, or leisure.

During the **last 7 days**, on how many days did you **walk** for at least 10 minutes at a time?

- ☐ _____ days per week
- ☐ No walking [Skip the next question if participant chose this option]

How much time did you usually spend **walking** on one of those days?

- ☐ _____ hours per day
- ☐ _____ minutes per day
- ☐ Don't know/Not sure

Appendix D

Intuitive Eating Scale-2

For each item, please check the answer that best characterizes your attitudes or behaviours.

Unconditional Permission to Eat

1. I try to avoid certain foods high in fat, carbohydrates, or calories.*

1 - Strongly disagree 2 - Disagree 3 - Neutral 4 - Agree 5 - Strongly agree

2. If I am craving a certain food, I allow myself to have it.

1 - Strongly disagree 2 - Disagree 3 - Neutral 4 - Agree 5 - Strongly agree

3. I get mad at myself for eating something unhealthy.*

1 - Strongly disagree 2 - Disagree 3 - Neutral 4 - Agree 5 - Strongly agree

4. I have forbidden foods that I don't allow myself to eat.*

1 - Strongly disagree 2 - Disagree 3 - Neutral 4 - Agree 5 - Strongly agree

5. I allow myself to eat what food I desire at the moment.

1 - Strongly disagree 2 - Disagree 3 - Neutral 4 - Agree 5 - Strongly agree

6. I do NOT follow eating rules or dieting plans that dictate what, when, and/or how much to eat.

1 - Strongly disagree 2 - Disagree 3 - Neutral 4 - Agree 5 - Strongly agree

Eating for Physical Rather Than Emotional Reasons

1. I find myself eating when I'm feeling emotional (e.g., anxious, depressed, sad), even when I'm not physically hungry.*

