

Experiences of People with Prediabetes in a Self-Compassion and Physical Activity Intervention:
A Qualitative Study using Participatory Theme Elicitation

by

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Abstract

Background: Type 2 Diabetes (T2D) is a chronic condition that impacts almost one in 10 people in Canada. *Prediabetes* signifies high T2D risk and is a call to action for risk-reducing behaviours like physical activity. Difficult emotions, stigma, and lack of support can prevent people with prediabetes from getting active. Self-compassion is a kind and protective approach taken towards oneself that should help people cope with prediabetes. The MOVE IT Study is a group-based intervention that teaches people with prediabetes self-compassion and physical activity behaviour-change strategies. Research is needed to explore how MOVE IT Study participants used self-compassion to improve their physical activity. Participatory Theme Elicitation (PTE) is a method of analyzing qualitative data alongside people with lived experience that should be useful for the present study.

Aims: (1) To qualitatively explore how participants in the MOVE IT Study used self-compassion to cope with prediabetes and improve their health. (2) To evaluate the acceptability and usefulness of PTE as a co-analysis technique.

Methods: A critical realist lens and the principles of patient engagement framed this research. Fourteen MOVE IT Study intervention sessions were audio-recorded and transcribed, representing $N = 14$ participants ($M_{age} = 54$ years, $SD_{age} = 7$ years; 100% women). Transcripts were subjected to PTE alongside five co-researchers who had previously completed the MOVE IT Study (Age range = 51-74 years, 100% women, 40% White, 40% Indigenous, 20% Filipino). PTE was evaluated using the Public and Patient Engagement Evaluation Tool and a group interview with co-researchers.

Results: Six themes were generated from the data representing a “prototypical” participant’s journey of learning self-compassion and becoming more physically active through the MOVE IT

Study. Cutting across these themes, participants in the MOVE IT Study used self-compassion to identify opportunities for growth, cope with physical activity setbacks and support their mental health, take action to protect their physical health, and support long-term lifestyle change.

Conclusions: Self-compassion training is relevant and useful to people with prediabetes who are seeking to become more active. PTE was a practical, highly acceptable method of co-analysis that produced meaningful results and should be used in future research.

Keywords: health promotion; exercise; self-care; participatory research; patient engagement

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Dedication

This thesis is dedicated to my parents, Tom, and Rita. Thank you for loving and supporting me in all that I do. The best parts of myself are those that remind me of you.

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Chapter I: Introduction

Jane (fictional) is a 55-year-old woman who was recently diagnosed as having prediabetes, the precursor to Type 2 Diabetes (T2D). Prediabetes is defined as having blood sugar levels that are higher than normal, but still below the threshold needed for a T2D diagnosis (Diabetes Canada, 2018). Jane is part of the one in three adults in Canada currently living with prediabetes or diabetes (Public Health Agency of Canada, 2023). When Jane's doctor told her she had prediabetes, her first reaction was fear. Jane knew the potential consequences of having T2D such as heart disease, kidney disease, eyesight problems and potential amputation (Diabetes Canada, 2018). She also knows that Canadians with T2D die at twice the rate of those without this disease (Diabetes Canada, 2018). Jane recalls her mother struggling with diabetes and does not want to follow the same path.

Jane is upset with herself about her prediabetes diagnosis. She thinks to herself, *"I should have known better. I should have made changes to my lifestyle... This is all my fault"*. Sometimes it's easier for Jane to just ignore her T2D risk altogether (Patierno et al., 2023). Jane wants to reach out to others for support but hesitates to do so, *"everybody always says that people with Type 2 bring it on themselves"* (Browne et al., 2013). She worries what people will think when she tells them she has prediabetes.

Jane is nervous about the lifestyle changes she will need to make to prevent T2D. The doctor said she needs to exercise more and lose weight (Sallis, 2015), but she isn't sure what that means or even where to start. Jane thinks that exercise is painful and difficult, plus, she's just not the type of person who exercises (Blom et al., 2021). Adding to her challenges, Jane doesn't know where she can access safe and affordable opportunities to be active in her community (ParticipACTION, 2021). Even if she could find a way to be more active, Jane would feel guilty

about taking time away from her family to exercise on her own (Dennison et al., 2019). The fear, shame, uncertainty, and barriers to health Jane is experiencing prevent her from managing her diabetes risk. Unsupported in making healthy behaviour changes, Jane becomes part of the 50% of people with prediabetes who develop T2D in their lifetime (Van Herpt et al., 2020). T2D can be prevented, and a prediabetes diagnosis can be a positive turning point in a person's health. How can we change the way that Jane's story ends?

Self-compassion is a psychological resource consisting of mindfulness, self-kindness, and common humanity (Neff, 2003a) that should help people cope with the difficulties associated with prediabetes and support health promoting behaviour changes like physical activity (e.g., Morgan et al., 2020). The MOVE IT Study is an 8-week intervention conducted out of the Exercise and Health Psychology Lab at the University of Manitoba that teaches people with prediabetes self-compassion and physical activity behaviour-change strategies (Signore et al., 2022).

Substantial quantitative evidence supports the applicability of self-compassion to chronic disease risk reduction and behaviour change (e.g., Phillips & Hine, 2021). There is, however, a gap in the qualitative self-compassion and health literature. As discussed in the following sections, less is known about the lived experiences of people who use self-compassion to cope with a chronic disease risk and change their health behaviours. The present study uses a participatory qualitative approach to explore the lived experiences of people with prediabetes who participated in the MOVE IT study (Signore et al., 2022). More specifically, this study will answer the question: did people with prediabetes in the MOVE IT study use self-compassion to cope with their diabetes risk and increase their engagement in physical activity or other health behaviours, and if so, how?

Chapter II: Literature Review

Prediabetes and Diabetes

In Canada, 9.4% of people (or 3.7 million) live with diagnosed diabetes (Public Health Agency of Canada, 2023). Each hour approximately 20 adults are newly diagnosed with T2D, and the death rate of Canadians with diabetes is about double that of those without this disease (Diabetes Canada, 2018). T2D is a chronic condition which impacts the body's production of, or response to, the hormone insulin and leads to impaired blood sugar regulation. Elevated blood sugar resulting from T2D can cause health complications such as heart disease, kidney disease, nerve damage, eyesight problems, and limb amputation (Diabetes Canada, 2018). Prediabetes, the precursor to T2D, is a condition where an individual's blood sugar is elevated, but not to a diabetic level (Diabetes Canada, 2018). About 6 million adults in Canada have a prediabetes diagnosis, though many more live undiagnosed with this condition (Public Health Agency of Canada, 2022). If no steps are taken to mitigate T2D risk, about 50% of people with prediabetes will develop T2D in their lifetime (Van Herpt et al., 2020). However, risk of T2D can be reduced, particularly if risk-factors are identified and addressed early.

Some risk factors for T2D are related to lifestyle behaviours and are within an individual's control. Modifiable risk factors for T2D include physical activity, nutrition, obesity status, smoking status, blood pressure (Public Health Agency of Canada, 2022), and use of pharmacological interventions that can lower T2D risk (Zand et al., 2018). Other T2D risk factors are outside of an individual's control. Non-modifiable risk factors for T2D include older age, family history of T2D, barriers to health in the built environment, and social determinants of health (e.g., income, education, housing) (Public Health Agency of Canada, 2022). Considering the diversity of risk factors associated with T2D, multiple approaches are needed to address this

health problem. The most recent recommendations from the Framework for Diabetes in Canada (Public Health Agency of Canada, 2022), suggest that person-centered approaches are most effective for diabetes prevention, management, and care.

Person-centered approaches holistically encompass an individual's physical, social, mental, and spiritual wellbeing, and the broader social determinants of health (Public Health Agency of Canada, 2022). Community and policy-level interventions are needed to support individuals whose T2D risk stems primarily from social inequities (e.g., experiencing poverty, housing insecurity, or food insecurity; Jernigan et al., 2012; Raphael et al., 2012). Individual-level, behavioural interventions may help those who are already meeting their basic needs to optimize their personal health behaviours for T2D risk reduction (e.g., nutrition, physical activity; Nathan et al., 2015). For many, a combination of social and individual approaches to health promotion may be needed. Health behaviour change is multi-faceted, and one approach (i.e., individual, or social) should not be prioritized above another. Manitoba's Diabetes Action Plan states that promoting physical activity opportunities in the community, advising patients about the physical activity guidelines, and raising awareness about T2D risk can help to increase preventive behaviours among people at risk for T2D (Government of Manitoba, 2023). The Action Plan, therefore, seeks to expand community-based chronic disease prevention programming across Manitoba (Government of Manitoba, 2023).

A diagnosis of prediabetes is a critical moment in the timeline of an individual's health where they can choose to take action, address their modifiable risk factors, and prevent a future diagnosis of T2D (Hindhede, 2014). There is currently no cure for T2D, and therefore prevention of this disease before its onset is critical (Public Health Agency of Canada, 2022). Physical activity is one of the most effective ways to reduce T2D risk and can reduce risk independently

of diet and weight loss (Gill & Cooper, 2008). Enhancing physical activity is a target within Manitoba's Diabetes Action Plan (Government of Manitoba, 2023). Canada's 24-Hour Movement Guidelines recommend that adults engage in 150 minutes of moderate-to-vigorous aerobic physical activities, and at least two sessions of muscle strengthening exercises per week to maintain health and reduce their risk for chronic conditions such as T2D (Ross et al., 2020).

Physical (In)activity in Canada

Up to 82.5 % of adults in Canada do not meet the guidelines for moderate-to-vigorous activity regardless of their occupation, education, and gender (Prince et al., 2020). Using self-report and accelerometer data from the Canadian Health Measures Survey (2012 to 2017), Prince et al. (2020) categorized 4080 adults into “high”, “intermediate”, and “low” physical activity categories. Demographic factors accounted for significant differences in sedentary time, light physical activity, and steps per day. People in the lowest activity group worked in the professional sector, identified as women, and had higher levels of education (Prince et al., 2020). Those in the highest activity group worked in the personal and customer services sector, identified as men, and had lower levels of education (Prince et al., 2020).

Of the 2519 Canadian adults surveyed by Yun et al. (2018), 55.1% reported that low physical activity was a moderately to very serious health issue on the same level as tobacco use and unhealthy diets. Despite this awareness, physical activity levels in Canada remain low (ParticipACTION, 2021), suggesting people face barriers to engaging in physical activity. Yun et al. (2018) found that both policy-level and individual strategies to increase physical activity are acceptable to the public; policy interventions such as providing more green spaces, improving active transportation, and changing community designs were seen as beneficial by over half of

respondents (55-67.3% approval). Individual interventions such as providing education were also viewed as favourable by the majority (52.6-65.4% approval; Yun et al., 2018).

Though individual approaches to health should not be prioritized over policy-level interventions, individual approaches are relevant (Abraham & Michie, 2008), acceptable to the public (Yun et al., 2018), and can prove effective (Gormley et al., 2022). A common way to intervene on individual-level health is providing education and information (Abraham & Michie, 2008). Many education-based health interventions support people in self-regulating their behaviours (Abraham & Michie, 2008). Self-regulation is the process of setting goals, enacting a plan, monitoring progress, and making necessary behavioural adjustments to achieve a desired outcome (Baumeister & Heatherton, 1996). An immense amount of self-regulation is required for an individual to overcome the barriers, distractions, ambivalence, and momentary urges, that can detract from physical activity (Baumeister & Heatherton, 1996; Terry & Leary, 2011).

Physical Activity Self-Regulation Among People with Prediabetes

Self-regulating ones' behaviour to engage in physical activity is a challenge, and this challenge may be compounded by the experience of prediabetes. As described below, inadequate support, stigma, difficult emotions, and personal barriers related to prediabetes can all thwart behaviour change attempts and keep people physically inactive. While a prediabetes diagnosis can be a turning point in a person's health where they are particularly receptive to physical activity counselling (Ledford et al., 2020), supportive conversations about physical activity may not take place in all primary care settings (Sallis, 2015). If physical activity is discussed at all, patients may be counselled to simply exercise "more" or "more vigorously" with the goal of losing weight (Sallis, 2015). Conversations about physical activity that are framed around weight

rather than health are perceived as discouraging by patients (Reddeman et al., 2019) and can contribute to experiences of stigma felt by people with prediabetes (Tylka et al., 2014).

Though typically associated with T2D, both weight stigma and diabetes stigma are applicable to the experiences of people with prediabetes. Weight stigma is the experience of marginalization, social exclusion, or discrimination because of one's body shape or size (Tylka et al., 2014). Weight stigma is most frequently experienced by people who are overweight or obese (Tylka et al., 2014). Being overweight ($\text{BMI} = 25 \text{ to } 29.9 \text{ kg/m}^2$) or obese ($\text{BMI} > 30 \text{ kg/m}^2$) is a risk factor for T2D (Abdullah et al., 2010), and therefore many people with prediabetes or T2D may also face stigma about their weight. Among people with T2D, experiencing weight discrimination is related to higher blood sugar levels, more diabetes distress, and fewer self-care behaviours, leading to T2D exacerbation (Potter et al., 2015; Teixeira & Budd, 2010). Weight stigma is also associated with lower levels of physical activity and higher rates of disordered eating among people with T2D (Puhl et al., 2022). Extending these findings, weight stigma may thwart efforts to engage in risk-reducing behaviours like physical activity among people with prediabetes.

Distinct from weight stigma, diabetes stigma is the experience of marginalization, social exclusion, or discrimination due to having diabetes (Browne et al., 2013). Diabetes stigma is most common among people with T2D compared to those with Type 1 Diabetes. T2D stigma stems from social assumptions that T2D is self-inflicted through personal behaviour choices, laziness, or a lack of self-control (Beverly et al., 2019; Browne et al., 2013). Diabetes stigma can hinder diabetes self-management by increasing anxiety and depression (Schabert et al., 2013), or deterring people from self-care behaviours for fear of drawing attention to their condition (Holmes-Truscott et al., 2018; Jenkins et al., 2011). Experiences of diabetes stigma are also

associated with disordered eating among people with T2D (Puhl et al., 2022). Diabetes stigma may cause people with prediabetes to feel distressed, isolated, and unable to change their situation. Indeed, distressing emotions can undermine self-regulation as discussed in the next section. Both people with T2D and prediabetes should benefit from learning strategies to cope with stigma (Browne et al., 2013; Potter et al., 2015).

Distressing emotions about having prediabetes can create another barrier to physical activity self-regulation. People report experiencing distress, concern, guilt, or shame in response to their prediabetes diagnosis (Strachan et al., 2018). These emotions may stem from diabetes stigma, fear for ones' health, or uncertainty about the future. Difficult emotions such as these can impede self-regulation and are associated with less engagement in health behaviours among both clinical (Sirois, Molnar, et al., 2015) and non-clinical (Sirois, Kitner, et al., 2015) populations. Difficult emotions can distract from goals (Bruyneel et al., 2009; Schmeichel, 2007), interfere with decision-making (Bruyneel et al., 2009), inhibit goal-directed behaviour and self-control (Tang et al., 2015), and promote procrastination (Sirois & Pychyl, 2016). To avoid facing difficult emotions, some people may deny or downplay the health risk of prediabetes (Strachan et al., 2018) and may therefore feel that physical activity behaviour change is not an important goal. Resources are needed to support people with prediabetes in coping adaptively with their health risk, making it easier to engage in the self-regulation needed to change their physical activity.

Finally, people with prediabetes may struggle to self-regulate their physical activity because they face barriers to prioritizing their personal health. People who understand the risks associated with T2D may be more likely to prioritize a physical activity behaviour change compared to people who do not understand their health risk (Friis, Vind, et al., 2016). One population-based study suggested that people with T2D may have lower health literacy

compared to those without T2D and may not be fully aware of their health risk (Friis, Lasgaard, et al., 2016). Social support from friends and family can also affect one's willingness to prioritize their own health, with people in less supportive situations less likely to engage in physical activity (Nieminen et al., 2013). Competing demands such as work stress (Heraclides et al., 2011), and gender norms that encourage some people to prioritize the health of others over their own (Dennison et al., 2019) can act as barriers to prioritizing personal health, particularly among women. Approaches to increasing physical activity among people with prediabetes should therefore provide education about the importance of reducing T2D risk, opportunities for social support and connection, and psychological skills training to help people view their own health as an important priority. Within the Manitoba Diabetes Action Plan, increased mental health support was identified by people with lived experience of diabetes as something that would help them better manage their illness (Government of Manitoba, 2023). One psychological skill which may help people with prediabetes to cope with their health risk and increase their physical activity is self-compassion.

Self-Compassion

Self-compassion, as conceptualized by Neff (2003a), is a psychological resource that allows people to take a warm and supportive stance towards their experiences, particularly during challenging times. In 2003, during the positive psychology movement (Azar, 2011), Neff brought self-compassion into mainstream psychological inquiry by operationalizing her definition of self-compassion and developing a tool with which to measure it (Neff, 2003a; Neff, 2003b). It is common, across societies and cultures, for people to have less compassion for themselves than they do for others (Germer & Neff, 2019). Often, people may respond to the failures of others with kindness and understanding, while responding to their own personal

shortcomings with harsh self-criticism (Germer & Neff, 2019). Neglecting to have compassion for oneself can be harmful, as it may lead people to be consumed by self-criticism, isolate themselves from others, or feel that their situation will never improve in response to the smallest of failures (Neff & Germer, 2013).

Three Components of Self-Compassion

Self-compassion is theorized to comprise of three interconnected components (Neff, 2003a); mindfulness, self-kindness, and common humanity. Though conceptually distinct, these three components are interconnected and work synergistically as part of a complete self-compassionate practice (Neff, 2003a). *Mindfulness* is the foundation of self-compassion, as one must first become aware that they are suffering before they can extend themselves compassion (Neff, 2023). Mindfulness is an awareness and acceptance of the present moment, without judgement or desire for one's experience to be different (Neff, 2003a). Mindfulness helps people recognize that difficult situations and emotions are only temporary, grounds people in the present moment, and mitigates rumination and denial during times of suffering (Neff, 2003a).

Understanding the temporary nature of suffering can provide the presence of mind necessary to offer oneself kindness in the face of difficulties (Neff, 2003a). *Self-kindness* is the desire to treat oneself with support, in the way one would treat a good friend, rather than responding to personal shortcomings or failures with harsh self-criticism (Neff, 2003a). People may assume that self-criticism is the only way to avoid mistakes and prevent personal failures (Chwyl et al., 2021), but if all failure is met with self-punishment people may avoid challenging themselves or entering situations where they could fail in the first place (Powers et al., 2011). Taking risks and accepting challenges can lead to personal growth and new opportunities; it is important that

people can take healthy risks, safe with the knowledge that failure will be met with an internal sense of kindness and encouragement.

Finally, people may be more open to the idea of facing difficulties or experiencing failure if they recognize that suffering is a shared human experience. *Common humanity* is the recognition that all people suffer in different ways, and suffering is an essential life experience (Neff, 2003a). When facing suffering, a person may assume that their difficulty is somehow unique, that no one could possibly understand what they are going through, or that they must be uniquely incompetent to have brought about their suffering. In most cases, these assumptions are false. A recognition of common humanity allows one to feel less isolated and more interconnected in their experience of suffering; they are not the only person to whom bad things happen (Neff, 2003a). This recognition can reduce the perceived gravity of difficult situations and allow one to view a challenge in a more realistic light.

State and Trait Self-Compassion

Neff's (2003a) original work defined self-compassion as a person's tendency towards increased compassionate self-responding and decreased uncompassionate self-responding. In other words, self-compassion was originally conceptualized as a psychological trait (Neff et al., 2021). In recent years the assumption that people's level of self-compassion is constant across all situations and domains of life has been challenged (Zuroff et al., 2021). Although someone may score high on trait self-compassion, they may find it easier to apply self-compassion to certain contexts (e.g., family and relationships) compared to others (e.g., work or academics; Zuroff et al., 2021). Considering the potential for variability in self-compassion across life domains, researchers have begun to examine present-moment self-compassion (i.e., as a psychological state). State self-compassion is compassion for oneself felt in the present moment about a

specific situation (Neff et al., 2021). Neff and colleagues (2021) have developed and validated a measure to assess state self-compassion, but most self-compassion research to date has used the trait self-compassion scale (Neff, 2003b), or a variation of this scale. When discussing self-compassion theory and research, I will be referring to trait self-compassion unless otherwise stated. However, both types of self-compassion likely share similar benefits (Neff et al., 2021).

The Yin and Yang of Self-Compassion

The three components of self-compassion can also be expressed in different ways: gentle and nurturing, or fierce and protective (Braehler & Neff, 2020). Germer and Neff (2019) use the metaphor of the Yin and Yang to describe how two seemingly opposite ways of relating to oneself (i.e., nurturing, and fierce) are complementary and interdependent. Yin self-compassion represents gentleness, characterized by comforting, soothing, and validating (Braehler & Neff, 2020). This way of self-responding can be likened to the comfort a parent offers to their crying child. Yin self-compassion should elicit ones' natural care response, provide a sense of safety and security, allow one to be in tune with their emotions, and promote adaptive psychological coping in response to distress (Germer & Neff, 2019). The fierce (Yang) side of self-compassion is characterized by the desire to protect oneself from harm, provide for ones' needs, give voice to the truth, and advocate for oneself (Neff, 2021). This way of self-responding can be compared to a mother bear protecting her cubs, or a parent working three jobs to provide for their family. The Yang of self-compassion should help people recognize that they deserve to be free from suffering, take action, and improve their situation.

The Yin and Yang of self-compassion are both part of a balanced self-compassionate practice. Although it is normal for a person to feel more comfortable expressing one "side" of self-compassion, embracing both gentle and fierce self-compassion is important. One cannot

relate to themselves with only gentleness and no fierceness, as this could lead to amotivation and complacency – which are not compassionate ways of responding to oneself (Germer & Neff, 2019). Conversely, one cannot only act fiercely without gentleness, as this could lead to abrasiveness, isolation, or poor emotional coping skills (Germer & Neff, 2019).

Self-Compassion is not Complacency

When people do not fully understand what self-compassion is, do not believe in the benefits of treating themselves kindly, or perceive self-criticism as a sign of strength or responsibility, they may endorse some misgivings about self-compassion (Robinson et al., 2016). Some people may worry that self-compassion will cause them to lapse into laziness, self-indulgence, and complacency, and that harsh self-criticism is the key to motivation and goal achievement (Chwyl et al., 2021). Though the desire to avoid self-criticism can motivate people to manage their behaviours, failure is a natural part of life and is bound to occur in the pursuit of most goals. For highly self-critical people, the onslaught of harsh self-criticism that accompanies a failure can thwart future attempts at goal pursuit (Neff, 2023) by causing people to avoid situations where failure is possible (Powers et al., 2011).

Self-compassion is a better motivator than self-criticism. People who are self-compassionate set high personal standards and are more likely to persist in the face of failure (Semenchuk et al., 2018). Self-compassion is positively related to engagement in health promoting behaviours (Sirois, Kitner, et al., 2015) and coping in difficult situations (Ewert et al., 2021). People who are self-compassionate are also more likely to apologise after making a mistake compared to their less self-compassionate counterparts (Vazeou-Nieuwenhuis & Schumann, 2018). Clearly, self-criticism is not the panacea of behavioural management, and

self-compassion may be a more effective way to hold oneself accountable, manage difficult behaviours, and accomplish goals.

Self-Compassion Interventions

People vary when it comes to compassionate self-responding; some people are more self-compassionate while others are more self-critical (Neff, 2003b, 2023). Fortunately, self-compassion can be intervened upon and improved over time (Neff & Germer, 2013). Two common methods of intervening on self-compassion include Compassion-Focussed Therapy (CFT; Gilbert, 2010) and the Mindful Self-Compassion Program (MSC; Germer & Neff, 2019). CFT is a form of psychotherapy that can be practiced individually or in groups over four to 16 weeks (Gilbert, 2010). CFT helps users cultivate a compassionate inner voice through exercises like compassionate imagery, directing compassionate thoughts to oneself and others, responding to self-criticism with self-compassion, letter writing, and journaling (Leaviss & Uttley, 2015). Differing from CFT, MSC is not psychotherapy, it is a group-based education program which is open to all users (Germer & Neff, 2019). MSC is grounded in the work of Neff (2003a) and includes writing activities, group discussions, informal practices, and formal meditations designed to increase trait self-compassion (Neff & Germer, 2013). A typical MSC program takes place across eight weekly sessions and concludes with a half-day retreat (Neff & Germer, 2013).

In addition to CFT and MSC, many other self-compassion interventions inspired by these programs have been developed (Ferrari et al., 2019). These interventions range from single sessions to multi-week, multi-component programs, and have been conducted across a variety of populations (Ferrari et al., 2019). Research generally supports the efficacy of self-compassion interventions for improving self-compassion and other psychological variables. A meta-analysis of 20 compassion-based interventions (including self-compassion interventions) by Kirby et al.

(2017) found significant moderate effects for self-compassion, depression, anxiety, psychological distress, and well-being. These results were corroborated by a meta-analysis of 27 self-compassion interventions (Ferrari et al, 2019) which demonstrated that intervening on self-compassion produced significant, moderate to large improvements in self-compassion, rumination, stress, depression, and anxiety. Considering these findings together, both reviews suggest that people can increase their self-compassion through training and increases in self-compassion may translate into psychological benefits such as reductions in depression and anxiety (Kirby et al., 2017; Ferrari et al., 2019).

Self-Compassion, Prediabetes, and Physical Activity

From a theoretical perspective, both state and trait self-compassion should help people with prediabetes cope adaptively with their health risk and engage in more physical activity. Mindfulness should allow people with prediabetes to take a balanced approach to the difficult emotions accompanying their health risk, without catastrophizing or, alternatively, minimizing the seriousness of their condition. Self-kindness should encourage people with prediabetes to treat themselves with warmth and understanding as they navigate the pitfalls of coping with a T2D risk and increasing their physical activity. Self-kindness should also act as a motivating force that inspires people to protect and prioritize their personal health. Finally, common humanity should help people with prediabetes understand that millions of people share their risk for T2D, recognize they are not alone in their struggles, and remain connected to others despite the stigma they may face.

Research supports the benefits of self-compassion for coping with prediabetes. As previously stated, people with prediabetes may face stigma about their weight or T2D risk (Browne et al., 2013; Potter et al., 2015). This stigma can be internalized and incorporated into ones' sense of

self (i.e., self-stigma; Schabert et al., 2013), leading to more critical self-responding, isolation, and greater difficulties in managing health behaviours related to T2D (Puhl et al., 2022). Self-compassion is a useful resource for people who experience stigma (Wong et al., 2019). Self-compassion was found to attenuate the effects of self-stigma on depression and anxiety among LGBTQ+ adults (Chan et al., 2020), on life satisfaction among people with HIV (Yang & Mak, 2017), and on physical symptoms, depression, and quality of life among people with obesity (Hilbert et al., 2015). Self-compassion should therefore help people with prediabetes cope with stigma and prevent stigma from hindering their engagement in health behaviours like physical activity.

Concerns about ones' health and uncertainty about the future can add to the stress of receiving a prediabetes diagnosis (Strachan et al., 2018). Self-compassionate people remain resilient when facing chronic illness. Three systematic reviews (Austin, Drossaert, Schroevers et al., 2021; Hughes et al., 2021; Kılıç et al., 2021) and one scoping review (Semenchuk, Kullman, et al., 2021) have demonstrated that self-compassion is associated with reduced negative affect, depression, anxiety, and stress among people living with chronic diseases. Further, a scoping review specific to people with prediabetes, Type 1 Diabetes, and T2D found that self-compassion both associated with, and led to, more adaptive affective reactions such as reduced diabetes distress and reduced depression (Morgan et al., 2020). If people with prediabetes can respond adaptively to distress about their diagnosis, they should have more psychological resources available to devote towards physical activity behaviour changes.

Some people with prediabetes may face self-inflicted, social, or gender-related barriers to prioritizing their health and engaging in physical activity. Self-compassionate people take a proactive approach to their health (Semenchuk et al., 2022), have a desire to protect themselves

(Neff, 2021), and engage in behaviours that are in their best interest (Neff, 2003a). Correlational evidence shows a relationship between self-compassion and engagement in health behaviours including sleep, medical adherence, nutrition, and physical activity (Phillips & Hine, 2021). Further, a randomized controlled trial investigated the impact of a group self-compassion intervention on blood glucose control among individuals with T2D (Karami et al., 2018). Participants in the self-compassion condition lowered their blood glucose from pre-intervention to post-intervention significantly more than the control group (Karami et al., 2018). This finding suggests that self-compassion interventions may promote engagement in health behaviours involved in diabetes self-management. However only one self-compassion intervention to date, which is currently being conducted in the Exercise and Health Psychology Lab at the University of Manitoba (Faculty of Kinesiology and Recreation Management), has specifically targeted engagement in physical activity among people with prediabetes (Signore et al., 2022).

The MOVE IT Study

The Move Today for a Healthy Tomorrow Intervention Trial (MOVE IT) is a randomized controlled efficacy trial. Participants with prediabetes are allocated to either an 8-week intervention that pairs self-compassion and physical activity behaviour change training, or to an 8-week attention control arm that pairs education on health topics with physical activity behaviour change training (Signore et al., 2022). The intervention will determine whether adding self-compassion to physical activity behaviour change training produces superior improvements in physical activity and psychological outcomes compared to “ideal care” (i.e., physical activity behaviour change training combined with health education; Signore et al., 2022).

Participants in the MOVE IT Study are recruited from the community via Facebook advertisement and receive a one-hour, individualized meeting to discuss their T2D risk and

physical activity goals before being randomized to their intervention condition and engaging in seven, weekly, 2-hour psychoeducation sessions with a group of 5-10 other participants. These sessions are facilitated by research assistants with a physical activity psychology background who have received training in self-compassion (Signore et al., 2022). In the intervention arm, participants are taught to apply self-compassion specifically to their T2D risk and physical activity behaviour change. A summary of the intervention and control condition content is provided in Appendix A. All MOVE IT Study meetings are conducted via Zoom videoconferencing, audio-recorded, and archived as research data. Measurement points occur at pre-intervention, post-intervention, 6-weeks post-intervention, and 12-weeks post intervention. At each point, participants track their physical activity using a hip worn ActiGraph accelerometer and complete a battery of self-report measures distributed through an online survey.

Currently, only results from the MOVE IT Study pilot and feasibility trial are available (Signore et al., 2022), and the main efficacy trial is still underway. The results of the pilot and feasibility trial show the MOVE IT Study is feasible to deliver, and preliminary quantitative findings show results in the expected direction. In addition, qualitative interviews conducted to assess intervention acceptability found the MOVE IT study was acceptable to participants (Signore et al., 2022). While these results are promising, only the results of the larger efficacy trial can determine whether the intervention significantly improves physical activity among people with prediabetes. If the results of the efficacy trial are positive, future directions for the MOVE IT Study could include conducting community-based effectiveness testing within local diabetes care organizations. While community implementation will be informed by the quantitative findings, there is room for qualitative evidence to contribute to the future directions of the MOVE IT Study.

Qualitative research could help identify how, specifically, participants in the MOVE IT Study intervention arm used self-compassion training to cope with their T2D risk or increase their physical activity. Qualitative data could also inform which self-compassion practices participants find the most relevant or useful. Finally, the meaningful experiences portrayed in qualitative research could complement the quantitative findings from the MOVE IT Study efficacy trial and create a more compelling case for decision-makers to adopt the MOVE IT intervention within their organizations. The published qualitative data from the MOVE IT pilot and feasibility study specifically examines intervention acceptability and provides some commentary on participants' use of self-compassion but does not explore this topic in depth (Signore et al., 2022). More qualitative accounts of participants' experiences of learning and applying self-compassion in the MOVE IT Study intervention arm are needed.

Qualitative Research on Self-Compassion and Health

Though less qualitative evidence about people's uptake and use of self-compassion is available from the MOVE IT Study, other studies have qualitatively examined self-compassion in the context of health. Qualitative research can provide insights into the nuances of people's lived experiences that quantitative research may not (Markula & Silk, 2011) and is well-suited to exploring self-compassion and health (Austin, Drossaert, Sanderman et al., 2021). To showcase the work done in this area, a literature review of qualitative self-compassion and health-related research is provided below. A database search for this literature review was originally conducted in May of 2023 and was updated in May of 2024 (Appendix B). This literature review is not intended to be exhaustive, but rather representative of the contexts and methods used to qualitatively examine self-compassion and health.

Qualitative Research on Self-Compassion and Health Promoting Behaviours

Considering self-compassion in the context of health promoting behaviours, both Berry et al. (2010) and Egan and Mantzios (2018) used phenomenology to examine self-compassion in relation to nutrition and physical activity (Berry et al., 2010; Egan & Mantzios, 2018). Among community-dwelling adults, eating well and staying active were not regarded as self-compassionate, but rather, obligatory acts of “looking after” oneself (Egan & Mantzios, 2018). The term “self-kindness” was met with suspicion, as participants had misgivings about lowering their personal behavioural standards if they treated themselves with too much kindness (Egan & Mantzios, 2018). In contrast, young women exercisers interviewed by Berry et al. (2010) embraced the idea of self-compassion as a tool that could help them overcome self-criticism in exercise settings (Berry et al., 2010). Self-compassion helped women exercisers appreciate the unique aspects of their bodies, take ownership of their health, engage in less social comparison, and connect with other women (Berry et al., 2010). Together, these findings suggest that people may worry self-compassion will lead to complacency and health behaviour lapses, but when self-compassion is embraced, it can help support health behaviours. Dispelling misgivings about self-compassion may be an important first step when introducing self-compassion as a resource for health promotion.

Qualitative Research on Self-Compassion and Mental Illness

Self-compassion has also been qualitatively explored in the context of mental illness. Kelly et al. (2021), Geller et al. (2022), and Bremer et al. (2023) used qualitative description, thematic analysis, and phenomenology, respectively, to explore self-compassion among people with eating disorders. Some participants were initially doubtful of the usefulness or benefit of self-compassion (Kelly et al., 2021, Geller et al., 2022), and described how the habitual self-criticism accompanying their eating disorders made it difficult to accept self-compassion (Kelly

et al., 2021). Other individuals were more open to self-compassion and did not voice these misgivings (Bremer et al., 2023). Despite some initial hesitations, participants in each of these studies agreed that self-compassion should be a useful tool for eating disorder recovery (Kelly et al., 2021; Geller et al., 2022; Bremer et al., 2023).

Waite et al. (2015) used interpretive phenomenological analysis to explore perceptions of self-compassion and self-criticism among people with psychosis, and Pierorazio et al. (2024) used codebook thematic analysis to explore self-compassion among people with complex dissociative disorders. In both studies, participants described self-compassion as a useful resource that could promote self-acceptance, self-care, and recovery in the context of their mental health disorders (Waite et al., 2015; Pierorazio et al., 2024)

Finally, Agin-Liebes et al. (2024) used interpretative phenomenological analysis to examine experiences of self-compassion among people with alcohol use disorder in a psilocybin-assisted intervention. Participants described self-compassion as a key learning from the intervention that helped them navigate self-criticism, self-blame, and shame related to their disorder. Overall, these studies provide insight into the barriers and facilitators to self-compassion among people with mental illnesses and demonstrate that individuals living with these conditions feel self-compassion is relevant to their recovery.

Qualitative Research on Self-Compassion and Physical Illness

In the context of physical illness, qualitative research has explored experiences of, or thoughts towards, self-compassion among people with cancer (Austin, Drossaert, Sanderman et al., 2021; McLaughlin et al., 2024), prediabetes (Strachan et al., 2018), and chronic pain (Barnes et al., 2021). The methods used in these studies included thematic analysis, qualitative description, and narrative inquiry, respectively. Participants across all four studies experienced

distressing emotions and self-criticism related to their illness (e.g., frustration towards ones' body or shame about increased reliance on others). Self-compassion was viewed as a psychological resource that could help people with chronic illnesses cope with difficult emotions, reduce feelings of self-criticism, and encourage self-care (Austin, Drossaert, Sanderman et al., 2021; Barnes et al., 2021; Strachan et al., 2018; McLaughlin et al., 2024). These qualitative findings support the utility of self-compassion in the context of coping with a chronic illness.

Qualitative Research on Self-Compassion and Health Interventions

Qualitative research has examined participants' experiences in interventions targeting both self-compassion and health outcomes. These interventions have applied self-compassion to health-related distress (Boggiss et al., 2023; Bogosian et al., 2016; Lathren et al., 2018; Wilson et al., 2024), dietary change (Rahimi-Ardabili et al., 2020), and physical activity (de Bruin et al., 2020; Signore et al., 2022). Participants in these interventions were youth with Type 1 Diabetes, individuals with multiple sclerosis, young adult cancer survivors, adults with chronic kidney disease, overweight adults, office workers, and individuals with prediabetes, respectively. Across each of these qualitative accounts, participants found self-compassion helpful for coping with challenges related to their health or health behaviours (Boggiss et al., 2023; Bogosian et al., 2016; de Bruin et al., 2020; Lathren et al., 2018; Rahimi-Ardabili et al., 2020; Signore et al., 2022; Wilson et al., 2024). Apart from Lathren et al. (2018), the qualitative accounts provided in these studies were secondary to the main purpose of the research, or focused only on intervention acceptability (e.g., Boggiss et al., 2024). Participants in these studies also recounted their experiences of adopting self-compassion retrospectively which may have resulted in a loss of detail. Though these studies inform the acceptability of self-compassion and health-related

interventions, they do not provide a nuanced account of what it is like for an individual to treat themselves with compassion as they actively work to improve their health. Richer, thicker descriptions of how self-compassion interventions can help people cope with health-related challenges, engage in self-regulation, and adopt health behaviours are needed. To date, only one study has provided such a description.

Lathren et al. (2018) conducted a qualitative analysis of audio-recorded group intervention sessions from a mindful self-compassion intervention among young adult cancer survivors. This research is unique because participants' conversations in the context of the intervention itself were the source of qualitative data. By providing real-time insights into participants' adoption of self-compassion over the course of an 8-week intervention, Lathren et al. (2018) describe more nuance and depth than most previous qualitative studies examining self-compassion and health. Across the intervention sessions, self-compassion encouraged stronger emotional coping skills through self-kindness, common humanity with other young adult cancer survivors, and mindful awareness of supportive social relationships. Participants also used self-compassion to express greater acceptance, gratitude, and awareness towards their bodies and cope with health-related anxiety (Lathren et al., 2018). Participants provided concrete examples that support the benefits of self-compassion for this population and could inform future intervention delivery. The work of Lathren et al. (2018) is a unique contribution to the self-compassion literature and their methods should be used in future research.

Gaps in the Qualitative Self-Compassion Literature

Compared to the vast body of quantitative research, there are fewer qualitative explanations of how self-compassion may help people attain better health. Even less is known about people's experiences of applying self-compassion specifically to the context of prediabetes

and physical activity behaviour change. Qualitative accounts of self-compassion and health are often limited to one of two main purposes: (1) to explore people's thoughts about using self-compassion, or (2) to assess intervention acceptability as a secondary outcome of a multiple-methods research protocol. Despite the somewhat limited scope of these qualitative studies, they have supported the benefits of self-compassion across multiple populations, informed the acceptability of self-compassion interventions for improving health, and identified considerations for future intervention development. More qualitative research is needed to understand why self-compassion interventions may work to promote health and support the theoretical relationship between self-compassion, self-regulation, and health. The methods used by Lathren et al. (2018) should be optimal for collecting the rich qualitative data needed to fill these gaps.

The MOVE IT study presents an opportunity to draw from the methods of Lathren et al. (2018) and add to the qualitative self-compassion literature. As previously noted, people with prediabetes participate in the MOVE IT Study over Zoom videoconferencing, and audio-recorded intervention sessions are archived as research data. These archived intervention sessions have not been subjected to qualitative analysis, and such an analysis could fill the gaps in the self-compassion literature identified above. Qualitative data from the MOVE IT study could show how people with prediabetes use self-compassion to cope with their T2D risk and increase their physical activity, provide evidence for the benefits of self-compassion training among this population, and help justify community implementation of the MOVE IT Study.

Patient Engagement in Qualitative Research

Having lived experience of one's research topic can be an asset when identifying nuances in a qualitative dataset (Markula & Silk, 2011), but not all researchers have lived experience of their research topic. Patient engagement is a participatory approach which meaningfully and

actively involves patients as co-researchers who use their lived experiences of health and illness to inform or guide a research project (Canadian Institutes of Health Research, 2019). In this context, a “patient” is anyone who is engaged in a research project because they have lived experience of the health topic under study. Patients are commonly engaged in qualitative research; in a systematic review of 142 studies that engaged patients, 103 (73%) used a qualitative design (Domecq et al., 2014).

Patient engagement is distinct from research participation; patients are not examined as “subjects” under study, but rather, they take a co-ownership role alongside academic researchers (Canadian Institutes of Health Research, 2019). This research practice pairs the methodological and theoretical expertise of academic researchers with the lived expertise and “real world” priorities of patient co-researchers (Manafò et al., 2018). Patient engagement can occur at all stages of the research cycle, from developing a question, priority setting, and grant writing, to recruitment, implementation, data collection, analysis, and knowledge dissemination (Chudyk, Horrill, et al., 2022).

Patient engagement is recognized internationally to strengthen health research, with leading organizations in Canada (Strategy for Patient Oriented Research; Canadian Institutes of Health Research, 2019), the United States (the Patient Centered Outcomes Research Institute; Forsythe et al., 2016), the United Kingdom (National Institutes of Health Research; INVOLVE, 2015) and Australia (Statement on consumer and community involvement in health and medical research; National Health and Medical Research Council, 2016). These organizations have developed foundational documents to guide patient engagement and shape its implementation in their respective nations.

Reviews of patient engagement literature show that most engagement studies involve patients in the early stages of the research process (e.g., priority setting) and less frequently in the analysis or interpretation of data (Domecq et al., 2014; Hoekstra et al., 2020). While engaging patients early in a research project is a strength (Chudyk, Stoddard, et al., 2022), it is unfortunate that engagement drops off at these later stages. Patient perspectives can add context to qualitative data and make research findings more meaningful to the community (Domecq et al., 2014; Forsythe et al., 2016). Although emerging research more frequently engages patients in qualitative analyses (Forsythe et al., 2016), patient engagement is still an under-utilized practice at this stage of the research process.

Barriers to engaging patients in qualitative data analyses may include the hesitancy of academic researchers to relinquish power at this crucial stage of research (Egid et al., 2021), time constraints, or financial constraints (Campbell & Vanderhoven, 2016). Furthermore, patient co-researchers may be hesitant to accept data analysis tasks considering the extensive training or time required to learn and complete many participatory data analyses (Best et al., 2022). Time requirements may be particularly salient as patient co-researchers are often minimally compensated for their time (Richards et al., 2022). These barriers lead to academic researchers assuming full decision-making power at the analysis stage. Alternatively, patient co-researchers may “member check” qualitative findings, rather than becoming involved in the main analysis (e.g., Gupta et al., 2022). However, member checking may have a lesser impact on the outcomes of a qualitative research project compared to participatory approaches where patient co-researchers are embedded in the analysis process (Birt et al., 2016).

Participatory Theme Elicitation

A simple but effective method of participatory data analysis is needed to ensure patients can be engaged at this stage of the qualitative research process. Participatory Theme Elicitation (PTE) is a 5-step method for participatory qualitative analysis which was developed by Best and Colleagues (2017) and draws from the principles of Patient and Public Involvement (i.e., a similar approach to patient engagement; Modigh et al., 2021). PTE is practical, requires minimal training, ensures all voices are heard, and can be completed over a few short sessions without over-burdening patient co-researchers (Best et al., 2022). This method has proven acceptable among a variety of populations including youth (Best et al., 2017), adults with depression (Best et al., 2022), adults using health and social care services (Blair et al., 2022), children in medical research (Luchtenberg et al., 2020), frontline employees (Moriarty et al., 2021), teachers (Neill et al., 2021), and people with serious mental illness (Yap et al., 2020). Relevant to the present research context, PTE has been used to evaluate qualitative data from two physical activity interventions (Best et al., 2017; Yap et al., 2020). The results of PTE are generally consistent with thematic analysis conducted by a single academic researcher, but patient co-researchers can identify additional thematic content relevant to their lived experiences (Blair et al., 2022). This new approach to participatory data analysis shows promise and more research is needed to explore the breadth of contexts in which it can be applied. PTE should be a useful method of co-analyzing qualitative data from the MOVE IT Study alongside people who have lived experience of a T2D risk. This analysis should generate insights that an academic researcher without lived experience may not generate alone.

The Present Research

This research will qualitatively explore the experiences of people with prediabetes who participated in the MOVE IT Study self-compassion intervention. I will use PTE to engage people who previously completed the MOVE IT Study as co-researchers in the analysis and interpretation of qualitative data from audio-recorded MOVE IT Study intervention sessions. Together, we will answer the question: did participants in the MOVE IT Study use self-compassion to cope with their diabetes risk and increase their engagement in physical activity or other health behaviours, and if so, how?

This thesis will address three research gaps: (1) the need for rich qualitative accounts of peoples' experiences of using self-compassion to cope with a chronic disease risk and improve their physical activity, (2) the under-utilization of patient engagement within the analysis of qualitative data; and (3) the need for more research supporting PTE as a novel, but efficient, acceptable, and trustworthy method of engaging patients in qualitative data analysis. This research will also supplement quantitative data from the MOVE IT Study efficacy trial and may provide support for community implementation. Finally, the findings of this study may be transferred to inform the usefulness and applicability of self-compassion and health interventions to other populations.

Chapter III: Methodology and Method

Philosophical Approach

The present research drew from critical realist assumptions about the nature of reality and knowledge-production (Ryba et al., 2022). Critical realists endorse a realist ontology whereby there exists a single, objective, and underlying truth to the world (i.e., one truth), and a constructivist epistemology whereby people do not experience the world objectively, but rather,

construct their knowledge of reality (i.e., multiple realities; Ryba et al., 2022). For critical realists, there is a clear distinction between the truth and our constructed interpretations of reality. Our interpretations are not assumed to accurately represent the truth because the events we experience are caused by both measurable/observable, and unmeasurable/unobservable forces (i.e., stratified ontology; Ryba et al., 2022). As such, critical realists recognize the value of quantitative methods (e.g., statistical association) for explaining measurable and observable relationships, but see these explanations as thin and lacking in complexity. Critical realists are more interested in whether the products of research can describe or explain the complex connections between behaviours, events, and certain outcomes (Ryba et al., 2022). Qualitative research is well suited to a critical realist approach because qualitative research questions create space for causal complexity and do not seek out one “right” answer.

My endorsement of a critical realist philosophy influenced the research methods I chose. My realist ontology allowed me to accept that T2D is a harmful chronic condition, physical activity reduces T2D risk, and many people facing T2D risk do not engage in enough physical activity. My stratified ontology helped me to acknowledge the complex relationship between self-compassion and the self-regulation of physical activity that cannot be fully quantified through surveys and statistical methods, making this relationship well-suited to qualitative inquiry. Finally, my constructivist epistemology helped me understand that each participant in the MOVE IT Study brought with them a lifetime of knowledge and past experiences that shaped how they learned and applied self-compassion. Because each participant had a different subjective experience, using a participatory approach like Participatory Theme Elicitation (PTE; Best et al., 2022) to analyze the data helped capture the potential complexity and diversity of participants’ experiences. Finally, my research question was suited to critical realism. I was not

seeking to quantify the strength or consistency of the relationship between self-compassion and physical activity among people with prediabetes. Rather, I sought to explain the complex pathway through which learning about self-compassion in the MOVE IT Study may have helped participants improve their health.

Researcher Profile

Within the critical realist approach, knowledge is constructed; the researcher influences and is influenced by their research. Therefore, it is important to acknowledge my positionality as a researcher in the present study. I am a young, healthy, physically active, and educated person who has not experienced prediabetes or other chronic diseases in my lifetime. I am privileged to live in conditions that support the maintenance of my good health. I have the knowledge and time to prepare nutritious foods, sufficient leisure time to engage in physical activity, and safe spaces where I can be active. I also have access to quality healthcare, and a support network of people who care about my wellbeing. As a White person living in North America, I have not experienced the racism, discrimination, or intergenerational trauma that negatively impacts the health of people belonging to marginalized groups.

I cannot personally relate to the experience of having prediabetes or being a participant in the MOVE IT Study. Therefore, engaging people with these lived experiences as co-researchers may add more nuance and insight to the data analysis than I could provide alone. As an academic researcher, I can offer value to this qualitative inquiry as someone who has researched self-compassion for five years, completed self-compassion training, and facilitated over 55 hours of self-compassion intervention content to people facing a risk of chronic illness (including MOVE IT Study facilitation). I also contribute specific knowledge of research approaches like patient

engagement and PTE. In collaborating with patient co-researchers, we will bring a strong combination of lived expertise and theoretical/methodological knowledge to this research.

Study Design

This qualitative study used the principles of patient engagement and took a participatory approach to the data analysis. I engaged people with lived experience of prediabetes and MOVE IT Study participation in a five-step method of participatory data analysis called PTE (Best et al., 2022). Together, we co-generated a set of themes that answered our research question. Reporting adhered to the COREQ Guidelines (Tong et al., 2007). A research timeline could be found in Appendix C.

Participants

Participants in the MOVE IT study were aged 40 to 74 years, at moderate to high T2D risk based on the CANRISK questionnaire (Canadian Pharmacists Association, 2011), engaged in less than 150 minutes of moderate-to-vigorous physical activity per week, and were below the population mean on self-compassion at baseline (i.e., a score of 3.6 or lower; Neff et al., 2021). A large majority of MOVE IT study participants were women, though men were eligible to participate. This sample was well suited to exploring how people with prediabetes might use self-compassion to cope with their risk for chronic disease and increase their engagement in health behaviors. Women in Canada tend to have lower levels of physical activity compared to men (Prince et al., 2020). Women may also prioritize the health of family members above their own, leading them to engage in fewer health-promoting behaviors (Mosca et al., 2006). Furthermore, women often score lower on self-compassion compared to men (Yarnell et al., 2019), making them good candidates for interventions that aim to increase self-compassion.

Available Data

Each of the seven, two-hour MOVE IT Study group sessions in the self-compassion condition followed a similar format. The first hour included 15 minutes of discussion about participants' physical activity progress, a 30-minute lesson on physical activity behavior change, and 5 to 10 minutes of workbook activities and discussion. The second hour included 15 minutes of discussion about participants' self-compassionate practice, a 30-minute lesson on self-compassion with didactic teaching, formal and informal practices, and writing activities, and 10 minutes of closing discussion.

Four research assistants, all young, white, educated females, facilitated the past six cohorts of participants in the self-compassion arm of the MOVE IT Study. SK (the present author; an undergraduate kinesiology student at the time) facilitated the first, second, and fourth intervention cohorts, BNS (a PhD student) facilitated the third cohort, OP (a PhD student) facilitated the fifth cohort, and JP (a psychology honors graduate) facilitated the sixth cohort. All facilitators were familiar with self-compassion as their thesis research centered around this topic. Each facilitator had completed a 6-week online, Mindful Self-Compassion-based course (Réseau Compassion Network, 2024) to further develop their knowledge of self-compassion in preparation for facilitating the MOVE IT Study. To promote intervention fidelity, the facilitators followed a scripted outline when delivering the lessons on physical activity behavior change and self-compassion, and the principal investigator reviewed 20% of the sessions to ensure that the scripts were being followed (Signore et al., 2022). Sessions from cohorts one to six of the MOVE IT Study (March 2021 to November 2023) were audio-recorded using Zoom videoconferencing functions. In the self-compassion condition alone, there were 84 hours of qualitative data available for transcription.

Selecting the Dataset

Although there is no “correct” size for a qualitative dataset, a researcher must justify their chosen sample size (Markula & Silk, 2011). To capture a range of participants’ experiences over the course of the intervention, the present dataset consisted of two 7-week intervention cohorts from the self-compassion arm of the MOVE IT Study (14 intervention sessions, 28 hours of content). I estimated that within each session, there would be about 45 minutes of participant discussion that could be used in the analysis. Capturing 45-minutes of relevant discussion in each of 14 intervention sessions would result in a qualitative sample size consistent with that of previous similar work. Specifically, Lathren et al. (2018) analyzed eight 90-minute recorded intervention sessions, and Strachan et al. (2018) analyzed 21 interviews that were each one hour long. PTE as an analysis technique requires about 70 to 90 quotations that are relevant to the research question and representative of the dataset. Based on my experience of facilitating the intervention, I expected to identify an adequate number of relevant quotations in the dataset. However, I planned to transcribe one additional intervention cohort if the two selected for analysis did not yield enough data for PTE or the dataset lacked conceptual depth (Braun & Clarke, 2022).

I considered two additional factors when selecting the intervention cohorts that would be used as data: the facilitator and the number of participants. First, to represent participants’ experiences of learning self-compassion in the presence of different facilitators, I transcribed recorded sessions from one intervention cohort that I (SK) facilitated, and one intervention cohort led by another facilitator. Analyzing sessions that I facilitated was a strength because I was already familiar with the content of participants’ discussions - I expected this would be an advantage when engaging with the dataset during the analysis (Braun & Clarke, 2022). However, I intentionally sampled sessions that were led by another facilitator, as different

instructional styles may have evoked participant discussions that differed from those in my own sessions. Due to varying degrees of success with recruiting participants, the size of the MOVE IT study self-compassion intervention groups ranged from three to nine participants (see Table 1). I chose to sample data from larger participant groups so the dataset would represent the voices of more participants which aligns with my research approach.

Table 1
MOVE IT Study Self-Compassion Condition Information

Intervention Cohort	Date	Number of Group Members	Facilitator
1	March 2021 – May 2021	7	SK
2	May 2021 – July 2021	6	SK
3	September 2021 – November 2021	4	BNS
4	November 2021 – December 2021	3	SK
5	February 2022 – April 2022	9	OP
6	September 2023 – November 2023	8	JP

Considering these factors together, I selected intervention cohort 2 (facilitated by SK; 6 participants) and cohort 5 (facilitated by OP; 9 participants) for transcription. I decided to transcribe intervention cohort 2 over cohort 1, both of which I facilitated, because I felt my skill level as a facilitator was higher in cohort 2. Having more confidence in my role could have allowed for richer discussions among participants and therefore higher quality data in cohort 2. Although OP only facilitated intervention cohort 5, she had extensive experience facilitating self-compassion interventions as part of her dissertation research, and her sessions passed all fidelity checks. If Intervention cohorts 2 and 5 did not contain enough data to conduct PTE, I intended to transcribe data from Intervention cohort 3 (facilitated by BNS; 4 participants).

Transcription

To expedite the transcription process, I used automatic transcription software available through the Zoom Videoconferencing platform to generate transcripts from each intervention

session in my dataset. I then carefully read each transcript while simultaneously listening to the recorded intervention session to correct errors and differentiate between participants who were speaking.

Ethics and Confidentiality

The recording and use of intervention sessions from the MOVE IT Study as research data was approved by the University of Manitoba Human Ethics Board (HS23787 (E2020:006)). MOVE IT Study participants consented to the collection and use of their qualitative data and were reminded at the start of each intervention session that recordings would be used in future research. I maintained participant confidentiality when transcribing the intervention sessions by assigning each participant a set of pseudonym initials and redacting any information that could be identifying (e.g., workplace, names of family members). Although there was a chance that participants could be indirectly identified through their transcripts, the probability of this was small. An amendment to the MOVE IT Study ethical protocol outlining the specific aims and methods of the present study was approved by the University of Manitoba Human Ethics Board before research was commenced. A separate research protocol outlining the patient engagement activities described below was also approved by the University of Manitoba Human Ethics Board (HE2023-0348).

Protocol for Patient Engagement

Use of Language

The present study followed the principles of patient engagement as described by the Canadian Institutes of Health Research (2019) and other researchers in this field (e.g., Manafò et al., 2018; Chudyk, Stoddard et al., 2022). Within patient engagement research, language is important as it defines the relationship between the academic researcher(s) and individuals with

lived experience who are engaged in the research process. Some advocates have called for researchers to move away from the term “patient” when referring to non-academic people engaged in a research project (e.g., Gavin, 2018). People who have experienced an illness or accessed healthcare services may not identify as “patients” outside of a healthcare setting, and these shifting identities should be reflected in the language used by researchers (Gavin, 2018).

The MOVE IT Study was not conducted in a clinical setting, nor was it facilitated by healthcare providers. Therefore, using the term “patient” when referring to individuals at risk for T2D who previously participated in the MOVE IT Study may be inappropriate. There are also power dynamics associated with the term “patient” (e.g., the clinician-patient relationship; Nimmon & Stenfors-Hayes, 2016) that could be inadvertently re-created by using the word “patient” in the present study. Considering these factors, I used language that minimized the confusion of contexts, roles, and power dynamics. Specifically, I used the terms “participant co-researcher” or simply “co-researcher” when describing my work with individuals who were engaged in this research. These terms represented the people I worked with more accurately, as they were previously participants in the MOVE IT Study who accepted roles as co-researchers in the present study.

Readiness to Engage

I prepared myself to engage with participant co-researchers in a safe and respectful way by independently answering the prompts found on pages 3 to 11 of the Centre for Healthcare Innovation (CHI) Readiness to Engage Workbook (Shimmin & Roche, 2021). The prompts were designed to help researchers reflect on the personal values, views, and beliefs that they bring to the engagement process. The prompts also encourage researchers to consider how they will

promote equity, diversity, and inclusion within their engagement research. My responses to these questions can be found in Appendix D

Level of engagement

Defining roles, responsibilities, and expectations is an important principle within patient-engaged research (Bird et al., 2019). The spectrum of participation created by the International Association of Public Participation (2018) and adapted by Manafò et al. (2018) defines six levels of engagement which range from superficial (e.g., informing patients of what the researchers plan to do), to fully integrated (e.g., empowering patients to lead the research project). In this study, I engaged participant co-researchers at the second highest level (i.e., “collaborate”; Manafò et al. (2018). The work we did aligns with collaboration because PTE allows academic researchers and patient co-researchers to have a similar impact on the qualitative analysis and interpretation of findings (Best et al., 2022).

Recruiting Co-Researchers

Group engagement. Engaging people as a group is necessary for PTE, with most related studies engaging between four and 14 co-researchers (Best et al., 2017, Luchtenberg et al., 2020, Yap et al., 2020, Moriarty et al., 2021, Neill et al., 2021, Best et al., 2022, Blair et al., 2022). No PTE studies to date have stated their reasoning for the number of co-researchers they chose to work with. More often, PTE studies seem to intentionally involve co-researchers that represent more than one background or perspective. Past studies have made efforts to recruit both male and female teachers (Neill et al., 2021), patients from a mental health clinic with a wide age range (Best et al., 2022), boys and girls from a school (Best et al., 2017; Luchtenberg et al., 2020), professionals from a variety of sectors and service users (Blair et al., 2022), and research participants and academics (Yap et al., 2020).

Group size. I planned to engage five participant co-researchers in analyzing qualitative data from the MOVE IT Study using PTE. A group size of 5 is consistent with other PTE studies (e.g., Best et al., 2017). I also selected this group size based on my past experiences working with research participants. In smaller groups (e.g., 3 participants) there is more time available for in-depth discussion, but fewer perspectives are shared. In larger groups (e.g., 10 participants), more perspectives are shared, but in-depth discussion is limited due to time constraints. I expected that engaging with five co-researchers would balance the diversity of perspectives with the amount of time available for discussion, resulting in a productive PTE process.

Identifying participant co-researchers. I identified potential participant co-researchers using a list of MOVE IT Study participants from intervention cohorts 1, 3, 4, and 6, who consented to contact about future research opportunities. Participants from cohort 2 and cohort 5 whose transcripts were used in the dataset were exempt from engagement because analyzing data from sessions they personally participated in may have created group conflicts. I recruited participant co-researchers by email, as MOVE IT Study participants were responsive to this type of communication in the past (Signore et al., 2022). The recruitment email contained information about the background of the study, the role of participant co-researchers, expected time commitment, availability of compensation, timeline, and researcher contact information. Participants were asked to respond to the recruitment email within seven days if they wished to be involved as a co-researcher.

Co-researcher characteristics. Eligible participant co-researchers were individuals over the age of 40, who were currently experiencing (or had previously experienced) a moderate to high risk of developing T2D and attended at least five of the seven MOVE IT study sessions in the self-compassion condition (Signore et al., 2022). This final criterion ensured that co-researchers

had enough experience with self-compassion to contribute substantively to the analysis. All participants in previous waves of the MOVE IT study who consented to future contact met the above criteria, and therefore these eligibility considerations were not a concern during recruitment. I also limited recruitment to within a 20-kilometer radius of the City of Winnipeg, as some steps of PTE allow for richer discussions when conducted in-person. Finally, recruiting from the MOVE IT sample ensured some other pragmatic considerations were addressed: all MOVE IT study participants were fluent in the English language and had access to a device through which they could participate in Zoom videoconferencing.

Diversity considerations. I expected that recruiting diverse co-researchers would help capture a wide range of perspectives and past experiences with the MOVE IT Study that could inform our work. Although the potential for diversity was limited by the available MOVE IT Study participant pool, I took steps to prioritize diversity. Co-researchers were selected using the following criteria, listed in order of importance: (1) participation in the most recent MOVE IT Study intervention cohort, (2) variation in self-identified ethnicity, (3) variation in self-identified gender, and (4) variation in age. This information was gathered from the MOVE IT study dataset. If more than five people expressed interest in engagement, I planned to select the five with the most individual differences. In cases where diversity considerations could not be used to select one co-researcher over another (i.e., both were demographically similar), co-researchers were selected in the order they responded to the recruitment email.

Informed Consent

The need for patient co-researchers to “consent” to their role within a research team is highly debated in the engagement literature (e.g., Doria et al., 2018). The process of consent has been argued to blur the distinction between research participants and co-researchers, and devalue the

co-researcher role (Doria et al., 2018). However, many institutions require that co-researchers provide consent regardless of their role. Because I planned to collect information (i.e., “data”) from co-researchers during the study evaluation process, audio-record our meetings, and report on co-researchers’ aggregated demographic information, the University of Manitoba Human Ethics Board required that co-researchers in this study provide consent. The consent form (Appendix E) outlined the role of co-researchers, stated the availability of accessibility supports, described the data I planned to collect from co-researchers, explained their option to waive their anonymity, and reminded co-researchers they could end their engagement at any time. I distributed the consent form electronically via SurveyMonkey (www.surveymonkey.com). After signing the consent form, co-researchers were sent a PDF copy via email for their records.

Privacy and Confidentiality

Co-researchers did not have access to directly identifying information during the data analysis, as all MOVE IT Study participants were identified using pseudonym initials in the transcripts. De-identified data is not considered personal health information (Canadian Institute for Health Information, 2016) and therefore patient co-researchers were not required to complete PHIA training. There was a small possibility that MOVE IT Study participants could be indirectly identifiable through their quotations, but this was unlikely as co-researchers were analyzing data excerpts rather than full transcripts. Co-researchers were reminded to keep the identities of research participants confidential if they happened to encounter a quotation that they could attribute to a specific person. Each co-researcher also signed an oath of confidentiality before engaging in this study (Appendix F).

Compensating Co-Researchers

The Strategy for Patient Oriented Research – Patient Engagement Framework (Canadian Institutes of Health Research, 2019) recommends that patient co-researchers are offered compensation for the time, effort, lived experience, and skill they bring to a research project, as well as reimbursement for expenses incurred during engagement (e.g., parking fare, bus tickets, gasoline, meals). Offering compensation and reimbursement can also promote diversity on the research team by reducing financial barriers to engagement (Canadian Institutes of Health Research, 2022). There are many ways to compensate co-researchers (e.g., fixed service income, honoraria, in-kind payments), and the most appropriate method depends on the research context and preferences of those who are engaged. It is important that the amount of compensation provided is scaled to co-researchers' involvement in the project (Patient Centered Outcomes Research Institute; PCORI, 2015). Co-researchers who are highly engaged should be compensated similarly to other research professionals, whereas those who are less involved may be compensated with smaller honoraria (PCORI, 2015).

Co-researchers in this study were moderately-to-highly engaged (Manafò et al., 2018), therefore, I provided compensation that was similar to the hourly wage of a graduate student research assistant in the Faculty of Kinesiology and Recreation Management at the University of Manitoba (\$20.00 per hour). Payment took the form of Amazon.ca gift cards, as this was the option available to me as a graduate student. Co-researchers consented to receive compensation and were given the option to refuse payment or ask for payment alternatives (e.g., education, training, other forms of recognition; Canadian Institutes of Health Research, 2022). Appendix G presents a budget for compensating five co-researchers in this study. Co-researcher compensation was supported by the Faculty of Kinesiology and Recreation Management research expense fund. In addition, co-researchers were offered non-monetary forms of

recognition for their work, including acknowledgement in this thesis document and co-authorship on any resulting publications or presentations. Due to restrictions around the amount and type of payment I could provide, reimbursing co-researchers for expenses incurred was not possible in this study. However, these expenses were forecasted to be minimal as only two in-person meetings were required for this study.

Introductory and Terms of Reference Meeting

After identifying and consenting five participant co-researchers, I held an initial 90-minute group meeting to complete introductions and establish a Terms of Reference for our work together. This meeting was held on Zoom videoconferencing which is an acceptable way for the MOVE IT Study community to meet (Signore et al., 2022). The goals of this meeting were relationship-building, speaking broadly about the research project, and answering co-researchers' questions. We first completed introductions and icebreakers. Afterwards, I re-iterated the purpose of the study and described the PTE process, role of participant co-researchers, estimated time commitment, and availability of compensation. We also discussed the need to hold two in-person meetings, though all other engagement meetings would be held over Zoom.

After co-researchers were familiarized with the study, we co-developed a "Terms of Reference" document. A Terms of Reference guides the working relationship between academic researchers and people engaged as co-researchers. Creating this document lays the groundwork to foster mutual respect, inclusiveness, co-learning, and support (Chudyk, Stoddard, et al., 2022). To create this document, we answered a list of questions adapted from pages 12 to 16 of the CHI Readiness to Engage Workbook (Shimmin & Roche, 2021; Appendix H). Important considerations in this meeting were safety and sensitivity: we set ground rules for respectful communication during meetings and defined what a meaningful contribution to the research

meant, looked like, and felt like (Shimmin et al., 2017). Finally, I asked the co-researchers to identify any supports they needed throughout the engagement process (e.g., accessibility needs, practical supports, informational supports). The Terms of Reference document was distributed to each co-researcher after the meeting. This was a living document that could be updated and re-circulated if any changes were made to the ways we worked together.