1 - Strongly disagree 2 - Disagree 3 - Neutral 4 - Agree 5 - Strongly agree

2. I find myself eating when I am lonely, even when I'm not physically hungry.*

1 - Strongly disagree 2 - Disagree 3 - Neutral 4 - Agree 5 - Strongly agree

3. I use food to help me soothe my negative emotions.*

1 - Strongly disagree 2 - Disagree 3 - Neutral 4 - Agree 5 - Strongly agree

4. I find myself eating when I am stressed out, even when I'm not physically hungry.*

1 - Strongly disagree 2 - Disagree 3 - Neutral 4 - Agree 5 - Strongly agree

5. I am able to cope with my negative emotions (e.g., anxiety, sadness) without turning to food for comfort.

1 - Strongly disagree 2 - Disagree 3 - Neutral 4 - Agree 5 - Strongly agree

6. When I am bored, I do NOT eat just for something to do.

1 - Strongly disagree 2 - Disagree 3 - Neutral 4 - Agree 5 - Strongly agree

7. When I am lonely, I do NOT turn to food for comfort.

1 - Strongly disagree 2 - Disagree 3 - Neutral 4 - Agree 5 - Strongly agree

8. I find other ways to cope with stress and anxiety than by eating.

1 - Strongly disagree 2 - Disagree 3 - Neutral 4 - Agree 5 - Strongly agree

Reliance on Hunger and Satiety Cues

1. I trust my body to tell me when to eat.

1 - Strongly disagree 2 - Disagree 3 - Neutral 4 - Agree 5 - Strongly agree

2. I trust my body to tell me what to eat.

1 - Strongly disagree 2 - Disagree 3 - Neutral 4 - Agree 5 - Strongly agree

3. I trust my body to tell me how much to eat.

1 - Strongly disagree 2 - Disagree 3 - Neutral 4 - Agree 5 - Strongly agree

4. I rely on my hunger signals to tell me when to eat.

1 - Strongly disagree 2 - Disagree 3 - Neutral 4 - Agree 5 - Strongly agree

5. I rely on my fullness (satiety) signals to tell me when to stop eating.

1 - Strongly disagree 2 - Disagree 3 - Neutral 4 - Agree 5 - Strongly agree

6. I trust my body to tell me when to stop eating.

1 - Strongly disagree 2 - Disagree 3 - Neutral 4 - Agree 5 - Strongly agree

Body-Food Choice Congruence

1. Most of the time, I desire to eat nutritious foods.

1 - Strongly disagree 2 - Disagree 3 - Neutral 4 - Agree 5 - Strongly agree

2. I mostly eat foods that make my body perform efficiently (well).

1 - Strongly disagree 2 - Disagree 3 - Neutral 4 - Agree 5 - Strongly agree

3. I mostly eat foods that give my body energy and stamina.

1 - Strongly disagree 2 - Disagree 3 - Neutral 4 - Agree 5 - Strongly agree

* Reverse score items

Appendix E

Three-Factor Eating Questionnaire-R18

Cognitive Restraint

1. I deliberately take small helpings as a means of controlling my weight.
1 - Definitely true 2 - Mostly true 3 - Mostly false 4 - Definitely false
2. I consciously hold back at meals in order not to gain weight.
1 - Definitely true 2 - Mostly true 3 - Mostly false 4 - Definitely false
3. I do not eat some foods because they make me fat.
1 - Definitely true 2 - Mostly true 3 - Mostly false 4 - Definitely false
4. How frequently do you avoid 'stocking up' on tempting foods?
1 - Almost never 2 - Seldom 3 - Usually 4 - Almost always
5. How likely are you to consciously eat less than you want?
1 - Unlikely 2 - Slightly likely 3 - Moderately likely 4 - Very likely
6. On a scale of 1 to 8, where 1 means no restraint in eating (eating whatever you want, whenever you want it) and 8 means total restraint (constantly limiting food intake and never 'giving in'), what number would you give yourself?*

Uncontrolled Eating

1. When I smell a delicious and tempting dish, I find it very difficult to keep from eating, even if I have just finished a meal.
1 - Definitely true 2 - Mostly true 3 - Mostly false 4 - Definitely false
2. Sometimes when I start eating, I just can't seem to stop.
1 - Definitely true 2 - Mostly true 3 - Mostly false 4 - Definitely false
3. Being with someone who is eating often makes me hungry enough to eat also.
1 - Definitely true 2 - Mostly true 3 - Mostly false 4 - Definitely false
4. When I see a real delicacy, I often get so hungry that I have to eat right away.
1 - Definitely true 2 - Mostly true 3 - Mostly false 4 - Definitely false
5. I get so hungry that my stomach often seems like a bottomless pit.
1 - Definitely true 2 - Mostly true 3 - Mostly false 4 - Definitely false
6. I am always hungry so it is hard for me to stop eating before I finish the food on my plate.
1 - Definitely true 2 - Mostly true 3 - Mostly false 4 - Definitely false
7. I am always hungry enough to eat at any time.

1 - Definitely true 2 - Mostly true 3 - Mostly false 4 - Definitely false

8. How often do you feel hungry?*

1 - Only at mealtimes 2 - Sometimes between meals 3 - Often between meals 4 - Almost always

9. Do you go on eating binges though you are not hungry?*

1 - Never 2 - Rarely 3 - Sometimes 4 - At least once a week

Emotional Eating

1. When I feel anxious, I find myself eating.

1 - Definitely true 2 - Mostly true 3 - Mostly false 4 - Definitely false

2. When I feel blue, I often overeat.

1 - Definitely true 2 - Mostly true 3 - Mostly false 4 - Definitely false

3. When I feel lonely, I console myself by eating.

1 - Definitely true 2 - Mostly true 3 - Mostly false 4 - Definitely false

* Reverse score items

Appendix F

Study 1 - Writing Task

Please think about a situation related to your academic life that is painful or difficult for you right now. It could be some struggle in your academic life, or perhaps you are feeling inadequate in some way. Please don't think of a situation in which you are upset with someone else, but instead think of an academic situation where you are feeling badly about yourself or you are going through a hard time. Decide on a single situation that you will focus on throughout this study.

How difficult is this situation for you? Using the scale below, please check the rating that best describes your level of personal difficulty.

1	2	3	4	5
Not at all difficult	Somewhat difficult	Moderately difficult	Very difficult	Extremely difficult

We would now like you to take part in a brief exercise, to see if it is helpful in dealing with this painful or difficult situation.

In the space below, please write about what exactly is occurring in this difficult situation. Try to be as descriptive as possible.

(For example, *"I've been having a hard time finding motivation to do my school work early. I always wait until the last possible minute to start..."*)

*Remember – your responses will be anonymized and your writing is confidential. Don't worry about spelling, sentence structure, or grammar. You'll have 3 minutes to complete this task.