Participatory Theme Elicitation

PTE is a novel method of participatory qualitative data analysis (Best et al., 2017). The creators of PTE provide a detailed five-step description of how this method can be conducted, but do not aim to make PTE into a “mechanical approach...that is overly process driven, and ultimately meaningless” (Best et al., 2022, p. 224). PTE can be tailored to suit the needs of a specific research project. In this research project, I collaborated with five co-researchers to inductively analyze qualitative data from two audio-recorded cohorts of the MOVE IT Study self-compassion condition. In the following section, I describe the five steps of PTE and describe the adaptations that were made to this method to suit the context of the present study.

Step 1: Data Selection

Step 1 involves curating a subsample of a qualitative dataset that can be used for PTE. To do this, I read through all 14 transcripts twice: first for familiarization and again to identify as many relevant excerpts as possible across the entire dataset that were broadly representative of participants’ implicit or explicit discussions of self-compassion in the context of coping with their T2D risk and changing their physical activity or other health behaviours. I organized the excerpts using NVivo 12 software. There was no limit to the number of excerpts I could initially identify. The excerpts I selected represented a range of individual participants, intervention sessions, and experiences with self-compassion (both positive and negative). The selected

excerpts were also easily understood as “standalone statements” (Best et al., 2017) with minimal context required before and after.

Next, I partnered with my thesis advisor to select 70 to 90 of the previously identified excerpts to use in the PTE analysis. This dataset size was consistent with previous PTE research showing that analyzing 40 to 94 excerpts is acceptable to co-researchers. Though no upper limit of data excerpts has been identified, the number selected should suit the complexity of the research topic while avoiding co-researcher burden. Conducting data selection with a partner is consistent with the methods used in previous PTE studies (e.g., Best et al., 2022, Yap et al., 2020). Partnering with my advisor offered unique value as she had expertise in self-compassion and could identify implicit references to self-compassion in the data. Before beginning data selection, we read the full list of excerpts to gain familiarity with the dataset. We then made inclusion or exclusion decisions through discussion. Inclusion decisions were based on the following factors: (1) the original rationale for including the excerpt, (2) the relevance of the excerpt to the research question, (3) the uniqueness or novelty of the excerpt, and (4) adequate representation of each participant. Excerpts were excluded if: (1) they were not relevant to the research question, (2) the content of the excerpt was already repeated multiple times in the dataset, or (3) the participant quoted was already represented frequently in the dataset and the inclusion of further statement(s) from that participant would necessitate the exclusion of statement(s) from those quoted less frequently. I estimated this process would take between three and four hours. After dataset selection was complete, each excerpt received an identification number (e.g., Excerpt #1 = Q1).

Adaptation 1 for the present study. Best et al. (2022) propose that academic researchers should partner with a co-researcher with lived experience when selecting quotations for the final

dataset. However, I determined that involving a co-researcher at this stage was not feasible for this study. Dataset selection has the potential to be highly time consuming, and I was committed to compensating co-researchers for all contributions they made. Within my funding constraints, involving a single co-researcher at this stage may have necessitated involving fewer co-researchers in total, asking co-researchers to contribute un-compensated hours, or offering a lower compensation rate. To maximize the number of co-researchers I could involve, the number of stages I could involve them in, and the compensation I could provide, selecting the dataset with my thesis advisor was the best option for this project.

Adaptation 2 for the present study. Because co-researchers were not engaged in dataset selection, I involved them in an alternative way that fit within my constraints. I held a 60-minute dataset approval meeting on Zoom videoconferencing in which I asked all co-researchers to confirm they understood the excerpts in the dataset. If an excerpt was difficult to understand or lacked context, participant co-researchers could request it be edited to improve clarity, removed, or replaced with a different excerpt. This extra step was intended to help co-researchers become familiar with the dataset and therefore complete the activities required for PTE more easily, while also ensuring they were compensated appropriately. After the dataset was approved, I printed six copies of the excerpts and cut them into strips, creating identical data excerpt “card decks”: one for each of the co-researchers, and one for myself. Each card contained a single excerpt and its ID number that was previously assigned.

Step 2: Capacity Building

Step 2 involves familiarizing the co-researchers with the goals of the study and training them to conduct PTE. I met the co-researchers in-person at an agreed-upon location (a meeting room in a public library). Upon arriving, each co-researcher received a training package

containing the items listed in Table 2 and shown in Appendices I to M. I opened this session by playing a TEDx Talk on self-compassion by Kristin Neff (6 minutes; Appendix N). This video was intended to remind co-researchers of the self-compassionate skills they learned during the MOVE IT Study. We then reviewed two training documents I created for capacity building: the “What is Self-Compassion?” handout reiterates the components of self-compassion, and the “Self-Compassion Cheat Sheet” is a mind-map style handout showing how the components of self-compassion relate to one another alongside examples. I encouraged co-researchers to use both documents as reference points when conducting the data analysis. I then played a 4-minute video (Appendix O) describing the differences between quantitative and qualitative research to help co-researchers understand the goals of our analysis.

Table 2

Items in Participant Co-Researcher Capacity Building Package

Item	Reference
“What is Self-Compassion?” handout	Appendix I
“Self-Compassion Cheat Sheet”	Appendix J
Instructions for card sorting sheet	Appendix K
Card deck of images for practice sorting activity	Appendix L
Fictional quotations for practice card sorting activity	Appendix M
One coil-bound notebook	NA
Two pens	NA
15 cue cards	NA
15 paper clips	NA

In the next phase of the capacity building workshop, we completed two practice card sorting activities. These activities introduced co-researchers to the idea of sorting qualitative data. I gave each co-researcher (including myself) an identical card deck with images of 24 different objects and scenes (Appendix L). We then independently sorted the images into piles based on similarity using any criteria we found meaningful. I emphasized that there was no right or wrong way to sort the cards. We sorted the images for 5 minutes before sharing our sorting

decisions and rationale with the whole group. We then repeated this activity with 23 cards containing simple, fictitious “transcript excerpts” that I created for the purpose of this training (Appendix M). This activity demonstrated that different co-researchers may group information in different ways and that there is never only one correct answer in qualitative research. In total, I estimated that all the capacity building activities should require 120 minutes including time for welcoming co-researchers to the meeting, group discussions, and breaks.

Adaptation for the present study: Following the advice of my thesis committee, I supplemented this capacity building workshop with additional activities that had not been used in previous PTE studies. Specifically, the use of educational worksheets on the topic of our research (i.e., self-compassion) was unique to the present study and helped co-researchers identify relevant patterns in the data. In addition, while other PTE studies have built capacity by asking co-researchers to sort images, no other PTE studies have given co-researchers an opportunity to practice sorting fictional quotations. Adding these training components helped ensure co-researchers were well prepared and comfortable with the next steps of PTE.

Step 3: Open Sorting

Step 3 was completed independently by all co-researchers (including myself) in the 10 days following the capacity building meeting. I distributed identical card decks containing the data excerpts that were curated in Step 1 to each co-researcher and provided written instructions to sort the data excerpts into piles they thought were similar using any criteria they found meaningful (Appendix K). The only guidance for open sorting was that the activity should be completed independently, co-researchers must create at least two piles, and there could be no “miscellaneous” pile. Co-researchers also kept our research question in mind while completing open sorting, that is, “how (if at all) did participants in the MOVE IT Study use self-compassion

to cope with their diabetes risk, increase their physical activity, or increase any of their other health behaviours”. I suggested co-researchers spend approximately 90 to 120 minutes completing the sorting activity. After 10 days, I collected the card piles from the co-researchers. I then compared my own card sorting results (i.e., number of piles, names of piles) to those of the co-researchers and made note of differences in our card sorting techniques.

Step 4: Data Grouping

The objective of Step 4 was to generate a candidate set of themes by creating groups of data excerpts that represented an overarching consensus between all the piles of excerpts sorted independently by co-researchers in Step 3. This candidate set of themes would then be used as a foundation to generate a final set of themes through group discussion in Step 5. Data grouping was conducted using a network analysis. Network analyses are generally used to detect the structure of the relationships between different people, objects, or pieces of information (Goldengorin et al., 2013). To conduct the network analysis, I recorded the data excerpt piles created by each co-researcher and myself in an excel spreadsheet. Table 3 shows an example of this data grouping spreadsheet. I then uploaded the populated spreadsheet to an R Shiny App (online platform) developed by Best et al. (2022; <https://jbadham.shinyapps.io/PTEbasic/>) to conduct a network analysis of the data excerpt piles. This platform is an interactive web application that executes R in the backend. The PTE analysis platform uses a Louvain weighted community detection algorithm (Blondel et al., 2008) and R iGraph to visualize the results using a network diagram. While many types of network analyses exist (see Goldengorin et al., 2013), the Louvain method has been used the most frequently within PTE research (e.g., Blair et al., 2022), and is recommended by the developers of PTE (Best et al., 2022).

The network diagram contained nodes corresponding to each data excerpt. The nodes were connected by edges (lines), and the weight (thickness) of the edges was calculated using a similarity score that represented the number of co-researchers out of six that grouped the corresponding data excerpts into the same piles. For example, the edge between two nodes that six co-researchers grouped into the same pile would be six times thicker than the edge between two nodes that only one co-researcher grouped into the same pile. The distance between nodes also represented the number of co-researchers that grouped the corresponding data excerpts into the same piles. The distance between nodes was calculated by taking the inverse of the similarity score used to determine the edge weights. For example, the distance between two nodes that all six co-researchers grouped into the same pile would be six times shorter than the distance between two nodes that only one co-researcher grouped into the same pile.

Table 3

Sample of Data Entry Spreadsheet used in PTE Step 4: Data Grouping

Topic ^a	Person ^b	Group ^c
Q73	R1	1
Q43	R1	2
Q16	R1	3
Q74	R1	4
Q64	R1	1
Q67	R1	3
Q63	R1	2
Q59	R1	2
Q27	R2	2
Q31	R2	3
Q39	R2	4
Q14	R2	2
Q53	R2	3

^aTopic = Data excerpt ID

^bPerson = Co-researcher ID

^cGroup = Card pile ID

The Louvain community detection algorithm can identify clusters of nodes within a network that have a high edge density (i.e., the nodes are highly connected), a low inter-nodal distance (i.e., the nodes are close together), and share few connections with other clusters of nodes. The resulting clusters in the network diagram represent the consensus of the piles created by co-researchers during open sorting in Step 3. In other words, excerpts that were placed in the same piles by more co-researchers were more likely to be clustered together in the resulting network diagram. Parallels to “inter-rater-reliability” can be drawn to help understand the creation of the network diagram because the configuration of the diagram is determined by each co-researcher’s sorting decisions. However, reporting inter-rater reliability is not a common practice in PTE because the network diagram is used only as a visual tool in a later thematic analysis and does not constitute the final results of the study. The groupings of excerpts, colours of the nodes, their spatial clustering, and the thickness of the lines connecting them were presented to co-researchers in Step 5 to serve as a conceptual starting point for the development of our final set of themes.

Step 5: Data analysis and interpretation

The final step of PTE uses the clusters identified in the network diagram as a foundation for a thematic analysis through discussion with participant co-researchers. This step was completed in a 120-minute meeting held in person at a local library. I opened the meeting by reviewing the network diagram with co-researchers and explaining that the clusters of excerpts represented a consensus of each group members’ card sorting in Step 3. I also explained that the distance between nodes and the thickness of the lines connecting them represented their similarity. The network diagram was a useful tool for helping co-researchers understand the conceptual idea of creating “themes” in the data, and helped explain how the clusters of excerpts

were created from the group's open card sorting in Step 3. However, the extent to which co-researchers relied on the diagram to create the final set of themes was at their discretion. For example, Best et al. (2022) found that co-researchers relied more heavily on the diagram at the outset of the thematic analysis but drew more on the semantic meanings of the excerpts to create themes at later stages of the analysis.

Before beginning the analysis, I re-iterated the goal of the meeting which was to review the excerpts in each cluster to develop "themes" that would answer our research question (i.e., how did participants in the MOVE IT study use self-compassion to cope with their diabetes risk or increase their physical activity or other health behaviours). Themes were described as recurring patterns of meaning or ideas in the dataset. Through discussion, our aim was to break apart, add to, or re-arrange the clusters in any way we saw fit to develop a final set of themes. After this explanation, co-researchers were given a chance to ask for clarification before we began the data analysis task. As strongly suggested by Best et al. (2017, 2022) this stage of the analysis was driven by co-researchers. I posed questions to the co-researchers during the analysis process, and asked for clarification when needed, but as a group they held the final decision-making power.

Prior to the data analysis and interpretation meeting, I printed and cut each data excerpt onto a card that was colour-coded according to its cluster in the network diagram. Each cluster of cards was taped to a separate poster board. I presented these poster boards to co-researchers as a visual aide for creating our final set of themes. To facilitate the analysis, we collectively read through the excerpts one cluster at a time. For each cluster, I read the first three excerpts aloud and asked the co-researchers to share any meanings or patterns they believed were common to all three excerpts. I wrote these patterns on the poster board beside the excerpts before reading aloud

the next three excerpts and asking the group to identify additional patterns or confirm that their content aligned with the previous excerpts in the cluster. I continued reading three excerpts at a time and pausing for feedback from the co-researchers until all excerpts in the cluster had been reviewed. When co-researchers identified an excerpt that did not belong with the others in the cluster (e.g., because it was conceptually distinct), I removed it from the poster board and set it aside for further discussion. All excerpts that remained on the posterboard after our review were determined to comprise a candidate theme.

After reading through all excerpts in a cluster, I read aloud the patterns of meaning the co-researchers noticed throughout the whole cluster (which were jotted on the side of the poster board). Collectively, we drew from these patterns to determine a name for the newly formed candidate theme. Finally, we returned to any excerpts that had been set aside for further discussion. These excerpts were either grouped with an existing cluster or categorized into a new theme. Co-researchers had the option of using the spatial arrangement of excerpts in the network diagram to decide where distinct excerpts were re-grouped, or they could choose to use the semantic meaning of the excerpt to re-group it with other excerpts that had similar meanings. I repeated this process for each cluster of excerpts until all candidate themes were established. During the analysis, we could return to or revise previously established themes if new patterns of meaning emerged during our work. After all co-researchers were satisfied with the groupings of excerpts in each theme, I presented a broad overview of our findings to confirm co-researchers agreed with the final themes created.

Evaluating Engagement of Participant Co-Researchers

The quality of co-researchers' engagement was evaluated using two methods, one quantitative and one qualitative. The quantitative evaluation was the Public and Patient

Engagement Evaluation Tool (PPEET; Abelson et al., 2018). Participant co-researchers completed Module A of the PPEET (for short-term engagement activities) after the final data analysis meeting (i.e., after PTE Stage 5). Module A of the PPEET includes 13 statements assessing (1) communication and supports, (2) sharing views and perspectives, and (3) impacts and influence of engagement. Responses to these statements are rated on a 5-point Likert scale ranging from “1 = *strongly disagree*” to “5 = *strongly agree*”(Abelson et al., 2018) . To quantitatively assess engagement from an operational perspective, I completed the PPEET Project Questionnaire. The Project Questionnaire assesses the planning, execution, and impact of engagement within a research project across 38 questions (both short answer and 5-point Likert Scale ranging from “1 = *strongly disagree*” to “5 = *strongly agree*”; Abelson et al., 2018). Both of the PPEET questionnaires were housed on the online platform, SurveyMonkey (<https://www.surveymonkey.com/home/>).

The qualitative evaluation was a 60-minute group discussion held on Zoom videoconferencing. In this meeting, co-researchers first reviewed a summary of the themes we co-created in the analysis and interpretation meeting. This summary served to remind co-researchers of the outputs from our work together and gave them an opportunity to provide additional feedback on the themes. Next, we collectively revisited the Terms of Reference document that was created in the first meeting. While reviewing the Terms of Reference, co-researchers engaged in a group discussion about whether their needs, goals, and expectations for being engaged in the research project had been met. Using both quantitative and qualitative methods of assessment was an advantage of this study. The quantitative evaluation component allowed for the collection of concrete and concise data using a validated tool that is accepted by other patient-oriented researchers (e.g., Boivin et al., 2018), thereby increasing the credibility of

this work. The qualitative evaluation component allowed co-researchers to expand upon their answers to the survey and comment on their satisfaction levels in different ways. Using both methods also allowed co-researchers multiple ways of providing feedback thereby increasing accessibility, as some may have preferred providing verbal feedback as opposed to completing an online survey.

Evaluation of Qualitative Research

Evaluating the quality of qualitative research is important to establish its applicability and impact. Although evaluation criteria differ by research paradigm (Yadav, 2022), researchers have agreed upon some general standards for “good” qualitative work. The quality of the present research was evaluated using the concept of “trustworthiness” developed by Lincoln and Guba (1985) and elaborated upon by Ahmed (2024). The criteria to establish trustworthiness are credibility (i.e., do the descriptions and interpretations of the data accurately reflect participants’ lived experiences?), transferability (i.e., can the findings be applied to other contexts and situations?), dependability (i.e., is there consistency between the raw data and the overall findings?), and confirmability (i.e., would other people interpreting the data draw similar conclusions?). In the discussion section below, I explain and justify how this work meets each of the trustworthiness criteria created by Lincoln and Guba (1985). The concept of trustworthiness aligned with my critical realist approach because it evaluates the rigour of the meaning-making process and does not consider quantitative concepts like reliability or validity that should not be applied to qualitative work.

Maintaining Contact with Participant Co-Researchers

Co-researchers should be given updates about major project milestones and opportunities for involvement even after their main role in a study has concluded. When academic researchers

do not follow-up in this way, it can leave patient/participant co-researchers questioning whether the time and effort they committed to a project was truly respected or worthwhile (Richards et al., 2023). At the conclusion of engagement, I asked co-researchers how frequently they wanted to receive updates about the project. I also invited them to engage in future activities like reviewing or contributing to knowledge translation materials, reviewing the written study results, and attending presentations or co-presenting our findings.

Chapter IV: Results

Process Results

Dataset Selection and Descriptive Information

Dataset selection took place in January 2024. Across the transcripts of MOVE IT Study self-compassion intervention sessions from cohort 2 and cohort 5, I independently identified 200 data excerpts that were relevant to participants' use of self-compassion in the context of health behaviour change. I logged my rationale for including each excerpt using the coding function in NVivo. I then met with my thesis advisor, Dr. Strachan, to collaboratively select a subset of the original 200 excerpts for the final PTE dataset. Inclusion and exclusion decisions followed the pre-established criteria listed in the methods. Dataset selection required 3.5 hours and resulted in a sample of 74 quotations. Fourteen of the 15 participants who completed the intervention in cohorts 2 and 5 made relevant statements and were represented in the dataset ($n = 6$ from cohort 2, and $n = 8$ from cohort 5). The participants' average age was 54.2 years ($SD = 7.2$ years, range = 45 to 74 years) and 100% identified as women. Full demographic information is provided in Table 4.

Table 4
MOVE IT Study Participant Demographics

Variable	Mean (Standard Deviation) / N (%)
Age (years)	54.2 (7.2)
Education	
Some college or university	6 (40.0%)
A college degree	2 (13.3%)
An undergraduate degree	3 (20.0%)
A master's degree	4 (26.7%)
Ethnicity	
Black	1 (6.7%)
Indigenous	1 (6.7%)
Métis	1 (6.7%)
White	12 (80.0%)
Biological Sex	
Female	15 (100%)
Gender Identification	
Woman	15 (100%)
Marital Status	
Single	2 (13.3%)
Married	10 (66.7%)
Separated	1 (6.7%)
Divorced	1 (6.7%)
Widowed	1 (6.7%)
Employment Status	
Employed Full-Time	11 (73.3%)
Retired	4 (26.6%)

Participant Co-Researchers

Recruitment of participant co-researchers occurred from February 8 to 12, 2024. All 21 people who had previously completed the MOVE IT Study self-compassion intervention in any of the eligible cohorts (i.e., cohort 1, 3, 4, or 6) were eligible to become co-researchers and were contacted. Of those contacted, nine people indicated interest in the study. I selected five participant co-researchers using the pre-determined diversity considerations listed in the methods. Each co-researcher provided written informed consent and signed a confidentiality form before engaging in this research. I had previously established a relationship with each co-

researcher through my work on the MOVE IT Study. All co-researchers agreed to waive their anonymity so I could more fully acknowledge their contributions to this work.

The five co-researchers were between the ages of 51 and 74 years ($M_{\text{age}} = 57.2$ years, $SD = 10.69$ years), all identified as women, two identified as White, two as Indigenous, and one as Filipino. All co-researchers resided within the city of Winnipeg. Three co-researchers had completed cohort 6 of the MOVE IT Study (September to November 2023), and two had completed cohort 1 (February to April 2021). Overall, at least four out of the five co-researchers attended each group meeting as part of this study (Table 5). Reasons for missing group meetings included family obligations and illness. When it was not possible to meet with the group, co-researchers arranged to meet with me individually or completed tasks independently. Making separate arrangements was possible for each step in the research process except for the data analysis and interpretation meeting which required group discussion.

Table 5
Co-researcher Attendance and Participation

Co-Researcher (CR)	Meeting 1: Introduction and Terms of Reference	Meeting 2: Dataset Approval	Meeting 3: Capacity Building	Independent Task: Open Sorting	Meeting 4: Analysis and Interpretation	Meeting 5: Evaluation
Anita	X	X	X	X	X	X
Jennifer	X ^a	X	X	X	X	X
Kim	X	X ^a	X	X		X
Maria	X	X	X	X	X	X
Sasha	X	X	X	X	X	X
Virginia	X	X	X	X	X	X

^aindicates co-researcher completed meeting or task independently from the group

Introduction and Terms of Reference

The introductory and Terms of Reference meeting took place on February 22, 2024, via Zoom videoconferencing. Four of the five participant co-researchers attended, and one arranged

to complete this meeting individually. This group meeting required 1.5 hours, and the individual meeting required 1 hour. The completed Terms of Reference document is provided in Appendix P. One outcome of this meeting was the decision to hold in-person meetings at the Cornish Library (20 West Gate, Winnipeg, Manitoba). This meeting place was central and easily accessible to all co-researchers. In line with co-researchers' preferences, we also decided that all meeting materials would be distributed via emailed PDF one week before each group meeting, and physical copies would be provided at in-person meetings.

PTE Step 1: Dataset Approval

Dataset approval occurred on February 29, 2024, via Zoom videoconferencing. Four of the five participant co-researchers attended, and one co-researcher reviewed the excerpts independently. The aim of this 1-hour meeting was to ensure co-researchers understood each excerpt in the dataset. All but one excerpt was retained, resulting in a final dataset of 73 excerpts. The discarded excerpt was viewed by co-researchers as disorganized and difficult to understand. Co-researchers also identified excerpts that required additional punctuation or minor edits to improve readability, and these were corrected during the meeting. The frequency with which MOVE IT Study participants were quoted in the dataset is listed in Table 6.

Table 6

Frequency of MOVE IT Study Participant Representation in the Dataset

Pseudonym	Intervention Cohort	Age	Quotation Frequency
NJ	5	53	14
EB	2	74	11
AM	2	55	9
EL	5	55	8
BA	5	46	5
BD	2	55	4
FJ	2	48	4
MC	5	Not provided	4
MK	2	56	4

Table 6 (continued).

AC	5	52	3
KJ	5	49	3
RA	5	55	2
RD	5	62	1
PT	2	45	1

PTE Step 2: Capacity Building

Capacity building took place on March 7, 2024, in-person in a private meeting room at the Cornish Library. All five participant co-researchers were in attendance. The purpose of this 2-hour meeting was to train co-researchers to conduct the card sorting required for Step 3 of PTE (Open Sorting). After completing the capacity building activities described in the methods, all co-researchers confirmed they were well prepared to complete Open Sorting. Table 2 lists the training materials provided to co-researchers, Appendices I to M contain copies of these materials, and Appendix Q shows photos taken during the Capacity Building workshop.

PTE Step 3: Open Sorting

Open sorting took place from March 8 to March 18, 2024, and was completed by all co-researchers (including myself). Co-researchers were instructed to spend about 90 to 120 minutes sorting their cards. Each co-researcher created between 4 and 6 data excerpt card piles, while I created 10 card piles in my own sorting. The number of cards per pile ranged from two to 41 cards. Descriptions of the piles created by each co-researcher, the number of cards per pile, and the names of each pile are provided in Table 7.

Table 7
Results of Independent Card Sorting by all Co-researchers

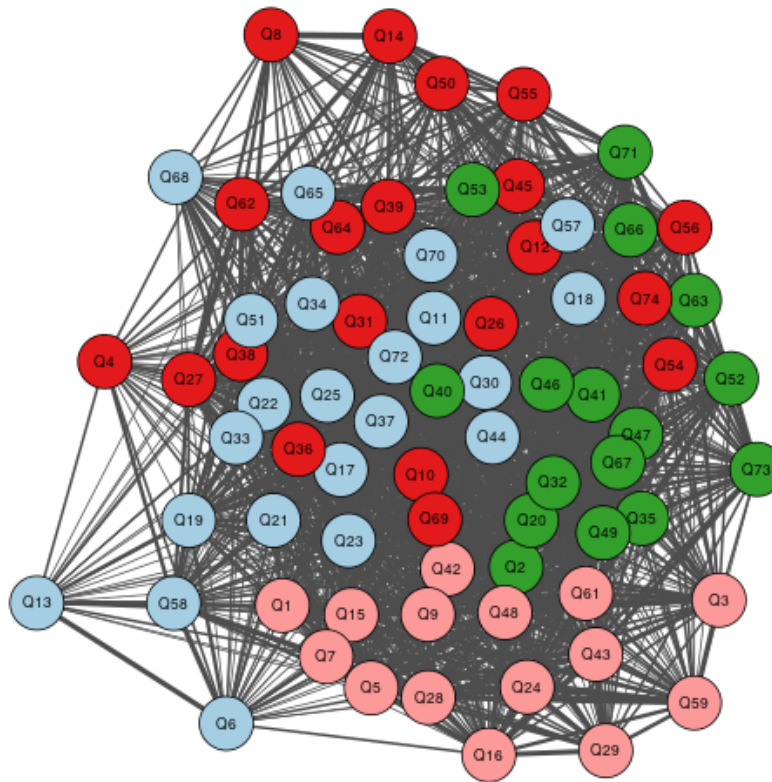
Co-Researcher	Piles	Names of Piles	Cards Per Pile
Anita	4	Taking action	14
		Common humanity	7
		Mindfulness	25
		Mental and emotional kindness	27
Jennifer	6	Taking action	10
		Common humanity	9
		Acts of movement	6
		Mindfulness	22
		Mental and emotional kindness	15
		Negative thoughts / self-talk and challenges	11
Kim	6	Active goal setting	16
		Common humanity	2
		Kindness	4
		Self-compassion	41
		Opportunities to improve	5
		Health	5
Maria	5	Taking action	16
		Common humanity	4
		Mindfulness	25
		Mental and emotional kindness	17
		Opportunities for growth	11
Sasha	10	Accepting health risk	7
		Women and self-compassion	6
		Acknowledging success	9
		Common humanity	2
		Self-criticism	8
		Fierce self-compassion	6
		Gentle self-compassion	10
		Mindfulness	9
		Overcoming setbacks	14
		Redefining exercise	2
Virginia	5	Taking action	10
		Common humanity	4
		Mindfulness	18
		Self-kindness	22
		Mental and emotional kindness	19

PTE Step 4: Data Grouping

Across all co-researchers, a total of 439 data grouping decisions were entered into a CSV file following the format shown in Table 3. The network analysis produced four clusters of excerpts containing between 15 and 22 excerpts per cluster (Appendix R). These clusters were visualized using a network diagram (Figure 1). Visual inspection of the network diagram shows some overlap between cluster 2 (green), cluster 3 (red), and cluster 4 (blue). The high edge weight and node density between these clusters suggests their respective excerpts were conceptually similar. The nodes within cluster 1 (pink), however, formed a dense group and shared little overlap with other clusters, suggesting the content of this cluster was conceptually distinct from the others.

Figure 1.

Network Diagram Visualizing Clusters of Data Excerpts



PTE Step 5: Data Analysis and Interpretation

Data analysis and interpretation took place on March 28, 2024, in-person at the Cornish Library. Four of the five participant co-researchers attended this meeting. The purpose of this two-hour meeting was to collectively review the network diagram and clusters of quotations and develop a final set of themes through discussion. During data analysis and interpretation, co-researchers decided to move six excerpts from their original cluster to a different cluster and categorized five excerpts into two new themes. Photos showing the materials used in the data analysis and interpretation meeting are provided in Appendix S. Overall, we generated six themes containing between two and 22 excerpts each. Table 8 shows the original clusters of excerpts, the themes created by participant co-researchers, and the names of each theme. An in-depth discussion of the qualitative findings is provided below.

Table 8
Theme development through Participatory Theme Elicitation

Group #	Proposed Group				Final Group ^a				Theme Label
1 (New)					Q28	Q43	Q59		“Stuck in Neutral, Unaware”
2 (New)					Q13	Q41			“Shifting, Understanding Self-Compassion Concepts”
3 (Pink)	Q1 Q28 Q43 Q61	Q15 Q29 Q48 Q7	Q16 Q3 Q5 Q9	Q24 Q42 Q59	Q1 Q28 Q43 Q61 Q58	Q15 Q29 Q48 Q7	Q16 Q3 Q5 Q9	Q24 Q42 Q59 Q20	‘First Gear, Self-Reflection and Opportunities for Growth’
4 (Green)	Q2 Q40 Q49 Q66	Q20 Q41 Q52 Q67	Q32 Q46 Q53 Q71	Q35 Q47 Q63 Q73	Q2 Q41 Q52 Q67 Q6	Q32 Q46 Q53 Q71	Q35 Q47 Q63 Q73	Q40 Q49 Q66 Q34	“Second Gear, Mental Kindness in the Face of Struggles”

Table 8 (continued).

5 (Red)	Q10	Q12	Q14	Q26	Q10	Q12	Q14	Q26	“Third Gear, Taking Action to Work Through Challenges”
	Q27	Q31	Q36	Q38	Q27	Q31	Q36	Q38	
	Q39	Q4	Q45	Q50	Q39	Q4	Q45	Q50	
	Q54	Q55	Q56	Q62	Q54	Q55	Q56	Q62	
	Q64	Q69	Q74	Q8	Q64	Q69	Q74	Q8	
					Q68	Q51			
6 (Blue)	Q11	Q13	Q17	Q18	Q11	Q13	Q17	Q18	“Cruising on the Highway, Taking What Feels Right and Leaving the Rest Behind”
	Q19	Q21	Q22	Q23	Q19	Q21	Q22	Q23	
	Q25	Q30	Q33	Q34	Q25	Q30	Q33	Q37	
	Q37	Q44	Q51	Q57	Q44	Q57	Q65	Q70	
	Q58	Q6	Q65	Q68	Q72				
	Q70	Q72							

^aBolded excerpt numbers represent excerpts that were removed from their original cluster

Qualitative Results

The PTE analysis resulted in the generation of six themes related to participants’ experiences of learning and applying self-compassion in the MOVE IT Study: (1) “Stuck in Neutral, Unaware”, (2) “Shifting, Understanding Self-Compassion Concepts”, (3) “First Gear, Self-Reflection and Opportunities for Growth”, (4) “Second Gear, Mental Kindness in the Face of Struggles”, (5) “Third Gear, Taking Action to Work Through Challenges”, (6) “Cruising on the Highway, Taking What Feels Right and Leaving the Rest Behind”.

From “Stuck in Neutral” to “Cruising on The Highway”: Mapping the Journey

Co-researchers developed a chronological storyline following a road-trip analogy to show how participants in the MOVE IT Study moved out of ambivalence, gained confidence related to both self-compassion and physical activity, and “shifted gears” along their journey. Reading from Theme 1 to Theme 6 we watch as participants shift out of neutral, navigate detours and potholes, and emerge on to a smooth open stretch of highway where they can cruise freely, confident in the skills they gained through the intervention. This storyline represents co-

researchers' creative process of meaning-making and was informed only by the content of the data excerpts rather than the session of the MOVE IT Study they originated from (i.e., excerpts from any study session could be sorted into any theme). The results of our analysis represent a "prototypical" participant's journey through the MOVE IT program, and each co-researcher could see aspects of their own self-compassion and health journeys within this prototype. Appendix T contains a conceptual map of the themes and the meanings within each theme.

Theme 1: Stuck in Neutral, Unaware

The first theme "Stuck in Neutral", describes participants' ambivalence about self-compassion, physical activity, or their diabetes risk. Participants voiced feelings of discouragement or self-criticism without describing a desire to use self-compassion, change their situation, or identify an opportunity for growth. For example, AM spoke of her tendency towards self-criticism without describing steps she could take to become more self-compassionate, *"I'm usually really, really quite hard on myself. So, nothing's changed. I'm still hard on myself. It's not gonna change in a week"* (AM, age 55, Group 2). This participant also shared feelings of discouragement after facing setbacks in her physical activity, *"After a while, you don't even want to try anymore, because you figure you're so far off from getting there that there's no point"* (AM, age 55, Group 2). AM's self-criticism may have presented a barrier as she worked to become more physically active. Finally, EB noted the dangers of remaining in denial about her health, but did not follow this statement with plans to take action or improve her situation:

I'm in denial that something bad will happen. I mean, there's a point of reckoning when you kind of say... 'oh, I only need 15 to 20 years.' And my doctor said, 'I don't think you have that'. And that was the first time a doctor had ever said anything like that to me. And so, it's the denial which is really dangerous. - EB, age 74, Group 2

As co-researcher #3 (Anita) interpreted these excerpts she said, *“I wonder if there's a factor of just accepting. This is what it is. And I'm just gonna stay here. Probably for the rest of my life”*. Co-researcher #4 (Jennifer) echoed, *“There's no positive spin on it, it's all just self-criticism”*. Co-researcher #1 (Virginia) interpreted the participants' experiences as, *“Unaware, because you don't even know that you're doing negative things. It's like you believe what you're thinking is true”*. As we collectively decided upon a name for this theme, Virginia suggested the phrase *“Stuck in Neutral”*, and the group unanimously agreed on this title. Anita added, *“I also like ‘Stuck in Neutral’, because it still implies that with a little push and with no resistance or less resistance, you can actually still get out of it”*. The co-researchers recognized that becoming physically active, learning self-compassion, or facing a diabetes risk may initially be met with resistance, but with encouragement participants could shift into self-compassion and action.

Theme 2: Shifting Gears, Understanding Self-Compassion Concepts

The second theme, “Shifting Gears” was characterized by participants increasing their openness to self-compassion but still struggling with its application. In these cases, participants demonstrated an understanding of self-compassion concepts, but were still hesitant about embracing self-compassion in their lives. For example, when PT was asked to describe her experience with a mindfulness meditation, she instead shared an experience where she had helped her son use mindfulness:

I noticed that [the meditation] reminded me of when... I used that on my son when he would have temper tantrums. I'd say ‘breathe in with the good, out with the bad’ and we would do that breathing. That's what I kept thinking was ‘in with the good, out with the bad’, throughout that whole thing. - PT, age 45, Group 2

Another participant understood the idea of common humanity (a core component of self-compassion), but was not open to sharing some of her struggles with others:

The common humanity of the situation is that, well, I see a lot of people in my situation. Although, I don't feel compelled to talk to them about it. Like we don't get together and talk about it. I don't like to talk about weight loss. - EB, age 74, Group 2

Though EB was beginning to accept the idea of common humanity, she may have been isolating herself by keeping her challenges private. Anita reflected on the excerpt above and stated, “*To me there's like an inkling of hope because they are talking about the fact that they recognize other people need to talk about [weight loss]*”. Co-researchers unanimously interpreted the two excerpts above as distinct from others in the dataset and believed they should form a separate theme. Anita suggested this new theme represented participants who were, “*Not quite there yet*” on their journey towards accepting self-compassion and improving their health. The theme name “Shifting Gears” shows how participants were shifting out of a neutral mindset (i.e., ambivalence) and moving towards acceptance, awareness, and growth.

Theme 3: First Gear, Self-Reflection and Opportunities for Growth

The third theme, “First Gear”, describes participants’ first steps towards behaviour change – acknowledging and accepting difficult truths. Within this theme, participants’ statements fell within two categories: self-honesty and identifying opportunities for growth. Participants demonstrated self-honesty when they acknowledged their self-critical tendencies or behavioural patterns that led to their diabetes risk. For example, AC shared how self-criticism and anxiety thwarted her attempts at an active lifestyle:

I have to have a really seamless [exercise] plan or else the anxiety just overwhelms me. And it becomes debilitating, and that frustrates me. And now that I'm to the point where

I'm pre-diabetic, I'm just disappointed in myself... So for me, that's gonna be a big hurdle with this to get into a comfortable routine that I'm okay with. And I also understand that I might have days where it just is too much. - AC, age 52, Group 5

Another participant, NJ, described how habitual self-criticism made it difficult to acknowledge her strengths and positive attributes:

I think because we're so used to thinking about our flaws. It's really hard to think about what we're good at, and I might say that I want to be kind or thoughtful, or that I try to be kind or thoughtful. But then the moments that I've not succeeded bubble to the top, right?
- NJ, age 53, Group 5

Participants also reflected on the circumstances that led to their current health concerns. These reflections were simple, honest, and factual. Participants did not ruminate on their situation or avoid the truth, suggesting they had accepted past events and were ready to move forward. RA shared that her role as a caregiver led her to prioritize the health of others over her own:

I used to be very active and slowly through the years I joined gyms, and I was committed, I joined the learn to run through the running room and I was running a few times a week. And then I just got- life, you know. I made different priorities. My daughter was my priority, and my husband was my priority, and I was not a priority. So, I kind of just went to the back burner. - RA, age 55, Group 5

Similarly, BD considered how her culture, family, and career path had encouraged her to care for others before herself. Though she felt caregiving was important, she recognized that neglecting her own needs was no longer a sustainable choice:

Because I value the fact that I can help the world so to speak, and I'm from a helping profession. I'm from a family culture too where I just grew up watching my grandparents

help people, and my mother is like that. So now, as an adult I'm beginning to realize that it's wearing me thin. I struggle with saying no to a good cause and making time for me. -

BD, age 55, Group 2

Responsibilities aside from caregiving also impacted participants' ability to care for their health.

EB described how she had prioritized a successful career over her health for many years:

I let this happen. I let this drift....And essentially, I have a feeling of responsibility that it was I who didn't have that self-caring... I didn't engage in more health promoting behaviors because I didn't take care of myself. I didn't self-activate I guess. And so, I wasn't proactive in correcting it. You know, because in the moment I just placed my priorities differently. And it became a trend. - EB, age 74, Group 2

After acknowledging these difficult truths, participants could better identify areas for change and growth. These opportunities encompassed participants' relationships with others, with their health, and with themselves. For example, BD reflected on the need to resist gendered caregiving roles and put her own needs first, *"Some of what we do must be because we are women and we think we must save the world... I just still feel the burden to save the world. So, I'm slowly moving away from that"* (BD, age 55, Group 2). AM and BA described how self-criticism hindered their ability to achieve their goals, but recognized making self-compassion a natural response would take time and practice:

That was a pathetic failure. There's no point setting [a goal] up because you're not gonna follow through anyways, and stuff like that. So yeah, that's probably gonna be one of my biggest areas to work on. - AM, age 55, Group 2

I caught myself being self-critical... And then I was like, 'okay, I'm supposed to say it somehow differently right now so that it makes me get off the couch or gives me permission to work through this and get on with it...' And it'll just take practice in my head to turn it around. - BA, age 46, Group 5

As co-researchers reflected on these excerpts, they recognized participants were taking a critical look at their current tendencies, but their tone was not harsh or judgemental. Rather, the excerpts within this theme represented moments of self-honesty that helped participants identify opportunities for change and growth. In line with this idea, Anita stated:

I think those [excerpts] are negative. But they're also what I would call self-reflection. So [the participants] are thinking about how they act on things and what they do and how they think about it, which to me is kind of like the process before moving forward. You're actually being honest with yourself and figuring out where I am, why am I here, and what kind of thoughts are going on in my head? Which isn't necessarily bad because you need to be honest with yourself. - Anita

Similarly, Virginia reflected on the opportunities for personal growth demonstrated in participants' words, "Yeah, it's showing that there's different levels of growth in the comments that were made... that awareness awakens in different ways at different times". Co-researchers also identified a pattern among the excerpts whereby participants would first voice a difficult truth or struggle, and then follow this statement with a desire to change their behaviours or thought patterns. This "positive spin" at the end of participants' statements set this theme apart from Theme 1 in which participants' statements were primarily negative or self-critical.

Following the naming of Theme 1 and Theme 2, this slow but steady process of self-honesty,

identifying opportunities for growth, and accepting the need for self-compassion was labelled as shifting into “First Gear” by the co-researchers.

Theme 4: Second Gear, Mental Kindness in the Face of Struggles

The fourth theme, “Second Gear” shows how participants applied self-compassion in a mental or emotional context to cope with setbacks. Affirmation, common humanity, self-kindness, and mindfulness are represented within this theme. Participants used affirmation to normalize struggles and reject the idea that their progress should be linear. Exemplifying this point, EB stated, *“If I take two steps forward it’s allowing myself to take that one step backwards. And then recognizing that eventually, as long as the trend is there, it’s like the stock market. It’s not a straight line, and that’s what I tell myself. Not a straight line”* (EB, age 74, Group 2). Similarly, MC discussed how she countered her self-critical thoughts with affirmations after missing a physical activity session:

Like my first reaction is, you bonehead, why aren't you doing it? But the self-compassionate part of me is saying, okay, we haven't done it, let's take a little step and work up to where we want to be. But just as long as we're doing something it's a start. -

MC, Group 5

Affirmation helped participants acknowledge the progress they had made, even if they had fallen short of their original goals. As noted by NJ, the recognition that small steps forward were still steps forward helped participants stay motivated to pursue an active lifestyle:

I had to use some of my self-compassion today, because yesterday and today there was nothing there. It was just work and exhaustion. So, tomorrow's another day. And that's okay. We've had a great week, and I feel pretty good about how the week went, and I'm

looking forward to the coming week. And really, I'm actually kind of surprised at how quickly I'm starting to feel better. - NJ, age 53, Group 5

In addition to affirming their progress, participants recognized the common humanity of facing barriers and setbacks in pursuit of their goals. These barriers were normalized within the group setting, helping participants reduce feelings of shame or discouragement. The normalization of barriers was exemplified by AC:

But for everyone that doesn't do their goal, I think we just have to forgive ourselves and think tomorrow is a new day and we're gonna start over. And I think about that when I don't eat well or when I'm a lump on the couch. So, I just try to forgive myself and say tomorrow is a new start and move forward. - AC, Age 52, Group 5

Participants also took a self-kind approach to their setbacks. They understood that sometimes their schedules were simply too busy, or their bodies were too tired to be active, and they forgave themselves when they missed a physical activity session. For example, KJ shared how self-compassion helped her cope with work-related stressors in the previous week:

I was laid off last week. And it was a really, really, rough week, and it still is... I think in the past something like this would have been really catastrophic to my health. And so, I think it really helped to keep me a little more focused, and a little more present. And while I didn't do all my exercise perfectly, I think it was very, very lifesaving in the fact that I was able to just take some time for myself, and not judge myself, and use some of the other tools that we've been learning. - KJ, age 49, Group 5

Despite sometimes falling short of their goals, participants were pleased with their progress towards developing new coping strategies and becoming kinder to themselves. For example, NJ spoke of the distinction between physical work and “brain work”:

I felt like I had a big week of brain work for this program, among other things. But this week was a big week of sitting with the feelings and the thoughts, and looking for those places of resistance, and actually realizing a lot of big, deep stuff. So that's where my growth was this week, was in that. - NJ, age 53, Group 5

Furthermore, BA spoke of the benefits of applying the self-compassionate technique “soften-soothe-allow” to cope with difficult emotions she experienced:

But also, the whole applying the mindfulness to the different emotions, and the soften, soothe, and allow. Because I really do find myself getting stuck in those circles, and I think that that [soften, soothe, allow] helps me push myself out of it to be able to get past it and to move on. - BA, age 46, Group 5

When participants coped well with setbacks, they were able to use mindfulness to recognize the impermanence of their struggles and remain present in the moment despite challenges. For example, EB described the importance of being mindful when facing adversity,

There will be a later, there will be an after, there will be a 'post'. It doesn't have to be like this forever, even though it's like this now. And if you're gonna be living life, you wanna live it fully. So being here and now is important. Doesn't matter where. It might not be fun. But it's kind of important. - EB, age 74, Group 2

These excerpts show how participants were simultaneously working towards both aims of the MOVE IT Study sessions: increasing their physical activity and increasing their self-compassion. These goals were dichotomized into physical work and brain work but likely had a synergistic effect; participants used self-kindness to cope with setbacks, coping with setbacks facilitated greater goal progress, and goal progress elicited more positive self-talk. Co-researchers noticed the self-kind tones of the excerpts within this theme. Jennifer stated, “I’m

hearing mental kindness, you know the thoughtfulness of themselves... recognizing there's gonna be struggles. Little ups and downs. Keep on going". Virginia commented on participants' use of affirmation to reframe physical activity setbacks "*...if there's a detour you can just say, oh I took the scenic route*". In other words, participants were on a non-linear journey, and staying open to unexpected setbacks and validating their progress would benefit them on this journey.

As a facilitator, I asked the co-researchers whether combining affirmation, common humanity, self-kindness, and mindfulness resulted in too broad of a theme. In response, Jennifer explained the importance of keeping these concepts together within one theme:

Even though it seems like there's a lot going on. They actually all kind of tie in together, right? Because the mindfulness, the positive, they all do work together. I think that if you were to start picking them apart it would be very hard to discern what exactly goes with what. - Jennifer

All co-researchers agreed to keep the excerpts together under the umbrella of “mental kindness”. When creating a name for this theme, we followed our previous naming scheme and selected the name “Second Gear”. Being in second gear signifies that participants had progressed in their ability to apply self-compassion effectively to their struggles and setbacks. Participants had moved beyond just acknowledging the need for self-compassion and were actively applying self-compassion in their lives.

Theme 5: Third Gear, Taking Action to Work Through Challenges

The fifth theme was characterized by participants taking action to overcome challenges on their journey towards better health. In contrast to the previous theme in which participants described the “brain work” of learning self-compassion, this theme demonstrates a more active side of self-compassion whereby participants took a stand to prioritize their needs, motivate

themselves, and develop strategies to achieve their goals. Regarding self-prioritization, participants had previously placed the needs of others before their own due to caregiving, family, or work demands. As they learned about self-compassion, participants recognized they deserved to be a top priority in their own lives. For example, BA negotiated family demands so she could find time to be active:

This week I actually scheduled myself on our family calendar in the kitchen. And I basically told my family do not bother me between this hour and this hour, I'm doing my workout. - BA, age 46, Group 5

Similarly, FJ described how prioritizing a work life balance helped her become more active:

I had a meeting that ran late, and I knew I had a meeting coming up early and I was like, 'I don't think I should do my 20-minute walk in the half hour that I have for lunch, because I'm not gonna have enough time'. And before I got myself to the kitchen, I'm like, 'screw it- I'm just gonna go'. But after the walk I felt so much better. - FJ, age 48, Group 2

NJ shared how engaging in self-care indirectly helped her progress towards her physical activity goals:

My foot has been really hurting me for about the last 3 weeks or so... So, I went and had a pedicure. And you know what, ever since I came home from that, my foot doesn't hurt anymore... And it also made me think that it's kind of like a reward for being physically active, too. - NJ, age 53, Group 5

Participants also prioritized other health needs aside from physical activity. For example, RA set aside time and engaged in activities to support her mental health during a stressful week:

Just basically, I'm taking more time for myself now. A little bit like with such a crazy week that I had, I made time to- you know, I've watched a show on my phone. You know, just making more time for myself, making it a conscious effort to think about myself more.

- RA, Age 55, Group 5

In addition to prioritizing their own needs, participants described how they motivated themselves to take action and improve their health. This motivation was related to both diabetes risk and physical activity. EL exemplified self-motivation when she stated, *"I don't want to get sick. And I want to be healthy in the coming years. And it's a reality that I need to change"* (EL, age 55, Group 5). Similarly, FJ shared that she was ready to take steps to reduce her diabetes risk:

I always knew [diabetes] was a potential risk. But then being told that, yeah, you are at risk seems a little bit more concrete. So, I'm a little bit more worried about it. But now that I know that it's something I need to deal with I can actually buckle down and deal with it. - FJ, Age 48, Group 2

Despite her apprehension about visiting healthcare providers, MK recognized that accessing healthcare was an act of self-compassion. MK overcame her resistance and began making appointments to learn more about her health:

One of the big silver linings was the reality check and the need to embrace self-compassion and self-care. And plus, the news of being at risk for diabetes, it really prompted that move to get checked. I made several doctor's appointments in the past month and have a requisition now for the blood work and the glucose test and all the other stuff that's gotta get tested. Because now I really wanna know. There's no room for denialism anymore. I want to know. - MK, age 56, Group 2

Participants also applied self-motivation to their physical activity goals, and often described giving themselves a “pep talk”. As RD stated simply, *“I’m only human after all. And tomorrow I’m going to kick ass”* (RD, age 62, Group 5). FJ shared how she had implemented a pep talk into her daily routine:

One of my strategies is to give myself my pep talk. I’ve been leaving myself notes on my mirror. So, I’m just in the process of writing out my note for this week, and I’ll stick it on the bathroom mirror, so I have to see it every time I go in there. - FJ, Age 48, Group 2

Although participants had taken steps to prioritize their health and implemented a motivating inner voice, they still faced inevitable setbacks. Participants used strategies such as making their goals flexible and re-defining success to navigate these setbacks. MC described how she re-framed her planned physical activity not as something she was “supposed” to do, but as something she had planned, and acknowledged that plans can always change:

For my plan, I didn’t always do what was written down to do - I’m not going to say ‘supposed’ to do. And on those days, I did 20 min of stretching or a half an hour of stretching rather than doing cardio or weights. So, I always ended up doing something. Just not what I actually had planned. - MC, Group 5

Similarly, AM described how she challenged her previous assumptions about how long a physical activity session was “supposed” to be:

Years ago, I would have never thought if you do a little bit, it’s better than nothing. My mind was, well, if I can’t do the full hour of cardio there’s no point trying anything cause it’s not gonna help. And so now when it’s like, if you do even 10 minutes a couple of times a day then it’s better than not doing anything. Now it’s like I’ve learnt to be at least a little bit gentler. - AM, age 55, Group 2.

As co-researchers reviewed these excerpts, co-researcher #2 (Maria) noted how participants were describing, “*action or taking action*”. Agreeing with Maria’s point, Anita added, “*Taking action. Yeah. And I’d say the first 2 rows [of excerpts]. There’s also like a bit of strategy in foretelling what kind of challenges might come up and how to work around them*”. Jennifer also noticed how the quotations described participants prioritizing themselves, “*taking action again and feeling good about it. That’s been a common theme across a few comments. Feeling good... Self-care, taking care of ourselves*”. Following our previous theme naming, co-researchers unanimously agreed that our story had reached “Third Gear”. This theme name represents participants shifting from using self-compassion in a purely mental or emotional sense, to embodying self-compassion in a physical or action-oriented way.

Theme 6: Cruising on the Highway, Taking What Feels Right and Leaving the Rest Behind

The sixth and final theme, “Cruising on the Highway”, represented participants’ mastery experiences with both self-compassion and their health. This theme was characterized by growth and self-acceptance, being prepared for the journey ahead, and new revelations. Considering growth and self-acceptance, participants still experienced setbacks and critical self-talk, but self-compassion had become a more natural and immediate response to these situations. EB demonstrated growth and acceptance when she stated:

I’ve gotta get my words of kindness in. I’m here and I’m proud of myself for being here. And I’m proud of myself for actually doing the stuff between the meetings. And I have to start with the present and move forward. And I use this thing that you told us, what would I say to someone else: ‘you’ve gotta start with the present and move forward’, and it’s all true. - EB, age 74, Group 2

Similarly, KJ described responding to her self-critical inner voice with self-compassion after engaging in less physical activity than she had planned:

Certainly, I used a lot of the self-compassion, and 'what would you say to a friend', and things like that... It wasn't perfect but it certainly provided some relief for a very, very stressful week. - KJ, age 49, Group 5

Participants also recognized the steps they were taking to improve their health were part of an ongoing lifestyle change and they were prepared for the journey ahead. This forward-thinking approach ensured participants had the tools they needed to pursue their health goals in the future. For instance, NJ used mindfulness and self-reflection to prepare for her physical activity journey:

I think talking about how you feel is really important. Because I know for me when I was out there doing things this week, I felt really good about myself. And I felt good about how I was feeling. And I was acknowledging that I'm thinking about that and using it as motivation for the next time. - NJ, age 53, Group 2

EL used self-kindness to re-frame aversive feelings towards physical activity and address self-criticism about falling short of her goals. This mindset helped her stay motivated for future physical activity sessions:

Being more positive in situations, instead of focusing on the negative feelings of 'I have to exercise', or 'I have to do this', just think 'I can do this'. So that's kind of a different way of looking at it. And one of the biggest things is to be kind to myself. Yeah, if I don't meet the goal, then I'll do it next week and keep moving. - EL, age 55, Group 5

AM also recognized that making physical activity part of her lifestyle would always be challenged by factors beyond her control; all she could control was her response to these challenges:

Some days are really good and other days, they didn't work out. And that's all right. And you know what, it doesn't change. There's always going to be days that don't work out, and the key is just not beating ourselves up for it and picking up and trying again the next day, trying again when we can. That's something I learnt this time around. - AM, age 55, Group 2,

As participants refined their understanding of self-compassion during the study, some spoke of revelations or mastery experiences that had occurred through their learning. These experiences were exemplified in two statements made by one participant, MK. First, MK used self-compassion to accept her body's need for both physical activity and rest:

I allowed myself to sleep in on Sunday morning, which I normally would not do - my body wanted to sleep a bit more. And it's amazing, like amazing! And I just didn't recognize or honour that my body was saying, 'you need to rest in order to do this'. So that was my big, big revelation. - MK, age 56, Group 2

MK also began adapting self-compassion practices to meet her own needs by adding personally meaningful components. Specifically, she incorporated spirituality into the self-compassionate exercise, "Soften, Soothe, Allow" by adding a component of prayer. MK's reflection demonstrates a mastery of this self-compassionate practice:

I find that each week in our sessions I take away something from the session that I can immediately apply. So, I was applying 'SSAP' persistently... so it was: Soften, Soothe, Allow, and then Pray. And that's who I am. That's my background. That's how I find my comfort... I needed to add a spiritual support in there for myself, so that was soften, sooth, allow, and pray. And that has been a persistent thing that has helped me get through stuff. And it's one of the important things that I'll take away from these sessions. - MK, age 56, Group 2

As co-researchers' reviewed the excerpts within this theme, Anita noticed how participants seemed to describe mastery experiences with self-compassion, *"So I'm seeing growth, acceptance, common humanity... I've got some tools in my tool bag... They're cruising"*.

Echoing Anita, Jennifer added:

They've done the steps and they're rolling with it and dealing with what the challenges are. And if they do come across problems, they know how to solve them... there's no more self-pity, no more self-criticism... No going back. - Jennifer

Co-researchers connected with this theme on a personal level and described how participants' experiences mirrored their own life experiences. Anita joked with the group, *"[Sasha] keeps saying that she hasn't quoted us in these, but I sure hear my voice. It just goes to show that we're not alone"*. Virginia shared how her own experiences of growth were similar to the ones voiced by participants in this theme:

It's taking what feels right and leaving the rest behind. Like what works for me might not work for other people. You start to realize that some things work for you and that's what makes us all unique. We can work together in a good way to be kind and great to each other. Like be there for each other, be present. - Virginia

We drew upon Anita's previous suggestion of *"cruising"* to create the theme name of "Cruising on the Highway", and Virginia's words, *"Taking what feels right and leaving the rest behind"* to add additional context to this theme name. The imagery of cruising on the highway depicts participants' ongoing journey with self-compassion and their health. This name does not imply that participants would never face challenges again, as uphill climbs, unexpected turns, and detours would likely be part of the road ahead. Rather, Cruising on the Highway signifies how participants had overcome their initial feelings of resistance towards self-compassion, learned to

treat themselves with kindness, practiced navigating barriers, and were prepared for their ongoing journeys. This final theme represents the ending of a prototypical participant's path through the MOVE IT Study, and the beginning of a lifelong journey of applying self-compassion to their physical activity and health.

Evaluation Results

Evaluation of Engagement

The PPEET for short term engagement activities was completed by three out of five co-researchers. All co-researchers were provided with two reminders to complete the survey over two weeks. The two co-researchers who did not complete the PPEET did not respond to the email reminders about the survey but provided detailed feedback about their engagement experiences in the subsequent evaluation interview. These co-researchers may have been more comfortable providing verbal feedback over written feedback. Results are summarized in Table 9 and indicate co-researchers were highly satisfied with their engagement in this study. As the primary researcher overseeing this project, I completed the PPEET project questionnaire. My responses demonstrate why this engagement initiative was well planned, well executed, and has the components necessary to be impactful (Appendix U).

The engagement process was assessed qualitatively through group discussion on April 11, 2024, via Zoom videoconferencing. All five participant co-researchers were in attendance. The purpose of this 60-minute meeting was twofold: (1) to review a summary of the themes we co-developed in our previous meeting and (2) to re-visit the Terms of Reference document and reflect on whether our original expectations and goals for the research were met. Regarding the first aim, co-researchers found the opportunity to review the results helpful, and felt their efforts

were validated by seeing a finished product at the end of their engagement in the study. Co-researchers did not request any modifications to the final set of themes.

Regarding the second aim, all co-researchers agreed their experience in the study was positive and fully met their expectations. Appendix V shows co-researchers' direct quotations in response to each evaluation discussion prompt. Briefly, co-researchers felt that we formed a strong team and worked well together. They also described satisfaction with the number of opportunities they had to share their thoughts, and appreciated my presence as a mediator to ensure quieter voices were heard. Co-researchers described how engaging in this study was a chance to come together with a group of like-minded women, build community, reflect on their collective experiences, and create an end-product they were proud of. Opportunities to meet in person were described as important for relationship building; co-researchers shared that meeting in-person fostered personal connections that may not have been developed if we had only met virtually. This relationship building contributed to more meaningful discussions during the analysis and interpretation meeting because we had established our group as a safe space for sharing. Finally, co-researchers enjoyed the friendship we had built through our work together and felt a sense of loss when the research project came to an end. Though we accomplished the goals of our project in the time we had, co-researchers expressed a desire for additional meetings so we could continue to connect as a group.

Table 9

Co-researchers' Responses to the PPEET Module A for Short-Term Engagement Activities

Questionnaire Item	% Agree or Strongly Agree
Communication and Supports	
I had a clear understanding of the purpose of the study.	100%
The supports I needed were available (e.g., travel etc.).	100%
I had enough information to contribute to the topic being discussed.	100%
Sharing Views and Perspectives	

Table 9 (continued).

I was able to express my views freely.	100%
I feel that my views were heard.	100%
A wide range of views on the topics discussed was shared.	100%
The other co-researchers in the study represented a broad range of perspectives on our research topic.	100%
Impacts and Influence	
I think the study achieved its objectives.	100%
I am confident the input I provided will be accurately and truly reflected in the final write-up of this research.	100%
I think the input provided through this activity will make a difference to the researchers.	100%
Final Thoughts	
As a result of my engagement in this study, I am better informed about how self-compassion can be useful for people who want to improve their health.	100%
Overall, I was satisfied with this engagement initiative.	100%
This engagement initiative was a good use of my time.	100%

Chapter V: Discussion

This study sought to answer the question: How did participants in the self-compassion intervention arm of the MOVE IT Study use self-compassion to cope with their diabetes risk and increase their physical activity or other health behaviours? I engaged with five participant co-researchers who had previously completed the MOVE IT Study to co-analyze and interpret the data using Participatory Theme Elicitation (PTE; Best et al., 2022). The co-analysis resulted in the generation of six themes which tell a chronological story of a “prototypical” MOVE IT Study participant’s experience of learning self-compassion, becoming more active, and caring for their health. Below, I link each theme to theory and research to demonstrate how the findings of this study fit into the broader self-compassion and physical activity behaviour change literature.

Discussion of Qualitative Findings

Theme 1: Stuck in Neutral, Unaware

The first theme shows participants in an initial state of ambivalence about self-compassion, physical activity, and their diabetes risk. Specific to ambivalence about self-compassion, some participants felt they were naturally self-critical which made self-compassion a difficult concept to engage with, *“I’m usually really, really quite hard on myself. So, nothing’s changed”* (AM, age 55, Group 2). Adding to this challenge, participants may have endorsed common misconceptions that self-compassion leads to complacency, self-indulgence, or negligence (Chwyl et al., 2021). People who report negative beliefs about self-compassion are less likely to use self-compassion in response to emotionally challenging situations and are more likely to use maladaptive coping strategies (Chwyl et al., 2021). Reluctance to use self-compassion may hinder peoples’ ability to cope with negative affect, and in turn, thwart engagement in health promoting behaviours (Sirois, Molnar, et al., 2015). Left unchecked, self-criticism could have hindered participants’ progress towards coping with their diabetes risk and increasing their physical activity. The statements in this theme justify a need for self-compassion education among people with prediabetes.

Participants also viewed the prospect of becoming active as something they were far from achieving, making it difficult to envision themselves as an active person, *“After a while, you don’t even want to try anymore, because you figure you’re so far off from getting there that there’s no point”* (AM, age 55, Group 2). Low-active people may not see physical activity as self-relevant (Morgan et al., 2021), and may have low self-efficacy for physical activity (Blom et al., 2021). Some participants described denying the seriousness of their health risk, thereby reducing the urgency of behaviour change. This finding aligns with previous qualitative work in which people with prediabetes downplayed their risk status (Strachan et al., 2018). Illness denial has been observed among patients across many medical domains and may contribute to delays in

seeking medical care (Patierno et al., 2023). The difficulties participants relay in this theme present opportunities to apply self-compassion. Self-kindness could have helped participants respond to themselves like a supportive friend when they felt discouraged about getting active, and the action oriented “Yang” of self-compassion (Neff, 2021) could have helped participants overcome denial and take steps to reduce their health risk.

Theme 2: Shifting Gears, Understanding Self-Compassion Concepts

The second theme shows participants becoming more open to the idea of self-compassion, and understanding the components of self-compassion, but struggling with its’ application. When asked to share about her experiences with a mindfulness meditation, one participant instead responded by describing how she helped her son be mindful, *“I noticed that [the meditation] reminded me of when... I used that on my son when he would have temper tantrums...”* (PT, age 45, group 2). This participant understood the definition of mindfulness but may have felt more comfortable describing mindfulness in the context of another person instead of her own experiences. Some people may find it easier to think about compassion in relation to other people rather than to themselves (Germer & Neff, 2019). Nevertheless, this participant’s efforts to discuss the meditation demonstrate learning and growth that could be developed through further self-compassion training.

Another participant (EB) accurately described common humanity by acknowledging that other people, like her, wanted to reduce their weight. However, this participant also shared feelings of isolation about her weight loss goals, *“I don’t like to talk about weight loss”* (EB, age 74, Group 2). The isolation this participant experienced may connect to feelings of weight stigma. Weight stigma is characterized by discrimination because of ones’ body shape or size (Tylka et al., 2014). People who face weight stigma may internalize this stigma (Puhl et al.,

2022) and feel shame about their bodies. When people feel shame, they tend to withdraw (Tracy & Robins, 2006) which could explain why some people avoid drawing attention to their weight loss goals. Self-compassion is described as an antidote to shame (Germer & Neff, 2019) and has been shown to mitigate internalized stigma among adults with obesity (Hilbert et al., 2015). Although EB does not describe using self-compassion to mitigate stigma or shame in this instance, her statement demonstrates a need for self-compassion. While EB understood the definition of common humanity, she may have required more practice to apply this self-compassionate concept to her weight loss goals. Taken together, both participants demonstrated some knowledge of self-compassion, but had not fully applied self-compassion to their own experiences. Continued practice through a self-compassion intervention could help participants in this situation apply self-compassion more fully.

Theme 3: First Gear, Self-Reflection and Opportunities for Growth

The third theme shows how participants used self-compassion to acknowledge the circumstances that contributed to their T2D risk and set intentions to change these circumstances in the future. Contrary to the idea that self-compassion leads to self-indulgence, complacency, or amotivation (Chwyl et al., 2021), self-compassion creates a safe psychological space to accept ones' flaws and shortcomings (Germer & Neff, 2019) which may have helped participants identify opportunities for change and growth. "Prediabetes" is a manufactured diagnosis that does not signify the immediate onset of T2D, rather, it draws attention to a patient's pre-existing risk factors and is a call to action for behaviour change (Hindhede, 2014). News of a T2D risk may also elicit negative affect (Strachan et al., 2018) which can result in denial (Patierno et al., 2023) and thwart behaviour change (Sirois, Molnar et al., 2015). Therefore, psychological

strength-building resources such as self-compassion training may be valuable in the context of a prediabetes diagnosis as exemplified by the excerpts within this theme.

Participants described self-criticism as one factor that contributed to their diabetes risk by interfering with their physical activity. Anxiety and harsh self-talk contributed to their low self-efficacy, problems with self-regulation, and avoidance of physical activity, *“I have to have a really seamless [exercise] plan or else the anxiety just overwhelms me”* (RA, age 55, group 5). Participants also recognized the utility of self-compassion for regulating their thoughts and feelings towards physical activity, *“I caught myself being self-critical... And it'll just take practice in my head to turn it around”* (BA, age 46, Group 5). A self-compassionate approach gives people tools to manage self-criticism when inevitable physical activity setbacks occur (Semenchuk et al., 2018). Rather than berating themselves or becoming paralyzed by negative affect (Sirois, 2014), self-compassionate people should pick themselves up and try again (Germer & Neff, 2019). Over time as people gain mastery experience through consistent practice, their self-efficacy for physical activity should grow (Bandura, 1997), and engaging in physical activity should become easier. The Self-Regulation Resource Model of Self-Compassion shows that increased self-efficacy mediates the relationship between self-compassion and health behaviours (Sirois, 2015). Overcoming self-criticism through self-compassion may have helped MOVE IT Study participants reduce their negative affect, self-regulate their behaviour, and build their self-efficacy to engage in more physical activity.