Appendix G

State Self-Compassion Scale-Long form

As you think about the difficult situation you just wrote about, please indicate how well each statement applies to how you are feeling toward yourself right now:

Self-Kindness

1. I'm giving myself the caring and tenderness I need.	1	2	3	4	5
Not at all true of me					Very true of me
2. I'm being kind to myself.	1	2	3	4	5
Not at all true of me					Very true of me
3. I'm being supportive toward myself.	1	2	3	4	5
Not at all true of me					Very true of me

Self-Judgment

1. I'm being pretty tough on myself.	1	2	3	4	5
Not at all true of me					Very true of me
2. I'm being a bit cold-hearted towards myself.	1	2	3	4	5
Not at all true of me					Very true of me
3. I feel intolerant and impatient toward myself.	1	2	3	4	5
Not at all true of me					Very true of me

Common Humanity

1. I see my difficulties as part of life that everyone goes through.	1	2	3	4	5
Not at all true of me					Very true of me
2. I'm remembering that there are lots of others in the world feeling like I am.					

1	2	3	4	5
Not at all true of me				Very true of me

3. I'm remembering that difficult feelings are shared by most people.

1	2	3	4	5
Not at all true of me				Very true of me

Isolation

1. I feel separate and cut off from the rest of the world.

1	2	3	4	5
Not at all true of me				Very true of me

2. I feel like I'm struggling more than others right now.

1	2	3	4	5
Not at all true of me				Very true of me

1. I'm feeling all alone right now.

1	2	3	4	5
Not at all true of me				Very true of me

Mindfulness

1. I'm keeping my emotions in balanced perspective.

1	2	3	4	5
Not at all true of me				Very true of me

2. I'm taking a balanced view of this painful situation.

1	2	3	4	5
Not at all true of me				Very true of me

3. I'm keeping things in perspective.

1	2	3	4	5
Not at all true of me				Very true of me

Over-Identification

1. I'm obsessing and fixating on everything that's wrong.

1	2	3	4	5
Not at all true of me				Very true of me

2. I'm getting carried away with my feelings.				
1	2	3	4	5
Not at all true of me				Very true of me
3. I'm blowing this painful incident out of proportion.				
1	2	3	4	5
Not at all true of me				Very true of me

Appendix H

Eating Behaviours When Practicing Self-Compassion and Self-Care

When facing difficult situations like the one you described, people exhibit different eating behaviours with certain goals. We would like you to think of the goal: being compassionate to yourself/taking care of yourself. With this goal in mind, please select all eating behaviours in the following list you would be likely to do.

- ☐ Eating when I'm emotional (e.g., lonely, depressed, bored, irritated, stressed, etc.) even when I'm not hungry*
- ☐ Eating while multitasking or distracted*
- ☐ Eating more than normal when I see others eating*
- ☐ Eating more delicious or high-calorie food when they are available*
- ☐ NOT allowing myself to eat forbidden foods*
- ☐ Criticizing myself for what and how much I eat*
- ☐ Taking into account my weight when eating*
- ☐ NOT trusting my body to tell me when to stop eating*
- ☐ Eating to fuel up only*
- ☐ Eating like clockwork*
- ☐ Having a routine for what and when I eat*
- ☐ Treating myself with alcohol*
- ☐ Finding other ways to cope with negative emotions without turning to food for comfort
- ☐ Being aware of my food while eating
- ☐ Eating the usual amount I eat when eating with others
- ☐ Resisting eating too much when there are delicious or high-calorie foods available
- ☐ Allowing myself to eat food that I crave
- ☐ NOT evaluating whether my eating is right or wrong
- ☐ Relying on my body for what, when, and how much to eat
- ☐ Noticing appearances, aromas, flavours, and textures of food
- ☐ Being able to tolerate being hungry for a while
- ☐ Eating different things everyday
- ☐ Eating food that I planned for or took time to prepare

* Maladaptive eating behaviours

Appendix I

Study 2 - Pre-Session Instruction and Reminder

Hi there,

I want to remind you that you have an upcoming appointment for the [Study Name] study on [Date and Time]. Please meet the experimenter at P505 Duff Roblin Building at your designated time. As mentioned in the study description, this study involves a taste test of **vegan and gluten-friendly** foods to accommodate as many as possible. The foods will be grapes, jujubes candy, hummus with carrots, and potato chips. You are **NOT eligible** if you have:

- (1) **A medical condition that prevents you from freely eating the foods provided.**
- (2) **An allergy or intolerance towards any of the foods provided.**

If you have any of the conditions listed above, please contact the experimenter so we can excuse you (you won't lose participation credits).