Through self-reflection, participants also acknowledged how years of caregiving had contributed to their T2D risk, *“My daughter was my priority, and my husband was my priority, and I was not a priority. So, I kind of just went to the back burner”* (RA, age 55, Group 5). This finding is logical as all participants in the sample identified as women and women are more

likely to accept primary caregiver roles (Pierret, 2006; Maclean et al., 2004). Carol Gilligan's Ethics of Care (1982) describes how women may conceptualize their roles in relation to others, with caregiving and interconnectedness being central to these roles. Though caregiving can be a fulfilling part of a person's life, it can become problematic when one neglects their own health needs to provide for the needs of others. Qualitative work has shown how the Ethics of Care contributes to mothers foregoing their own physical activity in favour of their children's needs or activities (McGannon & Schinke, 2013). Using self-compassion, participants in the MOVE IT Study voiced a need to set boundaries around caregiving, *"I just grew up watching my grandparents help people, and my mother is like that. So now, as an adult I'm beginning to realize that it's wearing me thin"* (BD, age 55, Group 2). Self-compassion is a valuable mindset for caregivers and is described as, "putting on your own oxygen mask first" (Germer & Neff, 2019; Simpson et al., 2022) suggesting that one cannot properly care for others until they have cared for themselves. Simpson et al. (2022) found that self-compassion was associated with more positive feelings about engaging in health behaviours among a sample of mothers. Considering many of the MOVE IT Study participants were women, identified as caregivers, and felt caregiving detracted from their physical activity, self-compassion was particularly applicable to their situations.

After identifying the circumstances leading to their current health risk, participants voiced a need for change or growth, *"...that's probably gonna be one of my biggest areas to work on"* (AM, age 55, Group 2). A growth mindset is the belief that one can change, grow, and improve over time (Dweck & Yeager., 2019). A recent meta-analysis found that growth mindsets are related to improved academic achievement, mental health, and social functioning (Burnette et al., 2023). A growth mindset related to physical activity is also associated with self-efficacy for

exercise, higher exercise intentions, and more self-reported exercise behaviour (Orvidas et al., 2018). Self-compassion should help people endorse a growth mindset; self-kindness helps people forgive themselves for failures, common humanity fosters the belief that mistakes are a normal part of life, and mindfulness keeps people from dwelling on their shortcomings and instead see the temporary nature of their struggles (Neff et al., 2003a). Self-compassion is associated with a growth mindset, and experimental manipulation of self-compassion can increase beliefs that failure is an opportunity for growth (Miyagawa et al., 2020). Learning about self-compassion in the MOVE IT Study may have helped participants adopt a growth mindset towards their health and physical activity. After identifying opportunities for growth, participants began enacting behaviour changes and overcoming hurdles to improving their health, which are described in the following themes.

Theme 4: Second Gear, Mental Kindness in the Face of Struggles

The fourth theme demonstrates participants' use of self-compassion in a mental or emotional sense to cope with setbacks in their physical activity and health journeys. The content of this theme aligns with the gentle or “Yin” side of self-compassion whereby people validate, comfort, or soothe themselves during times of emotional distress (Germer & Neff, 2019). Yin self-compassion is similar to emotional-approach coping (Austenfeld & Standon, 2004) which is a form of emotion focused coping (Lazarus & Folkman, 1984) characterized by cognitive reframing and acceptance, rather than denial or wishful thinking (Ben-Zur, 2020). A meta-analysis by Ewert et al. (2021) found that self-compassion was positively related to emotional-approach coping across 136 samples ($N = 38,913$ participants). Emotion-focused coping is commonly applied to health-related stressors (Lazarus & Folkman, 1984) and emotional-

approach coping can be adaptive in the context of chronic conditions (Austenfeld & Standon, 2004).

One aspect of Yin self-compassion, validation, can take the form of recognizing ones' strengths and good qualities (Germer & Neff, 2019). Participants engaged in validation when they acknowledged progress made towards their physical activity goals despite falling short of their initial plans. After failing to achieve a goal, a person's initial reaction may be to chastise themselves to prevent the failure from happening again, *"Like my first reaction is, you bonehead, why aren't you doing it?"* (MC, Group 5). Paradoxically, self-criticism is a poor motivator. When a person's motivation to succeed is driven by their desire to avoid self-criticism, they may instead avoid goal-directed behaviours to prevent the conditions necessary for self-criticism to ensue (i.e., if I don't try, I can't fail; Powers et al., 2011). A self-compassionate response to failure should allow people to try, fail, validate their efforts, and try again, *"The self-compassionate part of me is saying, okay, we haven't done it, let's take a little step and work up to where we want to be"* (MC, Group 5). Supporting these findings, self-compassion was positively associated with internalized motivations for exercise and re-engagement with exercise goals, and negatively associated with externalized motivations and negative emotions among people who experienced an exercise setback (Semenchuk et al., 2018). Relatedly, Zhang et al. (2023) found self-compassion was associated with moderate-to-vigorous physical activity through its relationship with reduced psychological distress and greater barrier self-efficacy. In the MOVE IT Study, self-compassion may have prevented self-criticism from derailing participants' physical activity goals by helping them validate their efforts after a setback.

Participants also validated their struggles with physical activity as common experiences that deserved to be met with empathy, *"But for everyone that doesn't do their goal, I think we just*

have to forgive ourselves and think tomorrow is a new day...” (AC, age 52, Group 5). Common humanity should help people reduce feelings of isolation, inadequacy, or shame by fostering the belief that all humans are connected through their shared experiences (Kotera et al., 2022).

Evidence from randomized trials supports the benefits of common humanity. Common humanity interventions among anxious young adults (Slivjak et al., 2022), healthcare workers (Ling et al., 2020) and university students (Dreisoerner et al., 2021) have been found to reduce anxiety and increase tolerance for anxiety-provoking situations, increase compassion for others, and increase life satisfaction, respectively. In the MOVE IT Study, applying common humanity to physical activity setbacks may have helped participants reduce their feelings of shame or discouragement and kept them engaged with their physical activity goals. The group setting of the MOVE IT sessions may have also fostered common humanity by providing opportunities for participants to gain insight into the lives of their peers (Kullman et al., 2024).

Another aspect of Yin self-compassion, comforting, can take the form of offering oneself the kindness and care one needs during challenging times. Participants used self-kindness to comfort themselves when facing work or family-related stressors that interfered with their ability to be active “...*I was able to just take some time for myself, and not judge myself, and use some of the other tools that we've been learning*” (KJ, age 49, Group 5). Within this discussion, participants described how their progress in the MOVE IT Study was about more than just physical activity; on some weeks they progressed towards their physical activity goals (i.e., “physical work”) and on others they prioritized their self-compassion practice (i.e., “brain work”). When in need of comfort, participants engaged in self-care, spoke to themselves as they would a good friend, and tried to stay present in the moment. The benefits of self-compassion training were exemplified by KJ, who described previously engaging in behaviours that were “*catastrophic*” to her health

during times of emotional distress but saw self-compassion as a “*lifesaving*” resource that helped her cope adaptively (KJ, age 49, Group 5). These findings are logical; a recent scoping review found that self-compassion interventions can lead to increased self-care behaviours among people with or at risk for chronic conditions (Semenchuk, Kullman, et al., 2021).

Finally, Participants used mindfulness to recognize the impermanence of their struggles and focus on the present rather than dwelling on their past mistakes or future worries , “*And if you're gonna be living life, you wanna live it fully. So being here and now is important*” (EB, age 74, Group 2). Mindfulness is taught within self-compassion training (Germer & Neff, 2019) and mindfulness also has benefits for health that are independent of self-compassion. Meta-analytic evidence shows that trait mindfulness is positively associated with physical activity, healthy eating, and sleep, and these relationships were consistently moderated by the mindfulness facet, “acting with awareness” (Sala et al., 2020). Acting with awareness means directing ones’ attention to the present moment (Brown & Ryan, 2003), which is consistent with participants’ descriptions of mindfulness in the MOVE IT Study.

Taken together, this theme describes participants’ experiences of applying “mental kindness” or Yin self-compassion to their physical activity and health journeys. Participants demonstrated Yin self-compassion by acknowledging small successes, validating their goal progress, recognizing the common humanity of their challenges, comforting themselves during difficult moments, and using mindfulness to recognize the temporary nature of suffering. These applications of self-compassion can be likened to emotion-focused coping, which is helpful in the context of chronic health conditions (Austenfeld & Standon, 2004). This theme supports the utility of self-compassion for helping people cope with difficult emotions related to their health.

Theme 5: Third Gear, Taking Action to Work Through Challenges

Though emotion-focussed coping can be helpful in the short term, research on the long-term benefits of this coping style is mixed (Ben-Zur, 2020). Once a person has successfully identified, expressed, and coped with their emotions, there may be little benefit in dwelling on these emotions over time (Baker & Berenbaum, 2007). After coping with difficult emotions, the next logical step may be taking action to address the root cause of those emotions (Baker & Berenbaum, 2007). An adaptive coping response may be progressing from emotion-focused coping to problem-focussed coping strategies (Ben-Zur, 2020), and self-compassion is positively associated with problem-focussed coping (Ewert et al., 2021). The fifth theme relates to this aspect of self-compassion and represents the Yang (fierce or action-oriented) side of self-compassion. The Yang side of self-compassion is characterized by prioritizing ones' needs, self-protection, and self-motivation (Neff, 2021), and is similar to problem-focused coping (Lazarus & Folkman, 1984).

In line with the Yang of self-compassion, participants negotiated the demands of others so they could prioritize their own needs, *"This week I actually scheduled myself on our family calendar in the kitchen..."* (BA, age 46, Group 5). This finding connects directly to Theme 3 in which participants identified caregiving and work responsibilities as barriers to their physical activity. The time and energy demands of caregiving can lead to poor health outcomes for caregivers, particularly women (Caputo et al., 2016). Self-compassion should help caregivers cope with the stressors of their role and permit themselves to meet their own needs. A positive relationship between self-compassion and the physical and mental health of caregivers has been found among mothers (Simpson et al., 2022), caregivers of ill and aging family members (Hsieh et al., 2019; Murfield et al., 2020), and caregiving professionals (Andrews et al., 2020).

People with sedentary careers are at a greater risk for physical inactivity (Prince et al., 2020), and may need to negotiate work demands to remain active. This negotiation was described by participants in the MOVE IT Study, *“I had a meeting that ran late, and I knew I had a meeting coming up early and I was like, ‘I don’t think I should do my 20-minute walk in the half hour that I have for lunch...’”* (FJ, age 48, Group 2). Though few studies have examined self-compassion in the context of workplace physical activity, two pilot interventions have added self-compassion training to physical activity interventions among office workers; one such intervention found self-compassion led to significant increases in self-reported leisure-time physical activity from pre-test to post-test (Horan & Taylor, 2018), while the other reported null findings for self-compassion and physical activity (Biber et al., 2021). Though the quantitative findings are mixed, the present study shows how self-compassion may have contributed to participants prioritizing their own needs and engaging in physical activity despite work-related time restrictions, *“...before I got myself to the kitchen, I’m like, ‘screw it- I’m just gonna go’. But after the walk I felt so much better”* (FJ, age 48, Group 2).

In addition to prioritizing ones’ needs, another way to embody the Yang of self-compassion is to protect oneself. Participants expressed a desire to protect their health in the years to come when they discussed their risk for T2D, *“...now that I know that it’s something I need to deal with I can actually buckle down and deal with it”* (FJ, Age 48, Group 2). These findings align with quantitative evidence and theory around self-compassion. One way to be self-compassionate is caring for ones’ health (Phillips & Hine, 2021), and self-compassionate people may take a proactive approach to prevent health problems before they arise (Semenchuk et al., 2022; Allan & Leary, 2010). One participant shared her readiness to move past denial and start addressing her T2D risk by making medical appointments, *“I made several doctor’s*

appointments in the past month and have a requisition now for the blood work and the glucose test and all the other stuff that's gotta get tested. Because now I really wanna know. There's no room for denialism anymore" (MK, age 56, Group 2). MK's statement is supported by meta-analytic evidence showing self-compassion is unrelated to emotional avoidance coping (i.e., denial; Ewert et al., 2021), and prospective research showing self-compassion's positive association with seeking medical care among women with cardiovascular disease risk (Semenchuk, Boreskie et al., 2021).

The Yang of self-compassion can also be a motivating force; people should develop a form of self-talk that represents a supportive but driven coach (Germer & Neff, 2019). Demonstrating this inner coaching, participants wrote themselves encouraging notes to support their physical activity goals, *"One of my strategies is to give myself my pep talk. I've been leaving myself notes on my mirror..."* (FJ, age 48, Group 2). Through their encouraging self-talk, participants may have developed more internalized motivations for physical activity, as their source of motivation was their own inner voice, rather than external factors (e.g., approval from others, physical appearance). This connection to internal motivation is supported by a recent scoping review showing that across multiple studies and populations, self-compassion was positively associated with more internalized forms of physical activity motivation (Kullman et al., 2024).

Some participants took a self-compassionate approach to physical activity goal setting by ensuring their plans were flexible enough to be adapted when barriers to physical activity arose *"...if you do even 10 minutes a couple of times a day then it's better than not doing anything"* (AM, age 55, Group 2). Though self-compassion can be motivating, self-compassionate people should take a balanced approach when they encounter setbacks such as lack of time, lack of energy, or emotional challenges. Rigid and inappropriate goal setting can lead to negative affect

and a higher likelihood of failure (Swann et al., 2023), and forcing oneself to engage in painful or intolerable activities may lead to physical activity aversion (Arlinghaus et al., 2017). Research on physical activity goal setting by Hawkins and colleagues (2020) shows open goals (e.g., “see how well you can do”) may lead to greater engagement in physical activity compared to more rigid goals (e.g., SMART goals; Specific, Measurable, Attainable, Realistic, and Timely).

Interestingly, participants in the MOVE IT Study were originally instructed to set their physical activity goals using the SMART goals framework (Signore et al., 2022), but the present study shows how participants moved away from rigid goal setting as the intervention progressed.

Overall, this theme describes how participants used action-oriented, Yang self-compassion to overcome barriers to their physical activity and health. Participants negotiated the demands of family and work to prioritize their physical activity, expressed a desire to protect their health, sought medical care, used motivating self-talk, and set flexible goals. These action-oriented coping strategies align with problem-focused coping (Lazarus & Folkman, 1984) and show how self-compassion is not only useful for coping with difficult emotions, but also taking action to improve ones’ situation by addressing the root cause of challenges.

Theme 6: Cruising on the Highway, Taking What Feels Right and Leaving the Rest Behind

The final theme represents participants’ mastery experiences with self-compassion in the context of their health; it highlights instances where they showed a strong understanding of the skills taught in the MOVE IT study, a commitment to long-term change, and preparedness for the journey ahead. Participants showed proficiency in self-compassionate practices like “what would I say to a friend” or “soften, soothe, and allow” (Germer & Neff, 2019), “...*soften, sooth, allow, and pray. And that has been a persistent thing that has helped me get through stuff. And it's one of the important things that I'll take away from these sessions*” (MK, age 56, Group 2).

These self-compassionate practices are described in the Mindful Self-Compassion program (Germer & Neff, 2019) and in Appendix W. Briefly, both practices are designed to help people cope with suffering using either kind self-talk or mindfulness, respectively.

Other skills demonstrated included mindfulness and self-kindness. One participant used mindfulness to reflect on her positive mood and sensory experiences during exercise, which in turn, increased her motivation for exercise, “*And I felt good about how I was feeling...I’m thinking about that and using it as motivation for the next time*” (NJ, age 53, Group 2). Two participants used kind self-talk to reframe negative thoughts and increase their self-efficacy for physical activity, “*...instead of focusing on the negative feelings of ‘I have to exercise’, or ‘I have to do this’, just think ‘I can do this’*” (EL, age 55, group 5), and one participant used self-kindness to meet her body’s need for rest, thereby increasing her energy levels and making self-regulation easier, “*...my body was saying, ‘you need to rest in order to do this’*” (MK, age 56, Group 2). These findings align with a meta-analysis showing self-compassion interventions can increase self-compassion (Ferrari et al., 2019), and a scoping review conducted by our research group showed self-compassion was consistently associated with physical activity related self-regulation, affect, motivation and self-efficacy (Kullman et al., 2024).

Excerpts within theme six show participants felt committed to making long term changes to their physical activity and self-compassion. People with prediabetes understand the behaviour changes required to mitigate a T2D risk are a lifelong endeavour (Bean et al., 2020), but long-term physical activity behaviour change is challenging. Among middle-aged and older adults, barriers to physical activity can arise at both individual (e.g., self-regulation) and social (e.g., access to resources) levels, leading to physical activity relapse (Spiteri et al., 2019). Though an individual-level intervention such as the MOVE IT Study will not solve social barriers to health,

it may help people respond to challenges more adaptively, and thereby avoid physical activity relapse. In a similar qualitative interview study, women with prediabetes described how using a self-compassionate approach helped them navigate challenges and increase their physical activity up to 12-months following a behaviour-change intervention (Bean et al., 2020). Interestingly, self-compassion was not taught to participants interviewed by Bean et al. (2020), and these findings suggest self-compassion may be a helpful and intuitive tool for people with prediabetes looking to make long-term physical activity changes.

In summary, the final theme demonstrates participants' understanding of a range of self-compassion skills and practices that can be carried forward beyond the intervention. From a design standpoint, the MOVE IT Study should produce long-term improvements in self-compassion that are suited to the long-term behaviour change needed in the context of prediabetes. Multiple-week interventions are more effective at increasing long-term trait self-compassion (Ferrari et al., 2019) compared to single-session inductions which produce increases in short-term state self-compassion (Neff, 2023). Though limited research explores the impact of self-compassion interventions on physical activity, the most promising designs are similar to that of the MOVE IT Study and include multi-week, group-based sessions that frame self-compassion in the context of physical activity (Kullman et al., 2024). The excerpts in this theme suggest that MOVE IT Study participants increased their trait self-compassion, and that using self-compassion helped them increase their physical activity. However, data on the long-term benefits of the MOVE IT Study will be needed to corroborate these findings.

Practical Implications

The present findings support self-compassion as a relevant and useful practice for people at risk for T2D who are working to change their health behaviours. Researchers and practitioners

should continue incorporating self-compassion training within health behaviour change programs for this and other populations. This study also provides three key insights into how self-compassion can be effectively framed and presented to participants in an intervention.

Insight 1. Participants in the MOVE IT Study were specifically taught to apply self-compassion to the context of their physical activity or diabetes risk and were encouraged to bring these situations to mind during their self-compassion practice (Signore et al., 2022). Framing self-compassion in this way has been recommended for increasing the effectiveness of self-compassion interventions that target specific behaviours (Kullman et al., 2024, Zhang et al., 2023). While an intervention may improve participants' self-compassion in a broad sense, they may not apply self-compassion to certain situations in their lives (e.g., physical activity) without specific prompting. The present study highlights many examples of participants applying self-compassion to both their diabetes risk and physical activity which suggests they learned to apply self-compassion in the desired ways. Future interventions should continue to frame self-compassion education around specific behaviours or events that are relevant to their target population.

Insight 2. The present findings suggest that for participants in the MOVE IT Study, developing self-compassion was an ongoing journey that evolved over time. Therefore, multiple-week education programs may be optimal for supporting participants as they overcome initial feelings of ambivalence (Chwyl et al., 2021) and gain confidence in their self-compassionate practice. This insight is supported by a scoping review conducted by our research group which suggested multiple-week interventions that target trait self-compassion may be more effective for long-term behaviour changes such as physical activity compared to single-session self-compassion inductions (Kullman et al., 2024). While multiple-week interventions can be more

time-consuming and expensive compared to single-session inductions, the potential for increased intervention effectiveness may justify these costs.

Insight 3. The present findings support the use of online, group-based, self-compassion interventions facilitated over videoconferencing. From the themes presented, it is apparent that participants successfully learned about self-compassion in this online environment. Participating in the study from the comfort of their own homes may have increased participants' sense of safety, thus making it easier to engage with the materials and share with others. Furthermore, connecting with other participants in the group may have helped to foster common humanity (Kullman et al., 2024). Supporting this insight, the MOVE IT pilot and feasibility study demonstrated that online intervention groups were highly acceptable to participants (Signore et al., 2022). However, one caveat is that while virtual self-compassion interventions can be effective, synchronous interventions with a live group facilitator may be more beneficial for teaching self-compassion and creating strong group connections compared to asynchronous or self-guided online interventions (Kullman et al., 2024).

Implications for Qualitative Self-Compassion Research

Compared to the amount of quantitative literature on self-compassion and health, there is less qualitative research available. The extant qualitative research often seeks to achieve one of two aims: exploring people's thoughts about using self-compassion or assessing the acceptability of a self-compassion intervention as a secondary outcome of a multiple-methods research protocol. Few studies have used qualitative methods to examine participants' uptake and use of self-compassion as a primary outcome of a self-compassion intervention. Furthermore, only one other study to my knowledge has examined participants' uptake and use of self-compassion in "real time" by analyzing recorded intervention sessions (Lathren et al., 2018). This type of qualitative

research is necessary because it can provide specific examples of why or how self-compassion interventions may work to promote health, and support theoretical relationships between self-compassion, self-regulation, and health behaviours.

Supporting the collection and use of “real-time” qualitative data, both the present study and the work of Lathren et al. (2018) identified key learnings that participants gained from their respective self-compassion interventions and demonstrated how these learnings were applied to cope with their illness or improve their health. Examining participants’ discussions during intervention sessions can also help researchers tap into new ideas that may not be accessed through interviews alone; participants in the MOVE IT Study in the intervention often built on the thoughts of others while describing their experiences, which sometimes took conversations in new directions. The intervention group also created a safe space for sharing where participants were among their peers in an informal discussion setting. This setting may have encouraged participants to speak more freely compared to a formal interview, and for this reason, may have produced richer qualitative data. Taken together, examining participants’ discussions during the MOVE IT Study intervention sessions provided fruitful data, and this method of data collection should be used in future research.

Despite these benefits, there are shortcomings of using recorded intervention sessions as research data that must be considered. For example, the researcher has less control over which topics are discussed during the intervention sessions and which participants are speaking. If a participant brings up an interesting point, the researcher can only hope this point was discussed further during the sessions and cannot probe for more information as they could in a live interview. Moreover, people who are naturally less talkative may be under-represented in recorded intervention sessions, as they are the least likely to share during group discussions.

While I took steps to ensure each participant was quoted at least one time during dataset selection and prioritized quotations from participants who spoke up less, the two strongest participant voices still comprised 34% of the PTE dataset, and one participant who made no relevant statements was not quoted. Ensuring adequate representation of each participant's voice should be a consideration for future researchers analyzing intervention group discussions. Finally, while the intervention group created a safe space for sharing, there was also a potential for social desirability bias to influence participants' statements during the sessions. Participants may have been more inclined to speak favourably about self-compassion if others in the group were also doing so. To mitigate this, a range of excerpts were selected for analysis, representing both positive and challenging experiences with self-compassion.

This study addressed the need for more qualitative accounts of how participants in self-compassion interventions uptake and use self-compassion. Participants in the MOVE IT study used self-compassion to identify opportunities for change and growth, respond to challenges with self-kindness (i.e., Yin self-compassion), take protective action to reduce their T2D risk (i.e., Yang self-compassion), and prepare themselves for a life-long journey towards better health. Related research by Signore et al. (2022) used post-intervention interviews to qualitatively examine participants' general experiences in the MOVE IT Study pilot and feasibility trial. Their results showed participants were receptive to self-compassion, identified opportunities to change their health behaviours, adopted a more flexible view of physical activity, validated their efforts, and used self-kindness to cope with setbacks (Signore et al., 2022). The present study builds upon the work of Signore et al. (2022) by examining participants' real-time discussions of self-compassion across each intervention session (as opposed to their recollection of its use and value after the intervention) and co-analysing this data alongside five women with lived experience of

the MOVE IT Study. The findings of both qualitative accounts of the MOVE IT Study align with one another and provide support for the applicability of self-compassion in the context of a T2D risk and physical activity behaviour change.

Implications for Participatory Theme Elicitation

Patient and public engagement is proposed to benefit every stage of the research cycle (Domecq et al., 2014), but few studies engage lay people in qualitative data analysis due to time, resource, or power-related barriers (Campbell & Vanderhoven, 2016; Egid et al., 2021). Participatory Theme Elicitation (PTE) is a qualitative analysis technique informed by the principles of Patient and Public Involvement (Best et al., 2017). Due to the novelty of PTE, less than 10 published studies report on its use. The present study provides further support for PTE as an acceptable, practical, and useful method of engaging lay people in qualitative data analysis. This study is also the first to use PTE in the context of self-compassion and health behaviour change. The results build on other PTE research by detailing process-related outcomes including the attendance of co-researchers, the number of relevant data excerpts originally identified versus the number selected for PTE (PTE Step 1), the results of each co-researcher's independent card sorting (PTE Step 3), data excerpt re-arrangement during data analysis and interpretation (PTE Step 5), and the number of hours required to complete each step of PTE. Only one other published PTE study reports in detail on process outcomes (Best et al., 2022), and more information on the process of PTE should help future researchers adopt this method.

This study shows the 5-step method of PTE can be followed as described by Best et al., (2022), with some tailoring to suit the study context. Adaptations made for this study included scheduling an additional “Introductory and Terms of Reference” meeting to promote relationship building, selecting the PTE dataset in collaboration with an academic researcher, scheduling an

additional “dataset approval” meeting to ensure co-researchers understood and approved the PTE dataset, and adding additional materials to the capacity building workshop (i.e., information handouts, practice quotation sorting exercise). Best et al. (2017, 2022) suggest PTE is flexible and can be modified to suit the needs and goals of individual research projects. In this project, the process of PTE was successful in that co-researchers were interested in this method, meetings were well-attended, co-researchers felt prepared to conduct the analysis, and the size of the PTE dataset was appropriate for generating meaningful results.

The efficiency and practicality of PTE make it a desirable method for both academic researchers and lay-person co-researchers alike. Cashman et al. (2008) reviewed four studies that employed participatory analyses (e.g., multiple discussion/interpretation sessions, team-based data coding) and found that time was listed as a challenge in each of these studies, with the analysis process requiring between two and nine months. Long analysis periods may lead to fatigue and makes retention of co-researchers difficult (Cashman et al., 2008). Indeed, a demanding workload can be a frustration among co-researchers who have obligations and responsibilities outside of a research project (Modigh et al., 2021). PTE was created to address the time-related barriers of other participatory techniques by using card sorting and network analysis to garner meaningful input from co-researchers in a more efficient way. In the present study, co-researchers spent approximately 8.5 to 9 hours on analysis-related activities over four weeks and found this timeframe acceptable. Despite the shorter analysis period, co-researchers produced results that were meaningful, logical, and fit well with related theory and research as described in the discussion above.

Though Best et al. (2022) describe in detail the steps required to conduct PTE, little information is provided about building strong relationships with co-researchers at the outset of

the research process. Building relationships is an important part of participatory research, as it ensures co-researchers feel welcomed, respected, and valued (Shimmin et al., 2017). The present study drew upon best practices for patient engagement described by Chudyk, Stoddard, et al. (2022) to build relationships through an “Introductory and Terms of Reference” meeting. This initial meeting set the tone for a positive work environment, gave co-researchers an opportunity to meet, and helped identify any supports they would need to participate. I would recommend that future researchers using PTE schedule an introductory and Terms of Reference Meeting before they begin formal PTE activities.

Co-analyzing the qualitative data using PTE produced a set of themes that I could not have generated independently. Co-researchers were interested in “big picture” concepts within the data that were meaningful to their own lived experiences, while I often took a more granular approach to the data. Illustrating this point, co-researchers each produced between four and six data extract card piles in Step 3 of PTE, whereas I produced 10 card piles (Table 7). As a researcher who was originally trained in a post-positivist paradigm (Markula & Silk, 2011), I attempted to break the data into small, neat, meaning units, making it difficult to identify the larger story being told within the excerpts. While researchers trained in other ontological and epistemological paradigms (e.g., interpretivist; Markula and Silk, 2011) may have interpreted the data in different or broader ways, eliciting the partnership of co-researchers helped me gain new perspectives on the data in this study. Co-researchers used their insider-perspective to tell a story that better represented participants’ experiences in the MOVE IT Study. Storytelling has been used to interpret qualitative data in other participatory analyses (e.g., Jackson, 2008), and the present study demonstrates how PTE can produce unique qualitative findings that differ from researcher-led analyses.

This research expands upon the traditional reporting of PTE by using co-researcher quotations to support each theme described in the results. To my knowledge, no previous PTE study has included co-researchers' statements about the data, nor is this practice typically seen in other qualitative co-analysis methods (e.g., Cashman et al., 2008; Jackson, 2008; Main et al., 2012). Co-researchers' interpretations provide justification for each theme and act as another data source, thereby achieving qualitative "triangulation" (Ahmed, 2024) and increasing the trustworthiness of these findings. Most importantly, reporting on co-researchers' interpretations demonstrates that the study findings were truly co-created. Future researchers using PTE or other co-analysis methods should consider using the direct quotations of co-researchers to support their qualitative findings.

Knowledge Translation

The Canadian Institutes of Health Research Guide to Knowledge Translation (2023) will inform the present study. Plans for knowledge translation were discussed with participant co-researchers in the final evaluation meeting. Co-researchers expressed a desire to be kept informed about upcoming knowledge translation activities and opportunities to contribute. Possible knowledge translation methods include posters, infographics, brochures, video or audio testimonials, presentations at academic conferences, and the publication of an academic research article. More specifically, I plan to present these research findings at the annual conference of the Canadian Society for Psychomotor Learning and Sport Psychology (October 17-19, 2024, Winnipeg, Manitoba). I also intend to publish this research in an academic journal such as *Qualitative Research in Sport, Exercise, and Health* (Impact Factor: 4.9), *Qualitative Health Research* (Impact Factor 3.2), *Health Expectations* (Impact Factor 3.2), or *Research Involvement and Engagement* (Impact Factor 1.4). Participant co-researchers have agreed to be co-authors on

any presentations or publications stemming from this work, and have been invited to co-develop conference presentation materials, co-present our research findings, and contribute to manuscript preparation. Considering their substantial contributions to the data analysis, co-researchers will be named as co-authors regardless of their contribution to knowledge translation activities. Before engaging in any of these activities, I will meet with co-researchers to establish clear roles and expectations for our work.

The outcomes of this research should inform future directions of the MOVE IT Study, specifically, a larger, community-based effectiveness trial. It will be important to use knowledge translation to create buy-in from organizations in the community who may implement the MOVE IT program in the future. Translating findings from MOVE IT to the community will be timely, given that the Government of Manitoba recently released a Diabetes Action Plan that lists expanding chronic disease prevention programming and increasing mental health supports as action items (Government of Manitoba, 2023) and these outcomes are relevant to the MOVE IT Study. The findings of the present study could be combined with the findings of the larger MOVE IT efficacy trial and shared with community organizations such as the Youville Diabetes Centre, the National Indigenous Diabetes Association, local ACCESS Centres, Klinik Community Health Centre, the Victoria Hospital Diabetes Education Centre, the RehFit Centre, or the Wellness Institute.

Strengths

Strengths of this research include the use of audio-recorded intervention sessions which allowed for real-time examination of participants' adoption and use of self-compassion in the MOVE IT Study. The details of participants' experiences captured within the recorded sessions may not have been fully represented in post-intervention interviews (e.g., Signore et al., 2022).

PTE was an efficient and practical method of analysis that resulted in the co-creation of meaningful themes that I could not have generated independently. The group of co-researchers represented a range of diverse backgrounds, which added depth to our discussions during the analysis. Co-researchers' direct quotations were used to increase the trustworthiness of our findings and support the rationale behind each theme, which is a practice not commonly seen in other participatory analyses but added strength to this study.

Engaging people with lived experience is proposed to benefit every stage of the research cycle (Domecq et al., 2014) and using a participatory analysis was a strength of this study. Employing the principles of patient engagement (Canadian Institutes of Health Research, 2019) strengthened this work. Specifically, completing the "Readiness to Engage Questionnaire" as the lead researcher on this study (Shimmin et al., 2017), setting a Terms of Reference with co-researchers (Chudyk, Stoddard, et al., 2022), and providing fair compensation (Canadian Institutes of Health Research, 2019) ensured co-researchers felt valued, respected, and could fully participate. When these principles of engagement are not followed, engagement can have a negative impact on co-researchers physical or mental health (Richards et al., 2023).

Evaluating the engagement process using both quantitative and qualitative methods was a strength of this research. While the PPEET is a widely accepted tool within patient engagement and is meaningful to researchers within this community, only 3/5 co-researchers in the present study completed the PPEET. This response rate suggests that some co-researchers may have preferred providing verbal feedback over written feedback, and the qualitative evaluation option ensured all voices were heard. The qualitative evaluation also elaborated upon co-researchers' responses to the PPEET and justified why they had a positive experience in the study. As described in the qualitative evaluation, co-researchers found PTE was a valuable opportunity to

meet with like-minded women, share their journeys, and contribute to a research project they felt passionately about. While many studies using engagement approaches report how engagement impacted the research outcomes (Chudyk, Stoddard, et al., 2022), demonstrating how engagement impacted co-researchers (e.g., through friendship and sharing) is a unique strength of this study. The benefits co-researchers voiced were mirrored by a scoping review showing that, when reported on, engagement can lead to increased skills and knowledge, personal development, friendship, and social support among co-researchers (Modigh et al. 2021). Co-researchers' wholehearted positive evaluation of the engagement process across both quantitative and qualitative evaluation methods demonstrates the strength of this research. These positive evaluations suggest PTE is more than acceptable to co-researchers and should be used in future work.

Finally, this study meets the criteria for qualitative trustworthiness as described by Lincoln and Guba (1985). The criteria used to assess trustworthiness are credibility, transferability, dependability, and confirmability (Lincoln & Guba, 1985). The definitions of the four trustworthiness criteria and the specific aspects of this study that promote trustworthiness are listed in Appendix X. Briefly, credibility was enhanced by co-analyzing the data alongside five people who had previously completed the MOVE IT Study and integrating their interpretations of the data into the results. Transferability was promoted in the discussion section of this document by demonstrating how the study findings can be applied to other contexts and situations. Dependability was promoted by selecting data excerpts for analysis that best represented self-compassion, training co-researchers on how to identify instances of self-compassion in the data and familiarizing co-researchers with the dataset during the analysis. Finally, confirmability was ensured by forming a consensus on the final set of themes with five

other co-researchers, engaging in reflexivity as the academic researcher leading this project, and comparing the results of this study to other qualitative findings generated from interviews with MOVE IT Study participants (Signore et al., 2022).

Limitations

Limitations of this study should be noted. First, only two out of six audio-recorded intervention cohorts were sampled as qualitative data, and it is possible that some experiences relevant to participants' use of self-compassion are not represented in the results. Despite this shortcoming, I identified 200 data excerpts within the sample that were relevant to participants' use of self-compassion in relation to coping with prediabetes, physical activity behaviour change, or other health behaviours. Of these 200 excerpts, 74 were selected for use in PTE – an appropriate number for this analysis technique. Another limitation was that I selected the 74 excerpts for the PTE dataset alongside my thesis advisor instead of a co-researcher with lived experience due to constraints on time and the amount of compensation I could provide as a graduate student. While working with a self-compassion expert was beneficial for identifying excerpts that were theoretically relevant to self-compassion, a person with lived experience may have selected different excerpts to include in the dataset. To mitigate this shortcoming, I added an additional “comprehension-check” meeting to the PTE process which allowed each co-researcher to provide input on the dataset.

Relatedly, PTE as a qualitative analysis technique prioritizes practicality, participation, and accessibility over some aspects of qualitative rigour (Best et al., 2022). Co-researchers in PTE do not read the original transcripts in full, rather, they work with a curated subset of transcript excerpts. Though selecting a subset of data for PTE increases efficiency and reduces burden on co-researchers (Best et al., 2022), a drawback is that academic researchers can decide which

aspects of the data co-researchers will see and which aspects they will not. Though Best et al. (2022) recommend that dataset selection occurs with at least one co-researcher with lived experience, the present study demonstrates how this is not always possible. Co-researchers may have interpreted the data differently if they had access to the full transcripts.

PTE is a step-by-step process whereas other more traditional qualitative analyses (e.g., Reflexive Thematic Analysis; Braun & Clarke, 2022) are iterative processes. The linear design of PTE allows it to be efficient and less burdensome to co-researchers, but opportunities to revisit data and generate richer themes may be missed. The way PTE facilitates the inclusion of multiple voices and perspectives might mitigate this shortcoming. A single researcher using Reflexive Thematic Analysis may review their dataset 20 times to gain new perspectives, whereas five co-researchers engaged in PTE may review the dataset only a few times, each with a different perspective (i.e., many hands make light work). In addition, opportunities to familiarize co-researchers with the data were built into the analysis process. Co-researchers read all data excerpts during the dataset approval meeting, at least once during open card sorting, and again during the analysis and interpretation meeting.

The facilitation of PTE in this study necessitated at least two in-person meetings, which excluded people in rural locations from engaging as co-researchers. This is a limitation because people from rural settings had participated in the MOVE IT Study, but a rural perspective was missing in our group of co-researchers. It is possible to conduct PTE remotely if all co-researchers have access to a laptop or tablet (see Blair et al. 2022) which was not the case in the present study. Despite the accessibility drawbacks of requiring in-person meetings, co-researchers valued the opportunity to meet in person because it built a stronger group dynamic.

Another potential shortcoming is that co-researchers did not frequently refer to the network diagram generated in Step 4 of PTE when developing the final set of themes. Though I discussed the network diagram with co-researchers at the outset of the data analysis meeting, I could have encouraged them to refer to the diagram more often. There were some instances where visual inspection of the network diagram could have helped co-researchers decide where to re-group certain excerpts that were moved from their original clusters. Tempering this limitation, Best et al. (2022) state that reliance on the network diagram is at the discretion of the co-researchers and is not a mandatory part of PTE (Best et al., 2022). Co-researchers in the present study developed a meaningful set of themes without much reference to the network diagram.

The final limitation is related to compensation. I was privileged to receive funding to compensate co-researchers through the Faculty of Kinesiology and Recreation Management Research Expense Fund. However, as a student I was restricted to compensating co-researchers with Amazon.ca gift cards and could not offer different options for compensation. Despite this shortcoming, co-researchers did not voice any concerns around receiving Amazon.ca gift cards and were provided with detailed instructions for redeeming the gift cards online.

Chapter VI: Conclusion

This qualitative, participatory study demonstrated that people with prediabetes in the MOVE IT Study self-compassion intervention used self-compassion to cope with their diabetes risk, increase their physical activity, and take steps to improve their health. Participants used self-compassion to identify areas for growth, respond to difficult emotions and setbacks with self-kindness, take action to protect their wellbeing, and prepare for their ongoing health promotion journeys. This study fills a research gap regarding the need for qualitative data on participants' adoption and use of self-compassion within self-compassion and health

interventions. This study also supports the use of PTE as a practical, acceptable, and useful method of co-analysis. Using PTE to co-analyze the data alongside five women who had previously completed the MOVE IT Study increased the trustworthiness of our results. These findings are primarily useful for informing future directions of the MOVE IT Study but may also be transferred to support other self-compassion and health interventions, or guide future researchers using PTE.

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Appendix A. Summary of MOVE IT Study Intervention and Control Condition Content

Supplemental Table 1

Summary of MOVE IT Study Intervention and Control Condition Content

Week	Intervention Condition	Attention Control Condition
1 (individual meeting)	A. Individualized meeting with a research assistant to discuss Type 2 Diabetes risk and physical activity goals	A. Individualized meeting with a research assistant to discuss Type 2 Diabetes risk and physical activity goals
2 (group meeting)	B. Physical activity goal setting C. Introduction to self-compassion	B. Physical activity goal setting C. Benefits of sleep
3 (group meeting)	A. Physical activity self-monitoring B. Yin and Yang of self-compassion	A. Physical activity self-monitoring B. Screen time and your health
4 (group meeting)	A. Physical activity section planning and coping planning B. Mindfulness	A. Physical activity action planning and coping planning B. Blood pressure and your health
5 (group meeting)	A. Physical activity self-efficacy part 1: Mastery experiences and vicarious experiences B. Mindfulness and resistance	A. Physical activity self-efficacy part 1: Mastery experiences and vicarious experiences B. Cholesterol and your health
6 (group meeting)	A. Physical activity self-efficacy part 2: Role modeling and verbal persuasion B. Meeting difficult emotions with self-compassion C.	A. Physical activity self-efficacy part 2: Role modeling and verbal persuasion B. Benefits of drinking water
7 (group meeting)	A. Physical activity enjoyment and barriers B. Embracing the good with self-compassion	A. Physical activity enjoyment and barriers B. Benefits of vitamin D
8 (group meeting)	A. Making long-term physical activity change B. Applying self-compassion to physical activity moving forward	A. Making long-term physical activity change B. The “infodemic”: How to interpret health information online

Appendix B. Search Strategy for Literature Review of Qualitative Self-Compassion and Health Research

Studies included in this literature review met at least one of the following criteria (1) qualitative explorations of self-compassion in the context of health behaviour engagement, (2) qualitative explorations of self-compassion in the context of disease or disease risk, or (3) qualitative accounts of self-compassion and health-related intervention studies, and (4) published in 2003 or later (i.e., the year Neff operationalized her definition of self-compassion). Studies examining caregivers (rather than patients) were excluded, given that the current research focusses on applying self-compassion to the experiences of people living with prediabetes (and not their caregivers or family members). The following search string was entered into the advanced search feature on PubMed: (*"self-compassion" AND (health* OR ill* OR chronic* OR disease* OR disorder* OR exercise OR "physical* activ*" OR nutrition OR eat* OR sleep*) AND qualitative*). The “search = ALL FIELDS” function in PubMed was used to increase the breadth of a database search by identifying search terms within article titles, abstracts, and MeSH terms. The search date was limited to articles published in 2003 or later. This search strategy was originally implemented in May of 2023 and was updated in May of 2024. The first database search yielded 163 results which I screened by hand to reveal 13 articles for inclusion. The second search yielded 68 results, and after screening 6 articles met the inclusion criteria. The database of self-compassion research compiled by Kristin Neff and colleagues on the Self-Compassion.org website was screened by hand. This strategy yielded no further articles.

Appendix C. Research Timeline



Appendix D. Lead Researcher Responses to the Centre for Healthcare Innovation (CHI)

“Readiness to Engage” Workbook (Shimmin & Roche, 2021)

Readiness to Engage Workbook

Questions for Research Teams & Partners to Consider when Planning and Evaluating Patient and Public Engagement

Internal Assessment Questions

Personal (questions to reflect upon individually)

What are my own personal values, experiences, interests, beliefs, and political commitments in the area of health we will be researching?

My values: I value health promotion and steps people can take to improve their health such as engaging in physical activity and using self-compassion. I have demonstrated this value through my four years of work as a research student in an exercise psychology lab. My work to date has primarily focused on psycho-education programs that can be used to promote health behaviours, such as the MOVE IT Study.

My experiences: I have been a research assistant working on the MOVE IT Study since the study began in 2020. I have had various roles on this project, including facilitating group sessions. To date, I have worked in some capacity with over 80 MOVE IT study participants, and directly facilitated the MOVE IT program for approximately 40 of these individuals.

My experiences: The primary goal of the MOVE IT study is to help people to become more physically active and support them in that process by teaching them self-compassion. I consider myself an active person and physical activity/exercise has been a value in my life for over 10 years. Considering self-compassion, I completed a 6-week online course on self-compassion in 2020 in preparation for facilitating the MOVE IT study. I think about self-compassion on a daily basis and try to use compassion for myself as often as I can.

Interests/Beliefs: Through facilitating the MOVE IT study, I have realized there are many things I need to know to do my job. But every time I facilitate another group of participants, I

remember how many things I still do not know. I do not know what it's like to be 40 to 74 years old, at risk for Type 2 Diabetes, and trying to become active for the first time (or after a long time of being inactive). When participants talk about how they were very active in their 20's, I think about their stories, and I think about how that is me now. I think about how long life is, and how much can change every decade. Many people were committed to being active in their 20's before work and family obligations demanded more of their time. I realize that could also be my situation in 20 years. I value being active now, but I do not know what it's like to have demands from children, aging parents, strict employers etc. Especially because most of our participants are women, in many cases I hear about how they subverted their own health to care for the health of their families. This is often the role placed upon women and I do not know what it is like to make those sacrifices. I am interested in doing a qualitative examination of participants' experiences in the MOVE IT Study, but I do not have lived experience of any of the issues discussed in the MOVE IT Study, and I may miss relevant patterns in the data for this reason. Therefore, I would like to seek the help of people who do have this lived experience and involve them as co-researchers.

Political commitments: None

2. How do these personal experiences relate to social and structural locations I inhabit (i.e., gender identity and expression, race, ethnicity, Indigeneity, socioeconomic status, age, ability, size, sexual orientation, immigrant status, religion) and processes of oppression (i.e., patriarchy, colonialism, racism, capitalism, transphobia, ableism, homophobia, xenophobia, sizeism, sanism)?

My experiences and values above are directly related to my social and structural location. I am a white settler in Canada, I consider myself middle-class, I am female, and I identify as a woman. I am privileged to have completed post-secondary education and I am currently working towards a graduate degree. In addition, I do not live with any visible or invisible disabilities; I am young, physically fit, and I am in good health. I also have a strong social support network of friends and family who live near me and support me. My social location shows that I do not experience discrimination based on my age, ethnicity, gender/sexual orientation, physical ability, body size, or mental health.

My social location affords me access to many resources that promote my health; I have leisure time to be active, I have money to buy healthy foods, and I have the knowledge to cook meals at home. I place value on the steps that individual people can take to promote their health because those steps have always been available for me to implement. I recognize that for many people, getting more active or eating healthier foods is not an important priority, especially when trying to access stable housing, get food on the table, and keep their family safe. A person must have so many necessities of life in place before they can even think to begin optimizing their health. Access to these basic needs can also be hindered by systems of oppression and discrimination (e.g., colonialism, racism, transphobia, ableism, homophobia, xenophobia, sizeism, and sanism). I understand that the research I do is conducted by people who are privileged (including myself) and is mainly directed at those who are also privileged enough to begin increasing their physical activity. I realize that this type of work is not the only solution for health promotion. Community

and social level interventions are also required to help people access basic needs that are conducive to good health.

From my perspective, what current health inequities (i.e., avoidable, and unjust inequalities in health between and within groups of people) exist with regard to the area of health in which we will be researching?

The MOVE IT Study aims to help people reduce their risk for Type 2 Diabetes (T2D) by helping them to become more physically active and teaching them self-compassion as a mental health promoting tool. My patient engagement work centers around a qualitative examination of the MOVE IT Study. From my perspective T2D is a condition that showcases the health inequities in Manitoba for the following reasons:

1. People typically think of T2D as a condition that is entirely brought on by lifestyle, and therefore if someone is at risk for or develops T2D it is their fault. Placing the sole responsibility for health on the individual is a healthist and capitalist way of thinking. Lifestyle is just one factor that can influence T2D. Age, family history, ethnicity, access to resources, past trauma, education, childhood experiences, and maternal health can all impact someone's chances of getting T2D.
2. Considering the many non-lifestyle related risk factors for T2D, the most under-served groups in our society are the most highly impacted by this condition. For example, indigenous people are now facing the repercussions of colonialism, residential schools, genocide, and generations of trauma in Canada, and are also the most highly impacted group by T2D in Manitoba. Although physical activity is one step that people can take to reduce their risk, there are many competing factors that can lead someone to develop T2D that are not within their individual control.
3. People may choose to take steps to reduce their T2D risk by joining programs like the MOVE IT Study, getting more active, or taking other steps such as improving their nutrition. However, just the act of taking these steps may indicate some level of privilege. A person must be meeting many basic needs already (e.g., income, stable housing, physical ability, spare time, safety) before they can begin taking steps to optimize their health. Many lifestyle programs are not accessible to the people who face the greatest oppression in our society and are likely not a priority for these groups. Often, the best thing we can do to improve people's health is to provide them with the basic needs for life.
4. With these points acknowledged, I think it is also important to recognize that the MOVE IT study does take steps to be accessible to people from diverse backgrounds and social/structural locations. For example, we conduct our group meetings on Zoom so that participants do not need to travel to participate and can join the study from the comfort and privacy of their own homes. This has been expressed as a preference by all participants, and has enabled people from rural communities, and people in urban settings without vehicles to participate. In addition to this, we do not require participants to travel for any aspect of the study. If materials or equipment need to be delivered to a

participant, a research assistant drives to their home. Finally, the MOVE IT program provides a supportive group environment, and participants receive a small honorarium of \$10 for every meeting/measurement they complete in the study. We also encourage participants' autonomy by working with them to create their own physical activity plans. We do not prescribe exercise plans to participants, nor do we force participants to adhere to their activity plans. Participants are still welcome to attend the group meetings and participate in the study regardless of whether they take steps to become more active. This means that people who are participating to meet their social needs are still welcome to attend.

What are my personal values, assumptions, perspectives, and experiences with regard to people living with the health condition(s) which we will be researching?

I have worked with participants in the MOVE IT Study (people at risk for Type 2 Diabetes) since 2020. Throughout this time, I have developed the utmost respect for our research participants. These individuals are patient, kind, giving of their time, open to learning, and always create a positive group environment.

Because I do not have lived experience of diabetes risk, I respect the primacy of MOVE IT Study participants' lived experiences. Every time I facilitate a MOVE IT Study group, I do not just get to know the participants as "participants" or as "people with a diabetes risk". I try to get to know the people in my group, what they do, what they value, their interests and the things they enjoy in life. The lived knowledge and experience that each participant brings to the group provides more value than I as a facilitator ever could. Most often, participants learn much more from one another than they do from the content of the program.

At the end of the day, each participant is an individual. They are much more than their role as a research participant or a person with a diabetes risk. The amazing thing about the MOVE IT study is that it seems to bring together groups of very kind people who are supportive of one another and share a common interest of getting healthier. I am grateful for the opportunity to have met each of our participants, I respect them, and I appreciate the time they lend to us for our study.

About this workbook

These questions are adapted and expanded upon from questions included in the 2017 BMC Health Services Research article Moving towards a more inclusive patient and public involvement in health research paradigm: the incorporation of a trauma-informed intersectional analysis by Carolyn Shimmin, Kristy D. Wittmeier, Josée Lavoie, Evan D. Wicklund and Kathryn M. Sibley. This article is distributed under the terms of the Creative Commons Attribution 4.0 International License (<http://creativecommons.org/licenses/by/4.0/>), which permits unrestricted use, distribution, and reproduction in any medium. This workbook was co-developed with the primary author, Carolyn Shimmin, and edited by Patricia Roche. Version 1.1 updated September 1, 2021

Appendix E. Participant Co-Researcher Consent Form



Faculty of Kinesiology and
Recreation Management

Faculty of Kinesiology and Recreation Management
Room 102 Frank Kennedy Centre
420 University Crescent
University of Manitoba (Fort Garry campus)
Winnipeg, MB R3T 2N2 Canada

Research Project Title: MOVE IT 2 Study

Principal Investigator: Sasha Kullman, Master's Student

Faculty of Kinesiology and Recreation Management, University of Manitoba.
kullmans@myumanitoba.ca
[REDACTED]

Research Supervisor: Dr. Shaelyn Strachan, Professor

Faculty of Kinesiology and Recreation Management, University of Manitoba.
Shaelyn.Strachan@umanitoba.ca
[REDACTED]

This information form should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

What is the purpose of this study?

In the MOVE IT study, you learned that self-compassion is a tool you can use to support your mental and physical health. My study will look at the discussions of participants in the MOVE IT Study to better understand how they used self-compassion in their lives.

What are we asking from you?

I am looking for 4 “participant co-researchers”. A participant co-researcher is someone who uses their personal experiences to bring a unique perspective to a research project. As a co-researcher, you would be a collaborator on this research project and help to shape our results.

What would my role as a participant co-researcher look like?

You would have an active and hands-on role in the research. Specifically, you would help to sort anonymized participant quotations into themes that describe their experiences in the MOVE IT study. I would train you to complete the tasks that are part of your role.

What is the time commitment?

I would ask you to participate in about 5 research meetings and 1 independent task from the end of February to the beginning of April 2024 (approximately 1 meeting every 1-2 weeks). Each meeting would last between 1-2 hours, for a total time requirement of about 10 hours. Three of our meetings would be on Zoom and two meetings would be in person. Below is a table with a breakdown of all the meetings.

When will the meetings be held?

We would discuss the exact times and dates of the meetings together so we can find times to meet that work for all our schedules.

Where will the meetings be held?

Three meetings will be held on zoom, and two meetings will be in person at a location we agree upon.

How will we communicate?

We will communicate using UM Zoom Videoconferencing and email.

Compensation

We will compensate you with a \$200 Amazon gift card for the approximately 10 hours you commit to this project.

Activity	Hours	Approximate Date	Compensation (\$ CAD)
Introductory meeting (Zoom)	1.5	Last week of February	30
Dataset approval meeting (Zoom)	1	First week of March	20
Training and quotation sorting (In-person)	2	Second week of March	40
Extra time for quotation sorting (Independent)	1.5	Third week of March	30
Group analysis (In-person)	2	Fourth week of March	40
Reviewing results and evaluating (Zoom)	1	First week of April	20

Optional Activities	Hours	Approximate Date	Compensation (\$ CAD)
Reviewing Summary of Results (Open to all, voluntary, independent)	2	Second week of May	NA – Voluntary Step Not Mandatory

*All Zoom meetings held on a UM Zoom account

* At in-person meetings, we will give you the materials needed to participate (e.g., pens and notepads) and provide refreshments.

Will the meetings be recorded?

To help keep accurate records of our discussions, we will be audio recording all our meetings. All meetings (both in-person and Zoom) will be audio-recorded using Zoom videoconferencing functions. During in-person meetings, Sasha Kullman will start a Zoom meeting from her University of Manitoba Zoom account for the sole purpose of recording the session. This zoom meeting will be secure, and no one will join the zoom meeting while recording is in progress.

All audio recordings will be stored in a secure place where only members of the research team can access them. All audio recordings will be destroyed by August 2024. Transcripts from our audio-recorded meetings will be automatically generated using functions available on our University of Manitoba Zoom account.

What are the benefits of becoming a participant co-researcher?

A direct benefit of becoming a participant co-researcher is the opportunity to learn more about the research process. Indirect benefits include building connections with others and having the chance to shape the results of a research study.

Are there any risks?

Becoming a participant co-researcher should put you at minimal risk. However, there is a small risk that reading quotations from other MOVE IT study participants could make you feel anxious or distressed. A list of mental health resources will be provided to all participant co-researchers.

Who will be identifiable in this study?

As a participant co-researcher, you will be working with data that is anonymized – meaning that any information that could be used to identify the participants being quoted has been removed. You should not be able to identify any other participants from the MOVE IT study in the data you are working with.

As a participant co-researcher, you will provide some research data to this study. Specifically, we will use demographic information from the surveys you completed in the MOVE IT study to describe our group of participant co-researchers. You will also complete surveys evaluating the research process at the end of this study. Your demographic information and survey responses will be presented as anonymized, aggregated data – they will not be traced back to you.

As a collaborator on this research project, you deserve to be acknowledged in any written documents or presentations that come out of this work. We will discuss together how, if at all, you would like to be acknowledged. For example, some people may be comfortable with being named as co-authors on a research paper, while others may prefer to use a nickname, pseudonym, or not be named at all. We will not share your name without your permission. We will discuss this more in our meetings together to make sure you are comfortable with the way your contributions are acknowledged.

Where will we store data from this study?

While the research is ongoing, all data will be stored on a secure University of Manitoba Microsoft Teams folder, a password-protected SurveyMonkey Account, and a password-protected lab computer that are only accessible to members of the research team.

After the research is concluded (September 2024) the data you provide for this study will be anonymized (all identifying information removed) and will be permanently stored on a password-protected computer inside of a locked laboratory at the University of Manitoba.

Any documents you sign throughout the study (consent forms, honorarium receipt forms) will be stored on a password-protected computer at the University of Manitoba for a maximum of 5 years (until September 2029) and then destroyed.

Withdrawing from the study

Your role in the study is voluntary and you are free to end your role at any time during the engagement process without negative consequences. If you need to end your role, you can contact Sasha Kullman (kullmans@myumanitoba.ca or [REDACTED]). If you leave the study early, you will be compensated for all the hours you contributed to the study up until the date you withdrew. Compensation will be provided within 1 week of the time you notify us you are withdrawing.

If you would like to withdraw your data from the study, you must do so before August 1, 2024. After this point this research will be published on an online database of master's theses at the University of Manitoba and will be impossible to withdraw your data.

Sharing the Results of the Study

As a participant co-researcher, you will have a hands-on role in shaping the results of this study. In the final research meeting, we will review and discuss the results of the study as a group. You will also receive a written summary of the study results in May of 2024.

Who will read the results of this study?

The results of this study will be shared in Sasha Kullman's master's thesis document. The results will also be shared in academic publications (journal articles), and at academic conferences (presentations or research posters). We may also share the results with community organizations. There may be opportunities for you to become involved with sharing the results of the study, we will talk more about this in our meetings.

Signing this form

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the researchers, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time, and /or refrain from answering any questions you prefer to omit, without prejudice or consequence. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation.

The University of Manitoba may look at your research records to see that the research is being done in a safe and proper way.

This research has been approved by the Research Ethics Board at the University of Manitoba, Fort Garry campus. If you have any concerns or complaints about this project, you may contact any of the above-named persons or the Human Ethics Officer at 204-474-7122 or HumanEthics@umanitoba.ca. A copy of this consent form has been given to you to keep for your records and reference.

☐ **Yes, I consent to becoming a participant co-researcher in this study and providing data in the form of Demographic information (taken from MOVE IT Study records) as well as an online survey and group interview.**

☐ **No, I do not consent to becoming a participant co-researcher in this study and providing data in the form of Demographic information (taken from MOVE IT Study records) as well as an online survey and group interview.**

Although we would like to compensate you for your time and effort in this study, we recognize that some people may choose to decline compensation for a variety of reasons.

Do you consent to receiving monetary compensation for my contribution to this research consistent with the compensation plans outlined above on pages 4 and 5?

☐ **Yes, I consent to receiving compensation.**

☐ **No, I do not consent to receiving compensation.**

Please type your name (First, Last) in the box below. Typing your name will represent your e-signature on this consent form.

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Appendix F. Participant Co-Researcher Confidentiality Form



Faculty of Kinesiology and
Recreation Management

Faculty of Kinesiology and Recreation Management
Room 102 Frank Kennedy Centre
420 University Crescent
University of Manitoba (Fort Garry campus)
Winnipeg, MB R3T 2N2 Canada

Research Project Title: **MOVE IT 2 Study**

Principal Investigator: **Sasha Kullman, M.A. Student**

Research Supervisor: **Dr. Shaelyn Strachan, Professor**

Co-Researcher Oath of Confidentiality and Conduct

As a co-researcher in the MOVE IT 2 Study, it is important that the following confidentiality and conduct guidelines are met. Please read and sign this form, indicating that you have understood, and will follow these guidelines throughout the time you are involved in the study.

I, _____ a co-researcher in the MOVE IT 2 Study

1. Agree to respect the health and personal information of others in this group. I will not share the health/personal information that other co-researchers discuss during our meetings with other people outside of our meetings.
2. Agree to respect the privacy of others by not taking pictures or recordings of other co-researchers during our meetings.
3. Agree to respect the confidentiality of participants in the MOVE IT study whose quotations I will be analyzing. Although all the quotations you will work with have been anonymized, there is a very small chance you may identify someone you know by their quotation. If you think you may be able to identify an individual by their quotation, please keep that information to yourself and do not share it with others in the group.
4. Agree to work collaboratively and supportively with others in this group in a way that aligns with our terms of reference document.
5. Agree to notify the Principal Investigator, Sasha Kullman, immediately if you believe a breach of confidentiality has occurred.

Your Signature _____ **Date** _____

Researcher's Signature _____ **Date** _____

Appendix G. Study Budget

Supplemental Table 2

Study Budget

Expenses Related to Engagement Activities				
Activity	Hours	Patient co-researchers	Hourly compensation (CAD)	Total (CAD)
Introductory and terms of reference meeting	1.5	5	\$20.00	\$150.00
PTE Step 1: Dataset approval meeting	1	5	\$20.00	\$100.00
PTE Step 2: Capacity building meeting (in-person #1)	2	5	\$20.00	\$200.00
PTE Step 3: Open sorting (independent)	1.5	5	\$20.00	\$150.00
PTE Step 5: Data analysis and interpretation (in-person meeting #2)	2	5	\$20.00	\$200.00
Reviewing results and evaluation meeting	1	5	\$20.00	\$100.00
Subtotal for engagement activities = \$900.00				
Expenses Related to Materials				
Item/Expense	Price	Number	Total (CAD)	
Notepads	\$2.00	5	\$10.00	
Pens	\$0.50	10	\$5.00	
Refreshments – In-Person Meeting #1	\$10.00	4 (co-researchers)	\$40.00	
Refreshments – In-Person Meeting #2	\$10.00	4 (co-researchers)	\$40.00	
Subtotal for materials = \$95.00				
GRAND TOTAL (all budget items) = \$995.00				

Appendix H. Guiding Questions for Terms of Reference

1. Do you feel your role in the research project is clearly defined?
2. Are there any ways you think your role in the research should be changed or expanded?
3. What are your expectations for being engaged in this research project?
4. What does a “meaningful contribution” mean, look like, and feel like to you?
5. What does a safe work environment mean to you? (e.g., physical, psychological, emotional, cultural, spiritual safety)
6. How will we respond if/when we disagree with the ideas of another member of our research team?
7. How can I support you in contributing to our research?
 - a. Are there any educational, informational, practical, or other supports you need?
8. What are your preferred methods of receiving and reviewing information prior to our meetings (e.g., written, verbal/conversational etc.)
9. How can I recognize your contributions to this work?
10. Do you understand how you will be compensated for your work? Do you have any concerns about the compensation that you would like to discuss together in this meeting or privately at another time?

Appendix I. “What is Self-Compassion?” Handout

What is Self-Compassion?

Having compassion for ourselves is similar to having compassion for others. Let’s think about what compassion for others looks like:

- We first take notice that someone is suffering.
- We feel moved by that person’s suffering – we feel their pain.
- We experience feelings of warmth, caring, and a desire to help the suffering person.
- We realize that all people fail, make mistakes, or suffer sometimes.
- We extend kindness to that person who is suffering and do not judge them.

Self-compassion involves acting the same way towards yourself:

- You acknowledge that you are going through a hard time, feeling difficult emotions, or criticizing yourself.
- You feel moved by your own suffering, rather than pushing your feelings aside.
- You give yourself the warmth and caring that you need.
- You take steps to help yourself or make the situation better.
- You realize that all people fail, make mistakes, or suffer sometimes – you are not alone.
- You give yourself kindness and do not judge yourself.

“Instead of mercilessly judging and criticizing yourself for various inadequacies or shortcomings, self-compassion means you are kind and understanding when confronted with personal failings – after all, who ever said you were supposed to be perfect?” – Kristin Neff

The Three Components of Self-Compassion

#1 Mindfulness: Mindfulness is being aware of our experiences and emotions in a balanced, non-judgemental way. Mindfulness helps us acknowledge when we are in pain and work through our emotions rather than avoiding them.

Example: “This is a difficult time for me right now, I feel hurt and upset. But this feeling will pass, and I will be happy again soon.”

Over-Identification: Over-identification is the opposite of mindfulness. Over-identification means getting carried away by our negative thoughts and feelings.

Example: “I am so upset. I think I will always feel this way. How could things possibly get better?”

#2 Self-Kindness: Self-kindness means treating ourselves with the same kindness and care we show to friends and loved ones. Self-kindness can also mean talking to ourselves in a supportive way, giving ourselves unconditional acceptance, or taking action to do what is in our best interest.

Example: “Things didn’t work out the way I wished they would, but I am not a failure. This is just a setback. Tomorrow is a new day, and I am a strong, capable person.”

Self-Criticism: Self-criticism is the opposite of self-kindness. Self-criticism is negative self-talk, being discouraging to ourselves, and using harsh words when we think about ourselves.

Example: “Things didn’t work out today, and it’s all my fault. If I hadn’t been so lazy this would never have happened. I really need to get my act together.”

#3 Common Humanity: Common humanity means recognizing that we are human, and it’s natural to make mistakes, fail, or experience suffering. Although everyone faces different challenges in life, it is a human experience to go through hard times.

Example: “I feel so embarrassed, I can’t believe I did that. But I know that people do embarrassing things every day, it’s normal and part of being human.”

Isolation: Isolation is the opposite of common humanity. Isolation is the feeling that we are completely alone in our experiences, and that no one could possibly understand what we are going through.

Example: How could anyone understand what I am going through right now? I am completely alone. There’s no point in asking for help.

Misconceptions about Self-Compassion

Misconception #1: If I have compassion for myself, I will never achieve my goals. I need self-criticism to motivate me.

Response: Self-compassion is not complacency – having self-compassion does not mean we stop trying. People often feel they need to be hard on themselves if they want to succeed. But being motivated to avoid self-criticism isn’t a very strong source of motivation. When we know that self-criticism awaits us if we fail, we may just choose not to try in the first place. When we are self-compassionate, we create a safe space to make mistakes because we know we are human, and humans make mistakes.

Misconception #2: Self-compassion is just self-pity. If I have compassion for myself, I will let myself do whatever I want all the time.