I also want to remind you to **eat something 2 hours before your appointment** (e.g., if your appointment is at 11:00am, please eat something around 9:00am). After eating, please refrain from eating or drinking anything else other than water until your appointment. I ask this of you to ensure that you are not too full or too hungry during the taste test.

Please feel free to contact the experimenter if you have any questions about the study's eligibility and instructions or if you can't make it to your appointment.

Thank you.

Appendix J

Study 2 - Consent Form

Study Name: Current Experiences and Taste Perceptions**Student Principal Investigators:** Natalia Nguyen, Master's Student, Department of Psychology**Student Advisor:** Dan Bailis, Professor, Department of Psychology, University of Manitoba**Student Research Assistant:** Michal Schwartz

This consent form, a copy of which you may keep for your records, is only part of the process of informed consent. If you would like more detail about something mentioned here, or information not included here, feel free to ask any of the people named above. Please take the time to read this document and any accompanying information carefully. It is very important that you understand:

- what is being asked of you,
- what the risks and benefits of participation are, and
- how the information you provide will be used and stored.

Purpose of the Study

I am doing this research for my Master's thesis under the supervision of Dr. Dan Bailis. The present study aims to learn about how current experiences may affect taste perceptions – the taste of the food at that moment. You are being asked to volunteer for this research. It is up to you whether you choose to participate or not.

Study Procedures

If you agree to participate in this study, you will be asked to eat something two hours before your in-person session. When you arrive to your session, you will first be asked some questions about yourself, your everyday eating behaviours, and your physical activities. You will then write for 10 minutes on the computer about a personal situation that might be painful or difficult for you. Finally, you will complete a taste test of four foods: grapes, jujubes candy, hummus with carrots, and potato chips. (The food products selected for this taste test will all be vegan and gluten-friendly to accommodate as many diets as possible). The entire study will take about **30 minutes** of your time.

Because of the taste test, you are **NOT eligible** for this study if you have:

- (1) A medical condition that prevents you from freely eating the foods provided.
- (2) An allergy or intolerance towards any of the foods provided.

Note: You will also be screened for these criteria at the start of your in-person session.

Study Risks

For eligible participants, all potential risks associated with this study are minimal. The questionnaires and writing tasks are previously published and widely used by other researchers. In the unlikely event that you experience distress from writing about a personal situation, please remember that you may **skip** any questions or writing prompts you prefer not to answer, and you

can also withdraw from the study at any time by notifying the experimenter. If you withdraw from the study part-way through, your consent is assumed to be withdrawn, and your answers to previous questions will not be used.

Study Benefits

By participating, you will be contributing to the knowledge of food perceptions.

Compensation

To thank you for your participation, you will receive 1 research-participation credit in your PSYC 1200 Introduction to Psychology course. You will still receive this credit for your participation even if you skip questions or writing prompts on the survey, or withdraw from the study part-way through.

Storage and Use of Data

Information collected in this survey will never be associated with your name or shared in any format that permits the information to be traced back to any individual. The consent form will be used to provide your research-participation credit in PSYC 1200 then stored separately from the study data. An arbitrary tracking number will be assigned to your responses on the computer and your rating of the foods by the experimenter. Because the data is anonymized immediately after data collection, it will not be possible to withdraw from the study and have your data removed after your participation. Only Natalia Nguyen, Dr. Dan Bailis and research assistants will have access to your anonymized responses. These individuals have completed research ethics training and the Personal Health Information Act training. They also signed an Oath of Confidentiality.

Your data will be transmitted to us online using the Qualtrics platform. Although no guarantees can be made regarding possible third-party interception of data sent via the Internet, Qualtrics complies with all applicable Canadian privacy laws and standards, and the servers hosting our data are geographically located in Canada. The anonymized data will be removed from Qualtrics servers after data collection is complete and stored electronically on a university network drive. The data set will be stored indefinitely in this format. It may be shared with other interested researchers (e.g., by uploading the file to an online data repository) for purposes of archiving, verifying, collaborating on, and extending this research. **An aggregate summary of the results from all participants will be posted on the Action and Identity Laboratory website (<https://actionandidentitylab.weebly.com>) no later than May 2025.** The survey data, including the written responses, will be reported as aggregate results in my Master's thesis and potentially in future journal publications and conference presentations. In the unlikely event that we wish to quote a participant's response, for the sake of illustration, we will refer to them simply as "a participant" and will not include any information that could potentially identify a participant as the source.