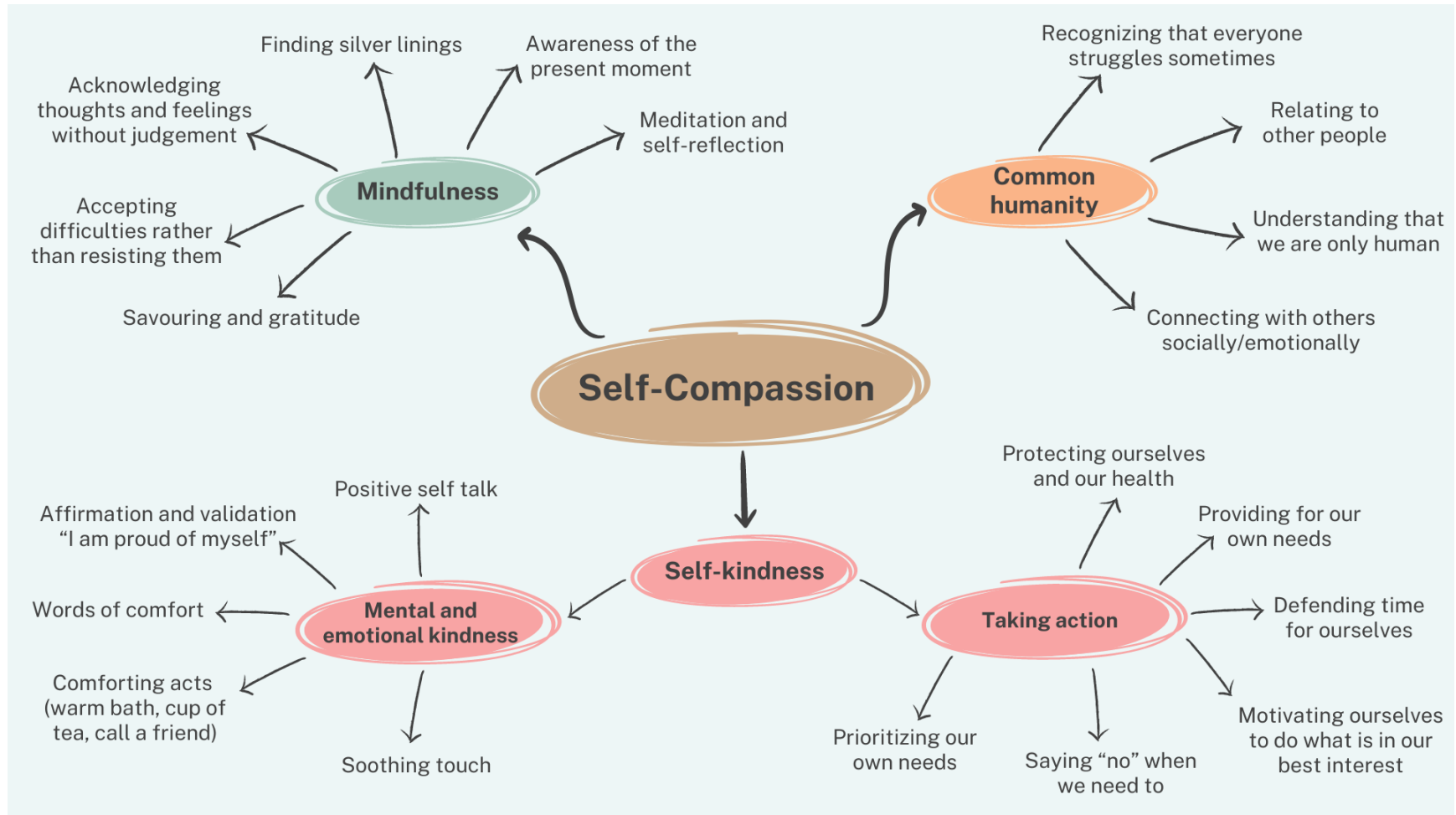
Response: Self-compassion is not self-pity or over-indulgence. Self-compassion is not returning home after a bad day and eating a pint of ice cream or watching tv all night. Instead, self-compassion wants to relieve our suffering without creating more suffering. It makes us more willing to accept, experience, and acknowledge our emotions which helps us move on. After a bad day, a self-compassionate person might reach out to a comforting friend, get a good night's sleep, or think about what they could do to improve the situation.

Misconception #3: Self-compassion is selfish. I should be thinking about others and not myself.

Response: Having compassion for ourselves is not selfish. When we are carried away by feelings of self-criticism or isolation, it becomes much harder to care for others. Caring for ourselves makes it easier to show up for the people we love.

The source for the material in this document is: <https://self-compassion.org/>

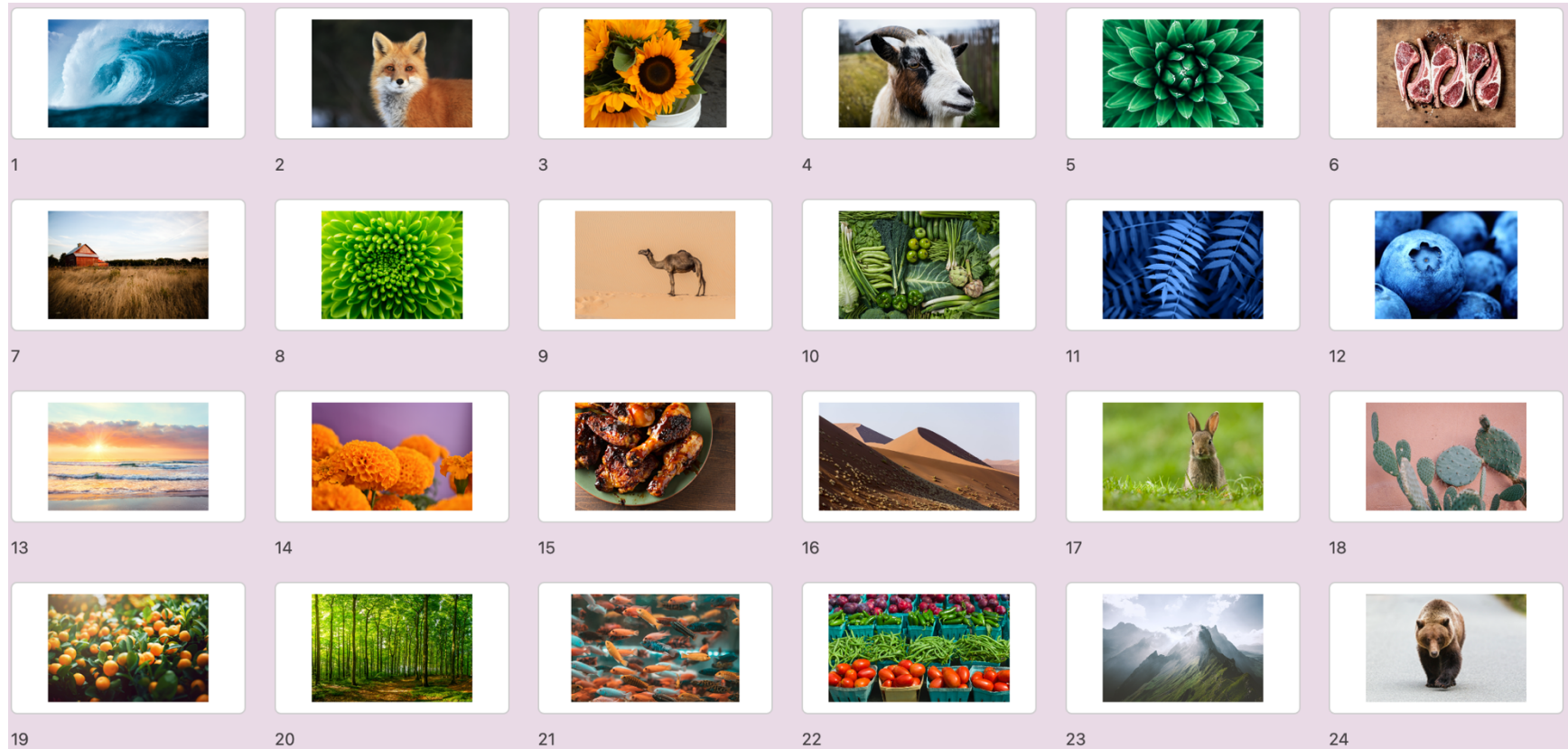
Appendix J. “Self- Compassion Cheat Sheet”



Appendix K. Instructions for Open Card Sorting

1. Read through all the cards once and jot notes about any patterns you notice in the quotations.
2. Read through the cards a second time, and as you do, place them into piles you think are similar using any criteria you find relevant.
 - a. Please create at least two piles, and try to sort each card into a pile (there should be no “miscellaneous” pile)
3. After making each pile, create a label card for it.
4. After you have created your piles, review them.
 - a. Should some piles be grouped together?
 - b. Should some be separated into more than one pile?
 - c. Does the name of the pile need to change?
5. After you are happy with each of your piles, paperclip them together. Sasha will arrange a plan to pick up the cards from you.

Appendix L. Card Deck of Images for Practice Sorting Activity



Appendix M. Fictional Quotations for Practice Card Sorting Activity

1. It's time to prioritize my own needs. And for me, that means getting active.
2. After years of taking care of other people, it was time to put my health first. I deserve it.
3. Getting more active is important for my health, and my health is important to me.
4. I said "no" to organizing the holiday party at work so I could have more free time to be active. That was an act of self-kindness.
5. At one point, I did feel a little alone – I was telling myself that no one would understand why I wanted to get active.
6. Negative self-talk was a big challenge for me.
7. When I didn't get my walking in, sometimes I felt discouraged, like I would never reach my goal.
8. I tried to replace my self-critical thoughts with kinder thoughts, like "you're getting stronger every day."
9. You need to be kind to yourself. Practice self-kindness every step of the way.
10. When I caught myself being self-critical, I would stop and try to say something nice to myself.
11. I realized that my friends and family love me, and they want me to be healthy and take care of myself. I need to feel that way about myself too.
12. I've never been one to have an exercise routine and I didn't know where to start. But I guess everyone starts off somewhere.
13. I gradually increased my walking. It was challenging at first, but I made slow and steady progress. Every bit counts.

14. You can achieve your goals at your own pace. The most important thing is to enjoy the process. Slow and steady.
15. I started with short walks around my neighborhood - just 15 minutes at a time. It's okay to start small.
16. I know lots of people who are trying to get more active. We are all in this together.
17. I was anxious about my health. But I realized that many people feel this way sometimes. This is common, I'm not alone in this.
18. Walking with friends also reminded me that I was not alone. A few of my friends had similar goals to be more active.
19. When I take time to notice the sounds of the birds, and the sun on my face, I enjoy my walks a lot more.
20. Exercise doesn't need to be so intense. It's nice to stop and smell the roses. That's what makes it enjoyable for me.
21. I've been paying attention to how I feel after my walks. I feel lighter and happier.
22. I was upset yesterday, and I didn't want to do anything. I tried to accept how I felt and work through it.
23. When I get discouraged, sometimes it's helpful to remember that these feelings are temporary. I will feel better soon, this will pass.

Appendix N. Link to Self-Compassion TEDx Talk by Kristin Neff

Self-Compassion TED Talk (6:23 to 12:17)

<https://www.youtube.com/watch?v=IvtZBUSplr4>

Appendix O. Link to Educational Research Methods Video

Qualitative Versus Quantitative Research

<https://www.youtube.com/watch?v=a-XtVF7Bofg>

Appendix P. Completed Terms of Reference Document

Supplemental Table 3

Completed Participant Co-Researcher Terms of Reference

Item #	Prompt	Co-Researcher Responses
1	Do you feel your role in the research project is clearly defined?	Yes
2	Are there any ways you think your role could be changed or expanded?	Uncertain. There could be opportunities to expand our roles once we begin working together if the need arises.
3	What are your expectations for being part of this research project?	• Fully participate as much as I can. • Working together as a team/group. • Meeting new people. • Learn what is expected of me and deliver it. • Asking questions. • Hopeful that the study will do good for the broader population. • Enjoying conversations, input, new knowledge. • Broadening understanding of human beings. • Supportive group.
4	What does making a “meaningful contribution” to the research mean / look like / feel like to you?	• Everyone has an opportunity to have a voice and have an opinion and express it. • Everyone has the opportunity to share if they want to. • Being able to see the results afterwards. • How will it benefit people in the future? • Being a part of knowledge sharing. • Seeing a change in myself, living example. • Be more vocal about challenges, verbalizing that I am being kind to myself. • Help people understand what self-compassion is and how to do it. Once we understand how to do it, we will do it more often. • Feel like I have contributed to changing the culture around using self-compassion. • If we talk about things more and make them normal to talk about, we get a snowball effect and the culture changes (mental health culture).

Supplemental Table 3 (continued).

5	What does a safe work environment mean to you?	• Physical, psychological, emotional, cultural, and spiritual safety. • Recognizing that all the above factors are important to safety. • Feeling comfortable enough to speak up if you are not feeling safe.
6	How will we respond if/when we disagree with the ideas of another co-researcher?	• Have a break or a time out to get a drink of water. • It's okay to agree to disagree. • Sometimes there is no one right answer, sometimes we must compromise. • Respectful of everyone's viewpoints and perspectives. • Discussion and being open to others' opinions. • Everyone is entitled to their own opinion. • Find a common ground.
7	How can I support you in contributing to the research?	• Snacks at in-person meetings! Food brings people together. • In-person meetings at a more central location (e.g., a library) • Sending information to review before meetings.
8	Would you like information to review before each meeting?	• Send information beforehand so we can come to meetings feeling prepared. Digital copies and PDFs are okay.
9	How can I recognize your contributions to this work?	• Any way you want to acknowledge us is acceptable. We can discuss more at the conclusion of the project.

Appendix R. Clusters of Excerpts Produced in the Network Analysis

Supplemental Table 4

Full List of Excerpts and Groups Produced During PTE Step 4: Data Grouping

Excerpt ID	Excerpt Text	Excerpt Info
Group 1		
Q1	That was a pathetic failure. There's no point setting [a goal] up because you're not gonna follow through anyways, and stuff like that. So yeah, that's probably gonna be one of my biggest areas to work on.	AM, Age 55, Group 2, Session 1
Q15	I've also realized that I really hate exercise. Exercise- absolutely that absolutely sucks. And I have never liked exercise. Exercise is a 4-letter word in my life. But I've learned that the idea of physical activity isn't quite so abhorrent.	EB, age 74, Group 2, Session 2
Q16	I let this happen. I let this drift...And essentially, I have a feeling of responsibility that it was I who didn't have that self-caring... I didn't engage in more health promoting behaviors because I didn't take care of myself. I didn't self-activate I guess. And so, I wasn't proactive in correcting it. You know, because in the moment I just placed my priorities differently. And it became a trend. And that's just what happened.	EB, age 74, Group 2, Session 2
Q24	I hit that certain weight, and I cannot get past it. And it's still not a healthy weight where I hit. So, I think that's where I start thinking, why even bother because you know you're gonna get stuck there. And how could I possibly get past it? Because nothing I've tried has worked before. Right? So, then that's where I get annoyed with myself, because then I'm like trying to reframe it in a form that's more compassionate and kind to myself. But I'm not there. I'm just annoyed with myself.	BA, age 46, Group 5, Session 2
Q28	I'm usually really, really, quite hard on myself. So, nothing's changed. I'm still hard on myself. It's not gonna change in a week.	AM, Age 55, Group 2, Session 2
Q29	I'm cutting myself a lot of slack that way and I'm really not being honest about it when I think of how I let [my health] go. I mean, I could have stopped this years ago. I could have changed my behaviour years ago. But I didn't because nothing was wrong. You know, I wasn't paying any penalties yet, it was quiet, silent.	EB, age 74, Group 2, Session 2

Supplemental Table 4 (continued).

Q3	I have to have a really seamless [exercise] plan or else the anxiety just overwhelms me. And it becomes debilitating, and that frustrates me. And now that I'm to the point where I'm pre-diabetic. I'm just disappointed in myself. But again, it's all that hamster wheel of anxiety. So, for me, that's gonna be a big hurdle with this to get into a comfortable routine that I'm okay with. And I also understand that I might have days where it just is too much and I can't do it. And I just have to be okay with that.	AC, Age 52, Group 5, Session 1
Q42	I caught myself being self-critical... when I was debating whether I should get up off the couch to go walk to the store... And I was like, you're acting like a child, right? Like that's exactly what it was. So, I caught the self-critical part. And then I was like, 'okay, I'm supposed to say it somehow differently right now so that it makes me get off the couch or gives me permission to work through this and get on with it...' And it'll just take practice in my head to turn it around.	BA, age 46, Group 5, Session 3
Q43	That really hit home when you mentioned denial, which is a form of resistance. Case to point... I'm in denial that something bad will happen. I mean, there's a point of reckoning when you kind of say... 'oh, I only need 15 to 20 years.' And my doctor said, 'I don't think you have that'. And that was the first time a doctor had ever said anything like that to me. And so, it's the denial which is really dangerous.	EB, age 74, Group 2, Session 4
Q48	I think, when you're in the middle of feeling bad about something... your thoughts don't naturally go to, oh, 'this too shall pass'. And I don't know about everyone, but my tendency would be to wallow in it. And if I were gonna make something good out of it, I'd have to sort of remind myself to say, well, 'remember this, remember this, because when things are better, then you'll know what the difference between sad and happy is.'	EB, age 74, Group 2, Session 5
Q5	I used to be very active and slowly through the years I joined gyms, and I was committed, I joined the learn to run through the running room and I was running a few times a week. And then I just got- life, you know. I made different priorities. My daughter was my priority, and my husband was my priority, and I was not a priority. So, I kind of just went to the back burner.	RA, Age 55, Group 5, Session 1
Q59	After a while, you don't even want to try anymore, because you figure you're so far off from getting there that there's no point.	AM, Age 55, Group 2, Session 6

Supplemental Table 4 (continued).

Q61	I don't know. I think because we're so used to thinking about our flaws. It's really hard to think about what we're good at, and I might say that I want to be kind or thoughtful, or that I try to be kind or thoughtful. But then the moments that I've not succeeded bubble to the top, right? So, I think it's just really hard to think of those things as your own personal traits.	NJ, age 53, Group 5, Session 6
Q7	The one thing that bothers me about self-compassion is really, where do I draw the line between helping the rest of the world and making time for myself? Because I value the fact that I can help the world so to speak, and I'm from a helping profession. I'm from a family culture too where I just grew up watching my grandparents help people, and my mother is like that. So now, as an adult I'm beginning to realize that it's wearing me thin. I struggle with saying no to a good cause and making time for me.	BD, age 55, Group 2, Session 1
Q9	I like the idea of compassion, whether it's for self or others. But It's the strategy that I may be a little concerned about. Because one of my self-compassion strategies is to really just enjoy some ice cream. I really do love ice cream for the sake of enjoying it. And perhaps it's part of the culture I grew up in, but as a general rule I don't know that I'm really hard on myself. If anything, I am a bit too nonchalant about life.	BD, age 55, Group 2, Session 1
Group 2		
Q2	But for everyone that doesn't do their goal, I think we just have to forgive ourselves and think tomorrow is a new day and we're gonna start over. And I think about that when I don't eat well or when I'm a lump on the couch. So, I just try to forgive myself and say tomorrow is a new start and move forward.	AC, Age 52, Group 5, Session 1
Q20	Cause before, this would have been like an all or nothing thinking where like, forget it, this is it. It's not gonna work out. Forget it, it's over, like I've tried so many times before and this is just not gonna work. Whereas this time around I've learned that it's not an all or nothing. It's kind of like, okay this is just a roadblock, and it'll pass. We'll get over it, and we'll get back on track again.	AM, Age 55, Group 2, Session 2
Q32	A really good way to be mindful is with my animals. And part of what I really enjoy about having them is watching them interact with whatever they're doing. And you know, walking the dog and watching her enjoy her walk is more fun for me than me enjoying my walk.	BA, age 46, Group 5, Session 3

Supplemental Table 4 (continued).

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| Q35 | At work I have a chaotic environment and it's very hard to focus on what I have to do, never mind trying to clear my mind. But again, getting back to nature, and trying to appreciate the moment and appreciate the things that we have in life. At least as, you know, as much as I can bring them into my awareness rather than always focusing on that busy mind that's rattling around in there. | NJ, age 53,
Group 5,
Session 3 |
| Q40 | I had to use some of my self-compassion today, because yesterday and today there was nothing there. It was just work and exhaustion. So, tomorrow's another day. And that's okay. We've had a great week, and I feel pretty good about how the week went, and I'm looking forward to the coming week. And really, I'm actually kind of surprised at how quickly I'm starting to feel better. I'm starting to more connect with that person I used to be that was active. So that's kind of nice. | NJ, age 53,
Group 5,
Session 3 |
| Q41 | I noticed that [the meditation] reminded me of when... I used that on my son when he would have temper tantrums. I'd say breathe in with the good, out with the bad and we would do that breathing. That's what I kept thinking was in with the good, out with the bad, throughout that whole thing. | PT, age 45,
Group 2,
Session 3 |
| Q46 | Sorry if I get emotional. I was laid off last week. And it was a really, really, rough week, and it still is. But it certainly helped a lot to kind of keep things in focus and keep things centered. I think in the past something like this would have been really catastrophic to my health, like, in terms of, I'm gonna go eat and I'm gonna go to domino's or whatever. And so, I think it really helped to keep me a little more focused, and a little more present. And while I didn't do all my exercise perfectly, or whatever, I think it was very, very lifesaving in the fact that I was able to just take some time for myself, and not judge myself, and use some of the other tools that we've been learning. | KJ, age 49,
Group 5,
Session 4 |
| Q47 | There will be a later, there will be an after, there will be a 'post'. It doesn't have to be like this forever, even though it's like this now. And if you're gonna be living life, you wanna live it fully. So being here and now is important. Doesn't matter where. It might not be fun. But it's kind of important. | EB, age 74,
Group 2,
Session 5 |
| Q49 | I felt like I had a big week of brain work for this program, among other things. But this week was a big week of sitting with the feelings and the thoughts, and looking for those places of resistance, and actually realizing a lot of big, deep stuff. So that's where my growth was this week, was in that. | NJ, age 53,
Group 5,
Session 5 |

- | | | |
|-----|---|---------------------------------------|
| Q52 | One of the things I was doing 3 times this week is planking. I have never done planking and I was planking between 37 seconds and 54 seconds. And during that time, I heard [the facilitator's] voice in my head because I was resisting doing it and I really didn't want to do it. But with that I was able to stop myself and just breathe, and concentrate on what I was doing, and that made the time go faster. | MC, age not given, Group 5, Session 5 |
| Q53 | I find just the worst one for me is being tired after work. I'm just not wanting to do anything. And the best way I found to overcome that is to recognize it as a form of resistance, and just say, well, I'm just resisting doing it- just go do it, and I'll be okay. So, I found that's been good for a lot of the time. But I've also realized that some nights I just really am too tired and I'm just not gonna do it. So that has to be okay sometimes. | NJ, age 53, Group 5, Session 6 |
| Q63 | If I take two steps forward it's allowing myself that one step backwards. And then recognizing that eventually, as long as the trend is there, it's like the stock market. It's not a straight line, and that's what I tell myself. Not a straight line. | EB, age 74, Group 2, Session 6 |
| Q66 | But also, the whole applying the mindfulness to the different emotions, and the soften, soothe, and allow. Because I really do find myself getting stuck in those circles, and I think that that [soften, soothe, allow] helps me push myself out of it to be able to get past it and to move on. And even where you feel [the emotion] in your body too, like that's something that I never thought of before this. But to be able to release it from your body after you've identified it helps to. | BA, age 46, Group 5, Session 7 |
| Q67 | Somebody once told me if you don't meet your goal, you just kind of keep going. Make a U turn and keep going like, just keep moving forward. | EL, age 55, Group 5, Session 7 |
| Q71 | This is a marathon, not a sprint. Every move is an improvement. Small steps are still steps forward. | EL, age 55, Group 5, Session 7 |
| Q73 | I think the silver lining is just realizing that you have to be really careful with lifestyle and food choices and realizing that exercise is really important rather than just putting it on the back burner all the time. Or saying, I'll do it tomorrow, or making excuses, like my family never exercised. Or not having an exercising family and having to be the person that spearheads it and says, okay, they haven't exercised, but we have to. | AM, Age 55, Group 2, Session 7 |

Supplemental Table 4 (continued).

Group 3		
Q10	I don't want to get sick. And I want to be healthy in the coming years. And it's a reality that I need to change.	EL, age 55, Group 5, Session 1
Q12	I always knew it [diabetes] was a potential risk. But then being told that, yeah, you are at risk seems a little bit more concrete. So, I'm a little bit more worried about it. But now that I know that it's something I need to deal with I can actually buckle down and deal with it.	FJ, Age 48, Group 2, Session 1
Q14	I'm moving, I'm weightlifting, I'm doing sit-ups, I'm doing leg lifts. And I'm making an effort. I'm making a conscious effort to like plow through it even when I'm tired and I don't feel like doing it. So, it's a work in progress. It's not what I wanted, but with that I accepted I will get to where I want to be or what I want eventually. But right now, I will take what I can get.	MC, age not given, Group 5, Session 2
Q26	So, eating's been kind of thrown out the window, and exercise has been kind of like an after-thought. So, everything's been kind of messed up. And I'm trying to not be so hard on myself because I'm like, okay, there's some other things that are important in life. But at the same time, you know, don't just throw everything out the window and still try to take care of some stuff. Otherwise, then everything's gonna be negative.	AM, Age 55, Group 2, Session 2
Q27	I've actually had a really good week. I've been really busy and really active for a lot of the week. So that's been nice. But realising that I either need to figure out how to get more support from my husband or to decide that I just don't need that support and just do it myself.	NJ, age 53, Group 5, Session 2
Q31	Anyways, some of the things that I had wrote down is, no one is going to rescue you. Like not some hot trainer that's gonna make me do what I need to do. Like no one is gonna rescue me. And I just again think tomorrow is a new day and I'll give it my best.	AC, Age 52, Group 5, Session 2
Q36	Previously if I said 'oh, I'm going to walk and do 20 minutes of walking', if I didn't do it, I would be very quick to be negative with myself. And this time around I recognized when I was tired and just needed to nap or lay down... And so, on June 4th I was really tired. I needed to have a nap which is not something I typically will allow myself to do. I did, and then I felt so good afterwards that I did have my activity for that night.	MK, age 56, Group 2, Session 3

Supplemental Table 4 (continued).

Q38	Just basically, I'm taking more time for myself now. A little bit like with such a crazy week that I had, I made time to- you know, I've watched a show on my phone. You know, just making more time for myself, making it a conscious effort to think about myself more.	RA, Age 55, Group 5, Session 3
Q39	One of the things I put down was if I'm tired and I just don't feel like I can manage and go do that, I'm gonna do some yoga instead. So, it's still moving, but not quite the same way.	EL, age 55, Group 5, Session 3
Q4	I remember a colleague of mine was just saying, some of what we do must be because we are women, and we think we must save the world. And she mentioned that the men would not do it... And I find it's the same with my husband. He knows how to be incisive and just say no. I just still feel the burden to save the world. So, I'm slowly moving away from that.	BD, age 55, Group 2, Session 1
Q45	For my plan, I didn't always do what was written down to do- I'm not going to say 'supposed' to do. And on those days, I did 20 min of stretching or a half an hour of stretching rather than and doing a cardio or weights. So, I always ended up doing something. Just not what I actually had planned. So, I guess that was okay.	MC, age not given, Group 5, Session 4
Q50	I had a meeting that ran late, and I knew I had a meeting coming up early and I was like, 'I don't think I should do my 20-minute walk in the half hour that I have for lunch, because I'm not gonna have enough time'. And before I got myself to the kitchen, I'm like, 'screw it- I'm just gonna go'. But after the walk I felt so much better. I came home. I made my lunch, and then I sat and just listened to the meeting. So, it actually worked out. And I felt a lot better after actually doing it.	FJ, Age 48, Group 2, Session 5
Q54	Before, years ago, I would have never thought if you do a little bit, it's better than nothing. My mind was, well, if I can't do the full hour of cardio there's no point trying anything cause it's not gonna help or it's not gonna work. And so now when it's like, if you do even 10 minutes a couple of times a day then it's better than not doing anything. Now it's like I've learnt to be at least a little bit gentler.	AM, Age 55, Group 2, Session 6

Supplemental Table 4 (continued).

Q55	I convinced myself and gave myself a pep talk to get on the bike and go. So I went, and by the time I finally went then I felt better. But then I think, 'well, it's about time, the night's almost over and now you finally went'. And then I'm like, okay, you're still negative talking while you're biking. It was like playing all day with my mind. And it's kinda like I think I'm going nuts with this. But I did it.	AM, Age 55, Group 2, Session 6
Q56	One of my strategies was to relate the [physical] activity to blood sugar and blood pressure. And so that worked well for me because it took it out of being active for the sake of being active, and it gave me a really important reason to do it. So, I found that helped.	NJ, age 53, Group 5, Session 6
Q62	This week I actually scheduled myself on our family calendar in the kitchen. And I basically told my family do not bother me between this hour and this hour, I'm doing my workout.	BA, age 46, Group 5, Session 6
Q64	I'm only human after all. And tomorrow I'm going to kick ass	RD, age 62, Group 5, Session 7
Q69	One of the big silver linings was the reality check and the need to embrace self-compassion and self-care. And plus, the news of being at risk for diabetes, it really prompted that move to get checked. I made several doctor's appointments in the past month and have a requisition now for the blood work and the glucose test and all the other stuff that's gotta get tested. Because now I really wanna know. There's no room for denialism anymore. I want to know. So, I see that as a big silver lining for myself.	MK, age 56, Group 2, Session 7
Q74	And you can do anything for 15 minutes. Just breaking it down even further, like, I used to think I had to do 5 times 30 minutes every week, and that just seems like a lot. But doing 15 min at a time doesn't seem unachievable.	FJ, Age 48, Group 2, Session 7
Q8	So, just kind of like whatever I could do. The other day I was just dancing while I was making dinner and doing arm circles. And I had stretching as counting as one of [my exercises] because I really feel like stretching is becoming very important.	NJ, age 53, Group 5, Session 1
Group 4		
Q11	This is all part of the road to success. It's not all real successes. Sometimes it's filled with things that are not quite as we would have envisioned them. But they're all part of the road to success.	EB, age 74, Group 2, Session 1

Supplemental Table 4 (continued).

Q13	The common humanity of the situation is that, well, I see a lot of people in my situation. Although, I don't feel compelled to talk to them about it. Like we don't get together and talk about it. I don't like to talk about weight loss.	EB, age 74, Group 2, Session 2
Q17	I think talking about how you feel is really important. Because I know for me when I was out there doing things this week, I felt really good about myself. And I felt good about how I was feeling. And I was acknowledging that I'm thinking about that and using it as motivation for the next time.	NJ, age 53, Group 2, Session 2
Q18	I've gotta get my words of kindness in. I'm here and I'm proud of myself for being here. And I'm proud of myself for actually doing the stuff between the meetings. And I have to start with the present and move forward. And I use this thing that you told us, what would I say to someone else: 'you've gotta start with the present and move forward', and it's all true.	EB, age 74, Group 2, Session 2
Q19	I'm sure that I am not the only person who has a struggle. Then you start thinking, if I was judging myself, I would say I was being lazy and noncommittal. But then, if I would tell a friend or someone else - I would tell them, 'I'm sorry you're feeling this way, sometimes when you start, you'll feel better. You're not lazy, you're just not there yet'. And then it felt good not to think so negatively.	EL, age 55, Group 5, Session 2
Q21	Like my inner critic. I wrote down like, 'you're lazy, why can't you commit? You're just making excuses not to be active'. And then my self-compassion answers were, 'You're really busy right now. You're definitely not lazy. You'll get there. And I believe in you'.	EL, age 55, Group 5, Session 2
Q22	I actually ended up writing, 'I believe in you'. So that kind of resonates with me to keep saying that to myself.	EL, age 55, Group 5, Session 2
Q23	Some days are really good and other days, they didn't work out. And that's all right. And you know what, it doesn't change. There's always going to be days that don't work out, and the key is just not beating ourselves up for it and picking up and trying again the next day, trying again when we can. That's something I learnt this time around.	AM, Age 55, Group 2, Session 2

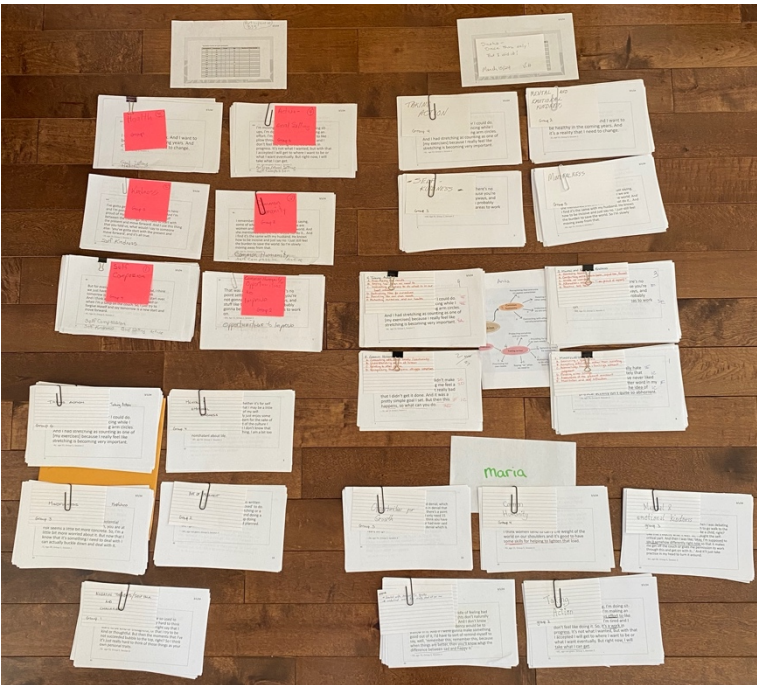
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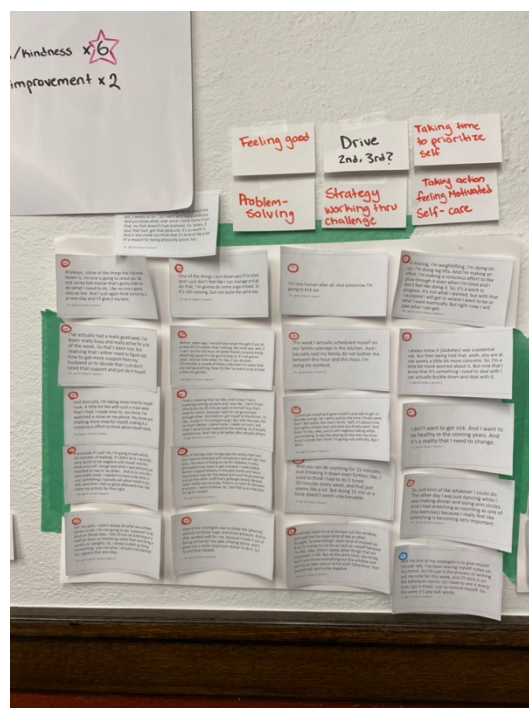
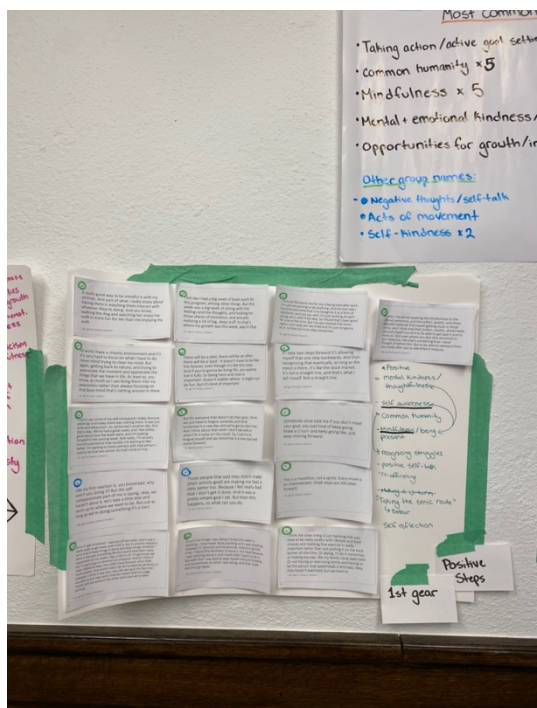
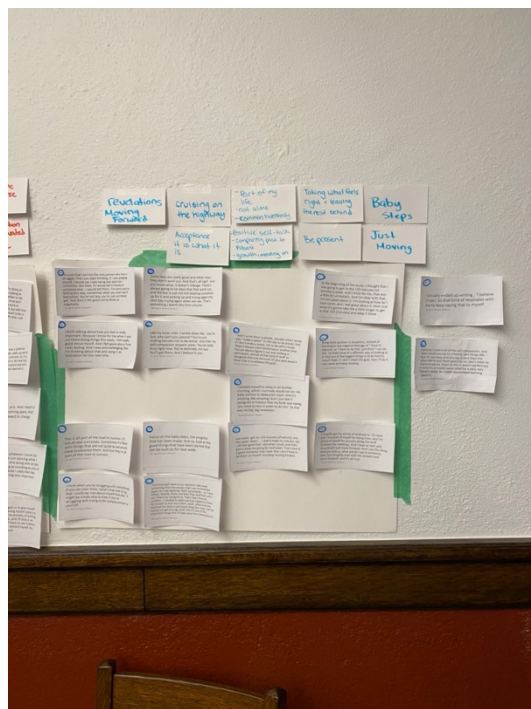
Q25	I think when you're struggling with something if you can even think, 'what's that one thing that I could say nice about myself that day'. It might be a baby step to help if you're struggling with trying to be compassionate to yourself.	NJ, age 53, Group 5, Session 2
Q30	Focus on the baby steps, the progress that has been made. And so, look at the good things that have been started that can be built on for next week.	NJ, age 53, Group 5, Session 2
Q33	I allowed myself to sleep in on Sunday morning, which I normally would not do- my body wanted to sleep a bit more. And it's amazing, like amazing! And I just didn't recognize or honour that my body was saying, 'you need to rest in order to do this'. So that was my big, big revelation.	MK, age 56, Group 2, Session 3
Q34	Like my first reaction is, you bonehead, why aren't you doing it? But the self-compassionate part of me is saying, okay, we haven't done it, let's take a little step and work up to where we want to be. But just as long as we're doing something it's a start.	MC, age not given, Group 5, Session 3
Q37	I didn't write down a phrase, actually, what I wrote was, "make a space" [in the day to be active]. And if I don't make a space, not to be self-[critical]. There's always room tomorrow or another time. You can always figure it out and nothing is permanent, and all of that kind of stuff, to recognize that one omission of your goal doesn't mean that it invalidates the goal.	EB, age 74, Group 2, Session 3
Q44	Certainly, I used a lot of the self-compassion, and 'what would you say to a friend', and things like that. It's not easy, and you say it, and then the other half of your brain goes no, no, don't listen to that kind advice, listen to me. It wasn't perfect but it certainly provided some relief for a very, very stressful week. So, I really appreciated learning about it.	KJ, age 49, Group 5, Session 4
Q51	One of my strategies is to give myself my pep talk. I've been leaving myself notes on my mirror. So, I'm just in the process of writing out my note for this week, and I'll stick it on the bathroom mirror, so I have to see it every time I go in there. Just to remind myself. So, this week it's pep talk words.	FJ, Age 48, Group 2, Session 5

Supplemental Table 4 (continued).

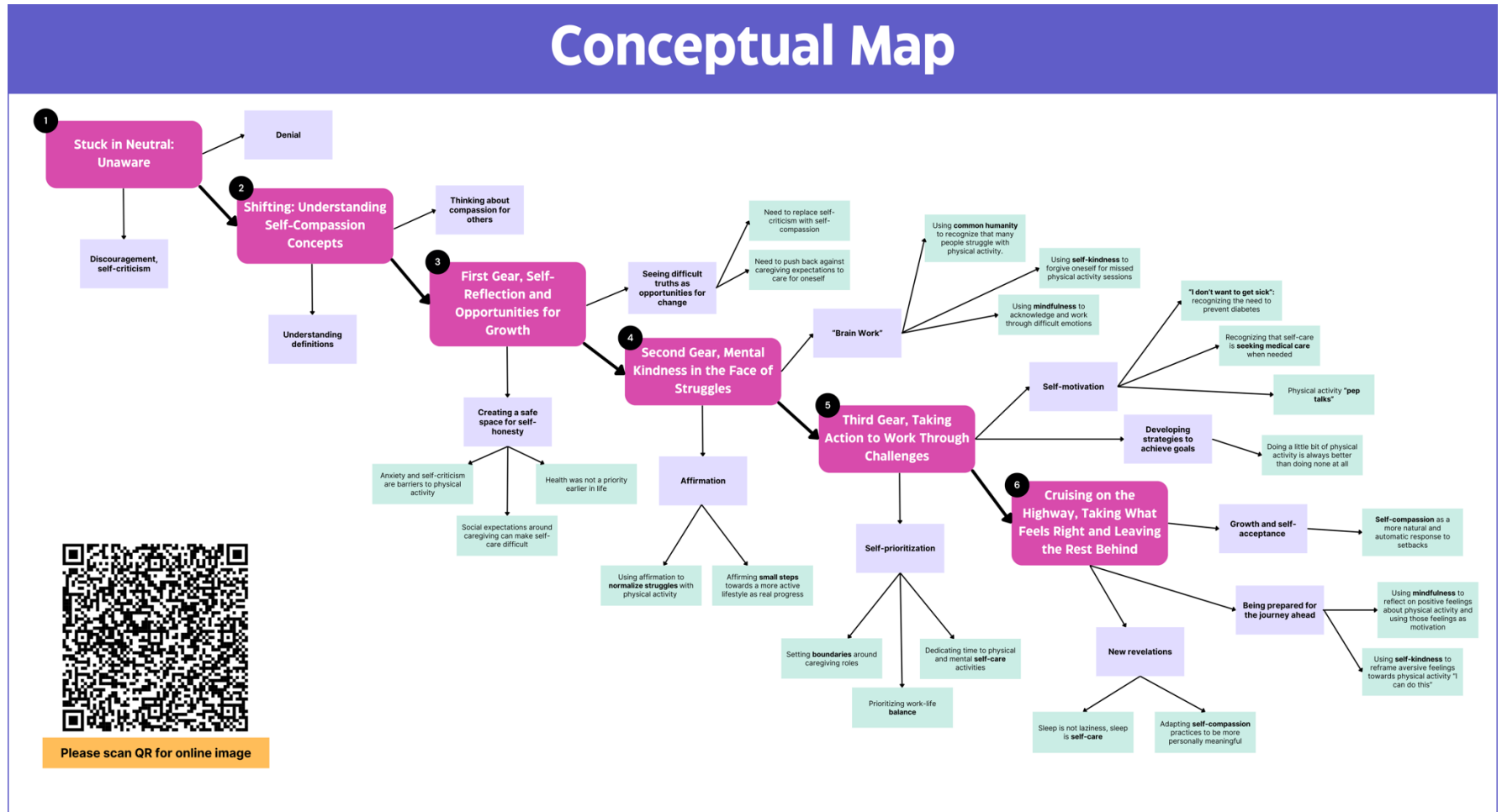
Q57	I find that each week in our sessions I take away something from the session that I can immediately apply. So, I was applying 'SSAP' persistently... so it was: Soften, Soothe, Allow, and then Pray. And that's who I am. That's my background. That's how I find my comfort... I needed to add a spiritual support in there for myself, so that was soften, sooth, allow and pray. And that has been a persistent thing like I said, that has helped me get through stuff. And it's one of the important things that I'll take away from these sessions.	MK, age 56, Group 2, Session 6
Q58	I think women tend to carry the weight of the world on our shoulders and it's good to have some skills for helping to lighten that load.	NJ, age 53, Group 5, Session 6
Q6	Those people that said they didn't make [their activity goal] are making me feel a little better too. Because I felt really bad that I didn't get it done. And it was a pretty simple goal I set. But then this happens, so what can you do.	NJ, age 53, Group 5, Session 1
Q65	Last week I got my 150 minutes [of activity], and this week I didn't.... I didn't make my minutes, but I still feel good that I did what I could, and that's gonna keep me going for next week. That's kind of a good revelation that I had- that I don't have to be down on myself. Just keep moving forward.	NJ, age 53, Group 5, Session 7
Q68	My foot has been really hurting me for about the last 3 weeks or so... So, I went and had a pedicure. And you know what, ever since I came home from that, my foot doesn't hurt anymore. So, ladies, if your feet hurt, get that pedicure, it's so worth it. And it also made me think that it's kind of like a bit of a reward for being physically active, too.	NJ, age 53, Group 5, Session 7
Q70	Being more positive in situations, instead of focusing on the negative feelings of 'I have to exercise', or 'I have to do this', just think 'I can do this'. So that's kind of a different way of looking at it. And one of the biggest things is to be kind to myself. Yeah, if I don't meet the goal, then I'll do it next week and keep moving.	EL, age 55, Group 5, Session 7
Q72	At the beginning of the study, I thought that I was going to get to the 150 minutes [of activity] a week. And I think for me, that was a little bit unrealistic. And I'm okay with that, I'm not upset about it. I'm looking at how far I have come, and I feel great about it. And I just know it's gonna take me a little longer to get to that 150 [minutes] and keep it there.	NJ, age 53, Group 5, Session 7

Appendix S. Photos from Data Analysis and Interpretation Meeting





Appendix T. Conceptual Map of Themes and Associated Meanings



Appendix U. Lead Researcher Responses to the Public and Patient Engagement Evaluation Tool (PPEET) Project Questionnaire

Patient and Public Engagement Evaluation Tool (PPEET) Version 2.0

Project Questionnaire (Abelson et al., 2015)

Guidance for organizations administering this questionnaire

The purpose of the project questionnaire is to review and assess the planning, execution, and impact of public and patient engagement component of specific projects that are being carried out within your organization (e.g., quality improvement, planning and design, etc.). The tool has been split into three distinct modules:

- Module A. Planning the engagement component of your project
- Module B. Assessing the engagement component of your project
- Module C. Assessing the impact of the engagement component of your project

To fully evaluate the engagement component of the project, each of the three modules should be used.

While the questionnaire serves as an evaluation tool, it can also be used to assist with the planning of evaluation activities, acting as a type of checklist to follow as you design your activities to confirm you're considering the key components of evaluation in your work.

Who should complete this questionnaire?

The individuals in the organization who have requested or sponsored the engagement component of the project or those responsible for its planning and execution should complete the questionnaire.

In organizations where there is an engagement team it may be that different people need to complete each section.

The questionnaire can also serve as a guide for a debriefing conversation with staff. You may want to use the tool as an interview guide and complete the questions together.

When should the questionnaires be administered?

- Module A is designed to help ensure you're on the right track with your engagement. This should be completed during the planning and implementation processes and serves as a type of checklist so you can be sure that you're fully considering important components of successful engagement.

- Module B should be completed immediately following the engagement component of your project. This module is designed to help you review the engagement that has just taken place to understand what worked well, and what could be improved for future engagements.
- Module C should be completed 3 – 6 months after the engagement component of your project is complete. The purpose of this module is to assess the impact of your engagement work. We suggest waiting 3 – 6 months to complete this module so you have time to see the impacts of your engagement, as these may not be immediate.

How do we need to personalize the questionnaire before beginning?

- Find all instances of [insert name of engagement initiative] in the questionnaire and replace this text with the title of the work you're evaluating.

Module A. Planning the Engagement Component of Your Project

We are interested in your feedback about the planning of the engagement component associated with the MOVE IT 2 Study.

This is the first of three modules to evaluate the engagement component of your project. Two additional modules should be completed following the completion of the project. This module is designed to help ensure you're on the right track and should be completed during the planning and implementation process; it can serve as a planning checklist so you can feel confident that you're considering the key elements of successful engagement.

The questionnaire includes 15 questions – some questions ask you to rate your level of agreement in response to a statement and others ask for you to provide your comments and feedback. You are encouraged to share your experiences and any information you feel is relevant. Remember, this is a tool to help improve your engagement work. Identifying challenges is an important part of that process.

Background Information

1. Please describe your role in the engagement component associated with this project (e.g., project lead, engagement lead, etc.)

Master of Arts student in the Faculty of Kinesiology and Recreation Management at the University of Manitoba. For this project, I was the project lead (thesis project), and engagement lead.

2. Please specify who is most directly affected by the outputs of this project (e.g., patients with arthritis, youth with mental health problems, residents of a particular neighbourhood, etc.)

The purpose of this research is to better understand how, if at all, adults with pre-diabetes in a self-compassion and physical activity behaviour change intervention used self-compassion to cope with their health risks and improve their physical activity or any other health behaviours.

The findings of this study may be shared with community organizations to create “buy in” for adopting this self-compassion intervention. If adopted, the intervention may help adults with pre-diabetes to learn about self-compassion and ultimately improve their health.

Part A. Integrity of Design and Process

3. The engagement plan for the project includes a clear statement of the objectives for the engagement.

- Strongly disagree
- Disagree
- Neither agree nor disagree
- Agree
- **Strongly agree**

4. The engagement plan has a clear strategy to recruit those most affected by the outputs of this project (e.g., relevant lived experience, socio-demographic or geographic communities).

- Strongly disagree
- Disagree
- Neither agree nor disagree
- Agree
- **Strongly agree**

5. The engagement plan has a clear strategy to engage individuals and groups who will adequately reflect the perspectives of those who will be most affected by the outputs of this project.

- Strongly disagree
- Disagree
- Neither agree nor disagree
- Agree
- **Strongly agree**

6. The engagement plan provides clear documentation of how the financial, logistical, and information needs of participants (e.g., travel, dietary, interpretive, childcare) will be accommodated.

- Strongly disagree
- Disagree
- Neither agree nor disagree
- **Agree**
- Strongly agree

7. The engagement plan includes a clear statement about how the outputs generated from the engagement will be shared with participants.

- Strongly disagree
- Disagree
- Neither agree nor disagree
- **Agree**
- Strongly agree

8. The engagement plan has clearly described strategies for communicating with participants.

Strongly disagree

Disagree

Neither agree nor disagree

Agree

Strongly agree

9. Plans are in place for how the PPE input will be used in the organization.

- Strongly disagree
- Disagree
- **Neither agree nor disagree** – *to be decided in collaboration with co-researchers*
- Agree
- Strongly agree

10. A clearly described process for communicating with participants about how PPE input will be used is in place.

- Strongly disagree
- Disagree
- Neither agree nor disagree
- **Agree**
- Strongly agree

Part B. Collaboration, Common Purpose, and Partnerships

11. Do you plan to work with other organizations as part of the engagement component of this project?

- Yes → Please list the organizations you plan to work with:
- **No → Skip to part C (Q14)**

Part C. Final Reflections

14. Overall, I am satisfied with the planning phase of the engagement component.

Strongly disagree

Disagree

Neither agree nor disagree

Agree

Strongly agree

15. I feel confident in my abilities to plan and execute the engagement activities associated with this project.

Strongly disagree

Disagree

Neither agree nor disagree

Agree

Strongly agree

Module B. Assessing the Engagement Component of Your Project

We are interested in your feedback about the public and patient engagement (PPE) component of the MOVE IT 2 Study.

This is the second of three modules to evaluate this PPE component. This module should be completed immediately following the completion of the engagement component of your project. It is designed to help you review the PPE component that has just taken place to understand what worked well, and what could be improved. If your PPE component is a reoccurring activity (e.g., an advisory council) you may wish to consider completing this module on a more regular basis, for example after each meeting. The final module (Module C) should be completed in 3 – 6 months to review the impact of the engagement associated with this project.

The questionnaire includes 16 questions – some questions ask you to rate your level of agreement in response to a statement and others ask for you to provide your comments and feedback. You are encouraged to share your experiences and any information you feel is relevant. Remember, this is a tool to help improve your PPE work. Identifying challenges is an important part of that process.

Part A. Integrity of Design and Process

1. The perspectives of those who will be most affected by the outputs of this project were reflected through those who participated in the engagement.

- Strongly disagree
- Disagree
- Neither agree nor disagree
- Agree
- **Strongly agree**

2. The financial, logistical and information needs of participants (e.g., travel, dietary, interpretive, childcare, etc.) were accommodated.

- Strongly disagree
- Disagree
- Neither agree nor disagree
- Agree
- **Strongly agree**

3. Adequate time was allocated to plan and implement the engagement component.

- Strongly disagree
- Disagree
- Neither agree nor disagree
- Agree
- **Strongly agree**

4. The goals for the engagement component were shared with participants.

- Strongly disagree
- Disagree
- Neither agree nor disagree

- Agree
- **Strongly agree**

5. Participants were told how the input from the engagement component would be used by the organization.

- Strongly disagree
- Disagree
- Neither agree nor disagree
- Agree
- **Strongly agree**

Part B. Influence and Impact

6. Was a summary report of the engagement component of the project prepared?

- **Yes**
- No → Skip to part C (10)

7. Who was the report shared with? (Please select all that apply)

- **Individuals who participated in the engagement activity**
- Management within your organization
- Board members
- Partners
- **Others, please specify:** *thesis advisor and committee members, researchers and students at the Faculty of Kinesiology and Recreation Management Research Day*

8. Please select from the following list how the engagement input was shared with relevant individuals and/or groups within or outside the organization.

- **Written reports were made available to interested individuals**
- **Presentations, briefings to individuals or groups**
- **Informal communications strategies (e.g., emails, phone conversations)**
- Other strategies were used. Please describe these below:

Part C. Collaboration, Common Purpose and Partnerships

9. We worked with other organizations as part of the engagement component of this activity.

- **No → Skip to Part D (Q13)**
- Yes → Please list the organizations you worked with below.

Part D. Final Reflections

12. Overall, I was satisfied with the engagement component of this project.

- Strongly disagree
- Disagree
- Neither agree nor disagree
- Agree
- **Strongly agree**

13. The engagement component added value to the project it supported.

- Strongly disagree

- Disagree
- Neither agree nor disagree
- Agree
- **Strongly agree**

14. As a result of my involvement in the engagement component associated with this project, I will be comfortable leading future engagement activities.

- Strongly disagree
- Disagree
- Neither agree nor disagree
- Agree
- **Strongly agree**

15. I would like to participate in PPE training to build my capacity to do more of this work.

- No
- **Yes → what PPE-related skills would you be interested in developing?**
 - Learning how to access established patient partner networks to recruit from a more diverse sample.
 - Learning how to recruit directly from the community (e.g., advertising online, advertising through community centres).
 - Learning how to engage patients from the outset of a project so they define its direction and lead the project through its entirety.
 - Learning about funding sources I can access to compensate patient partners.

Module C. Assessing the Impact of the Engagement Component of Your Project

We are interested in your feedback about the impact of the public and patient engagement (PPE) component of the MOVE IT 2 Study.

This is the last of three modules to evaluate the engagement component of your project. This module should be completed 3 – 6 months after the engagement component of your project has been completed to provide adequate time to assess tangible impacts.

The questionnaire includes 8 questions – some questions ask you to rate your level of agreement in response to a statement and others ask for you to provide your comments and feedback. You are encouraged to share your experiences and any information you feel is relevant. Remember, this is a tool to help improve your PPE work. Identifying challenges is an important part of that process.

1. Please describe the ways in which the public, patients and/or caregivers influenced the project through their engagement and the amount of influence they had.

Type of influence	No influence	Small amount of influence	Some influence	A lot of influence	Not sure
Selecting the PTE dataset	X				

Approving the PTE dataset			X		
PTE data analysis and interpretation				X	
Approving the final study results				X	
Knowledge translation					TBD

2. The output generated from the engagement component associated with this project was considered by those in a position to act on it.

- Strongly disagree
- Disagree
- Neither agree nor disagree
- Agree
- **Strongly agree**

3. Please describe how the contributions from the engagement component were considered by those in a position to act on them.

The output generated from the engagement component associated with this project influenced the project's outcomes.

- Strongly disagree
- Disagree
- Neither agree nor disagree
- Agree
- **Strongly agree**

5. Please describe how the output from the engagement component associated with this project influenced the project's outcomes.

Through the use of Participatory Theme Elicitation (PTE), the output of the engagement process was the final set of themes comprising this study's results. Therefore, the outcomes of the study were highly influenced by co-researchers. If I had conducted the analysis independently without co-researchers, the results of this study would likely be much different.

6. Overall, I was satisfied with the engagement component of the MOVE IT 2 Study.

- Strongly disagree
- Disagree
- Neither agree nor disagree
- Agree
- **Strongly agree**

7. The engagement component was a good use of our program resources.

- Strongly disagree
- Disagree
- Neither agree nor disagree
- **Agree**
- Strongly agree

8. Please provide any additional feedback regarding the influence that the engagement component of this project has had on you, your work, or your organization as a whole.

This engagement process was meaningful to both me and the co-researchers I worked with. I would certainly use PTE again as a practical and accessible method of qualitative co-analysis. The results of this study fill a gap in the qualitative self-compassion literature, support the future use of PTE in other studies, and may inform community implementation of the MOVE IT Study. I consider this research to be the capstone of my previous years working on the MOVE IT Study, and I valued the opportunity to reconnect with past participants who became co-researchers in the present study.

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Appendix V. Co-Researchers' Responses to Qualitative Evaluation of the Engagement Process

Supplemental Table 5

Co-researchers' Responses to Qualitative Evaluation of the Engagement Process

Prompt	Co-Researcher Responses
Did your involvement in this research project meet your expectations? Why or why not?	Anita: <i>I thought we were a good team together. But if you aren't a good team, then I could see that inhibiting the discussions and taking it different ways. So, you know what's really good for that is a really good mediator. And I think you [Sasha] have that skill set.</i> Kim: <i>I think I missed 2 meetings, so I'm feeling like there wasn't enough time, but that's probably more on me. It's kind of weird that I'm admitting this, but I like group work, meeting people.</i> Jennifer: <i>Of course, I know I speak a lot. I will be one of those ones to admit that I always have an answer to a question. I try not to. Always I tried to let other people speak. But I really enjoyed it, and I liked that we all could talk about [the research] so it definitely met my expectations. In fact, way more than what I was expecting.</i> Maria: <i>For me, maybe I'm like 'oh, should I say that?' Or I'm a little quieter. But I felt validated and happy when Sasha, the main mediator, would ask questions and everybody got the chance to speak up. I was happy, and I think the expectations, the ones from before I think they were met.</i> Virginia: <i>I think it was an amazing group, and I think we worked together better than my expectations, so I would give us an A for teamwork. I feel like I'm shy and reserved at the best of times, but I felt like I was comfortable in here. And I find that if I don't agree with things about justice or going in the right direction I do speak up, and I speak up loudly. And so, my being quiet in this group means that I'm in agreement with what you guys are saying, so it's all good. And I feel like it's so good to know that there are other like-minded people out there that make this world a better place for all of us. Miigwetch.</i>
Do you feel your thoughts/opinions/lived expertise were respected and valued throughout this research process?	All: Yes

Supplemental Table 5 (continued).

Do you feel you made a meaningful contribution to this research? Why or why not?	Kim: <i>Yes, I do.</i> Anita: <i>And doing this meeting, I think really helps us see the other side of it. Cause, yeah, I get the impression. Everyone feels the same that we really enjoyed it. But this [meeting] reminds us of what was meaningful about it and what actually, we ended up, producing at the end of it with a very, very good mediator.</i> Maria: <i>Yes</i> Virginia: <i>Yes</i>
Did we succeed at creating a safe work environment? Was there anything that could have been improved?	Virginia: <i>I love being part of this group. I feel like it wasn't long enough, but that's just because I enjoy your company. I enjoyed our conversation, it's enlightening! It's affirming. Thank you, you're good women.</i> Jennifer: <i>More time together</i> Kim: <i>More meetings</i> Maria: <i>Yes, everything was good</i>
Looking back, did you feel supported? Were there any other supports that could have been useful to you?	All: <i>Felt supported. Something that could be helpful for future groups is sending text message reminders in addition to email reminders.</i>
Did you feel that you were prepared to participate in research meetings and other tasks for the study? Why or why not?	Jennifer: <i>I don't know about the other ladies, but I do know that sometimes, just when you get to meet people [in person] it's sometimes easier to talk more personally because you don't feel like you're talking to a group of people you don't know. So, I found it very easy to relate to everybody, and it was much easier to talk. At the beginning, it wasn't so bad, but I mean it just felt much easier [after meeting in person]. It's like as if I knew everybody for a longer period of time. Like friends, instead of just a group of ladies who got together to discuss their journeys.</i> Maria: <i>Yeah, I think we got very good support. And your organization skills are very on point Sasha.</i>

Supplemental Table 5 (continued).

Any other comments?	Jennifer: <i>It was a good conversation that night [of the analysis meeting]. It was a lot of fun. It was too bad it had to end.</i> Kim: <i>I think it would be great too, it's not just exercise or diabetes. [Self-compassion] could be used in so many other fields of helping individuals with changing their lifestyle choices. Whether it's addictions or parenting, or whatever right like it's finding out you're not alone and practicing self-compassion. It's healthier, and it'll get you through to where you need to go in a smoother ride. You don't have to hit all those potholes. See? Staying with that theme.</i> Virginia: <i>I just feel like, oh, this is a group that I could see as friends, you know and it's good to be part of this community like, I really enjoyed being part of this community.</i>
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Appendix W. “What Would I Say to a Friend” and “Soften, Soothe, Allow” Self-Compassionate Exercises (Signore et al., 2022)

How Would I Treat a Friend?

“Think of a time, or at various times, when you’ve had a *close friend* who was suffering in some way. Not a partner or a family member – they are sometimes *too close* – but a friend you really cared about who was struggling. For example, maybe your friend had a misfortune, had failed, or felt inadequate. How do you typically respond to your friends in such situations? What do you *say*? What *tone* do you use? How is your *posture*? What *nonverbal* gestures do you use?”

[pause]

“Now think about various times when *you* were suffering in some way – had a misfortune, failed, or felt inadequate. Maybe these feelings apply when you think back to learning of your risk for diabetes, or a struggle you’ve had with physical activity. How do *you* typically respond to yourself in these situations? What do you *say*? What *tone* do you use? How is your *posture*? Which *nonverbal* gestures do you use?”

[pause]

“Do you notice any patterns of difference in how you respond to yourself and others?”

[pause for group discussion]

“Self-compassion is treating ourselves with the same kindness and understanding as we would treat a friend when things go wrong. It’s the reverse of the Golden Rule: do unto *yourself* as you would do unto others.”

Soften, Soothe, Allow

“Take a minute to get into a comfortable position and then close your eyes.”

[pause]

“Let’s begin. I would like you to bring to mind a mildly to moderately difficult situation that you have been in recently. If you can, think about any negative emotions you have felt about physical activity or having a diabetes risk. One of these examples would be ideal as we want to teach you to apply self-compassion to these situations.

For example, in the past we have asked you whether you experienced any difficult emotions when you learned that you were at risk for Type 2 Diabetes. If you did experience difficult emotions in this context, recall those now.

We have also asked you to think of times when you felt difficult emotions about physical activity, or even unpleasant sensations while exercising. If either of these situations conjure up negative emotions or sensations for you, I encourage you to work with them now.

If you can’t recall experiencing negative emotions in relation to your diabetes risk or your physical activity, choose any life event that led to mild to moderately difficult emotions for you.

Take a minute to get the situation to come to mind. Clearly visualize the situation. Who is involved? What is happening?”

[pause]

“**Step 1** is to label the emotions you are feeling – Anger? Sadness? Grief? Confusion? Fear?

Longing? Despair? Only you know what emotion you feel when you conjure up this situation.

What is the best adjective for how you feel?”

[pause]

“There, you have just labelled your emotion which is an act of mindfulness. Remember, try not to judge yourself for feeling the emotion. Just observe non-judgmentally and be aware.

Step 2 also involves being mindful. Now that we have labelled the emotion, try to identify where you experience any physical sensations of that emotion in your body. Scan your entire body and try to pinpoint where you feel it. Or if you are having trouble bringing up the exact experience, what sensations does this emotion create in your body. Does your heart race? Does your stomach flutter? Do your fists clench? Does your body feel heavy? What is the most dominant sensation for you?”

[pause]

“Once you have located where you have physical sensations, choose one place to focus on – maybe where the emotion most strongly expresses itself in your body. Try to focus your awareness on that sensation in your body. Notice everything you can notice about it – again trying not to attach labels or judgment.”

[pause]

“**Step 3** is when we add self-compassion to this mindfulness we have been using. Now we will use soften, soothe, and allow. First, focus your attention on where in your body you feel the emotion or sensation. Now *soften* into the location where you feel the emotion. Try to let the muscles soften or relax.”

[pause]

“Now *soothe* yourself or offer yourself comfort as you experience these difficult emotions or sensations. You can do this in a few different ways. You may want to use your Yin self-compassion skills and place a hand on your heart or give yourself a hug. Or maybe you want to imagine warmth in the part of your body you have chosen to focus on. You may also want to

offer yourself some words that you need to hear or would like to hear from a friend such as, *'I am so sorry you are feeling this way?'* or *'I care deeply about you'* or *'You will get through this'.*”

[pause]

“Finally, *allow* the discomfort to be there. Try to release the need for it to go away. Know that like any bodily sensation, this feeling will not last forever. This too shall pass. You can weather it. Take a moment to focus on allowing the emotion or sensation.”

[longer pause]

“Now slowly open your eyes.”

Appendix X. Evaluation of Qualitative Trustworthiness

Supplemental Table 6

Aspects of Trustworthiness in the Present Study

Aspect of Trustworthiness	Criterion	Contributing Factors
Credibility	Do the descriptions and interpretations of the data reflect participants' lived experiences?	1. Co-analyzing the data alongside five individuals who previously completed the MOVE IT Study ensures the results are accurate to the lived experience of MOVE IT Study participants. 2. Collecting data directly from the audio-recorded MOVE IT Study sessions ensures the raw data fully represents the events that occurred within the sessions. 3. Integrating participant co-researcher quotations into the results section provides a rationale for each theme developed and demonstrates that participant co-researchers' voices were centered when reporting on the results.
Transferability	Can the findings be transferred to other contexts and situations?	1. Although these findings are meant to primarily inform the MOVE IT Study, the benefits of self-compassion described in this study could be used to support the rationale of other self-compassion interventions in the context of health and behaviour change. 2. The discussion section of this document outlines the ways in which these qualitative findings relate to other theory and research, suggesting a degree of transferability to other contexts and situations.
Dependability	Is there consistency between the raw data and the overall findings.	1. Consistency between the raw data and overall findings was ensured by selecting participant quotations from the transcribed intervention sessions that best represented examples of self-compassion. 2. Participant co-researchers were trained at the outset of the project to identify different components of self-compassion within the data (e.g., mindfulness, self-kindness, common humanity). 3. Participant co-researchers had access to the dataset of quotations at every stage of the analysis, allowing them to become familiar with excerpts.

Supplemental Table 6 (continued).

Confirmability	Would other people interpreting this data come to similar conclusions?	1. A consequence of co-analysis is that the entire group of co-researchers must form a consensus on the final set of themes developed. Therefore, confirmability is built into the PTE process. 2. The academic researcher in this study (SK) engaged in the reflexive process of stating her positionality at the outset of the project. 3. Steps were taken to centre the voices of participant co-researchers including developing a Terms of Reference, basing the thematic analysis on a network analysis of all co-researchers' card sorting decisions combined, and encouraging participant co-researchers to lead all decision-making in the final analysis meeting. 4. Previous qualitative work from Signore et al. (2022) analyzing interview data from the MOVE IT Study produced findings that aligned with those in the present study.
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