Questions or Concerns

A designated University of Manitoba auditor may check that this study is being done safely and properly. To do this, they may visit the study site or review the research records. We will tell you if someone outside the research team will be there while you are participating. If this makes you uncomfortable, please tell the Principal Investigator, who will ask the auditor to return at another time.

This study has been reviewed and approved by the Research Ethics Board at the University of Manitoba, Fort Garry campus. However, this does not mean that participation is risk-free. If you have any questions, concerns, or complaints about this study, you may contact any members of the research team listed on the first page or the Office of Human Research Ethics at humanethics@umanitoba.ca or (204) 474-7122.

Consent

By checking “Yes” and signing this document, I have read the above information and have had the opportunity to ask and have answered any questions I may have.

I understand that:

- I will be taking part in a research study.
- I may freely leave the research study activities at any time.
- I do not waive my legal rights by participating in the study.

I agree to participate in this study.

☐ Yes

☐ No

Print Name: _____

Signature: _____

Date: _____

Appendix K

Study 2 - Writing Tasks

Please think about a situation related to your academic life that is painful or difficult for you right now. It could be some struggle in your academic life, or perhaps you are feeling inadequate in some way. Please don't think of a situation in which you are upset with someone else, but instead think of an academic situation where you are feeling badly about yourself or you are going through a hard time. Decide on a single situation that you will focus on throughout this study.

How difficult is this situation for you? Using the scale below, please check the rating that best describes your level of personal difficulty.

1	2	3	4	5
Not at all difficult	Somewhat difficult	Moderately difficult	Very difficult	Extremely difficult

We would now like you to take part in a brief exercise, to see if it is helpful in dealing with this painful or difficult situation.

Self-Compassion Condition

Mindfulness Writing Prompt

In the space below, please write about what thoughts and emotions are coming up for you right now regarding this difficult situation.

Note any uncomfortable emotions you may have, such as feeling stressed, ashamed, sad, anxious, and so on.

As you write and notice your feelings, see if you can validate your experience with an attitude of acceptance and non-judgment. Try not to downplay your feelings, but at the same time please try not to exaggerate them either.

(For example, "*I feel frustrated that my parents keep pressuring me to pursue a major that I'm not interested in...*")

*Remember – your responses are completely anonymous and your writing is confidential. Don't worry about spelling, sentence structure, or grammar.

[SPACE FOR WRITING]

Common Humanity Writing Prompt

In the space below, please write about how other people may share similar feelings when encountering situations like this.

Consider that experiencing difficult situations is a part of being human, and that you are not alone. Although the way people struggle is different and the amount of challenge varies, all people face difficulties in life. What you are experiencing is not abnormal, but is a part of life.

(For example, *“I am not the only one who struggles with these essay assignments. Most people have a difficult transition when they go away to college. It's not just me...”*)

*Remember – your responses are completely anonymous and your writing is confidential. Don't worry about spelling, sentence structure, or grammar.

[SPACE FOR WRITING]

Self-kindness Writing Prompt

In the space below, please write any words of support, encouragement and kindness to yourself that would be helpful to hear right now.

If you are not sure what to say, imagine what you would say to a close friend who was struggling with a similar difficult situation. What words would you use to convey compassion, support, and non-judgmental understanding? Now see if you can use this as inspiration for what to say to yourself.

(For example, *“You're doing the best you can. I'm so sorry you're struggling with this. It's going to be okay. I will help you and support you to get through this...”*)

*Remember – your responses are completely anonymous and your writing is confidential. Don't worry about spelling, sentence structure, or grammar.

[SPACE FOR WRITING]

Please take some time to read what you wrote to yourself and see how it feels to hear these words of kindness and concern directed towards you.

Notice if anything is particularly comforting or helpful.

Take a few slow, deep breaths as you read your own words. Let yourself receive this support.

Control Condition

Description Writing Prompt

Please complete this brief writing exercise and follow the instructions as closely as possible.

In the space below, please write about what exactly is occurring in this difficult situation. Try to be as descriptive as possible.

(For example, “*Our family is having an argument about whether or not I should pursue a major in Anthropology. It’s the only thing I’m interested in but my parents are scared that...*”)

*Remember – your responses are completely anonymous and your writing is confidential. Don’t worry about spelling, sentence structure, or grammar.

[SPACE FOR WRITING]

People Involved Writing Prompt

In the space below, please write about who is involved in the situation if it involves more than just you. Please describe the people involved with as much detail as possible, even if you are the only one involved (in this case describe yourself).

(For example, “*My mother, sister, and brother are taking different sides in this argument. My brother supports me, but my sister doesn’t...*”)

*Remember – your responses are completely anonymous and your writing is confidential. Don’t worry about spelling, sentence structure, or grammar.

[SPACE FOR WRITING]

Words Spoken Writing Prompt

In the space below, please write any words that have been spoken in the situation, either what you have said to yourself, what other people have said to you, or what you have said to other people. Please use as much detail as possible.

(For example, “*I told my mom that I studied for my test but I get really nervous in the exam room and it feels like what I studied slipped out of my mind. She told me that...*”)

*Remember-- your responses are completely anonymous and your writing is confidential. Don’t worry about spelling, sentence structure, or grammar.

[SPACE FOR WRITING]

Please take some time to read what you wrote to see if anything particularly stands out for you.

Appendix L

State Self-Compassion Scale-Short form

As you think about the difficult situation you just wrote about, please indicate how well each statement applies to how you are feeling toward yourself right now:

Self-Kindness

I'm giving myself the caring and tenderness I need.				
1	2	3	4	5
Not at all true of me				Very true of me

Self-Judgment

I feel intolerant and impatient toward myself.				
1	2	3	4	5
Not at all true of me				Very true of me

Common Humanity

I'm remembering that there are lots of others in the world feeling like I am.				
1	2	3	4	5
Not at all true of me				Very true of me

Isolation

I feel like I'm struggling more than others right now.				
1	2	3	4	5
Not at all true of me				Very true of me

Mindfulness

I'm keeping things in perspective.				
1	2	3	4	5
Not at all true of me				Very true of me

Over-Identification

I'm obsessing and fixating on everything that's wrong.				
1	2	3	4	5
Not at all true of me				Very true of me

Appendix M

Food Rating Sheet

Grapes:

1) How much do you like this food?

1 - Not at all 2 - Slightly 3 - Moderately 4 - Very 5 - Extremely

2) How sweet is this food?

1 - Not at all 2 - Slightly 3 - Moderately 4 - Very 5 - Extremely

3) How salty is this food?

1 - Not at all 2 - Slightly 3 - Moderately 4 - Very 5 - Extremely

4) How much of this food would you eat if you want to be compassionate to yourself?

1 - None 2 - Very little 3 - Quite a bit 4 - Some 5 - A lot

Hummus and Carrots:

1) How much do you like this food?

1 - Not at all 2 - Slightly 3 - Moderately 4 - Very 5 - Extremely

2) How sweet is this food?

1 - Not at all 2 - Slightly 3 - Moderately 4 - Very 5 - Extremely

3) How salty is this food?

1 - Not at all 2 - Slightly 3 - Moderately 4 - Very 5 - Extremely

4) How much of this food would you eat if you want to be compassionate to yourself?

1 - None 2 - Very little 3 - Quite a bit 4 - Some 5 - A lot

Jujubes Candy:

1) How much do you like this food?

1 - Not at all 2 - Slightly 3 - Moderately 4 - Very 5 - Extremely

2) How sweet is this food?

1 - Not at all 2 - Slightly 3 - Moderately 4 - Very 5 - Extremely

3) How salty is this food?

1 - Not at all 2 - Slightly 3 - Moderately 4 - Very 5 - Extremely

4) How much of this food would you eat if you want to be compassionate to yourself?

1 - None 2 - Very little 3 - Quite a bit 4 - Some 5 - A lot

Potato Chips:

1) How much do you like this food?

1 - Not at all 2 - Slightly 3 - Moderately 4 - Very 5 - Extremely

2) How sweet is this food?

1 - Not at all 2 - Slightly 3 - Moderately 4 - Very 5 - Extremely

3) How salty is this food?

1 - Not at all 2 - Slightly 3 - Moderately 4 - Very 5 - Extremely

4) How much of this food would you eat if you want to be compassionate to yourself?

1 - None 2 - Very little 3 - Quite a bit 4 - Some 5 - A lot

Appendix N

Procedure Script

Part 1 – Consent Form and Screening

Thanks for coming in. I'd like to start by giving you an informed consent form for everything we're going to be doing today. Please review the form, let me know if you have any questions, and sign the form when you're ready. There are two copies, one that you sign and return to me, and the other you can keep for your own records.

Thank you! Before we start I just want to ask you some screening questions:

- Do you have any medical condition that prevents you from freely eating the foods in the taste test like diabetes or irritable bowel syndrome (IBS)?
- Do you have any allergy or intolerance towards any of the foods in the taste test?

[If necessary, remind the participants that the foods will be grapes, hummus with carrots, jujubes candy, and potato chips. If participants said yes to any of the questions above, assign them their credit and tell them: "I'm sorry. Unfortunately you are not eligible for this study."]

Now I would like to ask you about instructions we emailed you before your session:

- Did you follow the study's instruction to eat something two hours before your session?
- When was the last time you ate something?
- How hungry do you feel right now on a scale from 1 – not hungry at all to 5 – extremely hungry?

Part 2 – Procedure Outline and Computer Survey

Thank you for answering those! So today, what we're going to be doing is examining how recalling a current experience affects taste perceptions. First, we would like you to answer some questions about yourself, your eating habits, and your physical activity level. Then we're going to ask you to do a writing task with 3 parts for several minutes. These tasks will be done on the computer here. And finally, we're going to ask you to do a taste test in the other room for several minutes.

The computer here is already set up for you to start the survey. Please don't exit the survey, go onto your phone, or open any other websites or applications while you are completing the survey. Also, please only use the arrows that are embedded within the survey to navigate forward or back. If you use the web browser buttons, you will exit the survey.

I'll be right next door if you have any questions while you are doing the survey, and please just knock on the door to signal me that you are done.

[Use this time to assign research participation credit and prepare food and water for the taste test]

Part 3 – Taste Test

Okay, thank you for your answers to the survey. Now I'm going to bring you over to a table in the other room here for the taste test. Please have at least a taste of each item so that you can rate them on the page for that food [Show participants that the form has two pages and each page has the name of the food on top].

Here's some water for you to cleanse your palate between each item. Please make sure to rate the item you just ate before moving on to the next. You are welcome to have as much of each food as you want in order to answer the question on the form. It is important that you answer the questions on the form as accurately as you can, so if you need more food to answer the questions, please let me know. I'm just right next door. And if you finish early, feel free to eat as much as you want. For sanitation purposes, we have to throw it away after you leave anyway. We're giving everyone the same amount of time for this task, so I'm going to check back in on you after 10 minutes. Also, please don't put your name or student number on the form, that way your response cannot be traced back to you in any way.

Part 4 – Debrief

Thank you very much for your participation today. Did you have any questions or observations about the purpose or procedures of the study that you wanted to talk about at this stage?

Before you go, there are some aspects of the research I would like to explain more fully than I could at the beginning.

First, the short questionnaire after writing task was meant to assess self-compassion. Self-compassion refers to treating oneself with kindness and sympathy, as opposed to self-criticism during difficult times. We are interested in how levels of self-compassion affect eating behaviours while also taking into account your own interpretations of self-compassion, which is the last question of the food rating form. We implied that the study is about current experiences and taste perceptions to obscure that possible connection until your data were complete.

Second, not everyone in the study completed the same writing task. After recalling an academic situation that has been difficult for you, by random assignment, you were asked either to write about the situation self-compassionately or to write about it in more detail. This is to make sure that we have one experimental group with relatively higher levels of self-compassion and one control group with lower levels of self-compassion.

Finally, the taste test at the end is actually a food choosing task, a measure of your food choice and consumption. Your food choice and consumption will be derived through weighing how much of each food you have eaten. We have to disguise the task as a taste test so that you wouldn't constrain yourself from eating as much as you want.

Thanks again for your participation. Please note that we held this additional information about the study until the end because it could have biased your responses if you had known about it beforehand. Therefore, we would appreciate it if you refrained from discussing these aspects of the study with others in the PSYC 1200 course who might participate in this study at a later time.

Also, from past research, we know that many participants will feel better about a personally difficult situation, simply from having written about it. But in case you are feeling distressed,

here's a contact sheet for campus and community mental health resources. This sheet also has a web address where you can come back to find a results summary of this research, around May 2025.